

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/31/2014
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NAME OF PROVIDER OR SUPPLIER  SAFE AT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 14TH STREET BEDFORD, IN 47421
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G000000	<p>This was a Federal home health recertification survey.</p> <p>The survey was partial extended on December 23rd, 2014</p> <p>Survey Dates: December 23-24th and December 29-31st , 2014</p> <p>Facility #: IN012617</p> <p>Medicaid Vendor # 201044850</p> <p>Surveyor: Nina Koch, RN, PHNS</p> <p>Census 149 Records Reviewed: 13 Home visits: 6</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  January 12, 1015</p>	G000000	Corrective Actions listed below.	
G000144	<p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of</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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	<p>patient care does occur.</p> <p>Based on clinical record and agency policy review and interview, the home health agency failed to maintain documentation in the clinical record or minutes of case conferences for 7 of 12 (1-5, 9 and 12 ) clinical records reviewed with the potential to affect all of the agency's 149 active patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1, start of care 1/14/2014, included a plan of care established by the patient's physician for the certification period 10/4/2014 through 12/2 2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</li> <li>2. Clinical record number 2, start of care 8/24/2014, included a plan of care established by the patient's physician for the certification period 8/11/2012 though 10/9/2012. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</li> <li>3. Clinical record number 3, start of care 11/28/2012, included a plan of care established by the patient's physician for</li> </ol>	G000144	<p>All patients will have a case conference/coordination of care documented in the EMR every 60 days. The Agency created a form to include in the Agency EMR. The Case Conference attendees may include the patient, caregiver, home health aide, field nurse, and the RN Case Manager. All RN Case Managers were in-serviced on 01/13/15 of the case conference process and requirements. The Agency will ensure ongoing compliance with this regulation by having the Agency complete a quality assurance review of all EMR documentation at re-certification time points to ensure patient care conferences were completed and documented. A copy of the Case Conference is faxed to the MD at re-certification timepoints. The Director of Nursing is responsible for ensuring on-going compliance with this regulation.</p>	02/10/2015			

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	<p>the certification period 9/21/2014 through 11/19/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>4. Clinical record number 4, start of care 9/27/2013, included a plan of care established by the patient's physician for the certification period 9/30/2014 through 11/28/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>5. Clinical record number 5, start of care 10/1/2014, included a plan of care established by the patient's physician for the certification period, 10/1/2014 through 11/29/2014/ The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>6. Clinical record number 9, start of care 8/4/2014, included a plan of care established by the patient's physician for the certification period, 10/3/2014 through 12/1/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>7. Clinical record number 12, start of</p>			

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	<p>care 7/16/2013, included a plan of care established by the patient's physician for the certification period, 1/12/2014 through 3/12/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>8. In an interview with employee G, the agency's nursing supervisor on December 30th at 430 PM, the supervisor agreed this information was missing from some of the clinical records.</p> <p>9. An agency policy, undated, titled "C-360 Coordination of Client Services" states, "Each staff registered nurse shall meet with the Nursing Supervisor/Team Leader weekly or as necessary to review all areas of client needs ... Case conferences will be documented on the Care Conference Summary form or in the progress notes."</p>						

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G000145	<p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure that a written summary report was sent to the patient's attending physician at least every 60 days for 8 of 12 clinical records. This has the potential to affect all of the agency's patients receiving home health services for greater than 60 days ( records 2, 5 and 7-12).</p> <p>Findings:</p> <p>1. Clinical record number 2, start of care 1/14/2014, failed to evidence a 60 day written summary report was sent to the patient's physician.</p> <p>2. Clinical record number 5, start of care 10/1/2014, failed to evidence a 60 day</p>	G000145	<p>All patients will have a 60 day summary completed at time of re-certification. This 60 day summary is documented at the bottom of Locator 21 of the medical Plan of Care and submitted to the Primary Care Physician at re-certification time points. All RN Case Managers were in-serviced on 01/13/15 on the necessity of completing the 60 day summary and the required content of the 60-day summary. The Agency will ensure ongoing compliance with this regulation by having the Agency complete a quality assurance review of all EMR documentation at re-certification time points. The Director of Nursing is responsible for ensuring on-going compliance with this regulation.</p>	02/10/2015

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	<p>written summary report was sent to the patient's physician.</p> <p>3. Clinical record number 7, start of care 8/12/2014, failed to evidence a 60 day written summary report was sent to the patient's physician.</p> <p>4. Clinical record number 8, start of care 8/18/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>5. Clinical record number 9, start of care 8/4/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>6. Clinical record number 10, start of care 9/17/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>7. Clinical record number 11, start of care 8/25/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>8. Clinical record number 12, start of care 7/16/13, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>9. In an interview with employee G, the</p>			

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G000229	<p>agency's supervising nurse on December 23rd 2014 at 430 PM, the employee was unable to provide additional documents to evidence that a 60 day summary was sent to the patient's physician.</p> <p>10. An agency policy, undated, titled "C-360, Coordination of Client Services" states, "A written summary report of services provided and response to care for each client shall be sent to the physician at least every sixty (60) days."</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</p>			

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	<p>the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks in 1 of 12 records reviewed of patients (#7) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled nursing and home health aide services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 7, start of care 8/12/2014, included a plan of care established by the patient's physician for the certification period 10/11/2014 through 12/9/2014 with orders for a home health aide visits five times weekly. The record failed to evidence home health aide supervisory visits by the registered nurse (RN) at least every fourteen days.</li> <li>2. In an interview with the employee G, the nursing supervisor on December 31st at 430 PM, the supervisor was unable to provide additional documentation of supervisory visits by an RN.</li> <li>3. An agency policy undated titled "Home Health Aide Supervision" states,</li> </ol>	G000229	<p>Patients receiving skilled services receive a home health aide supervisory visit every 14 days. All RN Case Managers were in-serviced on 01/13/15 of the requirement for every 14 day home health aide supervisory visits of all patients receiving skilled services. The Agency will ensure ongoing compliance with this regulation by having the Quality Assurance nurse ensure that all supervisory visits are scheduled in the EMR system and then documented as completed in the EMR system. The Director of Nursing is responsible for ensuring on-going compliance with this regulation.</p>	02/10/2015

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G000337	<p>"When skilled nursing services are being provided to a client, a registered nurse/therapist must make a supervisory visit at least every two weeks."</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record and agency policy review and interview, the home health agency failed to ensure the comprehensive assessment included a review of all medications 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 for 2 of 12 reviewed (records 4 and 9) with the potential to affect all of the agency's 149 active patients.</p>	G000337	The Agency performs a complete review of all medications including identification of actions, side effects, adverse reactions, etc., and this is completed with all start-of-care assessments, re-certification assessments, and resumption of care assessments. All RN Case Managers were in-serviced on the requirements of the regulation on 01/13/15. The Agency will ensure ongoing compliance with this regulation by having the Agency complete a quality assurance review of all EMR documentation at all certification time points. The Director of Nursing is responsible for compliance with this regulation.	02/10/2015

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record 4 failed to evidence review by the registered nurse of the patient's medications with the 9/25/2014 recertification comprehensive assessment.</li> <li>2. Clinical record 9 failed to evidence review by the registered nurse of the patient's medications with the 10/01/2014 recertification comprehensive assessment.</li> <li>3. In an interview with employee G, the agency's nursing supervisor on December 23rd at 430 PM, the supervisor was unable to provide additional documents to evidence compliance with medication review for patients 4 and 9.</li> <li>4. An agency policy, undated, titled "C-145 Comprehensive Client Assessment" states, "The comprehensive assessment will include a review of all medications the client is using (prescription and non-prescription). This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, drug interactions, duplicate drug therapy and non-compliance with therapy."</li> </ol>			

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N000000	<p>5. An agency policy, undated, titled "C-709 Medication Reconciliation" states, " If the client continues to receive home care after the first 60 days, the clinician doing the reassessment will again review all medications the client is taking, update the records and the client plan of care."</p> <p>This was a state home health re-licensure survey.</p> <p>Survey Dates: December 23-24th and December 29-31st , 2014</p> <p>Facility #: IN012617</p> <p>Medicaid Vendor # 201044850</p> <p>Surveyor: Nina Koch, RN, PHNS</p> <p>Census 149 Records Reviewed: 13 Home visits: 6</p>	N000000	Corrective Actions listed below.	

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N000484	<p>Quality Review: Joyce Elder, MSN, BSN, RN January 12, 1015</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.</p> <p>Based on clinical record and agency policy review and interview, the home health agency failed to maintain documentation in the clinical record or minutes of case conferences for 7 of 12 (1-5, 9 and 12 ) clinical records reviewed with the potential to affect all of the agency's 149 active patients.</p> <p>Findings:</p> <p>1. Clinical record number 1, start of care 1/14/2014, included a plan of care established by the patient's physician for the certification period 10/4/2014 through 12/2 2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p>	N000484	All patients will have a case conference/coordination of care documented in the EMR every 60 days. The Agency created a form to include in the Agency EMR. The Case Conference attendees may include the patient, caregiver, home health aide, field nurse, and the RN Case Manager. All RN Case Managers were in-serviced on 01/13/15 of the case conference process and requirements. The Agency will ensure ongoing compliance with this regulation by having the Agency complete a quality assurance review of all EMR documentation at re-certification time points to ensure patient care conferences were completed and documented. A copy of the Case Conference is faxed to the MD at re-certification timepoints. The Director of Nursing is responsible for ensuring on-going compliance with this regulation.	02/10/2015

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	<p>2. Clinical record number 2, start of care 8/24/2014, included a plan of care established by the patient's physician for the certification period 8/11/2012 though 10/9/2012. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>3. Clinical record number 3, start of care 11/28/2012, included a plan of care established by the patient's physician for the certification period 9/21/2014 through 11/19/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>4. Clinical record number 4, start of care 9/27/2013, included a plan of care established by the patient's physician for the certification period 9/30/2014 through 11/28/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>5. Clinical record number 5, start of care 10/1/2014, included a plan of care established by the patient;s physician for the certification period, 10/1/2014 through 11/29/2014/ The record failed to evidence minutes of case conferences or documentation of coordination of</p>			

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	<p>patient care in the clinical record.</p> <p>6. Clinical record number 9, start of care 8/4/2014, included a plan of care established by the patient's physician for the certification period, 10/3/2014 through 12/1/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>7. Clinical record number 12, start of care 7/16/2013, included a plan of care established by the patient's physician for the certification period, 1/12/2014 through 3/12/2014. The record failed to evidence minutes of case conferences or documentation of coordination of patient care in the clinical record.</p> <p>8. In an interview with employee G, the agency's nursing supervisor on December 30th at 430 PM, the supervisor agreed this information was missing from some of the clinical records.</p> <p>9. An agency policy, undated, titled "C-360 Coordination of Client Services" states, "Each staff registered nurse shall meet with the Nursing Supervisor/Team Leader weekly or as necessary to review all areas of client needs ... Case conferences will be documented on the Care Conference Summary form or in the</p>				

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N000529	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.			

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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>Based on clinical record and agency policy review and interview, the agency failed to ensure that a written summary report was sent to the patient's attending physician at least every 60 days as required by agency policy for 8 of 12 clinical records. This has the potential to affect all of the agency's patients receiving home health services for greater than 60 days ( records 2, 5 and 7-12).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2, start of care 1/14/2014, failed to evidence a 60 day written summary report was sent to the patient's physician.</li> <li>2. Clinical record number 5, start of care 10/1/2014, failed to evidence a 60 day written summary report was sent to the patient's physician.</li> <li>3. Clinical record number 7, start of care 8/12/2014, failed to evidence a 60 day written summary report was sent to the patient's physician.</li> <li>4. Clinical record number 8, start of care 8/18/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</li> </ol>	N000529	All patients will have a 60 day summary completed at time of re-certification. This 60 day summary is documented at the bottom of Locator 21 of the medical Plan of Care and submitted to the Primary Care Physician at re-certification time points. All RN Case Managers were in-serviced on 01/13/15 on the necessity of completing the 60 day summary and the required content of the 60 day summary. The Agency will ensure ongoing compliance with this regulation by having the Agency complete a quality assurance review of all EMR documentation at re-certification time points. The Director of Nursing is responsible for ensuring on-going compliance with this regulation.	02/10/2015	

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	<p>5. Clinical record number 9, start of care 8/4/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>6. Clinical record number 10, start of care 9/17/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>7. Clinical record number 11, start of care 8/25/2014, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>8. Clinical record number 12, start of care 7/16/13, failed to evidence that a 60 day written summary report was sent to the patient's physician.</p> <p>9. In an interview with employee G, the agency's supervising nurse on December 23rd 2014 at 430 PM, the employee was unable to provide additional documents to evidence that a 60 day summary was sent to the patient's physician.</p> <p>10. An agency policy, undated, titled "C-360, Coordination of Client Services" states, "A written summary report of services provided and response to care for each client shall be sent to the physician at least every sixty (60) days."</p>						

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had made a supervisory visit to the patient's home at least every two (2) weeks as required by agency policy in 1 of 12 records reviewed of patients (#7) that received home health aide and skilled services creating the potential to affect all of the agency's patients that receive skilled nursing and home health aide services.</p> <p>Findings:</p> <p>1. Clinical record number 7, start of care 8/12/2014, included a plan of care established by the patient's physician for</p>	N000606	<p>Patients receiving skilled services receive a home health aide supervisory visit every 14 days. All RN Case Managers were in-serviced on 01/13/15 of the requirement for every 14 day home health aide supervisory visits of all patients receiving skilled services. The Agency will ensure ongoing compliance with this regulation by having the Quality Assurance nurse</p>	02/10/2015

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	<p>the certification period 10/11/2014 through 12/9/2014 with orders for a home health aide visits five times weekly. The record failed to evidence home health aide supervisory visits by the registered nurse (RN) at least every fourteen days.</p> <p>2. In an interview with the employee G, the nursing supervisor on December 31st at 430 PM, the supervisor was unable to provide additional documentation of supervisory visits by an RN.</p> <p>3. An agency policy undated titled "Home Health Aide Supervision" states, "When skilled nursing services are being provided to a client, a registered nurse/therapist must make a supervisory visit at least every two weeks."</p>		<p>ensure that all supervisory visits are scheduled in the EMR system and then documented as completed in the EMR system. The Director of Nursing is responsible for ensuring on-going compliance with this regulation.</p>	