

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	<p>This was a federal home health complaint investigation.</p> <p>Complaint # IN00102294 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.</p> <p>Facility #: 012617</p> <p>Survey Dates: 2-23-12 & 2-24-12</p> <p>Medicaid Vendor #: 201044850</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 28, 2012</p> <p>Census 21</p>	G0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0110	<p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure clinical records included documentation of whether or not a patient had executed an advance directive in accordance with Subpart I of part 489 in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's 21 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive. 2. Clinical record number 2 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive. 	G0110	<ol style="list-style-type: none"> 1. All patient files are audited to ensure advance directives are documented and on file for each patient. The Director of Nursing and CEO in serviced nursing staff on completing advance directives before any care is provided, ensuring that the agency's policy regarding advance directives is followed and that advance directives are discussed and documented during the admission process. 2. Clinical records will be audited quarterly for evidence that advance directives are being completed before care is provided. The Director of Nursing will be responsible for monitoring this corrective action and ensuring that this deficiency was corrected and will not recur. 3. The Director of Nursing and CEO in serviced nursing staff on completing advance directives before any care is provided. 4. The completion date for this Plan of Correction is March 23, 2012. 	03/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. Clinical record number 3 evidenced a start of care date of 11-10-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive.</p> <p>4. Clinical record number 4 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive.</p> <p>5. Clinical record number 5 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive.</p> <p>6. The agency's owner, employee A, indicated, on 2-24-12 at 11:00 AM, the records did not evidence documentation of whether or not the patients had executed an advance directive.</p> <p>7. The agency's 6-17-11 "Advance Directives" policy states, "During the admission process, the nurse/therapist shall ask the patient, or if the patient is incapacitated, the patient's significant other, as to whether or not the patient has completed an advance directive . . . The nurse/therapist will document in the medical record admission form whether</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the patient has completed an advance directive, whether a copy of the advance directive has been obtained, and that the patient/significant other has been provided with information concerning advance directives during the admission process."</p> <p>8. The agency's 6-17-11 "Do Not Resuscitate (DNR) Do Not Intubate (DNI)" policy number 1021 states, "Do Not Resuscitate/Do Not Intubate orders are not substitutes for advance directives."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012	
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G0121	<p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on clinical record review and interview, the agency failed to ensure it had followed its own policies regarding reporting of suspected abuse in 1 (#4) of 5 records reviewed creating the potential to affect all of the agency's 21 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During an interview with the agency's owner, employee A, on 2-24-13 at 9:15 AM, the owner indicated he had called Adult Protective Services with regards to patient number 4 because of suspected exploitation of the patient by family members. 2. The agency's 6-17-11 "Patient Abuse, Neglect or Exploitation - Adult" policy number 1035 states, "An Abuse Assessment is to be performed immediately and appropriate action taken if the staff member has reasonable grounds to believe that an incident of abuse, neglect or exploitation or alleged abuse, neglect, or exploitation has occurred . . . A Patient Care Conference will be convened between the Agency Social Worker, Director of Nursing, Administrator and any and all involved 			G0121	<ol style="list-style-type: none"> 1. An abuse assessment was completed and documented in patient number 4's medical record. It was also noted in patient number 4's medical record that Adult Protective Services were contacted in regards to this patient and suspected exploitation. 2. The agency CEO will be responsible for ensuring that this deficiency is corrected and will not recur. The agency's policy & procedure regarding "Patient Abuse, Neglect or Exploitation – Adult" was reviewed with all owners and nursing staff to ensure the proper documentation is followed in the future. 3. The agency CEO will be responsible for ensuring that this deficiency is corrected and will not recur. 4. The completion date for this Plan of Correction is March 12, 2012. 		03/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Agency staff. Minutes of the conference are documented and retained in the patient's medical record . . . The incident is reported to the appropriate authorities as required by law. Documentation in the patient record should include a description of the abusive situation, that the call was placed and to whom."</p> <p>3. Clinical record number 4 failed to evidence documentation an Abuse Assessment had been performed, failed to evidence documentation of a Patient Care Conference, and failed to evidence documentation of a report to any authorities.</p> <p>4. The agency's owner, employee A, indicated, on 2-24-12 at 9:15 AM, the record did not include any of the agency required documentation.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012	
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G0158	<p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record review and interview, the agency failed to ensure skilled nurse visits had been provided as ordered by the physician on the written plan of care in 1 (# 2) of 5 records reviewed creating the potential to affect all of the agency's 6 current patients that received skilled nurse services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included a plan of care established by the physician for the certification period 11-7-11 to 1-5-12. The plan of care states, "RN to see pt [patient] 1 x wk x 2wks [one time per week for two weeks] to include supervisory visits then q [every] 30 days for supervisory visits through next 60 days." <p>The record included an initial skilled nursing visit note dated 11-7-11 and subsequent skilled nurse visit notes dated 11-15-11 and 11-21-11. The record failed to evidence an order for the 11-21-11 skilled nurse visit.</p> <ol style="list-style-type: none"> The Director of Nursing, employee B, indicated, on 2-24-12 at 11:05 AM, the skilled nurse visit was a supervisory visit 	G0158	<ol style="list-style-type: none"> The plan of treatment was updated to reflect the 11-21-11 skilled nurse visit. 2. A new form for supervisory visits only was ordered from Briggs and implemented, so as to not confuse exactly what kind of service the nurse is to be providing. 3. The Director of Nursing and CEO in serviced nursing staff on the new supervisory visit form and following the plan of treatment. 4. The completion date for this Plan of Correction is March 12, 2012. 	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	but that she had provided skilled services during the visit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G0170	<p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure skilled nurse visits had been provided as ordered by the physician on the written plan of care in 1 (# 2) of 5 records reviewed creating the potential to affect all of the agency's 6 current patients that received skilled nurse services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 2 included a plan of care established by the physician for the certification period 11-7-11 to 1-5-12. The plan of care states, "RN to see pt [patient] 1 x wk x 2wks [one time per week for two weeks] to include supervisory visits then q [every] 30 days for supervisory visits through next 60 days." The record included an initial skilled nursing visit note dated 11-7-11 and subsequent skilled nurse visit notes dated 11-15-11 and 11-21-11. The record failed to evidence an order for the 11-21-11 skilled nurse visit. The Director of Nursing, employee B, indicated, on 2-24-12 at 11:05 AM, the skilled nurse visit was a supervisory visit but that she had provided skilled services 	G0170	<ol style="list-style-type: none"> The plan of treatment was updated to reflect the 11-21-11 skilled nurse visit. A new form for supervisory visits only was ordered from Briggs and implemented, so as to not confuse exactly what kind of service the nurse is to be providing. The Director of Nursing and CEO in serviced nursing staff on the new supervisory visit form and following the plan of treatment. The completion date for this Plan of Correction is March 12, 2012. 	03/12/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	during the visit.			
--	-------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012	
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G0334	<p>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure a comprehensive assessment had been completed within 5 days of the start of skilled services in 1 (# 2) of 5 records reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 evidenced a start of care date of 11-7-11 and included a plan of care established by the physician for a subsequent certification period, 1-2-12 to 3-1-12. The plan of care states, "RN to see pt [patient] 2 hrs/day X 1 day for admission then q [every] 30 days for supervisory visits through next 60 days . . . HHA [home health aide] 3hrs/day X 3 days/wk X 9 wks. " <p>A. The record included a skilled nurse visit note, dated 1-30-12, that evidenced skilled services had been provided.</p> <p>B. The record failed to evidence the registered nurse had completed a comprehensive assessment upon completion of a skilled service.</p> <ol style="list-style-type: none"> The Director of Nursing, employee B, 	G0334	<ol style="list-style-type: none"> The plan of treatment was updated to reflect the 1/30/12 skilled nursing visit, and a comprehensive assessment was completed. 2. The Director of Nursing and CEO in serviced nursing staff on when a comprehensive assessment is to be completed. 3. The Director of Nursing and CEO are responsible for ensuring that comprehensive assessments are completed for any patients receiving skilled services. 4. The completion date for this Plan of Correction is March 12, 2012. 	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, on 2-24-12 at 11:10 AM, the skilled nurse visit provided on 1-30-12 was a supervisory visit but that skilled services had been provided during the visit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0518	<p>Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure clinical records included documentation of whether or not a patient had executed an advance directive in 5 (#s 1, 2, 3, 4, and 5) of 5 records reviewed creating the potential to affect all of the agency's 21 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive. 2. Clinical record number 2 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive. 3. Clinical record number 3 evidenced a start of care date of 11-10-11. The record failed to evidence documentation of 	N0518	<ol style="list-style-type: none"> 1. All patient files are audited to ensure advance directives are documented and on file for each patient. The Director of Nursing and CEO in serviced nursing staff on completing advance directives before any care is provided, ensuring that the agency's policy regarding advance directives is followed and that advance directives are discussed and documented during the admission process. 2. Clinical records will be audited quarterly for evidence that advance directives are being completed before care is provided. The Director of Nursing will be responsible for monitoring this corrective action and ensuring that this deficiency was corrected and will not recur. 3. The Director of Nursing and CEO in serviced nursing staff on completing advance directives before any care is provided. 4. The completion date for this Plan of Correction is March 23, 2012. 	03/23/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>whether or not the patient had executed an advance directive.</p> <p>4. Clinical record number 4 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive.</p> <p>5. Clinical record number 5 evidenced a start of care date of 11-7-11. The record failed to evidence documentation of whether or not the patient had executed an advance directive.</p> <p>6. The agency's owner, employee A, indicated, on 2-24-12 at 11:00 AM, the records did not evidence documentation of whether or not the patients had executed an advance directive.</p> <p>7. The agency's 6-17-11 "Advance Directives" policy states, "During the admission process, the nurse/therapist shall ask the patient, or if the patient is incapacitated, the patient's significant other, as to whether or not the patient has completed an advance directive . . . The nurse/therapist will document in the medical record admission form whether the patient has completed an advance directive, whether a copy of the advance directive has been obtained, and that the patient/significant other has been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided with information concerning advance directives during the admission process."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012	
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0522	<p>Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review and interview, the agency failed to ensure skilled nurse visits had been provided as ordered by the physician on the written plan of care in 1 (# 2) of 5 records reviewed creating the potential to affect all of the agency's 6 current patients that received skilled nurse services.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 11-7-11 to 1-5-12. The plan of care states, "RN to see pt [patient] 1 x wk x 2wks [one time per week for two weeks] to include supervisory visits then q [every] 30 days for supervisory visits through next 60 days."</p> <p>The record included an initial skilled nursing visit note dated 11-7-11 and subsequent skilled nurse visit notes dated 11-15-11 and 11-21-11. The record failed to evidence an order for the 11-21-11 skilled nurse visit.</p> <p>2. The Director of Nursing, employee B, indicated, on 2-24-12 at 11:05 AM, the</p>	N0522	<p>1. The plan of treatment was updated to reflect the 11-21-11 skilled nurse visit. 2. A new form for supervisory visits only was ordered from Briggs and implemented, so as to not confuse exactly what kind of service the nurse is to be providing. 3. The Director of Nursing and CEO in serviced nursing staff on the new supervisory visit form and following the plan of treatment. 4. The completion date for this Plan of Correction is March 12, 2012.</p>	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	skilled nurse visit was a supervisory visit but that she had provided skilled services during the visit.			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/24/2012	
NAME OF PROVIDER OR SUPPLIER SAFE AT HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0537	<p>Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on clinical record review and interview, the agency failed to ensure skilled nurse visits had been provided as ordered by the physician on the written plan of care in 1 (# 2) of 5 records reviewed creating the potential to affect all of the agency's 6 current patients that received skilled nurse services.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 11-7-11 to 1-5-12. The plan of care states, "RN to see pt [patient] 1 x wk x 2wks [one time per week for two weeks] to include supervisory visits then q [every] 30 days for supervisory visits through next 60 days."</p> <p>The record included an initial skilled nursing visit note dated 11-7-11 and subsequent skilled nurse visit notes dated 11-15-11 and 11-21-11. The record failed to evidence an order for the 11-21-11 skilled nurse visit.</p> <p>2. The Director of Nursing, employee B, indicated, on 2-24-12 at 11:05 AM, the</p>	N0537	<p>1. The plan of treatment was updated to reflect the 11-21-11 skilled nurse visit. 2. A new form for supervisory visits only was ordered from Briggs and implemented, so as to not confuse exactly what kind of service the nurse is to be providing. 3. The Director of Nursing and CEO in serviced nursing staff on the new supervisory visit form and following the plan of treatment. 4. The completion date for this Plan of Correction is March 12, 2012.</p>	03/12/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 LINCOLN AVE STE D & E BEDFORD, IN 47421
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	skilled nurse visit was a supervisory visit but that she had provided skilled services during the visit.			
--	--	--	--	--