

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/21/2014
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NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150
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(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
G000000	<p>This was a home health federal recertification survey. This was an extended survey.</p> <p>Survey Dates: February 18, 19, 20, and 21, 2014</p> <p>Facility #: 006094</p> <p>Medicaid Vendor #: 200097860</p> <p>Surveyor: Susan E. Sparks, PHNS</p> <p>Ohio Valley Home Health is precluded from providing its own home health aide competency evaluation program for a period of two (2) years beginning 2/28/14 due to being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration; 484.30 Skilled Nursing Services; 484.36 Home Health Aide Services; and 484.55 Comprehensive Assessment of Patients.</p> <p>Agency Census</p> <p>Skilled Patients 30 Home Health Aide Only Patients 19</p>	G000000	<p>Preparation and execution of this response and plan of correction do not constitute an admission or agreement by Ohio Valley Home Health of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. Credible Allegation of Compliance and Correction: For the purpose of any allegation that Ohio Valley Home Health is not in substantial compliance with the regulations set forth, this plan of correction constitutes Ohio Valley Home Health's credible allegation of correction and compliance.</p>	

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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G000106	<p>Personal Service Only Patients 0 Total 49</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 28, 2014</p> <p>484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on interview, the agency failed to ensure patients had been informed they have the right to voice their grievances in 5 of 5 home visits conducted with the potential to affect all 49 patients. (1, 2, 3, 4, and 5)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 2/19/14 at 10 AM, Patient 1, Home Visit 1, indicated the patient was unaware of a grievance system and a state hotline to call if there are problems.</li> <li>On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, indicated the patient was</li> </ol>	G000106	We have re-written our New Admission Packet with information regarding Patient Rights, including the State Hotline phone number. We are distributing this new packet to current patients and having them sign acknowledgement of receipt of this information. In order to prevent future problems with patient right's information, we will give every new patient this New Admission Packet and have them sign acknowledgement of receipt for this information. The Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information.	03/21/2014			

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	<p>unaware of a grievance system and a state hotline to call if there are problems.</p> <p>3. On 2/20/14 at 10:00 AM, Patient 3, Home Visit 3, indicated the patient was unaware of a grievance system and a state hotline to call if there are problems.</p> <p>4. On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, the caretaker indicated they were unaware of a grievance system and a state hotline to call if there are problems.</p> <p>5. On 2/20/14 at 11:30 AM, Patient 5, Home Visit 5, indicated the patient was unaware of a grievance system and a state hotline to call if there are problems.</p>		The first chart audit will be completed by March 21, 2014.		

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G000116	<p>484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>Based on interview and review of agency rights document, the agency had failed to ensure the patients had been informed of the state hot line to file complaints for 10 of 10 clinical records (1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) reviewed and 5 of 5 home visits (1, 2, 3, 4, and 5) conducted with the potential to affect all 49 patients.</p> <p>Findings:</p> <p>1. The Admission Packet Rights Document failed to evidence the patient was informed of the availability state hot line.</p> <p>On 2/21/14 at 4:00 PM the Administrator, Employee A indicated</p>	G000116	We have re-written our New Admission Packet with information regarding Patient Rights, including the State Hotline phone number. We are distributing this new packet to current patients and having them sign acknowledgement of receipt of this information. In order to prevent future problems with patient right's information, we will give every new patient this New Admission Packet and have them sign acknowledgement of receipt for this information. The Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information. The first chart audit will be completed by March 21, 2014.	03/21/2014			

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	<p>the state hotline was not part of the admission packet.</p> <p>2. On 2/19/14 at 10 AM, Patient 1, Home Visit 1, state of care (SOC) 1/30/13, indicated the patient was unaware of a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 1/30/13.</p> <p>2. On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, SOC 10/20/10, indicated the patient was unaware of a a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 10/20/10.</p> <p>3. On 2/20/14 at 10:00 AM, Patient 3, Home Visit 3, SOC 7/29/05, indicated the patient was unaware of a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 7/27/05.</p> <p>4. On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, SOC 12/14/09, and caretaker indicated they were unaware of a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 12/14/09.</p> <p>5. On 2/20/14 at 11:30 AM, Patient 5, Home Visit 5, SOC 12/8/11, indicated</p>				

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G000121	<p>the patient was unaware of a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 12/8/11.</p> <p>6. Clinical records #1-10 evidenced the patient had received the admission rights documents.</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD 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 interview, policy review, and review of the Indiana Nurse Practice Act 848 IAC 2-2-2 Responsibility as a member of the nursing profession Sec. 2. 11. (A)(B)(C), the agency failed to ensure home health aides and skilled nurses followed their policy and professional standards to ensure patient safety in 1 of 1 impaired nurses and 4 of 5 home visits (1, 2, 3, and 4) with the potential to affect all 49 patients.</p> <p>Findings:</p> <p>1. On 2/21/14 at 2:30 PM, the Administrator, Employee A, a registered nurse, indicated the agency had not reported the previous administrator, a registered nurse, for obvious drug usage.</p>	G000121	<p>A letter was faxed and mailed on 3-4-14 from Ohio Valley Home Health's attorney to the Indiana State Board of Nursing notifying them of the concerns regarding the previous Administrator's (Leah House, R.N.) suspected drug addiction and abuse. The Administrator will re-educate all management staff (including the owner of the agency, all Registered Nurses, all Licensed Practical Nurses, and office managers) by written memo dated no later than 3-21-14. This memo will ensure that all staff are aware of Ohio Valley Home Health's policy and the Indiana Nurse Practice Act 848 IAC 2-2-2 regarding the responsibility as a member of the nursing profession to report any suspicion of an impaired nurse. The staff will be instructed in this memo to report</p>	03/21/2014
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	<p>A. On 2/21/14 at 2:30 PM the Office Manager, Employee B, indicated the previous administrator would fall asleep while talking, would have days of nonsensicalness, would call other nurses to come and take her urine tests in order to get more prescriptions. She indicated many days she was non functioning.</p> <p>B. On 2/21/14 at 1:00 PM a Confidential Interview indicated the previous administrator is applying for patient care positions in the community.</p> <p>C. "848 IAC 2-2-2 Responsibility as a member of the nursing profession Authority: IC 25-23-1-7 Affected: IC 25-23 Sec. 2. The registered nurse shall do the following: ... (11) Notify, in writing, the appropriate party, which may include: (A) the office of the attorney general, consumer protection division; (B) his or her employer or contracting agency; or (C) the board; of any unprofessional conduct which may jeopardize the patient/client safety."</p> <p>2. On 2/19/14 at 10:00 AM, Patient 1, Home Visit 1, Employee I, registered nurse (RN), was observed performing a trach suctioning and cleaning. The RN broke the sterile technique two times</p>		<p>any such concerns immediately to the Administrator and/or Director of Nursing. This information will also be included in the New Employee handbook to ensure all future staff are also aware of this important policy. The Administrator and/or Director of Nursing will be responsible to follow up with any reported concerns and will report them immediately to the proper authorities for investigation. On 3-6-14, an in-service was given to all nurses (R.N.'s and L.P.N.'s) regarding Standard Universal Precautions and infection control information. The nurses were given a written test and completed a demonstration and skill check off with the Administrator to ensure competency. All staff will be reeducated by 3/21/14 on reporting and/ or communicating any safety concerns regarding patient care by written inservice and verbal instruction. All Home Health Aides are undergoing a complete skills check off with the Administrator and/or Director of Nursing both in patient's homes and in the office with pseudo-clients. These skill check offs will be completed by 3-21-14 to ensure that all aides are competent to perform quality care for the patients. All staff were instructed to ensure patients ability to call for help (via cellphone, lifeline within reach) before departing from patients</p>				

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	<p>and started over. The third time the RN prepared her field using the top of the patient's abdomen. The patient is an adult cerebral palsy patient who has a trach and is oxygen dependent. The patient has been on antibiotics for an infection in the trach. The RN had trouble opening the sterile water. She placed the bottle in the bend of her elbow with the lip of the bottle coming in contact with her uniform top. The RN opened the suctioning tip and suctioned the patient. The RN removed her gloves but did not sanitize her hands before regloving for the actual trach cleaning.</p> <p>A. In the process of replacing the gauze bandage under the g-tube, the RN dropped gauze on the floor. She picked it up and threw it away. She regloved without sanitizing her hands. The RN used her gloved finger to the get Neosporin from the tube and applied it to the open area around the g-tube.</p> <p>B. Employee I signed as receiving Universal Precaution training on 7/2/13 that states, "Wash hands thoroughly with soap and water before and after putting on gloves. Dry hands with paper towels and dispose of towels in a proper trash container."</p>		homes.To prevent future occurrences of this problem, all new employees (nurses and aides) will be observed by the administrator or designated RN during their first patient contact to ensure competency of skills.first contact with a patient. All home health aides will also be observed providing skilled care during routine supervisory visits by an R.N. at least every 60 days.				

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	<p>3. On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, Employee F, a home health aide (HHA), was observed performing a bed bath. The patient is a quadriplegic patient with limited use of both hands. The HHA prepared both wash basins and completed the total bath, including the genitalia, without changing the water. The patient has a Lifeline button necklace that was hanging on the end of the bed within reach so the patient doesn't lay on it at night. The HHA prepared to move the patient to the electric wheelchair. The HHA placed the legs of the Hoyer under the bed but did not spread the legs of the Hoyer, connected the sling and lifted the patient with the legs closed. The patient's electric wheelchair has a high back for support and the part that allows the patient to recline is broken. The patient must sit bent forward while in the chair and has a tendency to slide out of the chair. The HHA moved the Hoyer to face the chair, spread the legs and locked the Hoyer. The HHA put the chair under the patient. The patient was obviously uncomfortable. The HHA unhooked the sling, moved the Hoyer, put the the legs on the wheelchair, and propped the feet on the foot pedal. The HHA put the lapbelt on the patient. The patient indicated that it was uncomfortable to sit in the chair and was</p>			

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	<p>concerned about sliding from the chair. The HHA indicated she knew the chair was broken, but had not called the office. The patient indicated the RN knew the chair was broken. The HHA was asked where the lifeline was and she indicated on the end of the bed but did not get the lifeline. The patient motored to the kitchen and told the HHA what the patient wanted for lunch. The HHA fixed the sandwich. The HHA placed the patient's cell phone on the patient's slick material shorts and left. The patient's doors and walls have deep gouges where the patient has hit them with the chair. The patient was left eating the sandwich, sitting in an awkward position, and, since the patient obviously runs into the walls, the cell phone could be thrown from the lap.</p> <p>4. On 2/20/14 at 10:00 AM, Patient 3, Home Visit 3, Employee H, HHA, was observed performing a bed bath. The HHA prepared two basins of water. The bath was done properly for the face, arms and abdomen. The HHA changed the water. The aide then washed the patient's feet, legs, under the abdominal fold, and the perineal area going from back to front using the same water. The patient had an open area under the right breast. The HHA instructed the patient to call the doctor and did not notify the</p>			

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	<p>office.</p> <p>5. On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, Employee J, a Licensed Practical Nurse (LPN), was observed. The patient has a diagnosis of infantile cerebral palsy. The patient is 41, is non-verbal, non-ambulatory, and is in the care of the patient's sister. The LPN took the patient's blood sugar which was 186. The LPN was asked what the orders were for the insulin sliding scale. The LPN indicated insulin was to be administered at 200, but the sister wouldn't allow it. The sister had a water scale and the LPN administered water through the g-tube for the different levels of the blood sugar. Unless the blood sugar reached the highest levels, they didn't give the insulin on a regular basis. The LPN did not indicate there was a second test after the water was administrated nor was there a record of a second test.</p> <p>6. The website <a href="http://www.nursingassistanteducation.com">http://www.nursingassistanteducation.com</a> identifies how to give a bed bath and includes instructions on performing perineal care for men and women who do not have a perineal catheter. The instructions state, "fill the bath basin with clean water at 110 degrees ... and wash, rinse and dry the rectal area." The</p>			

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G000122	<p>instructions include specific instructions on how to wash the perineal area before the rectal area which are different for men and women.</p> <p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION</p> <p>Based on clinical record and document review, observation, interviews, and confidential interview, it was determined the agency failed to ensure the governing body appointed the administrator 1 of 1 administrators reviewed with the potential to affect all 49 patients (See G 129),</p> <p>s the administrator has failed to organize and direct the agency's ongoing functions and maintain an ongoing liaison with the staff and to have appointed a administrator to act in her absence in 1 of 1 administrators reviewed with the potential to affect all 49 patients, (See G 133) failed to ensure the staff had been orientated in their proper fields for 10 of 10 personnel records reviewed with the potential to affect all 49 patients, (See G 134) failed</p>	G000122	<p>On 2-28-14, The Advisory Board meeting washeld. All members being present by unanimous and written consent reviewed staffing changes and approved the following: Tobey Nelson, R.N., shall serve as Administrator and Acting Supervising Nurse (Director of Nursing). Margaret Kenney, R.N. shall serve as Supervisory Nurse (Assistant Director of Nursing) and Acting Administrator (Assistant Administrator) The minutes from this Advisory Board Meeting are signed and now kept in a binder as of 3-6-14. In order to prevent future problems with this issue, Statements of Responsibility will be written and maintained for Administrator, Assistant Administrator, Director of Nursing and Assistant Director of Nursing. These statements will ensure that any future changes in these positions will be reported in writing immediately to the Indiana Department of Health. The Administrator will be responsible to maintain these documents and</p>	03/06/2014

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G000129	<p>to ensure a qualified person was authorized in writing to act in her absence in 1 of 1 administrators reviewed with the potential to affect all 49 patients, (See G 137) and failed to ensure an appointed administrator or a qualified alternate is available during operating hours for 1 of 1 administrator reviewed with the potential to affect all 49 patients, (See G 139) failed to ensure all personnel were coordinating care in 4 of 5 homes visits with the potential to affect all 49 patients. (See G 143)</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.14: Organization, services, and administration with the potential to affect all 49 patients.</p> <p>484.14(b) GOVERNING BODY The governing body appoints a qualified administrator.</p>	G000129	<p>will review them at least annually to ensure compliance with this regulation.</p> <p>On 2-28-14, The Advisory Board</p>	03/06/2014	

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G000133	<p>Based on interview and review of documents, the agency failed to ensure the governing body appointed the administrator 1 of 1 administrators reviewed with the potential to affect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of agency documents failed to evidence the administrator had been appointed by the governing body.</li> <li>2. On 2/21/14 at 2:30 PM, the Administrator indicated the governing board had not appointed the Administrator.</li> </ol> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p>	G000133	<p>meeting washeld. All members being present by unanimous and written consent reviewed staffing changes and approved the following: Tobey Nelson, R.N., shall serve as Administrator and Acting Supervising Nurse (Director of Nursing). Margaret Kenney, R.N. shall serve as Supervisory Nurse (Assistant Director of Nursing) and Acting Administrator (Assistant Administrator). The minutes from this Advisory Board Meeting are signed and now kept in a binder as of 3-6-14. In order to prevent future problems with this issue, Statements of Responsibility will be written and maintained for Administrator, Assistant Administrator, Director of Nursing and Assistant Director of Nursing. These statements will ensure that any future changes in these positions will be reported in writing immediately to the Indiana Department of Health. The Administrator will be responsible to maintain these documents and will review them at least annually to ensure compliance with this regulation.</p> <p>Revised job descriptions will be</p>	03/21/2014	

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	<p>Based on clinical record and document review, observation, interview, and confidential interview, the administrator has failed to organize and direct the agency's ongoing functions for 1 of 1 agency with the potential to affect all 49 patients.</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 10/20/10, included a plan of care for the certification period 2/3/13 to 1/31/14 that evidenced physician orders for home health aides 2 hour a day 7 days a week. The aide plan of care was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>2. Clinical record 3, SOC 12/14/2009, included a plan of care for the certification period 1/14/2014 to 3/14/14 that evidenced physician orders for home health aides 5-7 times a week, 1-2 hour visits. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 1/30/14 to 3/30/14 that evidenced physician orders for</p>		<p>written for all Licensed Practical Nurses and Registered Nurses to ensure that the nurses are aware of the scope of service for each job. The following instructions will be included in these job descriptions: The Licensed Practical Nurse must report to the Registered Nurse/Supervising Nurse any changes that need to be made in a patient's Home Health Aide Care Plan. Only the Registered Nurse may develop and sign the Aide's Care Plan. By 3-21-14, all nurses (LPN's and RN's) will receive and sign a revised copy of their job description. The Administrator will answer all questions regarding the importance of following this policy and ensure that each nurse understands. This will be the job description given to any future employees in order to prevent any recurrence of this issue. The Administrator/Assistant Administrator will review and sign off on all current Home Health Aide Care Plans. The aides will be required to sign a verification statement confirming that they have received each patient's current Care Plan and know the Registered Nurse who developed it in order to report any concerns. The R.N. will review each patient's Aide Care Plan at least every 60 days and whenever changes are needed. In order to prevent any future problems with this issue, all Registered Nurses</p>				

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	<p>home health aides 2 to 4 times a week, 1 to 2 hours per visit. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>4. Clinical record 8, SOC 5/14/13, included a plan of care for the certification period 11/10/13 to 1/8/14 that evidenced physician orders for home health aides 1-3 times a week, 1-4 hour visits. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 that evidenced physician orders for home health aides 2 hours day, 5 days a week. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>6. A signed job description by Employee M for "Nursing Coordinator" states, "2. Demonstrate familiarity and abide by all agency policies, procedures, state, and federal rules."</p> <p>7. On 2/21/14 at 4:00 PM, the Administrator, Employee A, indicated</p>		<p>will also be re-educated by awritten memo no later than 3-21-14 regardingthe requirements for 14 day/30 day Home Health Aide supervisory visits. They will be informed that backdatingsupervisory visits is prohibited by Ohio Valley Home Health and will be causefor written disciplinary action up to and including possible termination ofemployment. The R.N.'s will sign an acknowledgement of receipt of this memo andverification that they understand the policy. To prevent future occurrences of this issue, the Administrator/Assistant Administrator willperform quarterly chart audits of at least 10% of active patient charts toensure that the Aide's Care Plan is developed, reviewed at least every 60 days,and signed by an R.N. The audit willalso include review of the supervisory visits for home health aides. If a trend is noted, chart audits will beincreased to monthly and further staff education will be provided until theproblem resolves.</p>	

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G000134	<p>the former Administrator set the Nursing Coordinator job up and changed it from the registered nurse to a licensed nurse job. She also instructed the Licensed practical nurse to sign the aide care plan.</p> <p>8. Confidential interview # 1, 2/19/14 at 6 PM, indicated the office manager and Nursing Coordination are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit. This person also indicated the supervisory visits are backdated and changed if the evaluation is negative</p> <p>9. Confidential interview # 3, 2/2/14 in the PM, indicated no one knows who the supervisory nurse is and who should be called with issues. Usually it's the office manager or the Nursing Coordinator. This person also indicated the supervisory visits are backdated to fit the time frame. Interviewee indicated he/she had participated in backdating of supervisory visits</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.</p>			

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	<p>Based upon personnel record review and interview, the administrator failed to ensure the staff had been orientated in their proper fields for 10 of 10 personnel records reviewed with the potential to affect all 49 patients. (A, D, E, F, G, H, I, J, K and L)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Personnel record A, Date of Hire (DOH) 6/17/73, failed to evidence an orientation upon hire.</li> <li>2. Personnel record D, DOH 12/4/13, failed to evidence an orientation upon hire.</li> <li>3. Personnel record E, DOH 12/10/99, failed to evidence an orientation upon hire.</li> <li>4. Personnel record F, DOH 11/8/96, failed to evidence an orientation upon hire.</li> <li>5. Personnel record G, DOH 8/8/07, failed to evidence an orientation upon hire.</li> <li>6. Personnel record H, DOH 2/24/99, failed to evidence an orientation upon hire.</li> </ol>	G000134	<p>A new employee orientation check list was developed for aides, LPN's, and RN's. This check list will be maintained in the employee's personnel file. All current staff will undergo re-orientation with these check lists by 3-21-14. To prevent any future problems, all new employees will undergo this same new orientation process. The Administrator/Director of Nursing will do a personnel file audit of every file by 3/21/14. Then the Administrator will review every new employee file each quarter for 4 quarters to ensure no future problems with this issue occur. If no trends are noted, personnel file reviews will be done on each employees annual review date.</p>	03/21/2014			

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G000137	<p>7. Personnel record I, DOH 7/8/13, failed to evidence an orientation upon hire.</p> <p>8. Personnel record J, DOH 8/1/07, failed to evidence an orientation upon hire.</p> <p>9. Personnel record K, DOH 9/7/09, failed to evidence an orientation upon hire.</p> <p>10. Personnel record L, DOH 12/3/13, failed to evidence an orientation upon hire.</p> <p>11. On 2/21/14 at 3:30 PM the Administrator, Employee A, indicated a formal orientation / skill check was not done.</p> <p>484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator.</p> <p>Based on interview and review of documents, the administrator failed to ensure a qualified person was authorized in writing to act in her absence in 1 of 1 administrators reviewed with the potential to affect all 49 patients.</p>	G000137	On2-28-14, The Advisory Board meeting was held. All members being present by unanimous and written consent reviewed staffing changes and approved the following: Tobey Nelson, R.N., shall serve as Administrator and Acting Supervising Nurse (Director of Nursing). Margaret Kenney, R.N. shall serve as Supervisory	03/06/2014			

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G000139	<p>Findings:</p> <p>1. Review of agency documents failed to evidence the administrator had appointed someone to act in her absence.</p> <p>2. On 2/21/14 at 2:30 PM, the Administrator indicated the governing board had not appointed the Administrator nor an alternate administrator to act on her behalf.</p> <p>484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).</p> <p>This person, or similarly qualified alternate, is available at all times during operating hours.</p> <p>Based on confidential interview, the agency failed to ensure the supervising nurse or a qualified alternate was directing the services furnished by the agency in 1 of 1 agency with the potential to affect all 49 patients.</p>	G000139	<p>Nurse (Assistant Director of Nursing) and Acting Administrator(Assistant Administrator)Theminutes from this Advisory Board Meeting are signed and now kept in a binderas of 3-6-14.In orderto prevent future problems with this issue, Statements of Responsibility willbe written and maintained for Administrator, Assistant Administrator,Director of Nursing and Assistant Director of Nursing. These statements will ensure that anyfuture changes in these positions will be reported in writing immediately tothe Indiana Department of Health.TheAdministrator will be responsible to maintain these documents and will reviewthem at least annually to ensure compliance with this regulation.</p> <p>On 2-28-14, The Advisory Board meeting was held. All members being present by unanimous and written consent reviewedstaffing changes and approved the following:TobeyNelson, R.N., shall serve as Administrator and</p>	03/21/2014	

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G000143	<p>Findings:</p> <ol style="list-style-type: none"> <li>Confidential interview # 1, 2/19/14 at 6 PM ,indicated the office manager and Nursing Coordinator are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit.</li> <li>Confidential interview # 2, 2/21/14 at 1 PM, indicated the administrator was not available when called. The office manager answers the questions.</li> <li>Confidential interview # 3, 2/2/14 in the PM, indicated no one knows who the supervisory nurse is and who should be called with issues. Usually it's the office manager or the Nursing Coordinator giving the directions.</li> </ol> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p>		<p>Acting Supervising Nurse(Director of Nursing). Margaret Kenney, R.N. shall serve asSupervisory Nurse (Assistant Director of Nursing) and Acting Administrator (AssistantAdministrator)The minutes from thisAdvisory Board Meeting are signed and now kept in a binder as of 3-6-14.In order to prevent future problems with this issue, Statements of Responsibility will be writtenand maintained for Administrator, Assistant Administrator, Director of Nursingand Assistant Director of Nursing. These statements will ensure that any future changes in these positionswill be reported in writing immediately to the Indiana Department of Health.A memo will be given to all staff no later than 3-21-14 with a revised Chain ofCommand. All staff will sign an acknowledgementof receipt of this information and will verify that they understand it.This Chain of Command will be included in the New Employee Handbook in order toprevent any further issues.TheAdministrator will give oversight to this process and use a check list of allemployee names to ensure that all this problem has been resolved and everyoneunderstands the Chain of Command.</p>		

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	<p>Based on home visits observation and interview, the agency failed to ensure all personnel were coordinating care in 1 of 5 home visits with the potential to affect all 49 patients. (2)</p> <p>Findings:</p> <p>1. On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, was observed with Employee F, a home health aide (HHA). The patient is a quadrapalegic patient with limited use of both hands. The HHA mover the patient to the electric wheelchair after the bath. The patient's electric wheelchair has a high back for support and the part that allows the patient to recline is broke. The patient must sit bent forward while in the chair and has a tendency to slide outward of the chair. The patient was obviously uncomfortable and indicated he was concerned he would slide from the chair. The HHA indicated she knew the chair was broken and had not called the office. The patient indicated the RN knew the chair was broken.</p> <p>2. At 1:30 PM the Administrator, Employee A, stated she did not know the chair was broken.</p>	G000143	An in-service was given to all staff regarding reporting changes and communication with the Registered Nurse/Director of Nursing/Administrator. Staff was educated on the importance of reporting any patient safety concerns immediately to the responsible R.N., including problems with any medical equipment. A memo will also be distributed to all employees with the Chain of Command to ensure that staff understands who to report this information to in the office. To avoid future problems, new employees will be given these in-services and the Chain of Command information. The will sign verification that they understand these instructions. The Administrator/Director of Nursing will do a personnel file audit of all employee files no later than 3-21-14 to ensure that every employee has signed verification of receipt of this information. New employee files will be audited by the Administrator every quarter for 4 quarters to ensure no future problems with this issue occur. If no trends are noted, personnel file reviews will be done on each employees annual review date.	03/21/2014			

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G000153	<p>484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.</p> <p>Based on review of the Annual Evaluation and interview, the agency failed to ensure the group of professional personnel reviewed the scope of services offered, clinical records, medical supervision, and plans of care in 1 of 1 agency reviewed with the potential to affect all 49 patients.</p> <p>Findings:</p> <p>1. An agency document titled the "Ohio Valley Home Health Program Evaluation" failed to identify the group of professional personnel reviewed the scope of services offered, clinical records, medical supervision, and plans</p>	G000153	<p>The agency's annual evaluation documentation was not signed when the surveyor was here. The Advisory Board reviewed all pertinent information( scope of services offered, clinical records, medical supervision, etc.) and obtained signatures on 2/25/14. All Advisory Board members have been informed that the next Annual Review meeting is scheduled for 2-9-15. A current Roster of Members of the Advisory Board will be maintained with this information. Going forward, we are developing a new notebook for annual reviews. The Administrator will ensure that each Annual Review date is scheduled for the next year at the end of the current meeting and all members are informed. Chart audit review</p>	03/21/2014

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G000158	<p>of care as these areas were not addressed.</p> <p>2. On 2/ 18/14 at 11:00 AM, the Administrator, Employee A, indicated there was no information about clinical record reviews for the Program Evaluation for 2013. The previous administrator did not collect data.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER 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 and policy review, home visit and interview the agency failed to ensure their staff followed the written plan of care as order in 5 of 10 cases reviewed with the potential to affect all 49 patients. (1, 4, 5, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 1/30/13, included a plan of care for the</p>	G000158	<p>records will be maintained in this notebook. Any new policy or policy changes will also be recorded and kept in this notebook along with any other pertinent information needed for the annual review of the agency. The Administrator will maintain and review the minutes from these meetings annually.</p> <p>All nurses will complete an in-service on charting and documentation by 3-21-14. They will also receive written instructions regarding the importance of following physician's orders/Plan of Care. A new nursing assessment form is now being utilized in order to improve documentation. A memo will be given to all nurses informing them of the importance of following the Plan of Care. They will be instructed in this memo that failure to follow the Plan of Care will be cause for disciplinary action up to and including possible termination</p>	03/21/2014

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	<p>certification period 11/26/13 to 1/24/14 with physician orders for nursing 1-3 times a week 8-9 hour visit. The clinical record evidences orders for straight cath every 4 hours, clean buttocks and coccyx daily and prn with normal saline and apply magic butt cream to areas, measure weekly. The clinical record failed to evidence straith cath's every 4 hours on 11/27, 11/29, 12/2, 12/4, 12/5, 12/9, 12/11, 12/12, 12/16, 12/18, 12/19, 12/23, 12/24, 12/26, 12/30, 12/31/13, 1/2, 1/6, 1/8, 1/9, 1/13, 1/15, 1/16, 1/20, 1/22, 1/23/14. The clinical record failed to evidence wound measurements at any time during the certification period.</p> <p>2. Clinical record 4, SOC 1/29/2005, included a plan of care for the certification period 12/12/13 to 2/9/14 with physician orders for nursing 2-3 times a week, 4-8 hours visits. The clinical record evidenced four visits week 2, 4, and 6. The clinical record evidenced a insulin sliding scale of 200-229=1 unit, 230-250=2 unit, 251-275=2.5 units, 276-300=3 units, 302 or greater =3.5 units. The clinical record failed to evidence insulin administration on 12/16 with a blood sugar (BS) of 214, 12/17 BS of 223, 12/24 BS of 245, 12/27 BS of 223, 12/31/13 BS of 266, 1/2/14 BS of 234, 1/3 BS of 207, 1/4 BS of 245, 1/8 BS of</p>		<p>of employment. All nursing documentation beginning March 6, 2014 will be reviewed by the Administrator for a period of 45 days. Special attention will be given to reviewing notes regarding straight caths, wound measurements, medication orders, and patient repositioning; however, all notes will be evaluated for accuracy. If no problems are found, the Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>				

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(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>232, 1/9 BS of 234, 1/10 BS of 232, 1/13 BS of 340, 1/15 BS of 348, 1/18 BS of 223, 1/22 BS of 345, 1/24 BS of 247, 1/29 BS of 201, 2/5 BS of 237, and 2/6/14 BS of 234.</p> <p>On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, Employee J, a Licensed Practical Nurse (LPN) was observed to take the patient's blood sugar which was 186. This surveyor asked the LPN what were the orders for the blood sugar sliding scale. The LPN indicated insulin was to be administered at 200 but the sister wouldn't allow it. The sister had a water scale and the LPN administered water through the g-tube for the different levels of the blood sugar. Unless the level reached the highest levels they didn't give the insulin on a regular basis.</p> <p>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 12/1/13 to 1/29/14 with physician orders for home health aide 2-4 times a week, 1-2 hours per visit. The clinical record evidenced attendant and homemaker visits but failed to evidence physician orders for visits.</p> <p>4. Clinical record 9, SOC 11/17/11, included a plan of care for the certification period 1/5/14 to 3/5/14 with</p>						

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	<p>physician orders for skilled nurse 5 to 7 times a week for 10-12 hours a visits. The clinical record failed to evidence orders for bilateral DAFO's for 2 hours on and 2 hours off while awake, patient to wear hand splints daily 2 hours at a times, TSLO brace daily for 15 to 20 minutes (Provide tactile stimulation during activity), Position head to right side for 15 minutes, then to left side for 15 minutes while lying prone, provide oral stimulation to lips 1-2 times on each side while prone. The clinical record evidenced the above activities 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/1, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14 and 2/15/14.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 with physician orders for HHA 2 hours a day 5 days a week and nursing visit 1 hour every week for medication set up. The clinical record failed to evidence 1 hour visits weeks 1, 2, 3, 4, 5, 6, 7, 8 and 9. The clinical record failed to evidence 2 hour visits 5 days a week for weeks 1, 2, 3, 4, 5, 6, 7, 8 and 9</p> <p>6. A policy titled "Pharmaceutical Administration", Revised 5/2/12, states, "Ohio Valley Registered Nurses and</p>			

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G000165	<p>Licensed Practical Nurses are the only clinical staff to administer prescribed pharmaceuticals in the home and only as ordered by the physician."</p> <p>7. A policy titled "Documentation", Revised 12/6/04, states, "Documentation reflects the quality of care and provides evidence of each health care team member's responsibility in giving care."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>Based on clinical record and policy review, home visit and interview the agency failed to ensure their staff administered drugs and treatments as ordered by the physician in 3 of 10 cases reviewed with the potential to affect all 49 patients. (1, 4, and 9)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 1/30/13, included a plan of care for the certification period 11/26/13 to 1/24/14 with physician orders for nursing 1-3 times a week 8-9 hour visit. The clinical</p>	G000165	<p>All nurses will complete an in-service oncharting and documentation by 3-21-14. They will also receive written instructions regarding the importance of following physician's orders/Plan of Care. A new nursing assessment form is now being utilized in order to improve documentation. A memo will be given to all nurses informing them of the importance of following the Plan of Care. They will be instructed in this memo that failure to follow the Plan of Care will be cause for disciplinary action up to and including possible termination of employment. All nursing documentation beginning March 6, 2014 will be reviewed by the</p>	03/21/2014

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	<p>record evidences orders for straight cath every 4 hours, clean buttocks and coccyx daily and prn with normal saline and apply magic butt cream to areas, measure weekly. The clinical record failed to evidence straith cath's every 4 hours on 11/27, 11/29, 12/2, 12/4, 12/5, 12/9, 12/11, 12/12, 12/16, 12/18, 12/19, 12/23, 12/24, 12/26, 12/30, 12/31/13, 1/2, 1/6, 1/8, 1/9, 1/13, 1/15, 1/16, 1/20, 1/22, 1/23/14. The clinical record failed to evidence wound measurements at any time during the certification period.</p> <p>2. Clinical record 4, SOC 1/29/2005, included a plan of care for the certification period 12/12/13 to 2/9/14 with physician orders for nursing 2-3 times a week, 4-8 hours visits. The clinical record evidenced four visits week 2, 4, and 6. The clinical record evidenced a insulin sliding scale of 200-229=1 unit, 230-250=2 unit, 251-275=2.5 units, 276-300=3 units, 302 or greater =3.5 units. The clinical record failed to evidence insulin administration on 12/16 with a blood sugar (BS) of 214, 12/17 BS of 223, 12/24 BS of 245, 12/27 BS of 223, 12/31/13 BS of 266, 1/2/14 BS of 234, 1/3 BS of 207, 1/4 BS of 245, 1/8 BS of 232, 1/9 BS of 234, 1/10 BS of 232, 1/13 BS of 340, 1/15 BS of 348, 1/18 BS of 223, 1/22 BS of 345, 1/24 BS of</p>		<p>Administrator for a period of 45 days. Special attention will be given to reviewing notes regarding straight caths, wound measurements, medication orders, and patient repositioning; however, all notes will be evaluated for accuracy. If no problems are found, the Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>				

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	<p>247, 1/29 BS of 201, 2/5 BS of 237, and 2/6/14 BS of 234.</p> <p>On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, Employee J, a Licensed Practical Nurse (LPN) was observed to take the patient's blood sugar which was 186. This surveyor asked the LPN what were the orders for the blood sugar sliding scale. The LPN indicated insulin was to be administered at 200 but the sister wouldn't allow it. The sister had a water scale and the LPN administered water through the g-tube for the different levels of the blood sugar. Unless the level reached the highest levels they didn't give the insulin on a regular basis.</p> <p>3. Clinical record 9, SOC 11/17/11, included a plan of care for the certification period 1/5/14 to 3/5/14 with physician orders for skilled nurse 5 to 7 times a week for 10-12 hours a visits. The clinical record failed to evidence orders for bilateral DAFO's for 2 hours on and 2 hours off while awake, patient to wear hand splints daily 2 hours at a times, TSLO brace daily for 15 to 20 minutes (Provide tactile stimulation during activity), Position head to right side for 15 minutes, then to left side for 15 minutes while lying prone, provide oral stimulation to lips 1-2 times on each side while prone. The clinical record</p>			

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G000168	<p>evidenced the above activities 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/1, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14 and 2/15/14.</p> <p>4. A policy titled "Pharmaceutical Administration", Revised 5/2/12, states, "Ohio Valley Registered Nurses and Licensed Practical Nurses are the only clinical staff to administer prescribed pharmaceuticals in the home and only as ordered by the physician."</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and policy review, observation, and interview, it was determined the agency failed to ensure skilled nurses followed the physician plan of care in 4 of 10 records reviewed with the potential to affect all patients that receive skilled nurse services (See G 170), failed to ensure the registered nurse reevaluated the patient's need by the completion of a comprehensive assessment on the patient's return home after a hospital admission in 1 of 1 clinical records reviewed of a patient discharged from a hospital with the potential to affect all patients who are hospitalized (See G</p>	G000168	The Registered Nurses were re-educated on 3-6-14on the importance of completing a comprehensive assessment on a patient'sreturn home from the hospital. Nurseswere instructed that, when a patient is admitted to the hospital, a Transfer toInpatient Facility assessment must be completed. Then when the patient returns home, acomprehensive Resumption of Care assessment must be completed within 48 hours to reconcilemedications, obtain new orders, etc.. New OASIS forms were obtained, and the nurseswere instructed on how to complete these assessment forms. A hospitalization log will be developed by3-21-14 in order to audit charts and maintain	03/21/2014

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G000170	<p>172), and failed to ensure all personnel were coordinating care in 1 of 5 home visits with the potential to affect all 49 patients (See G 176).</p> <p>The cumulative effect of these systemic problems, resulting in the agency's inability to meet the requirements of the Condition of Participation 484.30: Skilled Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and policy review, observation, and interview, the agency failed to ensure skilled nurses followed the physician plan of care in 4 of 10 records reviewed with the potential to affect all patients that receive skilled nurse services. (1, 4, 9, and 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 1/30/13, included a plan of care for the certification period 11/26/13 to 1/24/14 with physician orders for nursing 1-3 times a week 8-9 hour visit. The clinical record evidences orders for straight cath every 4 hours, clean buttocks and coccyx</p>	G000170	<p>hospitalization information for Quality Assurance. Nurses will be instructed to inform the Administrator of any hospitalized patients in order to maintain this log. The Administrator and/or Director of Nurses will perform quarterly chart audits of hospitalized patients to ensure that the appropriate assessments have been completed. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p> <p>All nurses will complete an in-service on charting and documentation by 3-21-14. They will also receive written instructions regarding the importance of following physician's orders/Plan of Care. A new nursing assessment form is now being utilized in order to improve documentation. A memo will be given to all nurses informing them of the importance of following the Plan of Care. They will be instructed in this memo that failure to follow the Plan of Care will be cause for disciplinary action up to and including possible termination of employment. All nursing documentation beginning March 6, 2014 will be reviewed by the Administrator for a period of 45</p>	03/21/2014

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	<p>daily and prn with normal saline and apply magic butt cream to areas, measure weekly. The clinical record failed to evidence strait cath's every 4 hours on 11/27, 11/29, 12/2, 12/4, 12/5, 12/9, 12/11, 12/12, 12/16, 12/18, 12/19, 12/23, 12/24, 12/26, 12/30, 12/31/13, 1/2, 1/6, 1/8, 1/9, 1/13, 1/15, 1/16, 1/20, 1/22, 1/23/14. The clinical record failed to evidence wound measurements at any time during the certification period.</p> <p>2. Clinical record 4, SOC 1/29/2005, included a plan of care for the certification period 12/12/13 to 2/9/14 with physician orders for nursing 2-3 times a week, 4-8 hours visits. The clinical record evidenced four visits week 2, 4, and 6. The clinical record evidenced a insulin sliding scale of 200-229=1 unit, 230-250=2 unit, 251-275=2.5 units, 276-300=3 units, 302 or greater =3.5 units. The clinical record failed to evidence insulin administration on 12/16 with a blood sugar (BS) of 214, 12/17 BS of 223, 12/24 BS of 245, 12/27 BS of 223, 12/31/13 BS of 266, 1/2/14 BS of 234, 1/3 BS of 207, 1/4 BS of 245, 1/8 BS of 232, 1/9 BS of 234, 1/10 BS of 232, 1/13 BS of 340, 1/15 BS of 348, 1/18 BS of 223, 1/22 BS of 345, 1/24 BS of 247, 1/29 BS of 201, 2/5 BS of 237, and 2/6/14 BS of 234.</p>		<p>days. Special attention will be given to reviewing notes regarding straight caths, wound measurements, medication orders, and patient repositioning; however, all notes will be evaluated for accuracy. If no problems are found, the Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>				

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	<p>On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, Employee J, a Licensed Practical Nurse (LPN) was observed to take the patient's blood sugar which was 186. This surveyor asked the LPN what were the orders for the blood sugar sliding scale. The LPN indicated insulin was to be administered at 200 but the sister wouldn't allow it. The sister had a water scale and the LPN administered water through the g-tube for the different levels of the blood sugar. Unless the level reached the highest levels they didn't give the insulin on a regular basis.</p> <p>3. Clinical record 9, SOC 11/17/11, included a plan of care for the certification period 1/5/14 to 3/5/14 with physician orders for skilled nurse 5 to 7 times a week for 10-12 hours a visits. The clinical record failed to evidence orders for bilateral DAFO's for 2 hours on and 2 hours off while awake, patient to wear hand splints daily 2 hours at a times, TSLO brace daily for 15 to 20 minutes (Provide tactile stimulation during activity), Position head to right side for 15 minutes, then to left side for 15 minutes while lying prone, provide oral stimulation to lips 1-2 times on each side while prone. The clinical record evidenced the above activities 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26,</p>			
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	<p>1/27, 1/28, 1/29, 1/30, 1/31, 2/1, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14 and 2/15/14.</p> <p>4. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 with physician orders for HHA 2 hours a day 5 days a week and nursing visit 1 hour every week for medication set up. The clinical record failed to evidence 1 hour visits weeks 1, 2, 3, 4, 5, 6, 7, 8 and 9.</p> <p>5. A policy titled "Pharmaceutical Administration", Revised 5/2/12, states, "Ohio Valley Registered Nurses and Licensed Practical Nurses are the only clinical staff to administer prescribed pharmaceuticals in the home and only as ordered by the physician."</p> <p>6. A policy titled "Documentation", Revised 12/6/04, states, "Documentation reflects the quality of care and provides evidence of each health care team member's responsibility in giving care."</p>			

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G000172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's need by the completion of a comprehensive assessment on the patient's return home after a hospital admission in 1 of 1 clinical records reviewed of a patient discharged from a hospital with the potential to affect all patients who are hospitalized. (7)</p> <p>Findings:</p> <p>1. Clinical record 7 evidenced a case conference note that identified the patient had been admitted to the hospital on 1/5/14 and discharged on 1/8/14. The record failed to evidence a resumption of care comprehensive assessment had been completed.</p> <p>2. On 2/21/14 at 3:30 PM, the Administrator, Employee A, indicated the resumption of care OASIS had not been completed.</p>	G000172	<p>The Registered Nurses were re-educated on 3-6-14on the importance of completing a comprehensive assessment on a patient'sreturn home from the hospital. Nurseswere instructed that, when a patient is admitted to the hospital, a Transfer toInpatient Facility assessment must be completed. Then when the patient returns home, acomprehensive Resumption of Care assessment must be completed within 48 hours to reconcilemedications, obtain new orders, etc.. New OASIS forms were obtained, and the nurseswere instructed on how to complete these assessment forms. A hospitalization log will be developed by3-21-14 in order to audit charts and maintain hospitalization information forQuality Assurance. Nurses will be instructed to inform the Administrator of anyhospitalized patients in order to maintain this log. TheAdministrator and/or Director of Nurses will perform quarterly chart audits of hospitalizedpatients to ensure that the appropriate assessments have been completed. If trends are found, chart audits will be conductedon a monthly basis until the problem resolves. If no trends are found, quarterly chart audits</p>	03/21/2014
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G000176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on home visits observation and interview, the agency failed to ensure all personnel were coordinating care in 1 of 5 home visits with the potential to affect all 49 patients. (2)</p> <p>Findings:</p> <p>1. On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, was observed with Employee F, a home health aide (HHA). The patient is a quadriplegic patient with limited use of both hands. The HHA mover the patient to the electric wheelchair after the bath. The patient's electric wheelchair has a high back for support and the part that allows the patient to recline is broke. The patient must sit bent forward while in the chair and has a tendency to slide outward of the chair. The patient was obviously uncomfortable and indicated he was concerned he would slide from the chair. The HHA indicated she knew the chair was broken and had not called the office. The patient indicated the RN knew the chair was broken.</p>	G000176	<p>will continue.</p> <p>An in-service was given to all staff regarding reporting changes and communication with the Registered Nurse/Director of Nursing/Administrator. Staff was educated on the importance of reporting any patient safety concerns immediately to the responsible R.N., including problems with any medical equipment. A memo will also be distributed to all employees with the Chain of Command to ensure that staff understands who to report this information to in the office. To avoid future problems, new employees will be given these in-services and the Chain of Command information. The will sign verification that they understand these instructions. The Administrator/Director of Nursing will do a personnel file audit of all employee files no later than 3-21-14 to ensure that every employee has signed verification of receipt of this information. New employee files will be audited by the Administrator every quarter for 4 quarters to ensure no future problems with this issue occur. If no trends are noted, personnel file reviews will be done on each</p>	03/21/2014			

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G000202	<p>2. At 1:30 PM the Administrator, Employee A, stated she did not know the chair was broken.</p> <p>484.36 HOME HEALTH AIDE SERVICES Based on interview, clinical record and policy review, and job description review, it was determined the agency failed to ensure continuing education for the home health aides from 1/1/13 to 12/31/13 was under the supervision of a registered nurse in 1 of 1 continuing education in-service programs reviewed with the potential to affect all 49 patients (See G 215), failed to ensure the home health aide is assigned to a specific patient by the registered nurse in 5 of 5 records reviewed of patients receiving aide services with the potential to affect all patients that receive aide services (See G 223), failed to ensure the written patient care instructions for the home health aide were prepared by the registered nurse in 5 of 5 records reviewed of patients who received home health aide services with the potential to affect all patients that receive home health aide services (See G 224), failed to ensure supervisory visit documentation was accurate and at least</p>	G000202	<p>employees annual review date.</p> <p>All homehealth aides are being given in-services to be completed by 3-21-14 regarding the following topics: Bed bath Infection control Standard precautions Documentation Communication Reporting Changes in Condition Patient Safety and Medical Equipment Monthly in-services will continue throughout the year. We have changed our plan for annual in-services to better reflect the topics required by state and federal regulations. The Home Health Aide Care Plans for each patient will be signed by the responsible RN in order to ensure that the aide knows who to report changes and concerns to in the office. A memo regarding chain of command was also distributed to reinforce understanding of who to report changes to. All Registered Nurses will be re-educated by a written memo no later than 3-21-14 regarding the requirements for 14 day/30 day Home Health Aide supervisory visits. The Supervisory Visit forms were revised to include more</p>	03/21/2014	

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	<p>every 2 weeks in 1 of 5 records reviewed of patients receiving skilled nurse and home health aide services with the potential to affect all patients that receive skilled nurse and home health aide services (See G 229), and failed to ensure the registered nurse observed the home health aide performing a skill every 60 days in 2 of 2 clinical records reviewed with home health aide services only with the potential to affect all patients receiving home health aide only services (See G 230).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.36: Home Health Aide Services.</p>		<p>information and areas to observe the aide's skill, patient concerns, DME problems, etc.. The R.N. will observe a specific skill being performed by the aide at least every 60 days. The R.N.'s will sign an acknowledgement and verification that they understand this requirement. The Administrator will review the in service log monthly to ensure that every aide has completed the appropriate in services in a timely manner. The Administrator and/or Director of Nurses will perform quarterly chart audits of to ensure that supervisory visits have been completed in the appropriate time frame. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>		

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G000215	<p>484.36(b)(2)(iii) COMPETENCY EVALUATION &amp; IN-SERVICE TRAI</p> <p>The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.</p> <p>Based on interview, the agency failed to ensure continuing education for the home health aides from 1/1/13 to 12/31/13 was under the supervision of a registered nurse in 1 of 1 continuing education in-service programs reviewed with the potential to affect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 2/21/14 at 3:30 PM, the Administrator, Employee A, indicated the in-services are purchased through a company with no control over the subject material and no quality checks of who is writing the in-services and the agreement was entered into by the old administrator and has not been reviewed since.</li> <li>On 2/21/14 at 3:30 PM, the Clinical Manager, Employee B, indicated the in-services are downloaded by the scheduler, printed out, put in their payroll envelope, filled out, and turned</li> </ol>	G000215	<p>All homehealth aides are being given in-services to be completed by 3-21-14 regarding the following topics: Bed bath Infection control Standard precautions Documentation Communication Reporting Changes in Condition Patient Safety and Medical Equipment We have changed our plan for annual in-services to better reflect the topics required by state and federal regulations. The R.N. Administrator is responsible for developing and maintaining these planned in-services. The Home Health Aide Care Plans for each patient will be signed by the responsible RN in order to ensure that the aide knows who to report changes and concerns to in the office. All Registered Nurses will be re-educated by a written memo no later than 3-21-14 regarding the requirements for 14 day/30 day Home Health Aide supervisory visits. The Supervisory Visit forms were revised to include more information and areas to observe the aide's skill, patient concerns, DME problems, etc.. The R.N. will observe a specific skill being performed by the aide at</p>	03/21/2014			

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G000223	<p>back in and a registered nurse is not the controlling factor. The Nursing Coordinator, a licensed practical nurse, is in charge of keeping track of the in-services.</p> <p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE The home health aide is assigned to a specific patient by the registered nurse.</p> <p>Based on clinical record and policy review, interview, and job description review, the agency failed to ensure the home health aide was assigned to a specific patient by the registered nurse in 5 of 5 records reviewed of patients who received home health aide services with the potential to affect all patients that receive home health aide services. (2, 3, 5, 8 and 10)</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC)</p>	G000223	<p>least every 60 days. The R.N.'s will sign an acknowledgement and verification that they understand this requirement. The Administrator will review the in-service log monthly to ensure that every aide has completed the appropriate in-services in a timely manner. The Administrator and/or Director of Nurses will perform quarterly chart audits of to ensure that supervisory visits have been completed in the appropriate time frame. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p> <p>The Administrator/Assistant Administrator will review and sign off on all current Home Health Aide Care Plans by 3/21/14. The aides will be required to sign a verification statement confirming that they have received each patient's current Care Plan and know the Registered Nurse who developed it in order to report any concerns. The R.N. will review each patient's Aide Care Plan at least every 60 days and whenever changes are needed. To prevent future occurrences of this issue, the Administrator/Assistant Administrator will perform</p>	03/21/2014			

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	<p>10/20/10, included a plan of care for the certification period 2/3/13 to 1/31/14 that evidenced physician orders for home health aides 2 hour a day 7 days a week. The aide plan of care was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>2. Clinical record 3, SOC 12/14/2009, included a plan of care for the certification period 1/14/2014 to 3/14/14 that evidenced physician orders for home health aides 5-7 times a week, 1-2 hour visits. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 1/30/14 to 3/30/14 that evidenced physician orders for home health aides 2 to 4 times a week, 1 to 2 hours per visit. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>4. Clinical record 8, SOC 5/14/13, included a plan of care for the certification period 11/10/13 to 1/8/14 that evidenced physician orders for home health aides 1-3 times a week, 1-4</p>		<p>quarterly chartaudits of at least 10% of active patient charts to ensure that the Aide's CarePlan is developed, reviewed at least every 60 days, and signed by an R.N. If a trend is noted, chart audits will be increased to monthly and further staff education will be provided until the problem resolves.</p>				

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	<p>hour visits. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 that evidenced physician orders for home health aides 2 hours day, 5 days a week. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>6. The agency document titled "Home Health Aide Care Plan" dated 1994, states the person filling out the form is to "Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc. as needed beside the appropriate item."</p> <p>7. A signed job description by Employee M for "Nursing Coordinator" states, "2. Demonstrate familiarity and abide by all agency policies, procedures, state, and federal rules."</p> <p>8. On 2/21/14 at 4:00 PM, the Administrator, Employee A, indicated the former Administrator set the Nursing Coordinator job up and changed it from</p>			

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G000224	<p>the registered nurse to a licensed nurse job. She also instructed the LPN to sign the aide care plan.</p> <p>9. Confidential interview # 1, on 2/19/14 at 6 PM, indicated the office manager and Nursing Coordinator are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit.</p> <p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on home health aide care plans and policy review, job description review, and interview, the agency failed to ensure the written patient care instructions for the home health aide were prepared by the registered nurse in 5 of 5 records reviewed of patients who received home health aide services with the potential to affect all patients that receive home health aide services. (2, 3, 5, 8 and 10)</p> <p>Findings:</p>	G000224	The Administrator/Assistant Administrator will review and sign off on all current Home Health Aide Care Plans by 3/21/14. The aides will be required to sign a verification statement confirming that they have received each patient's current Care Plan and know the Registered Nurse who developed it in order to report any concerns. The R.N. will review each patient's Aide Care Plan at least every 60 days and whenever changes are needed. To prevent future occurrences of this issue, the Administrator/Assistant	03/21/2014

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	<p>1. Clinical record 2, start of care (SOC) 10/20/10, included a plan of care for the certification period 2/3/13 to 1/31/14 that evidenced physician orders for home health aides 2 hour a day 7 days a week. The aide plan of care was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>2. Clinical record 3, SOC 12/14/2009, included a plan of care for the certification period 1/14/2014 to 3/14/14 that evidenced physician orders for home health aides 5-7 times a week, 1-2 hour visits. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 1/30/14 to 3/30/14 that evidenced physician orders for home health aides 2 to 4 times a week, 1 to 2 hours per visit. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>4. Clinical record 8, SOC 5/14/13, included a plan of care for the certification period 11/10/13 to 1/8/14</p>		<p>Administrator will perform quarterly chart audits of at least 10% of active patient charts to ensure that the Aide's CarePlan is developed, reviewed at least every 60 days, and signed by an R.N. If a trend is noted, chart audits will be increased to monthly and further staff education will be provided until the problem resolves.</p>		

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	<p>that evidenced physician orders for home health aides 1-3 times a week, 1-4 hour visits. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 that evidenced physician orders for home health aides 2 hours day, 5 days a week. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>6. The agency document titled "Home Health Aide Care Plan" dated 1994, states the person filling out the form is to "Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc. as needed beside the appropriate item."</p> <p>7. A signed job description by Employee M for "Nursing Coordinator" states, "2. Demonstrate familiarity and abide by all agency policies, procedures, state, and federal rules."</p> <p>8. On 2/21/14 at 4:00 PM, the Administrator, Employee A, indicated</p>			

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G000229	<p>the former Administrator set the Nursing Coordinator job up and changed it from the registered nurse to a licensed nurse job. She also instructed the LPN to sign the aide care plan.</p> <p>9. Confidential interview # 1, on 2/19/14 at 6 PM, indicated the office manager and Nursing Coordinator are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit.</p> <p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record review and confidential interviews, the agency failed to ensure supervisory visit documentation was accurate and at least every 2 weeks in 1 of 5 records reviewed of patients receiving skilled nurse and home health aide services with the potential to affect all patients that receive skilled nurse and home health aide services. (3)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care 12/14/09, included a plan of care for the</p>	G000229	AllRegistered Nurses will be re-educated by a written memo no later than 3-21-14 regarding the requirements for 14 day/30 day Home Health Aide supervisory visits. They will be informed that backdating supervisory visits is prohibited by Ohio Valley Home Health and will be cause for written disciplinary action up to and including possible termination of employment. The R.N.'s will sign an acknowledgement of receipt of this memo and verification that they understand the policy. To prevent future occurrences of this issue, the	03/21/2014

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	<p>certification period 11/15/13 to 1/13/14 with physician orders for home health aides and skilled nurse services. The supervision notes for the home health aides evidenced the 11/22/13 date being changed and the date on the 12/19/13 or 12/20/13 note being changed to be longer than 2 weeks.</p> <p>2. Confidential interview # 1, 2/19/14 at 6 PM, indicated the supervisory visits are backdated and changed if the evaluation is negative.</p> <p>3. Confidential interview # 2, 2/21/14 at 1 PM, indicated the supervisory visits are backdated to fit the time frame. Interviewee indicated he/she had participated in backdating supervisory visits.</p>		<p>Administrator/Assistant Administrator will perform quarterly chartaudits of at least 10% of active patient charts to ensure that the supervisory visits for home health aides are being done according to regulations. If a trend is noted, chart audits will be increased to monthly and further staff education will be provided until the problem resolves.</p>	

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G000230	<p>484.36(d)(3) SUPERVISION</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 60 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 review and confidential interviews, the agency failed to ensure the registered nurse observed the home health aide performing a skill every 60 days in 2 of 2 clinical records reviewed with home health aide services only with the potential to affect all patients receiving home health aide only services. (5 and 8)</p> <p>Findings:</p> <p>1. Clinical record 5, start of care (SOC) 12/8/11, included a plan of care for the certification period 12/1/13 to 1/29/14 that evidenced physician orders 2-4 times a week, 1 to 2 hours a visit. The clinical record failed to evidence the registered nurse completed the visit when the home health aide was performing care at least every 60 days. The supervision note dated 1/28/14 was</p>	G000230	All Registered Nurses will bere-educated by a written memo no later than 3-21-14 regarding the requirementsfor 14 day/30 day Home Health Aide supervisory visits. They will beinformed that backdating supervisory visits is prohibited by Ohio Valley HomeHealth and will be cause for written disciplinary action up to and includingpossibletermination of employment. The R.N.'s will sign an acknowledgement of receipt ofthis memo and verification that they understand the policy. The supervisory visit form has beenrevised to include spaces to document a skill performed by the aide during thevisit. This will enable our agency to perform actual skill check offs atleast once every 60 days with all of the aides according to regulations. To prevent future occurrences of this issue, theAdministrator/Assistant Administrator will perform quarterly chart audits of atleast 10% of active patient charts to	03/21/2014			

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	<p>not signed and identified the patient could transfer from the chair to the bedside commode. On 2/20/14 at 11:30 AM during a home visit, it was observed the patient could not transfer without assistance.</p> <p>2. Clinical record 8, SOC 5/14/13, included a plan of care for the certification period 11/10/13 to 1/8/14 that evidenced physician orders for home health aides 1-3 times a week , 1-4 hours a visit. The clinical record failed to evidence the registered nurse completed the visit when the home health aide was performing care at least every 60 days.</p> <p>3. Confidential interview # 1, 2/19/14 at 6 PM, indicated the supervisory visits are backdated and changed if the evaluation is negative.</p> <p>4. Confidential interview # 2, 2/21/14 at 1 PM, indicated the supervisory visits are backdated to fit the time frame. Interviewee indicated he/she had participated in backdating supervisory visits.</p>		ensure that the supervisory visits forhome health aides are being done according to regulations. If a trend is noted,chart audits will be increased to monthly and further staff education will beprovided until the problem resolves.		

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G000244	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review.</p> <p>Based on agency evaluation review and interview, the agency failed to ensure there had been clinical record reviews in 1 of 1 evaluations reviewed with the potential to effect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. An agency document titled "Ohio Valley Home Health Program Evaluation Summary", dated 1/23/13, failed to evidence "Summary Plan ... B. Professional Services, C. Clinical Record Reviews" had been completed.</li> <li>2. On 2/ 18/14 at 11:00 AM, the Administrator, Employee A indicated there is no information about clinical record reviews for the Program Evaluation for 2013. The previous administrator did not collect data.</li> </ol>	G000244	<p>The previous Administrator of our agency did not maintain accurate records of chart reviews. Therefore, this citation occurred. The current Administrator is now maintaining a chart audit log which began in January 2014 to verify that clinical record reviews are being completed on a quarterly basis. The Administrator will maintain a quarterly chart audit schedule. On 2-27-14, the "Plan, Do, Check and Act" format was chosen as a tool to identify and correct any negative trends discovered during these chart audits. The Administrator/Assistant Administrator will be responsible for the maintenance and performance of these chart audits.</p>	02/27/2014	

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G000245	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.</p> <p>Based on interview and review of the program evaluation summary, the agency failed to ensure the evaluation assessed the extent to which the agency's program was appropriate, adequate, effective and efficient in 1 of 1 program's reviewed with the potential to effect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The agency document "Ohio Valley Home Health Program Evaluation Summary", dated 1/23/13, failed to evidence the extent of the agency program as to its appropriateness, its adequacy, its effectiveness and its efficiency.</li> <li>2. On 2/21/14 at 11 AM, the Administrator, Employee A, indicated all she has is the form signed. There is no information/data to back it up. The form failed to evidence that the evaluation assessed the extent to which the agency's program was appropriate, adequate, effective, and efficient.</li> </ol>	G000245	<p>The Administratoris maintaining a chart audit log which began in January 2014 to verify thatclinical record reviews are being completed on a quarterly basis. Tenpercent of both active and discharged patient services will be reviewed.Going forward, we are developing a new notebook for annual board reviews.The Administrator will ensure that each Annual Review date is scheduled for the next year at the end of the current meeting and all members are informed. Chart audit review records will be maintained in a notebook. Any new policy or policy changes will also be recorded and kept in this notebook along with any other pertinent information needed for the annual review of the agency. Personnelfile audits will be done at the time of each employee's annual review in orderto ensure that professional licenses are renewed and current. A patientcomplaint log has been kept current and will be reviewed quarterly to identifytrends or problems. Patient survey responses will also be utilized for thispurpose. Beginning 3-6-14, patientsurveys will be increased to every 60-120 days and given to the patients duringrecertification</p>	03/06/2014	

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G000249	<p>484.52(a) POLICY AND ADMINISTRATIVE REVIEW Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.</p> <p>Based on the program evaluation summary review and interview, the agency failed to ensure data was collected for the evaluation in 1 of 1 program's reviewed with the potential to effect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The agency document "Ohio Valley Home Health Program Evaluation Summary", dated 1/23/13, failed to evidence that data was collected for the evaluation of the agency's program.</li> <li>On 2/21/14 at 11 AM, the Administrator, Employee A, indicated</li> </ol>	G000249	<p>assessments. The Administrator will maintain a quarterly chart audit schedule. On 2-27-14, the "Plan,Do, Check and Act" format was chosen as a tool to identify and correct any negativetrends discovered during these chart audits. TheAdministrator/Assistant Administrator will be responsible for the maintenanceand performance of these chart audits.</p> <p>The Administratoris maintaining a chart audit log which began in January 2014 to verify thatclinical record reviews are being completed on a quarterly basis. Tenpercent of both active and discharged patient services will be reviewed. TheAdministrator will maintain a quarterly chart audit schedule. On 2-27-14, the "Plan,Do, Check and Act" format was chosen as a tool to identify and correct any negativetrends discovered during these chart audits.A patientcomplaint log has been kept current and will be reviewed quarterly to identifytrends or problems. Patient survey responses will also be utilized for thispurpose. Beginning 3-6-14, patientsurveys will be increased to every 60-120 days and given to the patients duringrecertification assessments. Personnelfile</p>	03/06/2014

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G000250	<p>she has no data for the evaluation and knows of none gathered. They have not been gathering data for the evaluation.</p> <p>484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>Based on the program evaluation summary and policy review and interview, the agency failed to ensure active and closed clinical records were reviewed to determine whether established policies were followed in 1 of 1 program's reviewed with the potential to effect all 49 patients.</p>			G000250	<p>audits will be done at the time of each employee's annual review in order to ensure that professional licenses are renewed and current. Policies are reviewed annually at the Advisory Board Meeting, and minutes will be written and maintained in a notebook by the Administrator. The most recent Advisory Board meeting was held on 2-28-14 after the survey, and members reviewed the findings of this survey. Minutes were written and logged for this meeting. The Administrator/Assistant Administrator will be responsible for the maintenance and performance of these audits.</p> <p>The previous Administrator of our agency did not maintain accurate records of chart reviews. Therefore, this citation occurred. The current Administrator is now maintaining a chart audit log which began in January 2014 to verify that clinical record reviews are being completed on a quarterly basis. Ten percent of both active and discharged patient services will be reviewed. The Administrator will</p>		02/27/2014

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G000251	<p>Findings:</p> <ol style="list-style-type: none"> <li>The agency document "Ohio Valley Home Health Program Evaluation Summary", dated 1/23/13, failed to evidence a review of active and closed clinical records.</li> <li>On 2/21/14 at 11 AM, the Administrator, Employee A, indicated all she has is the form signed. There is no information / data to back it up.</li> <li>A policy titled "Quality Assurance &amp; Utilization Review", Revised 5/3/12, states, "Utilization review will be performed quarterly to maintain quality assurance for all patients. Patient charts will be reviewed by the administrator and/or supervisory nurse. Ten percent of both active and discharged patient services will be reviewed."</li> </ol> <p>484.52(b) CLINICAL RECORD REVIEW There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.</p> <p>Based on the program evaluation summary and policy review and interview, the agency failed to</p>	G000251	<p>maintain a quarterly chart audit schedule. On 2-27-14, the "Plan, Do, Check and Act" format was chosen as a tool to identify and correct any negative trends discovered during these chart audits. The Administrator/Assistant Administrator will be responsible for the maintenance and performance of these chart audits.</p> <p>The Administrator is maintaining a chart audit log which began in January 2014 to verify that clinical record reviews are being completed on a quarterly basis. Ten percent of both active and</p>	02/27/2014			

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	<p>continually review the active and closed clinical records every 60 days to determine adequacy of the plan of care and appropriateness of continuation of care in 1 of 1 program's reviewed with the potential to effect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The agency document "Ohio Valley Home Health Program Evaluation Summary", dated 1/23/13, failed to evidence a continuous review of active and closed clinical records.</li> <li>2. On 2/21/14 at 11 AM, the Administrator, Employee A, indicated all she has was the form signed. There was no information/data to back it up.</li> <li>3. A policy titled "Quality Assurance &amp; Utilization Review", Revised 5/3/12, states, "Utilization review will be performed quarterly to maintain quality assurance for all patients. Patient charts will be reviewed by the administrator and/or supervisory nurse. Ten percent of both active and discharged patient services will be reviewed."</li> </ol>		<p>discharged patient services will be reviewed. The results of these audits are maintained in a notebook and on a log. The Administrator will maintain a quarterly chart audit schedule. On 2-27-14, the "Plan, Do, Check and Act" format was chosen as a tool to identify and correct any negativetrends discovered during these chart audits. The Administrator/Assistant Administrator will be responsible for the maintenance and performance of these chart audits.</p>				

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G000330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and interview, it was determined the agency failed to ensure the registered nurse completed a medication review with the comprehensive reassessment that included a review of all medications for potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance in 3 of 10 record reviews with the potential to affect all 49</p>	G000330	The Registered Nurses were re-educated on 3-6-14on the importance of completing a comprehensive assessment on a patient'sreturn home from the hospital. Nurseswere instructed that, when a patient is admitted to the hospital, a Transfer toInpatient Facility assessment must be completed. Then when the patient returns home, acomprehensive Resumption of Care assessment must done. This assessment must include a review of all medications for potential adverse effects, drug	03/21/2014

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	<p>patients (See G 337), failed to ensure the comprehensive assessment was updated within 48 hours of the patient's return home after a hospital admission in 1 of 1 clinical records reviewed of a patient discharged from a hospital with the potential to affect all patients who are hospitalized (See G 340), and failed to ensure a transfer assessment was completed when the patient was admitted to the hospital in 1 of 1 clinical records reviewed of patient who had been hospitalized with the potential to affect all patients who transfer to the hospital and a discharge assessment for 1 of 2 discharge records reviewed with the potential to affect all discharged patients (See G 341).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.55: Comprehensive Assessment of Patients.</p>		<p>reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance. New OASIS forms were obtained, and the nurses were instructed on how to complete these assessment forms. A hospitalization log will be developed by 3-21-14 in order to audit charts and maintain hospitalization information for Quality Assurance. Nurses will be instructed to inform the Administrator of any hospitalized patients in order to maintain this log. The Administrator and/or Director of Nurses will perform quarterly chart audits of hospitalized patients to ensure that the appropriate assessments have been completed. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>		

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G000337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>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 review and interview, the agency failed to ensure the registered nurse completed a medication review with the comprehensive reassessment that included a review of all medications for potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance in 3 of 10 record reviews with the potential to affect all 49 patients. (5, 6, and 7)</p> <p>Findings:</p> <p>1. Clinical record 5, SOC 12/8/11, failed to evidence the registered nurse checked medications on the recertification OASIS dated 1/27/14 for potential adverse effects/drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy. The</p>	G000337	<p>The Registered Nurses were re-educated on 3-6-14 on the importance of completing a comprehensive assessment on a patient's return home from the hospital. Nurses were instructed that, when a patient is admitted to the hospital, a Transfer to Inpatient Facility assessment must be completed by a Registered Nurse. Then when the patient returns home, a comprehensive Resumption of Care assessment must be done, also by a Registered Nurse. This assessment must include a review of all medications for potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance. New OASIS forms were obtained, and the nurses were instructed on how to complete these assessment forms. A hospitalization log will be developed by 3-21-14 in order to audit charts and maintain hospitalization information for Quality Assurance. Nurses will be instructed to inform the</p>	03/21/2014			

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	<p>Medication Profile, a separate document, was dated 1/29/14 and completed by the licensed practical nurse, Employee M.</p> <p>2. Clinical record 6, SOC 9/22/10, failed to evidence the registered nurse checked medications on the recertification OASIS dated 1/1/14 for potential adverse effects/drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy. The medication review was completed by the licensed practical nurse, Employee M.</p> <p>3. Clinical record 7, SOC 1/4/12, failed to evidence the registered nurse checked medications on the recertification OASIS dated 12/21/13 for potential adverse effects/drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy. The medication review was completed by the licensed practical nurse, Employee M.</p> <p>4. On 2/21/14 at 3:30 PM, the Administrator, Employee A, indicated she did not realize the OASIS had not been completed correctly. The licensed practical nurse, Employee M, had been</p>		<p>Administrator of any hospitalized patients in order to maintain this log. The Administrator and/or Director of Nurses will perform quarterly chart audits of hospitalized patients to ensure that the appropriate assessments have been completed by a Registered Nurse. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>	

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G000340	<p>told to do the medication profile by a previous administrator.</p> <p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>Based on clinical record review and interview, the agency failed to ensure the comprehensive assessment was updated within 48 hours of the patient's return home after a hospital admission in 1 of 1 clinical records reviewed of a patient discharged from a hospital with the potential to affect all patients who are hospitalized. (7)</p> <p>Findings:</p> <p>1. Clinical record 7 evidenced a case conference note that identified the patient had been admitted to the hospital</p>	G000340	The Registered Nurses were re-educated on 3-6-14 on the importance of completing a comprehensive assessment on a patient's return home from the hospital within 48 hours of discharge. Nurses were instructed that, when a patient is admitted to the hospital, a Transfer to Inpatient Facility assessment must be completed by a Registered Nurse. Then when the patient returns home, a comprehensive Resumption of Care assessment must be done, also by a Registered Nurse. This assessment must be done within 48 hours of the time the patient returns home. New OASIS forms were obtained, and the nurses	03/21/2014	

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G000341	<p>on 1/5/14 and discharged on 1/8/14. The record failed to evidence a resumption of care comprehensive assessment had been completed.</p> <p>2. On 2/21/14 at 3:30 PM, the Administrator, Employee A, indicated the resumption of care OASIS had not been completed.</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.</p> <p>Based on clinical record review and interview, the agency failed to ensure a transfer assessment was completed when the patient was admitted to the hospital in 1 of 1 clinical records reviewed of patient who had been hospitalized with the potential to affect all patients who transfer to the hospital and a discharge assessment for 1 of 2 discharge records reviewed with the potential to affect all</p>	G000341	<p>were instructed on how to complete these assessment forms. A hospitalization log will be developed by 3-21-14 in order to audit charts and maintain hospitalization information for Quality Assurance. Nurses will be instructed to inform the Administrator of any hospitalized patients in order to maintain this log. The Administrator and/or Director of Nurses will perform quarterly chart audits of hospitalized patients to ensure that the appropriate assessments have been completed by a Registered Nurse. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p> <p>The Registered Nurses were re-educated on 3-6-14 on the importance of completing a comprehensive assessments appropriately. All Registered Nurses were instructed to perform a comprehensive assessment at the following times: * when a patient is admitted to the hospital (Transfer to Inpatient Facility assessment) * when the patient returns home,( Resumption of Care assessment) * when the</p>	03/21/2014			

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N000000	<p>discharged patients. (7 and 10)</p> <p>Findings:</p> <p>1. Clinical record 7 evidenced a case conference note the patient had been admitted to the hospital on 1/5/14 and discharged on 1/8/14. The record failed to evidence the nurse had completed a transfer.</p> <p>2. Clinical record #10 identified the patient had been discharged from the agency. The record failed to evidence the nurse had completed a discharge assessment.</p> <p>3. On 2/21/14 at 3:30 PM, the Administrator, Employee A, indicated the transfer and discharge had not been completed</p> <p>This was a home health state licensure survey.</p> <p>Survey Dates: February 18, 19, 20, and</p>	N000000	<p>patient is discharged from services,(a discharge assessment) New OASIS forms were obtained, and the nurses were instructed on how and when to complete these assessment forms. A hospitalization log will be developed by 3-21-14 in order to audit charts and maintain hospitalization information for Quality Assurance. Nurses will be instructed to inform the Administrator of any hospitalized patients in order to maintain this log.The Administrator will be notified of any patient discharges and will maintain a discharged log. These patient's charts will be audited for completed discharge assessments for the next 90 days. If no negative trends are found, discharge chart audits will be done quarterly. The Administrator and/or Director of Nurses will perform quarterly chart audits of hospitalizedpatients to ensure that the appropriate assessments have been completed by a Registered Nurse. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p> <p>Preparation and execution of this response and plan of correction do not constitute an admission or agreement by Ohio Valley Home Health of the truth of the facts</p>				

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N000442	<p>21, 2014</p> <p>Facility #: 006094</p> <p>Medicaid Vendor #: 200097860</p> <p>Surveyor: Susan E. Sparks, PHNS</p> <p>Agency Census</p> <p>Skilled Patients 30 Home Health Aide Only Patients 19 Personal Service Only Patients 0 Total 49</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 28, 2014</p> <p>410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency.</p> <p>Based on interview and review of documents, the agency failed to ensure the governing body appointed the administrator 1 of 1 administrators reviewed with the potential to affect all</p>	N000442	<p>alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. Credible Allegation of Compliance and Correction: For the purpose of any allegation that Ohio Valley Home Health is not in substantial compliance with the regulations set forth, this plan of correction constitutes Ohio Valley Home Health's credible allegation of correction and compliance.</p> <p>On 2-28-14, The Advisory Board meeting washeld. All members being present by unanimous and written consent reviewed staffing changes and approved the following: Tobey Nelson, R.N., shall serve as Administrator and</p>	03/06/2014			

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N000444	<p>49 patients.</p> <p>Findings:</p> <p>1. Review of agency documents failed to evidence the administrator had been appointed by the governing body.</p> <p>2. On 2/21/14 at 2:30 PM, the Administrator indicated the governing board had not appointed the Administrator.</p> <p>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on clinical record and document review, observation, interview, and</p>	N000444	<p>Acting Supervising Nurse (Director of Nursing). Margaret Kenney, R.N. shall serve asSupervisory Nurse (Assistant Director of Nursing) and Acting Administrator(Assistant Administrator)The minutes from this Advisory Board Meeting are signed and now kept in a binder as of 3-6-14.In order to preventfuture problems with this issue, Statements of Responsibility will be writtenand maintained for Administrator, Assistant Administrator, Director of Nursingand Assistant Director of Nursing. Thesestatements will ensure that any future changes in these positions will bereported in writing immediately to the Indiana Department of Health.The Administratorwill be responsible to maintain these documents and will review them at leastannually to ensure compliance with this regulation.</p> <p>Revised job descriptions will be written for allLicensed Practical Nurses and Registered Nurses to</p>	03/21/2014			

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	<p>confidential interview, the administrator has failed to organize and direct the agency's ongoing functions for 1 of 1 agency with the potential to affect all 49 patients.</p> <p>Findings:</p> <p>1. Clinical record 2, start of care (SOC) 10/20/10, included a plan of care for the certification period 2/3/13 to 1/31/14 that evidenced physician orders for home health aides 2 hour a day 7 days a week. The aide plan of care was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>2. Clinical record 3, SOC 12/14/2009, included a plan of care for the certification period 1/14/2014 to 3/14/14 that evidenced physician orders for home health aides 5-7 times a week, 1-2 hour visits. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 1/30/14 to 3/30/14 that evidenced physician orders for home health aides 2 to 4 times a week, 1 to 2 hours per visit. The aide care plan</p>		<p>ensure that the nurses are aware of the scope of service for each job. The following instructions will be included in these job descriptions: The Licensed Practical Nurse must report to the Registered Nurse/Supervising Nurse any changes that need to be made in a patient's Home Health Aide Care Plan. Only the Registered Nurse may develop and sign the Aide's Care Plan. By 3-21-14, all nurses (LPN's and RN's) will receive and sign a revised copy of their job description. The Administrator will answer all questions regarding the importance of following this policy and ensure that each nurse understands. This will be the job description given to any future employees in order to prevent any recurrence of this issue. The Administrator/Assistant Administrator will review and sign off on all current Home Health Aide Care Plans. The aides will be required to sign a verification statement confirming that they have received each patient's current Care Plan and know the Registered Nurse who developed it in order to report any concerns. The R.N. will review each patient's Aide Care Plan at least every 60 days and whenever changes are needed. In order to prevent any future problems with this issue, all Registered Nurses will also be re-educated by a written memo no later than 3-21-</p>				

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	<p>was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>4. Clinical record 8, SOC 5/14/13, included a plan of care for the certification period 11/10/13 to 1/8/14 that evidenced physician orders for home health aides 1-3 times a week, 1-4 hour visits. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 that evidenced physician orders for home health aides 2 hours day, 5 days a week. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>6. A signed job description by Employee M for "Nursing Coordinator" states, "2. Demonstrate familiarity and abide by all agency policies, procedures, state, and federal rules."</p> <p>7. On 2/21/14 at 4:00 PM, the Administrator, Employee A, indicated the former Administrator set the Nursing Coordinator job up and changed it from</p>		<p>14 regarding the requirements for 14 day/30 day Home Health Aide supervisory visits. They will be informed that backdating supervisory visits is prohibited by Ohio Valley Home Health and will be cause for written disciplinary action up to and including possible termination of employment. The R.N.'s will sign an acknowledgement of receipt of this memo and verification that they understand the policy. To prevent future occurrences of this issue, the Administrator/Assistant Administrator will perform quarterly chart audits of at least 10% of active patient charts to ensure that the Aide's Care Plan is developed, reviewed at least every 60 days, and signed by an R.N. The audit will also include review of the supervisory visits for home health aides. If a trend is noted, chart audits will be increased to monthly and further staff education will be provided until the problem resolves.</p>				

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	<p>the registered nurse to a licensed nurse job. She also instructed the Licensed practical nurse to sign the aide care plan.</p> <p>8. Confidential interview # 1, 2/19/14 at 6 PM, indicated the office manager and Nursing Coordination are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit. This person also indicated the supervisory visits are backdated and changed if the evaluation is negative</p> <p>9. Confidential interview # 3, 2/2/14 in the PM, indicated no one knows who the supervisory nurse is and who should be called with issues. Usually it's the office manager or the Nursing Coordinator. This person also indicated the supervisory visits are backdated to fit the time frame. Interviewee indicated he/she had participated in backdating of supervisory visits</p>			

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N000446	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based upon personnel record review and interview, the administrator failed to ensure the staff had been orientated in their proper fields for 10 of 10 personnel records reviewed with the potential to affect all 49 patients. (A, D, E, F, G, H, I, J, K and L)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Personnel record A, Date of Hire (DOH) 6/17/73, failed to evidence an orientation upon hire.</li> <li>2. Personnel record D, DOH 12/4/13, failed to evidence an orientation upon hire.</li> <li>3. Personnel record E, DOH 12/10/99, failed to evidence an orientation upon hire.</li> <li>4. Personnel record F, DOH 11/8/96, failed to evidence an orientation upon hire.</li> </ol>	N000446	<p>Anew employee orientation check list was developed for aides, LPN's, and RN's. This check list will be maintained in the employee's personnel file. All current staff will undergo re-orientationwith these check lists by 3-21-14. Toprevent any future problems, all new employees will undergo this same neworientation process. TheAdministrator/Director of Nursing will do a personnel file audit every quarterfor 4 quarters to ensure no future problems with this issue occur. If no trends are noted, personnel filereviews will be done on each employees annual review date.</p>	03/21/2014	

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	<p>5. Personnel record G, DOH 8/8/07, failed to evidence an orientation upon hire.</p> <p>6. Personnel record H, DOH 2/24/99, failed to evidence an orientation upon hire.</p> <p>7. Personnel record I, DOH 7/8/13, failed to evidence an orientation upon hire.</p> <p>8. Personnel record J, DOH 8/1/07, failed to evidence an orientation upon hire.</p> <p>9. Personnel record K, DOH 9/7/09, failed to evidence an orientation upon hire.</p> <p>10. Personnel record L, DOH 12/3/13, failed to evidence an orientation upon hire.</p> <p>11. On 2/21/14 at 3:30 PM the Administrator, Employee A, indicated a formal orientation / skill check was not done.</p>			

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N000451	<p>410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. Based on interview and review of documents, the administrator failed to ensure a qualified person was authorized in writing to act in her absence in 1 of 1 administrators reviewed with the potential to affect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of agency documents failed to evidence the administrator had appointed someone to act in her absence.</li> <li>2. On 2/21/14 at 2:30 PM, the Administrator indicated the governing board had not appointed the Administrator nor an alternate administrator to act on her behalf.</li> </ol>	N000451	<p>On 2-28-14, The Advisory Board meeting washeld. All members being present byunanimous and written consent reviewed staffing changes and approved thefollowing:Tobey Nelson, R.N., shall serve as Administratorand Acting Supervising Nurse (Director of Nursing). Margaret Kenney, R.N. shall serve asSupervisory Nurse (Assistant Director of Nursing) and Acting Administrator(Assistant Administrator)The minutes from this Advisory Board Meeting are signed and now kept in a binder as of 3-6-14.In order to preventfuture problems with this issue, Statements of Responsibility will be writtenand maintained for Administrator, Assistant Administrator, Director of Nursingand Assistant Director of Nursing. Thesestatements will ensure that any future changes in these positions will bereported in writing immediately to the Indiana Department of Health.The Administratorwill be responsible to maintain these documents and will review them at leastannually to ensure compliance with this</p>	03/06/2014
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N000454	<p>410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to:</p> <ol style="list-style-type: none"> <li>(1) respond to an emergency;</li> <li>(2) provide guidance to staff;</li> <li>(3) answer questions; and</li> <li>(4) resolve issues;</li> </ol> <p>within a reasonable amount of time, given the emergency or issue that has been raised.</p> <p>Based on confidential interview, the agency failed to ensure the supervising nurse or a qualified alternate was directing the services furnished by the agency in 1 of 1 agency with the potential to affect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Confidential interview # 1, 2/19/14 at 6 PM ,indicated the office manager and Nursing Coordinator are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit.</li> <li>2. Confidential interview # 2, 2/21/14 at 1 PM, indicated the administrator was not available when called. The office manager answers the questions.</li> </ol>	N000454	<p>regulation.</p> <p>On 2-28-14, The Advisory Board meeting was held. All members being present by unanimous and written consent reviewed staffing changes and approved the following: Tobey Nelson, R.N., shall serve as Administrator and Acting Supervising Nurse (Director of Nursing). Margaret Kenney, R.N. shall serve as Supervisory Nurse (Assistant Director of Nursing) and Acting Administrator (Assistant Administrator) The minutes from this Advisory Board Meeting are signed and now kept in a binder as of 3-6-14. In order to prevent future problems with this issue, Statements of Responsibility will be written and maintained for Administrator, Assistant Administrator, Director of Nursing and Assistant Director of Nursing. These statements will ensure that any future changes in these positions will be reported in writing immediately to</p>	03/21/2014	

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N000456	<p>3. Confidential interview # 3, 2/2/14 in the PM, indicated no one knows who the supervisory nurse is and who should be called with issues. Usually it's the office manager or the Nursing Coordinator giving the directions.</p> <p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on the review of the program evaluation summary and policy and interview, the agency failed to review active and closed clinical records in 1 of 1 program's reviewed with the potential to effect all 49 patients.</p> <p>Findings:</p>	N000456	<p>the Indiana Department of Health.A memo will be given to all staff no later than 3-21-14 with a revised Chain ofCommand. All staff will sign an acknowledgement of receipt of this information and will verify that they understand it.This Chain of Command will be included in the New Employee Handbook in order toprevent any further issues.The Administrator will give oversight to this process and use a check list of allemployee names to ensure that all this problem has been resolved and everyoneunderstands the Chain of Command.</p> <p>The Administratoris maintaining a chart audit log which began in January 2014 to verify thatclinical record reviews are being completed on a quarterly basis. Tenpercent of both active and discharged patient services will be reviewed. Results of these chart audits are maintained in a notebook and on a log.TheAdministrator will maintain a quarterly chart audit schedule.</p>	02/27/2014			

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	<p>1. The agency document "Ohio Valley Home Health Program Evaluation Summary", dated 1/23/13, failed to evidence a review of active and closed clinical records.</p> <p>2. On 2/ 18/14 at 11:00 AM, the Administrator, Employee A indicated there was no information about clinical record reviews for the Program Evaluation for 2013. The previous administrator did not collect data.</p> <p>3. On 2/21/14 at 11 AM, the Administrator, Employee A, indicated all she has is the form signed. There was no information / data to back it up.</p> <p>4. A policy titled "Quality Assurance &amp; Utilization Review", Revised 5/3/12, states, "Utilization review will be performed quarterly to maintain quality assurance for all patients. Patient charts will be reviewed by the administrator and/or supervisory nurse. Ten percent of both active and discharged patient services will be reviewed."</p>		<p>On 2-27-14, the "Plan,Do, Check and Act" format was chosen as a tool to identify and correct any negativetrends discovered during these chart audits.TheAdministrator/Assistant Administrator will be responsible for the maintenanceand performance of these chart audits.</p>		

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N000472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on the review of the program evaluation summary and policy and interview, the agency failed to review active and closed clinical records in 1 of 1 program's reviewed with the potential to effect all 49 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The agency document "Ohio Valley Home Health Program Evaluation Summary", dated 1/23/13, failed to evidence a review of active and closed clinical records.</li> <li>On 2/21/14 at 11 AM, the Administrator, Employee A, indicated all she has is the form signed. There was no information / data to back it up.</li> </ol>	N000472	The Administratoris maintaining a chart audit log which began in January 2014 to verify thatclinical record reviews are being completed on a quarterly basis. Tenpercent of both active and discharged patient services will be reviewed. These results are maintained in a notebook and on a log. TheAdministrator will maintain a quarterly chart audit schedule. On 2-27-14, the "Plan,Do, Check and Act" format was chosen as a tool to identify and correct any negativetrends discovered during these chart audits.TheAdministrator/Assistant Administrator will be responsible for the maintenancand performance of these chart audits.	02/27/2014			

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N000484	<p>3. A policy titled "Quality Assurance &amp; Utilization Review", Revised 5/3/12, states, "Utilization review will be performed quarterly to maintain quality assurance for all patients. Patient charts will be reviewed by the administrator and/or supervisory nurse. Ten percent of both active and discharged patient services will be reviewed."</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on home visits observation and interview, the agency failed to ensure all personnel were coordinating care in 1 of 5 home visits with the potential to affect all 49 patients. (2)</p> <p>Findings:</p> <p>1. On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, was observed with Employee F, a home health aide (HHA). The patient is a quadrapalegic patient with limited use of both hands. The HHA mover the patient to the electric</p>	N000484	An in-service was given to all staff regarding reporting changes and communication with the Registered Nurse/Director of Nursing/Administrator. Staff was educated on the importance of reporting any patient safety concerns immediately to the responsible R.N., including problems with any medical equipment. A memo will also be distributed to all employees with the Chain of Command to ensure that staff understands who to report this information to in the office. To avoid future problems, new employees will be given	03/21/2014			

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N000500	<p>wheelchair after the bath. The patient's electric wheelchair has a high back for support and the part that allows the patient to recline is broke. The patient must sit bent forward while in the chair and has a tendency to slide outward of the chair. The patient was obviously uncomfortable and indicated he was concerned he would slide from the chair. The HHA indicated she knew the chair was broken and had not called the office. The patient indicated the RN knew the chair was broken.</p> <p>2. At 1:30 PM the Administrator, Employee A, stated she did not know the chair was broken.</p> <p>410 IAC 17-12-3(b)(2)(B) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so. Based on interview, the agency failed to ensure patients had been informed they have the right to voice their grievances</p>	N000500	<p>these in-services and the Chain ofCommand information. The will sign verification that theyunderstand these instructions.TheAdministrator/Director of Nursing will do a personnel file audit of allemployee files no later than 3-21-14 to ensure that every employee has signedverification of receipt of this information. New employee files will be auditedby the Administrator every quarter for 4 quarters to ensure no future problemswith this issue occur. If no trends are noted, personnel file reviews will bedone on each employees annual review date.</p> <p>We have re-written our New Admission Packet with information regarding Patient Rights, including the State Hotline</p>	03/21/2014			

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	<p>in 5 of 5 home visits conducted with the potential to affect all 49 patients. (1, 2, 3, 4, and 5)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 2/19/14 at 10 AM, Patient 1, Home Visit 1, indicated the patient was unaware of a grievance system and a state hotline to call if there are problems.</li> <li>On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, indicated the patient was unaware of a grievance system and a state hotline to call if there are problems.</li> <li>On 2/20/14 at 10:00 AM, Patient 3, Home Visit 3, indicated the patient was unaware of a grievance system and a state hotline to call if there are problems.</li> <li>On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, the caretaker indicated they were unaware of a grievance system and a state hotline to call if there are problems.</li> <li>On 2/20/14 at 11:30 AM, Patient 5, Home Visit 5, indicated the patient was unaware of a grievance system and a state hotline to call if there are problems.</li> </ol>		<p>phone number. We are distributing this new packet to current patients and having them sign acknowledgement of receipt of this information. In order to prevent future problems with patient right's information, we will give every new patient this New Admission Packet and have them sign acknowledgement of receipt for this information. The Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information. The first chart audit will be completed by March 21, 2014.</p>		

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N000502	<p>410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on interview and review of agency rights document, the agency had failed to ensure the patients had been informed of the state hot line to file complaints for 10 of 10 clinical records (1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) reviewed and 5 of 5 home visits (1, 2, 3, 4, and 5) conducted with the potential to affect all 49 patients.</p> <p>Findings:</p> <p>1. The Admission Packet Rights Document failed to evidence the patient was informed of the availability state hot line.</p> <p>On 2/21/14 at 4:00 PM the Administrator, Employee A indicated the state hotline was not part of the admission packet.</p> <p>2. On 2/19/14 at 10 AM, Patient 1, Home Visit 1, state of care (SOC) 1/30/13, indicated the patient was unaware of a state hotline to call if there</p>	N000502	We have re-written our New Admission Packet with information regarding Patient Rights, including the State Hotline phone number. We are distributing this new packet to current patients and having them sign acknowledgement of receipt of this information. In order to prevent future problems with patient right's information, we will give every new patient this New Admission Packet and have them sign acknowledgement of receipt for this information. The Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information. The first chart audit will be completed by March 21, 2014.	03/21/2014			

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	<p>are problems. The clinical record indicated the patient signed for rights 1/30/13.</p> <p>2. On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, SOC 10/20/10, indicated the patient was unaware of a a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 10/20/10.</p> <p>3. On 2/20/14 at 10:00 AM, Patient 3, Home Visit 3, SOC 7/29/05, indicated the patient was unaware of a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 7/27/05.</p> <p>4. On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, SOC 12/14/09, and caretaker indicated they were unaware of a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 12/14/09.</p> <p>5. On 2/20/14 at 11:30 AM, Patient 5, Home Visit 5, SOC 12/8/11, indicated the patient was unaware of a state hotline to call if there are problems. The clinical record indicated the patient signed for rights 12/8/11.</p> <p>6. Clinical records #1-10 evidenced the patient had received the admission rights</p>			

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N000522	<p>documents.</p> <p>410 IAC 17-13-1(a) Patient Care 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: Based on clinical record and policy review, home visit and interview the agency failed to ensure their staff followed the written plan of care as order in 5 of 10 cases reviewed with the potential to affect all 49 patients. (1, 4, 5, 9 and 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 1/30/13, included a plan of care for the certification period 11/26/13 to 1/24/14 with physician orders for nursing 1-3 times a week 8-9 hour visit. The clinical record evidences orders for straight cath every 4 hours, clean buttocks and coccyx daily and prn with normal saline and apply magic butt cream to areas, measure weekly. The clinical record failed to evidence straith cath's every 4 hours on 11/27, 11/29, 12/2, 12/4, 12/5, 12/9, 12/11, 12/12, 12/16, 12/18, 12/19, 12/23, 12/24, 12/26, 12/30, 12/31/13, 1/2, 1/6, 1/8, 1/9, 1/13, 1/15, 1/16, 1/20, 1/22, 1/23/14. The clinical record failed</p>	N000522	All nurses will complete an in-service oncharting and documentation by 3-21-14. They will also receive written instructions regarding the importance of following physician's orders/Plan of Care. A new nursing assessment form is now being utilized in order to improve documentation. A memo will be given to all nurses informing them of the importance of following the Plan of Care. They will be instructed in this memo that failure to follow the Plan of Care will be cause for disciplinary action up to and including possible termination of employment. All nursing documentation beginning March 6, 2014 will be reviewed by the Administrator for a period of 45 days. Special attention will be given to reviewing notes regarding straight caths, wound measurements, medication orders, and patient repositioning; however, all notes will be evaluated for accuracy. If no problems are found, the Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of	03/21/2014			

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	<p>to evidence wound measurements at any time during the certification period.</p> <p>2. Clinical record 4, SOC 1/29/2005, included a plan of care for the certification period 12/12/13 to 2/9/14 with physician orders for nursing 2-3 times a week, 4-8 hours visits. The clinical record evidenced four visits week 2, 4, and 6. The clinical record evidenced a insulin sliding scale of 200-229=1 unit, 230-250=2 unit, 251-275=2.5 units, 276-300=3 units, 302 or greater =3.5 units. The clinical record failed to evidence insulin administration on 12/16 with a blood sugar (BS) of 214, 12/17 BS of 223, 12/24 BS of 245, 12/27 BS of 223, 12/31/13 BS of 266, 1/2/14 BS of 234, 1/3 BS of 207, 1/4 BS of 245, 1/8 BS of 232, 1/9 BS of 234, 1/10 BS of 232, 1/13 BS of 340, 1/15 BS of 348, 1/18 BS of 223, 1/22 BS of 345, 1/24 BS of 247, 1/29 BS of 201, 2/5 BS of 237, and 2/6/14 BS of 234.</p> <p>On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, Employee J, a Licensed Practical Nurse (LPN) was observed to take the patient's blood sugar which was 186. This surveyor asked the LPN what were the orders for the blood sugar sliding scale. The LPN indicated insulin was to be administered at 200 but the</p>		<p>active patient charts to ensure that the patients have all signed acknowledgement of the receipt of this patient rights information. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>				

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	<p>sister wouldn't allow it. The sister had a water scale and the LPN administered water through the g-tube for the different levels of the blood sugar. Unless the level reached the highest levels they didn't give the insulin on a regular basis.</p> <p>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 12/1/13 to 1/29/14 with physician orders for home health aide 2-4 times a week, 1-2 hours per visit. The clinical record evidenced attendant and homemaker visits but failed to evidence physician orders for visits.</p> <p>4. Clinical record 9, SOC 11/17/11, included a plan of care for the certification period 1/5/14 to 3/5/14 with physician orders for skilled nurse 5 to 7 times a week for 10-12 hours a visits. The clinical record failed to evidence orders for bilateral DAFO's for 2 hours on and 2 hours off while awake, patient to wear hand splints daily 2 hours at a times, TSLO brace daily for 15 to 20 minutes (Provide tactile stimulation during activity), Position head to right side for 15 minutes, then to left side for 15 minutes while lying prone, provide oral stimulation to lips 1-2 times on each side while prone. The clinical record evidenced the above activities 1/19,</p>			

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	<p>1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/1, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14 and 2/15/14.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 with physician orders for HHA 2 hours a day 5 days a week and nursing visit 1 hour every week for medication set up. The clinical record failed to evidence 1 hour visits weeks 1, 2, 3, 4, 5, 6, 7, 8 and 9. The clinical record failed to evidence 2 hour visits 5 days a week for weeks 1, 2, 3, 4, 5, 6, 7, 8 and 9</p> <p>6. A policy titled "Pharmaceutical Administration", Revised 5/2/12, states, "Ohio Valley Registered Nurses and Licensed Practical Nurses are the only clinical staff to administer prescribed pharmaceuticals in the home and only as ordered by the physician."</p> <p>7. A policy titled "Documentation", Revised 12/6/04, states, "Documentation reflects the quality of care and provides evidence of each health care team member's responsibility in giving care."</p>			

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N000537	<p>410 IAC 17-14-1(a) Scope of Services 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: Based on clinical record and policy review, observation, and interview, the agency failed to ensure skilled nurses followed the physician plan of care in 4 of 10 records reviewed with the potential to affect all patients that receive skilled nurse services. (1, 4, 9, and 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 1/30/13, included a plan of care for the certification period 11/26/13 to 1/24/14 with physician orders for nursing 1-3 times a week 8-9 hour visit. The clinical record evidences orders for straight cath every 4 hours, clean buttocks and coccyx daily and prn with normal saline and apply magic butt cream to areas, measure weekly. The clinical record failed to evidence straith cath's every 4 hours on 11/27, 11/29, 12/2, 12/4, 12/5, 12/9, 12/11, 12/12, 12/16, 12/18, 12/19, 12/23, 12/24, 12/26, 12/30, 12/31/13, 1/2, 1/6, 1/8, 1/9, 1/13, 1/15, 1/16, 1/20, 1/22, 1/23/14. The clinical record failed to evidence wound measurements at any</p>	N000537	<p>All nurses will complete an in-service oncharting and documentation by 3-21-14. They will also receive written instructions regarding the importance of following physician's orders/Plan of Care. A new nursing assessment form is now being utilized in order to improve documentation. A memo will be given to all nurses informing them of the importance of following the Plan of Care. They will be instructed in this memo that failure to follow the Plan of Care will be cause for disciplinary action up to and including possible termination of employment. All nursing documentation beginning March 6, 2014 will be reviewed by the Administrator for a period of 45 days. Special attention will be given to reviewing notes regarding straight caths, wound measurements, medication orders, and patient repositioning; however, all notes will be evaluated for accuracy. If no problems are found, the Administrator and/or Director of Nurses will perform quarterly chart audits of at least 10% of active patient charts to ensure that the patients have all</p>	03/21/2014			

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	<p>time during the certification period.</p> <p>2. Clinical record 4, SOC 1/29/2005, included a plan of care for the certification period 12/12/13 to 2/9/14 with physician orders for nursing 2-3 times a week, 4-8 hours visits. The clinical record evidenced four visits week 2, 4, and 6. The clinical record evidenced a insulin sliding scale of 200-229=1 unit, 230-250=2 unit, 251-275=2.5 units, 276-300=3 units, 302 or greater =3.5 units. The clinical record failed to evidence insulin administration on 12/16 with a blood sugar (BS) of 214, 12/17 BS of 223, 12/24 BS of 245, 12/27 BS of 223, 12/31/13 BS of 266, 1/2/14 BS of 234, 1/3 BS of 207, 1/4 BS of 245, 1/8 BS of 232, 1/9 BS of 234, 1/10 BS of 232, 1/13 BS of 340, 1/15 BS of 348, 1/18 BS of 223, 1/22 BS of 345, 1/24 BS of 247, 1/29 BS of 201, 2/5 BS of 237, and 2/6/14 BS of 234.</p> <p>On 2/20/14 at 11:35 AM, Patient 4, Home Visit 4, Employee J, a Licensed Practical Nurse (LPN) was observed to take the patient's blood sugar which was 186. This surveyor asked the LPN what were the orders for the blood sugar sliding scale. The LPN indicated insulin was to be administered at 200 but the sister wouldn't allow it. The sister had a</p>		signed acknowledgement of the receipt of this patient rights information. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.				

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	<p>water scale and the LPN administered water through the g-tube for the different levels of the blood sugar. Unless the level reached the highest levels they didn't give the insulin on a regular basis.</p> <p>3. Clinical record 9, SOC 11/17/11, included a plan of care for the certification period 1/5/14 to 3/5/14 with physician orders for skilled nurse 5 to 7 times a week for 10-12 hours a visits. The clinical record failed to evidence orders for bilateral DAFO's for 2 hours on and 2 hours off while awake, patient to wear hand splints daily 2 hours at a times, TSLO brace daily for 15 to 20 minutes (Provide tactile stimulation during activity), Position head to right side for 15 minutes, then to left side for 15 minutes while lying prone, provide oral stimulation to lips 1-2 times on each side while prone. The clinical record evidenced the above activities 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, 2/1, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7, 2/9, 2/10, 2/11, 2/12, 2/13, 2/14 and 2/15/14.</p> <p>4. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 with physician orders for HHA 2 hours a day 5 days a week and nursing visit 1 hour every week for medication set up.</p>			

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N000539	<p>The clinical record failed to evidence 1 hour visits weeks 1, 2, 3, 4, 5, 6, 7, 8 and 9.</p> <p>5. A policy titled "Pharmaceutical Administration", Revised 5/2/12, states, "Ohio Valley Registered Nurses and Licensed Practical Nurses are the only clinical staff to administer prescribed pharmaceuticals in the home and only as ordered by the physician."</p> <p>6. A policy titled "Documentation", Revised 12/6/04, states, "Documentation reflects the quality of care and provides evidence of each health care team member's responsibility in giving care."</p> <p>410 IAC 17-14-1(a)(1) Scope of Services Rule 14 Sec. 1(a)(1) The registered nurse shall perform nursing duties in accordance with the Indiana Nurse Practice Act (IC 25-23). Based on interview and review of the Indiana Nurse Practice Act 848 IAC 2-2-2 Responsibility as a member of the nursing profession Sec. 2. 11. (A)(B)(C), the agency failed to ensure the administrator's drug usage was reported to the proper authority in 1 of 1 impaired nurses with the potential to affect all patients for whom the administrator cared or made decisions about.</p>	N000539	A letter was faxed and mailed on 3-4-14 from Ohio Valley Home Health's attorney to the Indiana State Board of Nursing notifying them of the concerns regarding the previous Administrator's (Leah House, R.N.) suspected drug addiction and abuse. The Administrator will re-educate all management staff (including the owner of the agency, all Registered Nurses, all Licensed	03/21/2014			

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>On 2/21/14 at 2:30 PM, the Administrator, Employee A, a registered nurse, indicated the agency had not reported the previous administrator, a registered nurse, for obvious drug usage.</li> <li>On 2/21/14 at 2:30 PM the Office Manager, Employee B, indicated the previous administrator would fall asleep while talking, would have days of nonsensicalness, would call other nurses to come and take her urine tests in order to get more prescriptions. She indicated many days she was non functioning.</li> <li>On 2/21/14 at 1:00 PM a Confidential Interview indicated the previous administrator is applying for patient care positions in the community.</li> </ol> <p>C. "848 IAC 2-2-2 Responsibility as a member of the nursing profession Authority: IC 25-23-1-7 Affected: IC 25-23 Sec. 2. The registered nurse shall do the following: ... (11) Notify, in writing, the appropriate party, which may include: (A) the office of the attorney general, consumer protection division; (B) his or her employer or contracting agency; or (C) the board; of any</p>		<p>Practical Nurses, and office managers) by written memo dated no later than 3-21-14. This memo will ensure that all staff are aware of Ohio Valley Home Health's policy and the Indiana Nurse Practice Act 848 IAC 2-2-2 regarding the responsibility as a member of the nursing profession to report any suspicion of an impaired nurse. The staff will be instructed in this memo to report any such concerns immediately to the Administrator and/or Director of Nursing. This information will also be included in the New Employee handbook to ensure all future staff are also aware of this important policy. The Administrator and/or Director of Nursing will be responsible to follow up with any reported concerns and will report them immediately to the proper authorities for investigation. On 3-6-14, an in-service was given to all nurses (R.N.'s and L.P.N.'s) regarding Standard Universal Precautions and infection control information. The nurses were given a written test and completed a demonstration and skill check off with the Administrator to ensure competency.</p>				

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N000541	<p>unprofessional conduct which may jeopardize the patient/client safety."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's need by the completion of a comprehensive assessment on the patient's return home after a hospital admission in 1 of 1 clinical records reviewed of a patient discharged from a hospital with the potential to affect all patients who are hospitalized. (7)</p> <p>Findings:</p> <p>1. Clinical record 7 evidenced a case conference note that identified the patient had been admitted to the hospital on 1/5/14 and discharged on 1/8/14. The record failed to evidence a resumption of care comprehensive assessment had been completed.</p> <p>2. On 2/21/14 at 3:30 PM, the Administrator, Employee A, indicated</p>	N000541	<p>The Registered Nurses were re-educated on 3-6-14 on the importance of completing a comprehensive assessments appropriately. All Registered Nurses were instructed to perform a comprehensive assessment at the following times: * when a patient is admitted to the hospital (Transfer to Inpatient Facility assessment) * when the patient returns home,( Resumption of Care assessment within 48 hours) * when the patient is discharged from services,(a discharge assessment) New OASIS forms were obtained, and the nurses were instructed on how and when to complete these assessment forms. A hospitalization log will be developed by 3-21-14 in order to audit charts and maintain hospitalization information for Quality Assurance. Nurses will be instructed to inform the Administrator of any hospitalized patients in order to maintain this</p>	03/21/2014
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N000545	<p>the resumption of care OASIS had not been completed.</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on home visits observation and interview, the agency failed to ensure all personnel were coordinating care in 1 of 5 home visits with the potential to affect all 49 patients. (2)</p> <p>Findings:</p> <p>1. On 2/19/14 at 12:55 PM, Patient 2, Home Visit 2, was observed with Employee F, a home health aide (HHA).</p>	N000545	<p>log. The Administrator will be notified of any patient discharges and will maintain a discharged log. These patient's charts will be audited for completed discharge assessments for the next 90 days. If no negative trends are found, discharge chart audits will be done quarterly. The Administrator and/or Director of Nurses will perform quarterly chart audits of hospitalized patients to ensure that the appropriate assessments have been completed by a Registered Nurse. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p> <p>An in-service was given to all staff regarding reporting changes and communication with the Registered Nurse/Director of Nursing/Administrator. Staff was educated on the importance of reporting any patient safety concerns immediately to the responsible R.N., including problems with any medical equipment. A memo will also be distributed to all employees with the Chain of Command to ensure</p>	03/21/2014	

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N000550	<p>The patient is a quadriplegic patient with limited use of both hands. The HHA mover the patient to the electric wheelchair after the bath. The patient's electric wheelchair has a high back for support and the part that allows the patient to recline is broke. The patient must sit bent forward while in the chair and has a tendency to slide outward of the chair. The patient was obviously uncomfortable and indicated he was concerned he would slide from the chair. The HHA indicated she knew the chair was broken and had not called the office. The patient indicated the RN knew the chair was broken.</p> <p>2. At 1:30 PM the Administrator, Employee A, stated she did not know the chair was broken.</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on home health aide care plans and policy review, job description review, and interview, the agency failed</p>	N000550	<p>that staff understands whoto report this information to in the officeTo avoid futureproblems, new employees will be given these in-services and the Chain ofCommand information. The will sign verification that theyunderstand these instructions.TheAdministrator/Dir ector of Nursing will do a personnel file audit of allemployee files no later than 3-21-14 to ensure that every employee has signedverification of receipt of this information. New employee files will be auditedby the Administrator every quarter for 4 quarters to ensure no future problemswith this issue occur. If no trends are noted, personnel file reviews will bedone on each employees annual review date.</p> <p>The Administrator/Assistant Administrator will review and sign off on all currentHome Health Aide Care Plans by 3/21/14. The aides will be required to sign a</p>	03/21/2014			

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	<p>to ensure the written patient care instructions for the home health aide were prepared by the registered nurse in 5 of 5 records reviewed of patients who received home health aide services with the potential to affect all patients that receive home health aide services. (2, 3, 5, 8 and 10)</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record 2, start of care (SOC) 10/20/10, included a plan of care for the certification period 2/3/13 to 1/31/14 that evidenced physician orders for home health aides 2 hour a day 7 days a week. The aide plan of care was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</li> <li>2. Clinical record 3, SOC 12/14/2009, included a plan of care for the certification period 1/14/2014 to 3/14/14 that evidenced physician orders for home health aides 5-7 times a week, 1-2 hour visits. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</li> <li>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 1/30/14 to 3/30/14</li> </ol>		<p>verification statement confirming that they have received each patient's current Care Plan and know the Registered Nurse who developed it in order to report any concerns. The R.N. will review each patient's Aide Care Plan at least every 60 days and whenever changes are needed. To prevent future occurrences of this issue, the Administrator/Assistant Administrator will perform quarterly chart audits of at least 10% of active patient charts to ensure that the Aide's Care Plan is developed, reviewed at least every 60 days, and signed by an R.N. If a trend is noted, chart audits will be increased to monthly and further staff education will be provided until the problem resolves.</p>		

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	<p>that evidenced physician orders for home health aides 2 to 4 times a week, 1 to 2 hours per visit. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>4. Clinical record 8, SOC 5/14/13, included a plan of care for the certification period 11/10/13 to 1/8/14 that evidenced physician orders for home health aides 1-3 times a week, 1-4 hour visits. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 that evidenced physician orders for home health aides 2 hours day, 5 days a week. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>6. The agency document titled "Home Health Aide Care Plan" dated 1994, states the person filling out the form is to "Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc.</p>			

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N000563	<p>as needed beside the appropriate item."</p> <p>7. A signed job description by Employee M for "Nursing Coordinator" states, "2. Demonstrate familiarity and abide by all agency policies, procedures, state, and federal rules."</p> <p>8. On 2/21/14 at 4:00 PM, the Administrator, Employee A, indicated the former Administrator set the Nursing Coordinator job up and changed it from the registered nurse to a licensed nurse job. She also instructed the LPN to sign the aide care plan.</p> <p>9. Confidential interview # 1, on 2/19/14 at 6 PM, indicated the office manager and Nursing Coordinator are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit.</p> <p>410 IAC 17-14-1(c)(2) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months; Based on clinical record review and interview the agency failed to ensure the comprehensive assessment was updated upon hospital admission in 1 of 1 clinical records reviewed with a patient hospital admission with the potential to</p>	N000563	The Registered Nurses were re-educated on 3-6-14 on the importance of completing a comprehensive assessments appropriately. All Registered Nurses were instructed to perform a comprehensive assessment at the following	03/21/2014			

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	<p>affect all 49 patients. (7)</p> <p>Findings:</p> <p>1. Clinical record 7, start of care 7, for the certification period 12/14/13 to 2/21/14 evidenced a case conference note the patient had been admitted to the hospital on 1/5/14 and discharged on 1/8/14.</p> <p>2. On 2/21/14 at 3:30 PM, the Administrator, Employee A indicated the transfer OASIS had not been completed.</p>		<p>times: * when a patient is admitted to the hospital (Transfer to Inpatient Facility assessment) * when the patient returns home,( Resumption of Care assessment within 48 hours) * when the patient is discharged from services,(a discharge assessment) New OASIS forms were obtained, and the nurses were instructed on how and when to complete these assessment forms. A hospitalization log will be developed by 3-21-14 in order to audit charts and maintain hospitalization information for Quality Assurance. Nurses will be instructed to inform the Administrator of any hospitalized patients in order to maintain this log. The Administrator will be notified of any patient discharges and will maintain a discharged log. These patient's charts will be audited for completed discharge assessments for the next 90 days. If no negative trends are found, discharge chart audits will be done quarterly. The Administrator and/or Director of Nurses will perform quarterly chart audits of hospitalized patients to ensure that the appropriate assessments have been completed by a Registered Nurse. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p>		

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N000586	<p>410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas:</p> <p>(1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff.</p> <p>(2) Observing, reporting, and documenting patient status and the care or service furnished.</p> <p>(3) Reading and recording temperature, pulse, and respiration.</p> <p>(4) Basic infection control procedures and universal precautions.</p> <p>(5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</p> <p>(6) Maintaining a clean, safe, and healthy environment.</p> <p>(7) Recognizing emergencies and knowledge of emergency procedures.</p> <p>(8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property.</p> <p>(9) Appropriate and safe techniques in personal hygiene and grooming that include the following:</p> <p>(A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene.</p>			
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	<p>(F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform.</p> <p>Based on continuing education document review and interview, the agency failed to ensure continuing education for the home health aides from 1/1/13 to 12/31/13 was under the supervision of a registered nurse and at least 8 of the subjects were topics under Rule 14 Sec. 1(h) in 1 of 1 continuing education in-services reviewed with the potential to affect all 49 patients.</p> <p>Findings:</p> <p>1. On 2/21/14 at 3:30 PM, the Administrator, Employee A indicated the in-services are purchased through a company, with no control over the subject material and no quality checks of who is writing the in-services and the agreement was entered into by the old administrator and has not been reviewed since.</p> <p>2. On 2/21/14 at 3:30 PM, the Clinical Manager, Employee B indicated the in-services are downloaded by the</p>	N000586	<p>All home health aides are being given in-services to be completed by 3-21-14 regarding the following topics: Bed bath Infection control Standard precautions Documentation Communication Reporting Changes in Condition Patient Safety and Medical Equipment We have changed our plan for annual in-services to better reflect the topics required by state and federal regulations. The R.N. Administrator is responsible for developing and maintaining these planned in-services. The Home Health Aide Care Plans for each patient will be signed by the responsible RN in order to ensure that the aide knows who to report changes and concerns to in the office. All Registered Nurses will be re-educated by a written memo no later than 3-21-14 regarding the requirements for 14 day/30 day Home Health Aide supervisory visits. The Supervisory Visit forms were revised to include more information and areas to observe the aide's skill, patient concerns, DME problems, etc.. The R.N.</p>	03/21/2014	

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N000602	<p>scheduler, printed out, put in their payroll envelope, filled out, turned back in and a registered nurse is not the controlling factor. The Nursing Coordinator, a licensed practical nurse, is in charge of keeping track of the in-services.</p> <p>3. A review of the 12 continuing education topics completed in 2013 evidenced only 6 were on the required subjects under Rule 14 Sec. 1 (h).</p> <p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only cases). Based on clinical record and policy review, interview, and job description review, the agency failed to ensure the home health aide was assigned to a specific patient by the registered nurse in 5 of 5 records reviewed of patients who received home health aide services with the potential to affect all patients that receive home health aide services. (2, 3, 5, 8 and 10)</p> <p>Findings:</p>	N000602	<p>will observe a specific skill being performed by the aide at least every 60 days. The R.N.'s will sign an acknowledgement and verification that they understand this requirement. The Administrator will review the inservice log monthly to ensure that every aide has completed the appropriate inservices in a timely manner. The Administrator and/or Director of Nurses will perform quarterly chart audits of to ensure that supervisory visits have been completed in the appropriate time frame. If trends are found, chart audits will be conducted on a monthly basis until the problem resolves. If no trends are found, quarterly chart audits will continue.</p> <p>The Administrator/Assistant Administrator will review and sign off on all current Home Health Aide Care Plans by 3/21/14. The aides will be required to sign a verification statement confirming that they have received each patient's current Care Plan and know the Registered Nurse who developed it in order to report any concerns. The R.N. will review each patient's Aide Care Plan at least every 60 days and whenever changes are needed. A memo regarding communication</p>	03/21/2014

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NAME OF PROVIDER OR SUPPLIER  OHIO VALLEY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1513 STATE ST NEW ALBANY, IN 47150		
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	<p>1. Clinical record 2, start of care (SOC) 10/20/10, included a plan of care for the certification period 2/3/13 to 1/31/14 that evidenced physician orders for home health aides 2 hour a day 7 days a week. The aide plan of care was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>2. Clinical record 3, SOC 12/14/2009, included a plan of care for the certification period 1/14/2014 to 3/14/14 that evidenced physician orders for home health aides 5-7 times a week, 1-2 hour visits. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>3. Clinical record 5, SOC 12/8/11, included a plan of care for the certification period 1/30/14 to 3/30/14 that evidenced physician orders for home health aides 2 to 4 times a week, 1 to 2 hours per visit. The aide care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>4. Clinical record 8, SOC 5/14/13, included a plan of care for the certification period 11/10/13 to 1/8/14</p>		<p>and chain of command is being issued to all staff by 3/21/2014 in order to end confusion regarding who is in charge in the lines of authority. To prevent future occurrences of this issue, the Administrator/Assistant Administrator will perform quarterly chart audits of at least 10% of active patient charts to ensure that the Aide's Care Plan is developed, reviewed at least every 60 days, and signed by an R.N. If a trend is noted, chart audits will be increased to monthly and further staff education will be provided until the problem resolves.</p>		

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	<p>that evidenced physician orders for home health aides 1-3 times a week, 1-4 hour visits. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>5. Clinical record 10, SOC unknown, included a plan of care for the certification period 11/16/13 to 1/14/14 that evidenced physician orders for home health aides 2 hours day, 5 days a week. The aides care plan was signed by Employee M, a licensed practical nurse, operating as the Nursing Coordinator.</p> <p>6. The agency document titled "Home Health Aide Care Plan" dated 1994, states the person filling out the form is to "Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc. as needed beside the appropriate item."</p> <p>7. A signed job description by Employee M for "Nursing Coordinator" states, "2. Demonstrate familiarity and abide by all agency policies, procedures, state, and federal rules."</p> <p>8. On 2/21/14 at 4:00 PM, the Administrator, Employee A, indicated</p>			

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N000604	<p>the former Administrator set the Nursing Coordinator job up and changed it from the registered nurse to a licensed nurse job. She also instructed the LPN to sign the aide care plan.</p> <p>9. Confidential interview # 1, on 2/19/14 at 6 PM, indicated the office manager and Nursing Coordinator are making all the decisions. No one is sure who the supervisory nurse is at the moment. The previous one quit.</p> <p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on observation and interview, the agency failed to ensure the home health aide (HHA) reported changes in the patient's condition to the nurse in 2 of 5 home visit observations with the potential to affect all patients receiving home health aide services. (3 and 5)</p> <p>Findings:</p> <p>1. On 2/20/14 at 10:00 AM, Patient 3, Home Visit 3, the patient was observed with an open area under the right breast.</p>	N000604	An in-service was given to all home health aides regarding reporting changes and communication with the Registered Nurse/Director of Nursing/Administrator. The aides were educated on the importance of reporting any patient concerns or changes in condition (i.e. skin problems, medication problems) immediately to the responsible R.N., including problems with any medical equipment. A memo will also be distributed to all employees with the Chain of Command to ensure that staff understands who to report this information to in the office.	03/21/2014	

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N000606	<p>The HHA instructed the patient to call the doctor rather than notify the nurse.</p> <p>2. On 2/20/14 at 12:30 PM, Patient 5, Home Visit 5, the patient was observed with a raspy cough. The HHA asked the patient if the antibiotics the traveling doctors had prescribed were working. The patient indicated there were some problems. The HHA indicated the patient should call the traveling doctors rather than notify the nurse.</p> <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 confidential interviews, the agency failed to ensure supervisory visits were completed timely for 1 of 1 agency with the potential to affect all patients that receive home health aide services.</p> <p>Findings:</p> <p>1. Confidential interview # 1, 2/19/14 at</p>	N000606	<p>avoid future problems, new employees will be given these in-services and the Chain of Command information. The will sign verification that they understand these instructions. The Administrator/Director of Nursing will do a personnel file audit of all employee files no later than 3-21-14 to ensure that every employee has signed verification of receipt of this information. New employee files will be audited by the Administrator every quarter for 4 quarters to ensure no future problems with this issue occur. If no trends are noted, personnel file reviews will be done on each employees annual review date.</p> <p>All Registered Nurses will be re-educated by a written memo no later than 3-21-14 regarding the requirements for 14 day/30 day Home Health Aide supervisory visits. They will be informed that backdating supervisory visits is prohibited by Ohio Valley Home Health and will be cause for written disciplinary action up to and including possible termination of</p>	03/21/2014	

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	<p>6 PM, indicated the supervisory visits are backdated and changed if the evaluation is negative.</p> <p>2. Confidential interview # 2, 2/21/14 at 1 PM, indicated the supervisory visits are backdated to fit the time frame. Interviewee indicated he/she had participated in backdating supervisory visits.</p>		<p>employment. The R.N.'s will sign an acknowledgement of receipt of this memo and verification that they understand the policy. The supervisory visit form has been revised to include spaces to document a skill performed by the aide during the visit. This will enable our agency to perform actual skill check offs at least once every 60 days with all of the aides according to regulations. To prevent future occurrences of this issue, the Administrator/Assistant Administrator will perform quarterly chart audits of at least 10% of active patient charts to ensure that the supervisory visits for home health aides are being done according to regulations. If a trend is noted, chart audits will be increased to monthly and further staff education will be provided until the problem resolves.</p>	