

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157620	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/19/2014
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NAME OF PROVIDER OR SUPPLIER  SERVANT'S HEART HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1714 DIVIDEND DRIVE LOGANSFORT, IN 46947
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G000000	<p>This was a federal home health complaint investigation survey.</p> <p>Complaint IN00147206 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Dates: May 16 and 19, 2014</p> <p>Facility #: 011301</p> <p>Medicaid #: 200852690</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 21, 2014</p>	G000000	<p>This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.</p>	
G000143	<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>Based on clinical record review, policy</p>	G000143	<p><b>CORRECTIVE ACTION TAKEN: A staff meeting will be held on June 5, 2014 to re-educate all</b></p>	06/05/2014

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>review, and interview, the agency failed to ensure the agency maintained liaison with the laboratory and physician to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 3 clinical records reviewed with the potential to affect all 78 of the agency's patients. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2 included plans of care established by the physician for the certification periods 12/07/13 to 2/4/14 and 2/5 to 4/5/14 with orders for skilled nursing and home health aide services. The record failed to evidence all the services maintained liaison to ensure their efforts were coordinated and supported the plan of care.</p> <p>A. The record evidenced a document signed by employee A and dated 3/17/14 titled "Communication Note" which states, "Other Comments: [patient] called the [parent] office on February 10, 2014 and told [administrator] '[Employee C] was supposed to come and draw my blood today, and [he/she] called me and said [he's/she's] not coming today because [his/her] mother is dying. I need a nurse to draw my blood before my doctor's appointment today.'</p>		<p><b>nurses regarding the importance of Coordination of Care. Written instructions will be given regarding the new protocols for patients who have lab draws ordered which are:</b></p> <p><b>1. The Lab Draw Notification Form must be completed and submitted to the D.O.N. or Administrator within 24 hour of any lab draw.</b></p> <p><b>2. This notification form will be logged into the Patient's Lab Log by the D.O.N. or Administrator and then monitored until follow up is completed on every lab logged.</b></p> <p><b>3. The nurse who obtained the lab specimen is responsible to follow up with results and make sure the patient is notified of any medication and/or treatment changes. Written instructions will be given at this staff meeting on appropriate management of any patient hospitalization that occur. These steps are:</b></p> <p><b>1. Complete the Coordination of Care form to notify all staff of the hospitalization. This form is to be filed in the very front of every patient's chart.</b></p> <p><b>2. Find out what hospital the patient has been admitted to and for what diagnosis.</b></p> <p><b>3. Ensure that the Transfer Information for Hospitalization form has been faxed to the appropriate hospital so they</b></p>				

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	[administrator] called [employee B] and sent [him/her] to draw a PT/INR per [patient's] request. When [employee B] took the blood to [hospital laboratory], [he/she] was told by the lab tech that there was no doctor's order for the lab. [Administrator] then called [patient's] doctor, [physician's name], and spoke to [his/her] nurse. [Physician's nurse] reported to [administrator] that [patient] had no appointment with the doctor, but [he/she] would send an order to the lab for the PT/INR since we had drawn it already. [Administrator] then called [employee B] and gave her that information ... Results of investigation [employee B] reports that, when [he/she] took [patient's] blood to [hospital laboratory], the person in the lab told [employee B] to put the blood tubes in a tube basket inside the lab door. That's where [employee B] put the blood. The lab tech told [employee B] that they would throw the blood away if they did not receive a doctor's order within 4 hrs [hours]. [Employee C] reports that in the past when [he/she] has drawn [patient's] blood, [he/she] has taken the blood to [name of lab] where there was a standing order to run PT/INR. The lab would then send the results to [physician] who would adjust [patient's] coumadin as needed. The lab never sent [patient's] lab results to our office - only to [physician's] office.		<b>have information regarding the patient's medications, diagnosis, allergies, etc.. 4. Ensure that the hospital is notified that we will need discharge information and instructions when the patient is sent home. Written instructions will be given at this staff meeting regarding the writing and development of the Plan of Care to ensure that it includes:</b> <b>1. What lab to take specimens to for processing if the SN is responsible for obtaining specimens</b> <b>2. Where to fax lab results to : ¿ what physician(s) and the fax number(s) ¿ ensure that labs are faxed to our agency with every result</b> <b>3. Whenever labs are obtained, the Plan of Care should state specifically that the RN is responsible to follow up with any medication changes ordered by the physician and ensure that the patient is aware of those changes. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Starting 5-20-14: A new form was developed (see attached) entitled "Coordination of Care". This form will be completed by the R.N. for: ¿ All Admissions ¿ All transfers/resumption of care ¿ All first time Lab orders ¿ Any change in health care providers or preferred</b>	

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	<p>... [Employee C] reports that we have never received any lab results from [laboratory]."</p> <p>B. On 5/19/14 at 11:02 AM, employee A indicated there was no follow-up to see if the lab had received the order or if the test had been completed. The employee indicated results for this patient were not communicated between personnel furnishing services.</p> <p>2. The agency policy with an annual review date as 12/18/13 states, "Medical Supervision ... Purpose To assure the participation of physicians in the development and maintaining of the patient plan of care. ... Special instructions ... 13. Agency responsibilities include: ... b. Confidential and accurate communication about patients ... g. Facilitation of patient communication/follow-up."</p>		<p><b>laboratory facility All current patient records will be updated with this new form by June 5, 2014. This form will be kept in the front of the patient's chart and will be utilized to communicate more efficiently with all health care professionals involved with the patient's care. This will also verify what lab to take specimens to for the patient and ensure that orders are sent to the right lab.</b></p> <p><b>PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator and the Director of Nurses will follow up to ensure that these new procedures are being followed and are effective. A chart audit will be conducted within 30 days (no later than 6/20/14) of all patients who have been hospitalized or who have had labs ordered during the last 30 days to ensure that these new procedures are effective. If no negative results are discovered, another chart audit will be conducted in 60 more days (no later than 8/20/14) of all patients who have had labs ordered and all hospitalized patients during this 60 day period. If no negative findings occur, chart audits of 10 % of all charts will continue to be conducted at least quarterly to ensure no further problems</b></p>		

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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.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse followed up with the laboratory and physician to identify the patient's PT/INR results in 1 of 3 clinical records reviewed with the potential to affect all 78 of the agency's patients. (#2)</p> <p>Findings include:</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the agency maintained liaison with the laboratory to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 3 clinical records reviewed with the potential to affect all 78 of the agency's patients. (#2)</p>	G000176	<p><b>occur with this issue. If there are any negative findings, appropriate staff will be re-educated and chart audits will continue every 30 days until there are no negative findings. This plan will be implemented and completed by June 5, 2014.</b></p> <p><b>CORRECTIVE ACTION TAKEN:</b> A staff meeting will be held on June 5, 2014 to re-educate all nurses regarding the importance of Coordination of Care. Written instructions will be given regarding the new protocols for patients who have lab draws ordered which are: 1. The Lab Draw Notification Form must be completed and submitted to the D.O.N. or Administrator within 24 hour of any lab draw. 2. This notification form will be logged into the Patient's Lab Log by the D.O.N. or Administrator and then monitored until follow up is completed on every lab logged. 3. The nurse who obtained the lab specimen is responsible to follow up with results and make sure the patient is notified of any medication</p>	06/05/2014

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	<p>Findings include:</p> <p>1. Clinical record #2 included plans of care established by the physician for the certification periods 12/07/13 to 2/4/14 and 2/5 to 4/5/14 with orders for skilled nursing and home health aide services.</p> <p>A. The record evidenced a document signed by employee A and dated 3/17/14 titled "Communication Note" which states, "Other Comments: [Patient] called the [parent] office on February 10, 2014 and told [administrator] '[Employee C] was supposed to come and draw my blood today, and [he/she] called me and said [he's/she's] not coming today because [his/her] mother is dying. I need a nurse to draw my blood before my doctor's appointment today.' [Administrator] called [employee B] and sent [him/her] to draw a PT/INR per [patient's] request. When [employee B] took the blood to [hospital laboratory], [he/she] was told by the lab tech that there was no doctor's order for the lab. [Administrator] then called [patient's] doctor, [physician's name], and spoke to [his/her] nurse. [Physician's nurse] reported to [administrator] that [patient] had no appointment with the doctor, but [he/she] would send an order to the lab for the PT/INR since we had drawn it already. [Administrator] then called</p>		<p><b>and/or treatment changes. Written instructions will be given at this staff meeting on appropriate management of any patient hospitalization sthat occur. These steps are:</b></p> <p><b>1. Complete the Coordination of Care form to notify all staff of the hospitalization. This form is to be filed in the very front of every patient's chart.</b></p> <p><b>2. Find out what hospital the patient has been admitted to and for what diagnosis. 3. Ensure that the Transfer Information for Hospitalization form has been faxed to the appropriate hospital so they have information regarding the patient's medications, diagnosis, allergies,etc.. 4. Ensure that the hospital is notified that we will need discharge information and instructions when the patient is sent home. Written instructions will be given at this staff meeting regarding the writing and development of the Plan of Care to ensure that it includes:</b></p> <p><b>1. What lab to take specimens to for processing if the SN is responsible for obtaining specimens 2. Where to fax lab results to : ¿ what physician(s) and the fax number(s) ¿ ensure that labs are faxed to our agency with every result 3. Whenever labs are obtained, the Plan of Care</b></p>	
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	<p>[employee B] and gave her that information ... Results of investigation [employee B] reports that, when [he/she] took [patient's] blood to [hospital laboratory], the person in the lab told [employee B] to put the blood tubes in a tube basket inside the lab door. That's where [employee B] put the blood. The lab tech told [employee B] that they would throw the blood away if they did not receive a doctor's order within 4 hrs [hours]. [Employee C] reports that in the past when [he/she] has drawn [patient's] blood, [he/she] has taken the blood to [name of lab] where there was a standing order to run PT/INR. The lab would then send the results to [physician] who would adjust [patient's] coumadin as needed. The lab never sent [patient's] lab results to our office - only to [physician's] office. ... [Employee C] reports that we have never received any lab results from [laboratory]."</p> <p>B. The record failed to evidence any results of the PT/INR test that was drawn.</p> <p>2. On 5/19/14 at 11:02 AM, employee A indicated there was no follow-up to see if the lab had received the order or if the test had been completed. The employee indicated results for this patient were not communicated between personnel furnishing services.</p>		<p><b>should state specifically that the RN is responsible to follow up with any medication changes ordered by the physician and ensure that the patient is aware of those changes. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Starting 5-20-14: A new form was developed (see attached) entitled "Coordination of Care". This form will be completed by the R.N. for:</b></p> <ul style="list-style-type: none"> <li>¿ All Admissions</li> <li>¿ All transfers/resumption of care</li> <li>¿ All first time Lab orders</li> <li>¿ Any change in health care providers or preferred laboratory facility</li> </ul> <p><b>All current patient records will be updated with this new form by June 5, 2014. This form will be kept in the front of the patient's chart and will be utilized to communicate more efficiently with all health care professionals involved with the patient's care. This will also verify what lab to take specimens to for the patient and ensure that orders are sent to the right lab.</b></p> <p><b>PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator and the Director of Nurses will follow up to ensure that these new procedures are being followed and are effective. A chart audit will be conducted within 30</b></p>		

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G000236	<p>3. The agency policy with an annual review date as 12/18/13 states, "Job Description Registered Nurse Case Manager ... II. Except where services are limited to therapy only, for purposed of practice in the home health setting, the registered nurse shall do the following: ... f. Coordinate services ... ."</p> <p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p>		<p><b>days (no later than 6/20/14) of all patients who have been hospitalized or who have had labs ordered during the last 30 days to ensure that these new procedures are effective. If no negative results are discovered,another chart audit will be conducted in 60 more days (no later than 8/20/14)of all patients who have had labs ordered and all hospitalized patients during this 60 day period. If no negative findings occur, chart audits of 10 % of all charts will continue to be conducted at least quarterly to ensure no further problems occur with this issue. If there are any negative findings,appropriate staff will be re-educated and chart audits will continue every 30days until there are no negative findings. This plan will be implemented and completed by June 5, 2014.</b></p>	

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	<p>Based on clinical record review, interview, and policy review, the agency failed to ensure 1 of 1 closed records reviewed contained coordination of care notes and laboratory results creating the potential to affect all 78 current patient's of the agency. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 2/21/11 and discharge date of 4/1/14, included plans of care established by the physician for the certification periods 12/07/13 to 2/4/14 and 2/5 to 4/5/14 with orders for skilled nursing services 1 time per month for blood draw for PT/INR [Prothrombin Time and International Normalized Ratio]. The record failed to evidence skilled nursing services coordinated services with the laboratory and the physician on test results.</p> <p>A. The record evidenced a document signed by employee A and dated 3/17/14 titled "Communication Note" which states, "Other Comments: [patient] called the [parent] office on February 10, 2014 and told [administrator] '[Employee C] was supposed to come and draw my blood today, and [he/she] called me and said [he's/she's] not coming today because [his/her] mother is dying. I need a nurse to draw my blood before my</p>	G000236	<p><b>CORRECTIVE ACTION TAKEN:</b></p> <p><b>A staff meeting will be held on June 5, 2014 to re-educate all nurses regarding the importance of Coordination of Care. Written instructions will be given regarding the new protocols for patients who have lab draws ordered which are:</b></p> <p><b>1. The Lab Draw Notification Form must be completed and submitted to the D.O.N. or Administrator within 24 hour of any lab draw.</b></p> <p><b>2. This notification form will be logged into the Patient's Lab Log by the D.O.N. or Administrator and then monitored until follow up is completed on every lab logged.</b></p> <p><b>3. The nurse who obtained the lab specimen is responsible to follow up with results and make sure the patient is notified of any medication and/or treatment changes. Written instructions will be given at this staff meeting on appropriate management of any patient hospitalization that occur. These steps are:</b></p> <p><b>1. Complete the Coordination of Care form to notify all staff of the hospitalization. This form is to be filed in the very front of every patient's chart.</b></p> <p><b>2. Find out what hospital the patient has been admitted to and for what diagnosis.</b></p> <p><b>3. Ensure that the Transfer</b></p>	06/05/2014

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	<p>doctor's appointment today.'</p> <p>[administrator] called [employee B] and sent [him/her] to draw a PT/INR per [patient's] request. When [employee B] took the blood to [hospital laboratory], [he/she] was told by the lab tech that there was no doctor's order for the lab. [Administrator] then called [patient's] doctor, [physician's name], and spoke to [his/her] nurse. [Physician's nurse] reported to [administrator] that [patient] had no appointment with the doctor, but [he/she] would send an order to the lab for the PT/INR since we had drawn it already. [Administrator] then called [employee B] and gave her that information ... Results of investigation [employee B] reports that, when [he/she] took [patient's] blood to [hospital laboratory], the person in the lab told [employee B] to put the blood tubes in a tube basket inside the lab door. That's where [employee B] put the blood. The lab tech told [employee B] that they would throw the blood away if they did not receive a doctor's order within 4 hrs [hours]. [Employee C] reports that in the past when [he/she] has drawn [patient's] blood, [he/she] has taken the blood to [name of lab] where there was a standing order to run PT/INR. The lab would then send the results to [physician] who would adjust [patient's] coumadin as needed. The lab never sent [patient's] lab results</p>		<p><b>Information for Hospitalization form has been faxed to the appropriate hospital so they have information regarding the patient's medications, diagnosis, allergies,etc..</b></p> <p><b>4. Ensure that the hospital is notified that we will need discharge information and instructions when the patient is sent home. Written instructions will be given at this staff meeting regarding the writing and development of the Plan of Care to ensure that it includes:</b></p> <p><b>1. What lab to take specimens to for processing if the SN is responsible for obtaining specimens</b></p> <p><b>2. Where to fax lab results to : ¿ what physician(s) and the fax number(s) ¿ ensure that labs are faxed to our agency with every result</b></p> <p><b>3. Whenever labs are obtained, the Plan of Care should state specifically that the RN is responsible to follow up with any medication changes ordered by the physician and ensure that the patient is aware of those changes.</b></p> <p><b>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Starting 5-20-14: A new form was developed (see attached) entitled "Coordination of Care". This form will be completed by the R.N. for: ¿ All Admissions ¿ All transfers/resumption of</b></p>				

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	<p>to our office - only to [physician's] office. ... [Employee C] reports that we have never received any lab results from [laboratory]." The record failed to evidence laboratory testing results.</p> <p>B. On 5/19/14 at 11:15 AM, employee A indicated there was no documentation of communication with the laboratory or physician regarding laboratory results and there were no laboratory results in the chart. The employee also indicated that the chart did not contain information regarding the hospitalization from 3/9 to 3/11/14. Employee A indicated this was a concern that was addressed and a new procedure was put in place for patients requiring laboratory testing.</p> <p>2. The agency policy with an annual review date as 12/18/13 states, "Clinical Records/Medical Record Retention POLICY ... Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health and emotional status, treatments, and services rendered by the Registered professional nurses and other health care team members. PURPOSE To maintain an accurate record of the services provided by the agency for each client. To provide a mechanism by which client care</p>		<p><b>care ¿ All first time Lab orders ¿ Any change in health care providers or preferred laboratory facility All current patient records will be updated with this new form by June 5, 2014. This form will be kept in the front of the patient's chart and will be utilized to communicate more efficiently with all health care professionals involved with the patient's care. This will also verify what lab to take specimens to for the patient and ensure that orders are sent to the right lab.</b></p> <p><b>PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator and the Director of Nurses will follow up to ensure that these new procedures are being followed and are effective. A chart audit will be conducted within 30 days (no later than 6/20/14) of all patients who have been hospitalized or who have had labs ordered during the last 30 days to ensure that these new procedures are effective. If no negative results are discovered, another chart audit will be conducted in 60 more days (no later than 8/20/14) of all patients who have had labs ordered and all hospitalized patients during this 60 day period. If no negative findings occur, chart audits of 10 % of</b></p>				

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N000000	<p>information is documented, maintained, protected, utilized, and transferred as appropriate. ... SPECIAL INSTRUCTIONS Clinical Record: 1. A confidential clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every client receiving home health services. 2. In addition to the plan of care, the clinical record shall contain appropriate identifying information, including, but not limited to: ... O. signed and dated clinical and progress notes of nurses, therapists, and social workers ... 5. Documentation shall establish that effective interchange, reporting, and coordination of client care does occur. ... "</p> <p>This was a state home health complaint investigation survey.</p> <p>Complaint IN00147206 - Substantiated:</p>	N000000	<p><b>all charts will continue to be conducted at least quarterly to ensure no further problems occur with this issue. If there are any negative findings, appropriate staff will be re-educated and chart audits will continue every 30days until there are no negative findings. This plan will be implemented and completed by June 5, 2014.</b></p> <p>This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not</p>				

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N000486	<p>State deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Dates: May 16 and 19, 2014</p> <p>Facility #: 011301</p> <p>Medicaid #: 200852690</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 21, 2014</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the agency maintained liaison with the laboratory and physician to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 3 clinical records reviewed with the potential to affect all 78 of the agency's patients. (#2)</p>	N000486	<p>constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.</p> <p><b>CORRECTIVE ACTION TAKEN:</b> <b>A staff meeting will be held on June 5, 2014 to re-educate all nurses regarding the importance of Coordination of Care. Written instructions will be given regarding the new protocols for patients who have lab draws ordered which are: 1. The Lab Draw Notification Form must be completed and submitted to the D.O.N. or Administrator</b></p>	06/05/2014			

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	<p>Findings include:</p> <p>1. Clinical record #2 included plans of care established by the physician for the certification periods 12/07/13 to 2/4/14 and 2/5 to 4/5/14 with orders for skilled nursing and home health aide services. The record failed to evidence all the services maintained liaison to ensure their efforts were coordinated and supported the plan of care.</p> <p>A. The record evidenced a document signed by employee A and dated 3/17/14 titled "Communication Note" which states, "Other Comments: [patient] called the [parent] office on February 10, 2014 and told [administrator] '[Employee C] was supposed to come and draw my blood today, and [he/she] called me and said [he's/she's] not coming today because [his/her] mother is dying. I need a nurse to draw my blood before my doctor's appointment today.' [administrator] called [employee B] and sent [him/her] to draw a PT/INR per [patient's] request. When [employee B] took the blood to [hospital laboratory], [he/she] was told by the lab tech that there was no doctor's order for the lab. [Administrator] then called [patient's] doctor, [physician's name], and spoke to [his/her] nurse. [Physician's nurse] reported to [administrator] that [patient]</p>		<p><b>within 24 hour of any lab draw.</b></p> <p><b>2. This notification form will be logged into the Patient's Lab Log by the D.O.N. or Administrator and then monitored until follow up is completed on every lab logged.</b></p> <p><b>3. The nurse who obtained the lab specimen is responsible to follow up with results and make sure the patient is notified of any medication and/or treatment changes. Written instructions will be given at this staff meeting on appropriate management of any patient hospitalization that occur. These steps are:</b></p> <p><b>1. Complete the Coordination of Care form to notify all staff of the hospitalization. This form is to be filed in the very front of every patient's chart.</b></p> <p><b>2. Find out what hospital the patient has been admitted to and for what diagnosis. 3. Ensure that the Transfer Information for Hospitalization form has been faxed to the appropriate hospital so they have information regarding the patient's medications, diagnosis, allergies, etc..</b></p> <p><b>4. Ensure that the hospital is notified that we will need discharge information and instructions when the patient is sent home. Written instructions will be given at this staff meeting regarding the writing</b></p>		

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	<p>had no appointment with the doctor, but [he/she] would send an order to the lab for the PT/INR since we had drawn it already. [Administrator] then called [employee B] and gave her that information ... Results of investigation [employee B] reports that, when [he/she] took [patient's] blood to [hospital laboratory], the person in the lab told [employee B] to put the blood tubes in a tube basket inside the lab door. That's where [employee B] put the blood. The lab tech told [employee B] that they would throw the blood away if they did not receive a doctor's order within 4 hrs [hours]. [Employee C] reports that in the past when [he/she] has drawn [patient's] blood, [he/she] has taken the blood to [name of lab] where there was a standing order to run PT/INR. The lab would then send the results to [physician] who would adjust [patient's] coumadin as needed. The lab never sent [patient's] lab results to our office - only to [physician's] office. ... [Employee C] reports that we have never received any lab results from [laboratory]."</p> <p>B. On 5/19/14 at 11:02 AM, employee A indicated there was no follow-up to see if the lab had received the order or if the test had been completed. The employee indicated results for this patient were not</p>		<p><b>and development of the Plan of Care to ensure that it includes:</b></p> <p><b>1. What lab to take specimens to for processing if the SN is responsible for obtaining specimens</b></p> <p><b>2. Where to fax lab results to :</b> ¿ what physician(s) and the fax number(s) ¿ ensure that labs are faxed to our agency with every result</p> <p><b>3. Whenever labs are obtained, the Plan of Care should state specifically that the RN is responsible to follow up with any medication changes ordered by the physician and ensure that the patient is aware of those changes.</b></p> <p><b>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Starting 5-20-14:</b> A new form was developed (see attached) entitled "Coordination of Care". This form will be completed by the R.N. for: ¿ All Admissions ¿ All transfers/resumption of care ¿ All first time Lab orders ¿ Any change in health care providers or preferred laboratory facility All current patient records will be updated with this new form by June 5, 2014. This form will be kept in the front of the patient's chart and will be utilized to communicate more efficiently with all health care professionals involved with the patient's care. This</p>	

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	<p>communicated between personnel furnishing services.</p> <p>2. The agency policy with an annual review date as 12/18/13 states, "Medical Supervision ... Purpose To assure the participation of physicians in the development and maintaining of the patient plan of care. ... Special instructions ... 13. Agency responsibilities include: ... b. Confidential and accurate communication about patients ... g. Facilitation of patient communication/follow-up."</p>		<p><b>will also verify what lab to take specimens to for the patient and ensure that orders are sent to the right lab.</b></p> <p><b>PERSON(S)RESPONSIBLE FOR THIS PLAN: The Administrator and the Director of Nurses will follow up to ensure that these new procedures are being followed and are effective. A chart audit will be conducted within 30 days (no later than 6/20/14) of all patients who have been hospitalized or who have had labs ordered during the last 30 days to ensure that these new procedures are effective. If no negative results are discovered,another chart audit will be conducted in 60 more days (no later than 8/20/14)of all patients who have had labs ordered and all hospitalized patients during this 60 day period. If no negative findings occur, chart audits of 10 % of all charts will continue to be conducted at least quarterly to ensure no further problems occur with this issue. If there are any negative findings,appropriate staff will be re-educated and chart audits will continue every 30days until there are no negative findings. This plan will be implemented and completed by June 5, 2014.</b></p>	

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N000545	<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 clinical record review, policy review, and interview, the agency failed to ensure the registered nurse followed up with the laboratory and physician to identify the patient's PT/INR results in 1 of 3 clinical records reviewed with the potential to affect all 78 of the agency's patients. (#2)</p> <p>Findings include:</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the agency maintained liaison with the laboratory to ensure their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 3 clinical records reviewed with the potential to affect all 78 of the agency's patients. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2 included plans of care established by the physician for the certification periods 12/07/13 to 2/4/14 and 2/5 to 4/5/14 with orders for skilled</p>	N000545	<p><b>CORRECTIVE ACTION TAKEN:</b> A staff meeting will be held on June 5, 2014 to re-educate all nurses regarding the importance of Coordination of Care. Written instructions will be given regarding the new protocols for patients who have lab draws ordered which are: 1. The Lab Draw Notification Form must be completed and submitted to the D.O.N. or Administrator within 24 hour of any lab draw. 2. This notification form will be logged into the Patient's Lab Log by the D.O.N. or Administrator and then monitored until follow up is completed on every lab logged. 3. The nurse who obtained the lab specimen is responsible to follow up with results and make sure the patient is notified of any medication and/or treatment changes. Written instructions will be given at this staff meeting on appropriate management of any patient hospitalization sthat occur. These steps are: 1. Complete the Coordination of Care form to notify all staff</p>	06/05/2014			

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	<p>nursing and home health aide services.</p> <p>A. The record evidenced a document signed by employee A and dated 3/17/14 titled "Communication Note" which states, "Other Comments: [Patient] called the [parent] office on February 10, 2014 and told [administrator] '[Employee C] was supposed to come and draw my blood today, and [he/she] called me and said [he's/she's] not coming today because [his/her] mother is dying. I need a nurse to draw my blood before my doctor's appointment today.' [Administrator] called [employee B] and sent [him/her] to draw a PT/INR per [patient's] request. When [employee B] took the blood to [hospital laboratory], [he/she] was told by the lab tech that there was no doctor's order for the lab. [Administrator] then called [patient's] doctor, [physician's name], and spoke to [his/her] nurse. [Physician's nurse] reported to [administrator] that [patient] had no appointment with the doctor, but [he/she] would send an order to the lab for the PT/INR since we had drawn it already. [Administrator] then called [employee B] and gave her that information ... Results of investigation [employee B] reports that, when [he/she] took [patient's] blood to [hospital laboratory], the person in the lab told [employee B] to put the blood tubes in a</p>		<p><b>of the hospitalization. This form is to be filed in the very front of every patient's chart. 2. Find out what hospital the patient has been admitted to and for what diagnosis. 3. Ensure that the Transfer Information for Hospitalization form has been faxed to the appropriate hospital so they have information regarding the patient's medications, diagnosis, allergies, etc.. 4. Ensure that the hospital is notified that we will need discharge information and instructions when the patient is sent home. Written instructions will be given at this staff meeting regarding the writing and development of the Plan of Care to ensure that it includes:</b></p> <p><b>1. What lab to take specimens to for processing if the SN is responsible for obtaining specimens 2. Where to fax lab results to : ¿ what physician(s) and the fax number(s) ¿ ensure that labs are faxed to our agency with every result 3. Whenever labs are obtained, the Plan of Care should state specifically that the RN is responsible to follow up with any medication changes ordered by the physician and ensure that the patient is aware of those changes. PREVENTION OF FUTURE DEFICIENCY IN THIS</b></p>	

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	<p>tube basket inside the lab door. That's where [employee B] put the blood. The lab tech told [employee B] that they would throw the blood away if they did not receive a doctor's order within 4 hrs [hours]. [Employee C] reports that in the past when [he/she] has drawn [patient's] blood, [he/she] has taken the blood to [name of lab] where there was a standing order to run PT/INR. The lab would then send the results to [physician] who would adjust [patient's] coumadin as needed. The lab never sent [patient's] lab results to our office - only to [physician's] office. ... [Employee C] reports that we have never received any lab results from [laboratory]."</p> <p>B. The record failed to evidence any results of the PT/INR test that was drawn.</p> <p>2. On 5/19/14 at 11:02 AM, employee A indicated there was no follow-up to see if the lab had received the order or if the test had been completed. The employee indicated results for this patient were not communicated between personnel furnishing services.</p> <p>3. The agency policy with an annual review date as 12/18/13 states, "Job Description Registered Nurse Case Manager ... II. Except where services are limited to therapy only, for purposed</p>		<p><b>AREA: Starting 5-20-14: A new form was developed (see attached) entitled "Coordination of Care". This form will be completed by the R.N. for:</b></p> <ul style="list-style-type: none"> <li>¿ All Admissions</li> <li>¿ All transfers/resumption of care</li> <li>¿ All first time Lab orders</li> <li>¿ Any change in health care providers or preferred laboratory facility</li> </ul> <p>All current patient records will be updated with this new form by June 5, 2014. This form will be kept in the front of the patient's chart and will be utilized to communicate more efficiently with all health care professionals involved with the patient's care. This will also verify what lab to take specimens to for the patient and ensure that orders are sent to the right lab.</p> <p><b>PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator and the Director of Nurses will follow up to ensure that these new procedures are being followed and are effective. A chart audit will be conducted within 30 days (no later than 6/20/14) of all patients who have been hospitalized or who have had labs ordered during the last 30 days to ensure that these new procedures are effective. If no negative results are discovered, another chart audit</b></p>	

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N000608	<p>of practice in the home health setting, the registered nurse shall do the following: ... f. Coordinate services ... "</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p>		<p><b>will be conducted in 60 more days (no later than 8/20/14) of all patients who have had labs ordered and all hospitalized patients during this 60 day period. If no negative findings occur, chart audits of 10 % of all charts will continue to be conducted at least quarterly to ensure no further problems occur with this issue. If there are any negative findings, appropriate staff will be re-educated and chart audits will continue every 30days until there are no negative findings. This plan will be implemented and completed by June 5, 2014.</b></p>	

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	<p>Based on clinical record review, interview, and policy review, the agency failed to ensure 1 of 1 closed records reviewed contained coordination of care notes and laboratory results creating the potential to affect all 78 current patient's of the agency. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 2/21/11 and discharge date of 4/1/14, included plans of care established by the physician for the certification periods 12/07/13 to 2/4/14 and 2/5 to 4/5/14 with orders for skilled nursing services 1 time per month for blood draw for PT/INR [Prothrombin Time and International Normalized Ratio]. The record failed to evidence skilled nursing services coordinated services with the laboratory and the physician on test results.</p> <p>A. The record evidenced a document signed by employee A and dated 3/17/14 titled "Communication Note" which states, "Other Comments: [patient] called the [parent] office on February 10, 2014 and told [administrator] '[Employee C] was supposed to come and draw my blood today, and [he/she] called me and said [he's/she's] not coming today because [his/her] mother is dying. I need a nurse to draw my blood before my</p>	N000608	<p><b>CORRECTIVE ACTION TAKEN:</b></p> <p><b>A staff meeting will be held on June 5, 2014 to re-educate all nurses regarding the importance of Coordination of Care. Written instructions will be given regarding the new protocols for patients who have lab draws ordered which are:</b></p> <p><b>1. The Lab Draw Notification Form must be completed and submitted to the D.O.N. or Administrator within 24 hour of any lab draw.</b></p> <p><b>2. This notification form will be logged into the Patient's Lab Log by the D.O.N. or Administrator and then monitored until follow up is completed on every lab logged.</b></p> <p><b>3. The nurse who obtained the lab specimen is responsible to follow up with results and make sure the patient is notified of any medication and/or treatment changes. Written instructions will be given at this staff meeting on appropriate management of any patient hospitalization sthat occur. These steps are:</b></p> <p><b>1. Complete the Coordination of Care form to notify all staff of the hospitalization. This form is to be filed in the very front of every patient's chart.</b></p> <p><b>2. Find out what hospital the patient has been admitted to and for what diagnosis.</b></p> <p><b>3. Ensure that the Transfer</b></p>	06/05/2014			

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NAME OF PROVIDER OR SUPPLIER  SERVANT'S HEART HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 1714 DIVIDEND DRIVE LOGANSPORT, IN 46947			
(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>doctor's appointment today.'</p> <p>[administrator] called [employee B] and sent [him/her] to draw a PT/INR per [patient's] request. When [employee B] took the blood to [hospital laboratory], [he/she] was told by the lab tech that there was no doctor's order for the lab. [Administrator] then called [patient's] doctor, [physician's name], and spoke to [his/her] nurse. [Physician's nurse] reported to [administrator] that [patient] had no appointment with the doctor, but [he/she] would send an order to the lab for the PT/INR since we had drawn it already. [Administrator] then called [employee B] and gave her that information ... Results of investigation [employee B] reports that, when [he/she] took [patient's] blood to [hospital laboratory], the person in the lab told [employee B] to put the blood tubes in a tube basket inside the lab door. That's where [employee B] put the blood. The lab tech told [employee B] that they would throw the blood away if they did not receive a doctor's order within 4 hrs [hours]. [Employee C] reports that in the past when [he/she] has drawn [patient's] blood, [he/she] has taken the blood to [name of lab] where there was a standing order to run PT/INR. The lab would then send the results to [physician] who would adjust [patient's] coumadin as needed. The lab never sent [patient's] lab results</p>		<p><b>Information for Hospitalization form has been faxed to the appropriate hospital so they have information regarding the patient's medications, diagnosis, allergies,etc..</b></p> <p><b>4. Ensure that the hospital is notified that we will need discharge information and instructions when the patient is sent home. Written instructions will be given at this staff meeting regarding the writing and development of the Plan of Care to ensure that it includes:</b></p> <p><b>1. What lab to take specimens to for processing if the SN is responsible for obtaining specimens</b></p> <p><b>2. Where to fax lab results to : ¿ what physician(s) and the fax number(s) ¿ ensure that labs are faxed to our agency with every result</b></p> <p><b>3. Whenever labs are obtained, the Plan of Care should state specifically that the RN is responsible to follow up with any medication changes ordered by the physician and ensure that the patient is aware of those changes.</b></p> <p><b>PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Starting 5-20-14: A new form was developed (see attached) entitled "Coordination of Care". This form will be completed by the R.N. for: ¿ All Admissions ¿ All transfers/resumption of</b></p>				

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	<p>to our office - only to [physician's] office. ... [Employee C] reports that we have never received any lab results from [laboratory]." The record failed to evidence laboratory testing results.</p> <p>B. On 5/19/14 at 11:15 AM, employee A indicated there was no documentation of communication with the laboratory or physician regarding laboratory results and there were no laboratory results in the chart. The employee also indicated that the chart did not contain information regarding the hospitalization from 3/9 to 3/11/14. Employee A indicated this was a concern that was addressed and a new procedure was put in place for patients requiring laboratory testing.</p> <p>2. The agency policy with an annual review date as 12/18/13 states, "Clinical Records/Medical Record Retention POLICY ... Clinical records are legal documents containing comprehensive, accurate, and organized information concerning the client's health and emotional status, treatments, and services rendered by the Registered professional nurses and other health care team members. PURPOSE To maintain an accurate record of the services provided by the agency for each client. To provide a mechanism by which client care</p>		<p><b>care ¿ All first time Lab orders ¿ Any change in health care providers or preferred laboratory facility All current patient records will be updated with this new form by June 5, 2014. This form will be kept in the front of the patient's chart and will be utilized to communicate more efficiently with all health care professionals involved with the patient's care. This will also verify what lab to take specimens to for the patient and ensure that orders are sent to the right lab.</b></p> <p><b>PERSON(S)RESPONSIBLE FOR THIS PLAN: The Administrator and the Director of Nurses will follow up to ensure that these new procedures are being followed and are effective. A chart audit will be conducted within 30 days (no later than 6/20/14) of all patients who have been hospitalized or who have had labs ordered during the last 30 days to ensure that these new procedures are effective. If no negative results are discovered,another chart audit will be conducted in 60 more days (no later than 8/20/14)of all patients who have had labs ordered and all hospitalized patients during this 60 day period. If no negative findings occur, chart audits of 10 % of</b></p>		

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	information is documented, maintained, protected, utilized, and transferred as appropriate. ... SPECIAL INSTRUCTIONS Clinical Record: 1. A confidential clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every client receiving home health services. 2. In addition to the plan of care, the clinical record shall contain appropriate identifying information, including, but not limited to: ... O. signed and dated clinical and progress notes of nurses, therapists, and social workers ... 5. Documentation shall establish that effective interchange, reporting, and coordination of client care does occur. ... "		<b>all charts will continue to be conducted at least quarterly to ensure no further problems occur with this issue. If there are any negative findings, appropriate staff will be re-educated and chart audits will continue every 30days until there are no negative findings. This plan will be implemented and completed by June 5, 2014.</b>	