

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157081	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER ACME HEALTH SERVICE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6302 N RUCKER RD STE J INDIANAPOLIS, IN 46220
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G000000	<p>This was a federal home health recertification survey. This is a partial extended survey.</p> <p>Survey dates: December 11, 12, 15, and 16, 2014</p> <p>Facility #"005287</p> <p>Medicaid #: 100263330A</p> <p>Surveyor: Michelle Weiss, RN, MSN, PHNS</p> <p>123 unduplicated admissions</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 22, 2014</p>	G000000		
G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely</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>discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure the plan of care was accurate and contained all tasks the aide was to perform for 3 of 10 records reviewed. (#1, 2, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care for the certification period 6/2/14 - 7/31/14 that identified the patient was an amputee.</p> <p>On 12/11/14 at 2 PM, the patient indicated he was not an amputee. He had a right total knee replacement.</p> <p>2. Clinical record #2 included a plan of care for the certification period 11/23/14 -1/21/15 that identified the patient had oxygen.</p> <p>On 12/12/ 14 at 9:30 AM during a home visit, the patient was observed not to have oxygen.</p> <p>#3. Clinical record #9 included a plan of care for the certification period 9/30/14 -11/28/14 that included orders for home</p>	G000159	G-0159 All agency RNs have received remediation re: completion of POCs, including all services/tasks provided, correct diagnoses, surgical procedures, functional limitations, and correct DME/supplies. Clinical records found with deficiencies have been corrected with revision to POC orders after confirmation with physicians. (Client #1: Removed amputee from POC. Client #2: Removed oxygen from POC. Client #9: Tasks for aide added to POC.) Clinical Supervisor is reviewing all POCs for compliance prior to submission to physicians. Clinical Director is performing random audits to ensure this responsibility is completed. Quarterly chart reviews will continue to assess issue to prevent recurrence.	12/31/2014			

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G000175	<p>health aide services. The plan of care failed to evidence what tasks the home health aide was to perform.</p> <p>On 12/15/14 at 5 PM, employee H, clinical services director, indicated she would have expected the tasks to be on the plan of care.</p> <p>4. The undated policy titled "Plan of Care" stated, "The POC [plan of care] will include, but not be limited to: ... Surgical procedures pertinent to care."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review, observation, and interview, the agency failed to ensure the registered nurse implemented preventative and evaluative nursing measures for 2 of 10 records reviewed (#2 and 3).</p> <p>Findings include:</p> <p>1. On 12/12/14 at 9:45 AM, a home visit was made to patient #2. The patient was observed to have Foley catheter which had come apart and the end that of the tubing that led to the drainage bag was laying on the floor. There was nothing</p>	G000175	G-0175 All agency Registered Nurses have received remediation re: responsibility for initiating rehabilitative and preventative nursing procedures. RNs have also received education re: complete assessment and documentation of wounds including full measurements at admission, weekly, and when a significant change is seen. Client #2: F/C straps and drainage tubing straps have been implemented to prevent catheter dislodgement. Family and agency aides have been instructed in use as well as emptying UD bag frequently to prevent pulling. Client #3:	12/31/2014

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G000334	<p>used to secure the tubing to the patient. Clinical record 2 identified the patient had a history of frequent urinary tract infections.</p> <p>On 12/12/14 at 4:30 PM, employee H, clinical services director, indicated the patient moves around and pulls the Foley and the drainage bag tubing apart. Also, the drainage bag becomes heavy because it needs to be emptied more frequently which puts pressure on the connection.</p> <p>2. Clinical record #3 included a plan of care for the certification period 12/10/14 -2/7/15 that identified the patient had open wounds. The goal on the plan off care was for the wounds to to heal 50% within 9 weeks. Skilled nurse notes dated 12/11, 12/12, 12/13, and 12/14/14 failed to evidence any wound measurements. Therefore, it could not be determined if the wounds were healing.</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of</p>		<p>Wounds are being assessed and measured fully as poor policy - healing is being assessed and documented. Clinical Supervisor auditing nursing visit noted weekly to ensure compliance and deficiency does not reoccur. Clinical Director will audit randomly as well as quarterly to prevent recurrence and identify any problems.</p>	

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N000000	<p>care.</p> <p>Based on clinical record review, observation, and interview, the agency failed to ensure the comprehensive assessment was accurate and complete for 1 of 10 records reviewed. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 12//12/14 at 2 PM, patient # 3 was observed having 3 separate wounds under the patient's left arm, each one about 1/2 dollar in size. Clinical record #3 contained a start of care comprehensive assessment dated 12/10/14 that failed to evidence the patient the 3 wounds under the left arm. On 12/15/14 at 4:30 PM, employee I, home care supervisor, and employee H, clinical services director, indicated there were 3 wounds under the patient's arm. 	G000334	<p>G-0334 Clinical Supervisor and/or Clinical Director is auditing every Comprehensive Assessment for accuracy and completeness of all systems including complete wound assessments/measurements. RNs have received remediation for existing problems to prevent recurrence. Compliance will be assessed during admission, random, and quarterly audits.</p>	12/31/2014

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N000524	<p>This was a state home health relicensure survey.</p> <p>Survey dates: December 11, 12, 15, and 16, 2014</p> <p>Facility #"005287</p> <p>Medicaid #: 100263330A</p> <p>Surveyor: Michelle Weiss, RN, MSN, PHNS</p> <p>123 unduplicated admissions</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 22, 2014</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted.</p>	N000000		

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	<p>(viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure the plan of care was accurate and contained all tasks the aide was to perform for 3 of 10 records reviewed. (#1, 2, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care for the certification period 6/2/14 - 7/31/14 that identified the patient was an amputee.</p> <p>On 12/11/14 at 2 PM, the patient indicated he was not an amputee. He had a right total knee replacement.</p> <p>2. Clinical record #2 included a plan of care for the certification period 11/23/14 -1/21/15 that identified the patient had oxygen.</p> <p>On 12/12/ 14 at 9:30 AM during a home visit, the patient was observed not to have oxygen.</p>	N000524	N-0524 All agency RNs have received remediation re: completion of POCs, including all services/tasks provided, correct diagnoses, surgical procedures, functional limitations, and correct DME/supplies. Clinical records found with deficiencies have been corrected with revision to POC orders after confirmation with physicians. (Client #1: Removed "amputee" from POC. Client #2: Removed oxygen from POC. Client #9: Tasks for aide added to POC). Clinical Supervisor is reviewing all POCs for compliance prior to submission to physicians. Clinical Director is performing random (at least weekly) audits to ensure this responsibility is being completed. Quarterly chart audits will also continue to assess issue to prevent recurrence.	12/31/2014			

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N000543	<p>#3. Clinical record #9 included a plan of care for the certification period 9/30/14 -11/28/14 that included orders for home health aide services. The plan of care failed to evidence what tasks the home health aide was to perform.</p> <p>On 12/15/14 at 5 PM, employee H, clinical services director, indicated she would have expected the tasks to be on the plan of care.</p> <p>4. The undated policy titled "Plan of Care" stated, "The POC [plan of care] will include, but not be limited to: ... Surgical procedures pertinent to care."</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.</p> <p>Based on clinical record review, observation, and interview, the agency failed to ensure the registered nurse implemented preventative and evaluative nursing measures for 2 of 10 records reviewed (#2 and 3).</p> <p>Findings include:</p>	N000543	N-0543 All agency RNs including Clinical Supervisor have received remediation re: responsibility for initiating rehabilitative and preventative nursing procedures. RNs have also received education re: complete assessment and documentation of all wounds including full measurements at admission, weekly, and when a significant	12/31/2014

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	<p>1. On 12/12/14 at 9:45 AM, a home visit was made to patient #2. The patient was observed to have Foley catheter which had come apart and the end that of the tubing that led to the drainage bag was laying on the floor. There was nothing used to secure the tubing to the patient. Clinical record 2 identified the patient had a history of frequent urinary tract infections.</p> <p>On 12/12/14 at 4:30 PM, employee H, clinical services director, indicated the patient moves around and pulls the Foley and the drainage bag tubing apart. Also, the drainage bag becomes heavy because it needs to be emptied more frequently which puts pressure on the connection.</p> <p>2. Clinical record #3 included a plan of care for the certification period 12/10/14 -2/7/15 that identified the patient had open wounds. The goal on the plan off care was for the wounds to to heal 50% within 9 weeks. Skilled nurse notes dated 12/11, 12/12, 12/13, and 12/14/14 failed to evidence any wound measurements. Therefore, it could not be determined if the wounds were healing.</p>		<p>change is seen (Client #2: F/C straps and drainage tubing straps have been implemented to prevent catheter dislodgement. Family and agency aides have been instructed in use as well as emptying UD bag frequently to prevent pulling. Client #3: Wounds are being assessed and measured fully as per policy - healing is being assessed and documented. Clinical Supervisor auditing nursing visit notes weekly to ensure compliance and deficiency does not recur. Clinical Director will audit charts randomly weekly as well as quarterly to prevent recurrence and ensure deficiency not recurring.</p>		