

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K059	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/18/2013
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NAME OF PROVIDER OR SUPPLIER  PROMISE CARE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2109 W STATE RD 28 PO BOX 867 FRANKFORT, IN 46041
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G000000	<p>This was a home health federal Medicaid recertification survey.</p> <p>Facility # 012133</p> <p>Survey Dates: October 15, 16, 17, and 18, 2013</p> <p>Medicaid #: 201003130</p> <p>Surveyors: Bridget Boston RN, PH Nurse Surveyor, Team Leader Shannon Pietraszewski RN, PH Nurse Surveyor, Team Member</p> <p>Census: 23 Skilled: 4 Home Health Aide Only: 19</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 25, 2013</p>	G000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G000230	<p><b>484.36(d)(3) SUPERVISION</b></p> <p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed a supervisory visit no less frequently than every 60 days while the aide is rendering patient care in 1 of 8 clinical records reviewed of patients receiving only home health aide services for more than 60 days. (# 9)</p> <p>Findings include:</p> <p>1. Clinical record # 9, start of care 12/12/12, evidenced orders for home health aide services beginning 4/4/13 one to two hour visits, 1 - 3 times a week throughout the certification period and evidenced the patient received home health aide services through 10/4/13. The clinical record evidenced supervisory visit was conducted on 7/3/13 and 10/4/13 the aide was not observed rendering care.</p>	G000230	G 230 The Administrator will in-service nursing staff that supervisory visits must be made to patients homes no less frequently than every 30 days whether the home health aide is present or not present and no less frequently than every 60 days to the patients home, while the home health aide is providing care. Supervisory forms have been updated to include documentation of what care the aide provided, while the nurse was present. The "Home Health Aide Supervision" Policy has been updated to include the statement that a registered nurse must make a supervisory visit to the patient's residence at least every 60 days when the aide is present providing care. 10% of all clinical records will be audited quarterly for evidence that supervisory visits are done no less than every 30 days with or without the home health aide and no less than every 60 days while the aide is providing care. The	11/14/2013	

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	<p>On 10/18/13 at 2:40 PM, employee B indicated the aide was not observed providing care to the patient between the time period 7/3/13 and 10/4/13.</p> <p>2. The undated policy titled "Home Health Aide Supervision" failed to address and include the requirement of the registered nurse to observe the aide while rendering care at least every 60 days and stated, "The frequency of supervision will be in response to state / federal requirements (as applicable) and agency policy. ... Supervisory visits of home health aides shall be according to the following frequency: ... Home health aides services only: ... a registered nurse must make a supervisory visit to the patient's residence at least every 30 days, either when the aide is present or when the aide is absent."</p>		Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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G000337	<p><b>484.55(c)</b> <b>DRUG REGIMEN REVIEW</b> The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the comprehensive reassessment included a review of all the patient's medications and an assessment for potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance in 3 of 9 clinical records reviewed of patients receiving home health aide only services (#s 4, 5, and 9) and 2 of 3 clinical records reviewed of patients receiving skilled nursing services (# 6 and 8 ) with the potential to affect all patients.</p> <p>The findings include:</p> <p>1. Clinical record # 4, start of care 8/23/13, evidenced a comprehensive assessment dated 8/25/13 completed by employee C. The record failed to evidence a medication review was performed as part of the comprehensive assessment to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and</p>	G000337	G 337 The Administrator will in-service nursing staff that the comprehensive assessment must include a review of all medications that the patient is currently using in order to identify any potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance with drug therapy. Comprehensive assessments have been updated to include the above listed drug review items, so that the assessing nurse can review with the patient at the time of the comprehensive assessment. 10% of all clinical records will be audited quarterly for evidence that the Drug Review Regimen is being done at the time of each comprehensive assessment by the assessing nurse. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/14/2013	

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	<p>noncompliance.</p> <p>2. Clinical record # 5, start of care 12/23/11, evidenced updated comprehensive assessments dated 6/14/13 and 10/11/13 completed by employee D and an updated comprehensive assessment dated 8/14/13 completed by employee C. The record failed to evidence a medication review was performed as part of the updated comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>On October 15, 2013, at 3:30 PM, employee D indicated she did not complete the medication review with the updated assessments. Employee B indicated the nurse completing the comprehensive assessment was to notify her if there were medication changes and indicated the record did not evidence the assessing nurse completed the medication review to to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>3. Clinical record # 9, start of care 12/12/12, evidenced an updated comprehensive assessment dated 10/4/13. The record failed to evidence a</p>						

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	<p>medication review was performed as part of the updated comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>4. Clinical record # 6, start of care 7/26/11, evidenced an updated comprehensive assessment dated 9/10/13. The record failed to evidence a medication review was performed as part of the updated comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>On 10/16/13 at 10:30 AM, employee B indicated the medication review was not completed by the assessing nurse to identify potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, and noncompliance.</p> <p>5. Clinical record # 8, start of care 1/2/13, evidenced an updated comprehensive assessment dated 8/27/13. The record failed to evidence a medication review was performed as part of the updated comprehensive assessments to identify potential adverse effects, drug reactions, ineffective drug</p>						

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	<p>therapy, significant side effects, and noncompliance.</p> <p>6. The undated policy titled "Medication Management stated, "Comprehensive patient assessment performed at start of care and other defined points in time include a review of all medications the patient is taking (prescribed, samples, over the counter, herbal remedies, PRN medications) and records this is the patient record. ... Medications in the home are reviewed with he patient / family to determine current medications and the patient's understanding of the medications actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented. ... Patient will be informed, as appropriate, about any potential clinically significant adverse reaction or other concerns before giving a new medication."</p> <p>7. The undated policy titled "Medication Profile" stated, "The registered nurse of therapist will complete the medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription [sic] including regularly scheduled medications and those taken intermittently or as needed. ... Purpose ... To identify possible ineffective drug</p>			

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	therapy, adverse reactions, significant side effects, drug allergies, and contraindicated medications."			

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G000339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review and interview, the agency failed to ensure a comprehensive assessment with the required OASIS items was updated the last 5 days of every 60 day period in 1 (# 8) of 10 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record # 8 evidenced a start of care date of 1/2/13 and that the physician had ordered services be continued for every certification period thereafter. The record evidenced a plan of care dated 9/1/13 through 10/30/13 and failed to evidence a signature on the comprehensive assessment that was updated the last 5 days of the 7/3/13 to 8/31/13 sixty-day recertification period.</p>	G000339	G339 The Administrator will in-service nursing staff that the comprehensive assessment must be updated and revised the last 5 days of every 60 days of every certification period and that nurses have to make sure that all forms are signed and dated before they turn into the office. 10% of all clinical records will be audited quarterly for evidence that the comprehensive assessment is completed and signed by the assessing nurse for all re-certifications the last 5 days of every 60 days. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/14/2013			

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	2. On 10/18/13 at 1:30 PM, the agency's administrator indicated the assessment was not signed by the assessing nurse; therefore, another skilled nurse visit note with the assessing nurse's signature was stapled to the recertification assessment.			

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N000000	<p>This was a home health state relicensure survey.</p> <p>Facility # 012133</p> <p>Survey Dates: October 15, 16, 17, and 18, 2013</p> <p>Medicaid #: 201003130</p> <p>Surveyors: Bridget Boston RN, PH Nurse Surveyor, Team Leader Shannon Pietraszewski RN, PH Nurse Surveyor, Team Member</p> <p>Census: 23 Skilled: 4 Home Health Aide Only: 19</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 25, 2013</p>	N000000					

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed a supervisory visit no less frequently than every 30 days in 1 of 8 clinical records reviewed of patients receiving only home health aide services for more than 30 days. (# 9)</p> <p>Findings include:</p> <p>1. Clinical record # 9, start of care 12/12/12, evidenced orders for home health aide services beginning 4/4/13 one to two hour visits, 1 - 3 times a week throughout the certification period and evidenced the patient received home health aide services through 10/4/13. The clinical record evidenced supervisory visit was conducted on 7/3/13 and 10/4/13.</p> <p>On 10/18/13 at 2:40 PM, employee B indicated the the only supervisory visits were 7/3/13 and 10/4/13.</p>	N000606	N 606 The Administrator will in-service nursing staff that patients that receive home health aide only services must have supervisory visits made to patient's homes no less frequently than every 30 days whether the aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. The Administrator will also in-service nursing staff that supervisory visits will be made no less frequently than every 60 days to the patients home, while the home health aide is providing care. Supervisory forms have been updated to include documentation of what care the aide provided, while nurse was present. The "Home Health Aide Supervision" Policy has been updated to include the statement that a registered nurse must make a supervisory visit to the patient's residence at least every 60 days when the aide is present providing care. 10% of all clinical records will be audited quarterly for evidence that supervisory visits are done no less than every	11/14/2013			

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	2. The undated policy titled "Home Health Aide Supervision" failed to address and include the requirement of the registered nurse to observe the aide while rendering care at least every 60 days and stated, "The frequency of supervision will be in response to state / federal requirements (as applicable) and agency policy. ... Supervisory visits of home health aides shall be according to the following frequency: ... Home health aides services only: ... a registered nurse must make a supervisory visit to the patient's residence at least every 30 days, either when the aide is present or when the aide is absent."		30 days with or without the home health aide present and no less than every 60 days while the aide is present and providing care. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		