

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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 visit was for a federal home health recertification survey that resulted in an extended survey.</p> <p>Survey dates: October 15, 16, 17, 20, and 21, 2014</p> <p>Facility #: 005836</p> <p>Medicaid #: 200118810A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Health Force of Indiana is precluded from providing its own training and competency evaluation program for a period of 2 years beginning October 21, 2014, - October 21, 2016, for being out of compliance with the Conditions of Participation 484.18: Acceptance of Patients, Plan of Care, Medical Supervision; 484.30: Skilled Nursing Services; and 484.32: Therapy Services.</p> <p>Agency Census: Skilled Patients 46 Home Health aide only 26 Total: 72</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 30, 2014</p>	G000000		
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000110	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on document, policy, and clinical record review; observation; and interview, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, for 8 of 8 active clinical records reviewed creating the potential to affect all the agency's 72 current patients. (#1, 2, and 4-9)</p> <p>Findings include:</p> <p>1. The agency's admission packet, distributed at SOC (start of care), failed to include the updated state of Indiana</p>	G000110	All nurses will be in-serviced on updated Advanced Directives dated 7/1/13. (See exhibit A and B) All current patients received updated Advance Directives and signed form upon receipt. (See exhibit C) Current Advanced Directives added to all admission packets. Revised Advance Directives will be added to admission audit form with each admission. (See exhibit D) RN completing admission will be responsible for completing checklist and signing off and returning admission paperwork to office. Medical Records/LPN will be responsible for verifying that the checklist has been completed and will then place the checklist in	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>advanced directives document, revised July 1, 2013.</p> <p>2. Clinical record #1, SOC 8/8/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p> <p>3. Clinical record #2, SOC 9/26/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p> <p>4. Clinical record #4, SOC 9/26/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 11:00 AM, a home visit was conducted for patient #4. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>5. Clinical record #5, SOC 7/23/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 1:30 PM, a home visit was conducted to patient #5. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p>		the patients chart. This will be done on all charts.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>6. Clinical record #6, SOC 12/06/13, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 10:00 AM, a home visit was conducted to patient #6. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>7. Clinical record #7, SOC 3/06/13, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 11:45 AM, a home visit was conducted to patient #7. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>8. Clinical record #8, SOC 8/28/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p> <p>9. Clinical record #9, SOC 9/2/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p> <p>10. On 10/15/14 at 2:15 PM, employee P</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000121	<p>(director of nursing) indicated being unaware of the July, 2013 revision to the Indiana Advanced Directives document.</p> <p>11. The agency policy with a revised date of May, 2004, titled "Advance Directive Procedure" states, "POLICY The organization recognizes that all persons have a fundamental right to make decisions relating to their own care ... Valid advance directives will be followed to the extent permitted and required by law. ... SPECIAL INSTRUCTIONS 1. Provide the patient with written information as required by the Act. a. during the admissions process, the Registered Nurse/Therapist shall provide the patient with the following written information. This information must be given to the patient before care is provided."</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. Based on clinical record review, agency policy review and interview, the agency failed to ensure staff followed its own policy and procedure regarding pain assessment and follow-up in 1 of 8 active patient records reviewed creating the</p>	G000121	All staff will be in-serviced on current policy for pain management/intervention which states that pain is to be assessed at all visits. (See exhibit A and B) Staff also educated on where to address pain on all current visit	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>potential to affect all 72 patients of the agency. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV [skilled nursing visits] 1-3/month x [times] 2 months. Assess / monitor / evaluate: ambulation, caregiver knowledge and compliance with medications, home safety, hydration status, mobility, patient knowledge and compliance with medications, patient knowledge and compliance with treatment, patient / caregiver knowledge and compliance with MD [medical doctor] follow up, safety issues within the home, signs and symptoms of infection, skin integrity, vital signs, provide treatment / intervention; pulse oximetry ... PTV [physical therapy visits] 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility,</p>		<p>and evaluation forms. (see exhibit C, D, E, F, and G) Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see exhibit H) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care. This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission (see exhibit H) and weekly thereafter until 90% accuracy has been reached. This will be documented on calendar to be kept in chart. (See exhibit I) Once 90% accuracy has been maintained for 4 weeks Director of Nursing or designee will ensure that ongoing compliance is maintained through chart audits to be done every 60 days. (see exhibit J, K, and L)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>strength, transfers." The plan of care failed to include pain management as a specific intervention on the plan of care and the record failed to evidence follow-up assessments to address effectiveness the pain management.</p> <p>A. The record evidenced a document dated 9/26/14 titled "Admission Oasis" signed by the registered nurse (employee I) that stated, "M1240 Has this patient had a formal pain assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? [checked] 2 - Yes, and it indicates severe pain. ... "</p> <p>B. The record evidenced a document dated 9/26/14, signed by employee I, titled "Formal Pain Assessment" that stated, "Do you ever experience pain? 'Yes if yes, continue' pain location 1 'knees' Onset of pain 'chronic' Intensity (0-10 scale) 4-5 Precipitating factors RA [rheumatoid arthritis], walking Control measures 'rest' 'medication' ... How long does the pain last? 'comes and goes' What is the pain preventing patient from doing? 'being more active'"</p> <p>C. The record evidenced a document dated 9/29/14 titled "Physical Therapy Progress Notes" signed by employee U</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>(physical therapy assistant) that stated, "Type of visit: [checked] Re-visit ... Pain: location: 'L [left] knee' Rate: '6/10.'" The record failed to evidence the patient's pain was addressed at this visit.</p> <p>D. The record evidenced a document dated 10/6/14 titled "Physical Therapy Progress Notes" signed by employee U that stated, "Type of visit: [checked] Re-visit ... Pain: Location: 'L Knee' Rate: '6/10.'" The record failed to evidence the patient's pain was addressed at this visit.</p> <p>E. The record evidenced a document dated 10/8/14 titled "Skilled Nursing Visit Note" signed by employee L (registered nurse) that stated, "Nursing assessment and observation signs / symptoms ... PAIN Origin: 'RA [Rheumatoid Arthritis]' Location: 'knees' Duration: 'intermittent' Intensity: (0-10) '3-6'." The record failed to evidence the patient's pain was addressed at this visit.</p> <p>2. On 10/20/14 at 12:10 PM, employee P (director of nursing) indicated the registered nurse documented the patient as having 'severe pain' on admission; therefore, pain would be assessed on every visit and should have been listed as an intervention on the plan of care but was not. The employee indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>10/8/14 skilled nursing visit note should have included the nurse's documentation of pain management or pain control to the patient at this visit but did not.</p> <p>3. The agency policy with a revision date of May 2004 titled "Pain Assessment / Management" states, "POLICY All patients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. ... PURPOSE To support the patient's right to expect that pain will be recognized and addressed appropriately. To coordinate the efforts of all members of the team in effective pain management. To assess the effectiveness of interventions and strive for effective pain management. ... SPECIAL INSTRUCTIONS 1. Pain assessment is an integral part of the initial comprehensive assessment and the patient's right to expect appropriate assessment and management is explained and honored. If the patient has pain that interferes with activity or movement on a daily basis or is determines to be intractable, pain management will be a specific intervention on the plan of care. ... 3. Pain is assessed on every home visit and documented on a pain or symptom flow sheet. ... 5. The follow-up assessments will address effectiveness of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000141	<p>the pain management program and identify if there is a need for referral for additional or alternative therapy. If the established plan is ineffective and the pain management needs cannot be met within the agency pain management parameters, a referral will be made to an alternative provider. 6. Assessment of presence of pain and treatment / response will be incorporated into all agency assessment / reassessment tools."</p> <p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on personnel file review, policy review, and interview, the agency failed to ensure personnel policies were followed for all employees for 1 of 10 employee files reviewed with the potential to affect all 72 patient's of the agency. (employee Q)</p> <p>Findings include:</p> <p>1. The agency policy with a revision date of May, 2004, titled "License,</p>	G000141	Human Resources and office managers educated on current personnel policies. (see exhibit A and B) All personnel charts will be reviewed and audited monthly to ensure compliance. (see exhibit C) Assistant Administrator or designee will be responsible to ensure compliance.	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000144	<p>Registration, or certification requirements" states, "POLICY If a position requires licensure, registration, or certification, it shall be the employee's responsibility to keep these documents current. ... A copy of the employee's current license certification shall be maintained in his/her personnel file."</p> <p>2. Personnel file Q, date of hire 4/1/13, evidenced a document titled "Indiana Online Licensing Person Information [employee Q] ... License Information ... License type: Physical Therapist ... Expiration Date: 6/30/2014." The record failed to evidence documentation of employee Q's current license status.</p> <p>3. On 10/21/14 at 3:35 PM, employee P (director of nursing) indicated being unaware the file for employee Q contained documentation of an expired license.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the registered nurse</p>	G000144	All staff will be educated and in-serviced on updated Coordination of Patient Services policy. (see exhibit A and B) All	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>coordinated with the aide providing services and the physician to ensure the patient was receiving appropriate care in 1 of 6 active patient records reviewed of patients receiving skilled nursing services creating the potential to affect all patients of the agency receiving skilled nursing services. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care 7/23/14, contained a plan of care for the certification period 9/21 to 11/19/14 that identified the primary diagnosis as late effect cardiovascular disorder and a secondary diagnosis of Diabetes Mellitus and included orders for skilled nursing services 2-4 times per month to assess, monitor, and evaluate and home health aide services 2-3 times per week to assist with activities of daily living, light housekeeping, personal care, and skin care.</p> <p>A. The record evidenced a skilled nursing visit dated 10/3/14 by employee M (registered nurse) stating, "Analysis / Intervention / Instructions / Patient Response ... 'Pt [patient] had a red area on the side of her left great toe [with] tiny pin point open area [with] tiny drop of red blood. area measured 0.3 cm [centimeter] (L) [length] x [by] 0.1 cm</p>		<p>staff also educated on reporting any change of condition immediately to the RN/Case manager. Educated on proper documentation, physician notification, and obtaining new orders. Staff educated of importance of adding any new orders to the Plan of Care. Home Health Aides educated on not implementing any new interventions without a physicians order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes to the Plan of Care. This will be tracked by employee log sheet initialed by supervising nurse. (see exhibit C) Compliance will be ensured by Director or designee through Case conference with office staff bi-weekly. Minutes will be kept for documentation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>(W) [width]. area was red [and] a little swollen around toe. no drainage or odor. Pt afebrile, temp [temperature] - 96.5. area not tender to touch. Pt verb [verbalized] that [he/she] did not bump [his/her] toe. Pt verb that she already has M.D. [medical doctor] appt [appointment] on Tuesday and would have toe checked at that time. Called [primary physician's name] office, spoke [with] [staff at physician's office] and informed her of pt's status of toe [and] pt's [next] appt, [and] if pt needed to come in sooner. [staff at physician's office] verb that she would send the message to the NP [nurse practitioner] d/t [due/to] [physician] not being in today [and] will call back [with] orders. [employee P (director of nursing)] called and informed of all the above."</p> <p>B. The record evidenced a home health aide visit dated 10/9/14 by employee B (home health aide) stating, "Skin Care [checked] Comments: '[patient name] went to the dr and he checked out her left big toe nail and she was told to soak her feet in Epsom salt'." The record failed to evidence the registered nurse had delegated this task to the aide.</p> <p>C. The record evidenced a home health aide visit dated 10/16/14 by</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>employee B stating, "[check] soaked [patient's name] toe in Epsom salt because the dr told her it was infected and needed to soak."</p> <p>D. The record evidenced a skilled nursing visit dated 10/17/14 by employee J (registered nurse) stating, "SKIN ... 'reddened area on lateral aspect of [left] great toe near top of nail has lightened to pink. no tenderness on palpation. temp of are same as rest of foot, warm. client reports soaking [left] foot BID [two time per day] in warm [water]. Instructed to continue [with] soaking until completely healed.'"</p> <p>The record evidenced a home health aide supervisory visit note by employee J on 10/17/14 that stated, "Client requires aide for assistance with: 'bathing, grooming, dressing, transfers, assist [and] foot soaking until healed.' Are there any changes in client's condition medication changes, or physician visits? NO Care Coordination: [blank]."</p> <p>2. On 10/21/14 at 9:47 AM, employee P indicated an update to the plan of care should have been made in regards to the assistance with foot soaks for the wound on the left great toe. The employee indicated being unable to locate</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>documentation to evidence the registered nurse coordinated care with the physician, home health aide, or other personnel providing services to the patient.</p> <p>3. The agency policy with a revision date of May 2004, titled "Skilled nursing services" states, "POLICY Skilled nursing services will be provided by a registered nurse or a licensed practical / vocation nurse under the supervision of a registered nurse and in accordance with a medically approved plan of care (physician's orders). ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... b. regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs. f. counsels the patient and family/caregivers in meeting their needs."</p> <p>4. The agency policy with a revision date of May 2004, titled "Coordination of patient services" states, "POLICY All</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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	
G000156	484.18 personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may be done through formal care conferences, maintaining complete, current care plans; and written and verbal interaction. ... SPECIAL INSTRUCTIONS 1. All condition changes, missed visits, medication changes, or any concerns or questions involving a client should be reported immediately to the case manager during business hours. ... Each employee is responsible for documenting this care coordination, with both the field staff and the case manager documenting. ... 10. The case manager will identify provide communication to assure that all disciplines and departments are informed of changes to plan and/or need for modification."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record review, agency policy review, and interview, it was determined the agency failed to ensure visits were made as ordered on the plan of care in 2 of 8 active patient records reviewed creating the potential to affect all 72 of the agency's patients (See G 158), failed to ensure orders for therapy services included the amount, frequency, and duration of the specific procedures and modalities to be used for 5 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency that receive therapy services (See G 161), and failed to ensure verbal orders were put in writing and signed and dated with the date of receipt by the registered nurse in 4 of 8 active patient records reviewed and the agency policy was congruent with federal regulations creating the potential to affect all the agency's patients (See G 166).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.18; Acceptance of Patients, Plan of Care, and Medical Supervision.</p>	G000156	All staff educated/in-serviced on the federal/state regulation stating that all orders sent to physicians are to be signed and/or co-signed and dated by RN prior to sending to physician. (see exhibit A and B)This will be tracked through weekly verification by medical records/LPN. Ongoing compliance will be ensured by director or designee through audits done with each certification period. (see exhibit C, D, and E)	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000158	<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. Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 2 of 8 active patient records reviewed creating the potential to affect all 72 patients of the agency. (#1 and #5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #1, start of care 8/8/14, included a plan of care for the certification period of 8/8 to 10/8/14 with orders for skilled nursing 1-2 times per month for 2 months and physical therapy 2-3 times per week for nine weeks, beginning week 2. The record evidenced one physical therapy visit during week 2. On 10/16/14 at 2:35 PM, employee P (director of nursing) indicated there was a visit made on 8/15/14 for week 2. Clinical record #5, start of care 7/23/14, included a plan of care for the certification period of 9/21 to 11/19/14 	G000158	All staff educated and in-serviced on new missed visit policy that states all missed visits will be reported to physician within 7 days. (see exhibit A and B) Staff also educated on the importance of notifying supervising nurse of all missed visits and how to properly fill out missed visit form. (see exhibit C) This will be ensured by weekly verification done by medical records/LPN. Ongoing compliance will be ensured by Director or designee through audits to be done with each certification period. (See exhibits D, E, and F)	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
G000161	<p>with orders for skilled nursing 2-4 times per month for 2 months, physical therapy services 2-3 times per week for 10 weeks, and home health aide services 2-3 times per week for 10 weeks. The record evidenced one physical therapy visit during week 1.</p> <p>On 10/21/14 at 9:49 AM, employee P indicated being unable to locate a second physical therapy visit for week 1 of the new certification period.</p> <p>3. The agency policy with a revised date of May 2004, titled "Clinical documentation" states, "SPECIAL INSTRUCTIONS 1. All skilled services provided by nursing, therapy, or social services will be documented in the clinical record. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician."</p> <p>484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.</p> <p>Based on clinical record review and</p>	G000161	All staff educated/in-serviced on the federal/stateregulation stating	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>agency policy review, the agency failed to ensure orders for therapy services included the amount, frequency, and duration of the specific procedures and modalities to be used for 5 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency that receive therapy services. (#1, 2, 5, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "PTV [physical therapy visits] 2-3/week x 4 weeks. Assess and or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers." The plan of care failed to include the amount, frequency, and duration of the specific physical therapy procedures to be used.</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that stated, "PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance</p>		<p>that all orders sent to physicians are to be signed and/orco-signed and dated by RN prior to sending to physician. (see exhibit A andB)This will be tracked through weekly verification by medical records/LPN.Ongoing compliance will be ensured by director or designee through audits donewith each certification period. (see exhibit C, D, and E) All therapists and assistants educated/in-serviced on providing Home Exercise Programs to both clients and office to be kept in clients chart upon initial eval or by visit number three. (see exhibit A and B) This will be monitored by medical records/LPN through weekly verification and logged on therapy tracking form that is also to be kept in clients chart. (see exhibit F)On going compliance will be ensured through audits performed with each certification by Director of nursing or designee. (exhibit G, H, and I))</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers." The plan of care failed to include the amount, frequency, and duration of the specific physical therapy procedures and modalities to be used.</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee F that stated, "PT [physical therapy] eval et [and] tx [treat] as indicated. "</p> <p>3. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 stating, "PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility" The plan of care failed to include the amount, frequency, and duration of the specific physical therapy procedures and modalities to be used.</p> <p>The record contained a physician's verbal order dated 9/19/14 signed by employee F stating, "PT eval et tx as indicated. "</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>4. Clinical record #8, start of care 8/28/14, contained a plan of care for certification period 8/28 to 10/26/14 stating, "PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, strength, transfers" The plan of care failed to include the amount, frequency, and duration of the specific physical therapy procedures and modalities to be used.</p> <p>5. Clinical record #9, start of care 9/2/14, contained a plan of care for certification period 9/2 to 10/31/14 stating, "PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, ROM, strength, transfers" The plan of care failed to include the amount, frequency, and duration of the specific physical therapy procedures and modalities to be used.</p> <p>6. The agency policy with a revision date of May 2004 titled "Care Plans" states,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"3. The care plan shall include, but not be limited to: a. Nursing diagnosis (es) / problems and needs identified. b. reasonable, measurable, and realistic goals as determined by the assessment and patient expectations. c. A list of specific interventions with plans for implementation. d. indicators for measuring goal achievement and identified time frames. 4. the physician plan of care may be used as a care plan if specific interventions are clearly identified for home care staff to address patient care needs."</p> <p>7. The agency policy with a revision date of April 1999 titled "Therapy services" states, "SPECIAL INSTRUCTIONS ... 2. Physician orders will be obtained for the kind, type and intensity of therapy services. After the assessment is completed, the therapist will communicate specific treatments and modalities to be used. The therapist or the agency designee will obtain there verbal order from the physician for the specific modalities. 3. The therapist will consult and collaborate with the registered nurse who is the casemanager. The therapist will participate in implementing the physician's plan of care and evaluating patient progress."</p> <p>8. The agency policy with a revision date</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
G000166	<p>of May 2004 titled "Plan of Care" states, "2. The plan of care shall be completed in full to include: ... c. type, frequency, and duration of all visits/services. d. specific procedures and modalities for therapy services."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on clinical record review and interview, the agency failed to ensure verbal orders were put in writing and signed and dated with the date of receipt by the registered nurse in 4 of 8 active patient records reviewed and the agency policy was congruent with federal regulations creating the potential to affect all the agency's patients. (#1, 2, 4, and 5)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "21. SNV [skilled nursing visit] 1-3/month x [times] 2 months. ... PTV [physical</p>	G000166	All clinical nurses educated/in-serviced on Federal and state regulation stating that the clinician performing initial assessment is to write the Plan of Care and to review before signing and sending to physician. (see exhibit A and B) This will be monitored by Medical Records/LPN through weekly verification. Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibit C and D)	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>therapy visits] 2-3/week x 4 weeks. ... 23. Nurse's signature and Date of verbal SOC [start of care] where applicable: [employee F (LPN-licensed practical nurse) employee P (director of nursing)] 10/03/2014" The plan of care failed to evidence the physicians verbal order for services was received by the registered nurse.</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 stating, "21. SNV 1-3/month x [times] 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. ... 23. Nurse's signature and Date of verbal SOC [start of care] where applicable: [employee F employee P] 09/26/2014" The plan of care failed to evidence the physicians verbal order for services was received by the registered nurse.</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee F stating, "SN [skilled nursing] evaluation for HHC [home health care] services. PT [physical therapy] eval et [and] tx [treat] as indicated. "</p> <p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV [skilled nursing visits] 1-3/month x [times] 2 months. ... PTV [physical therapy visits] 1-1/week x 1 week PTV 2-3/week x 9 weeks. ... 23. Nurse's signature and Date of verbal SOC where applicable: [employee D (LPN) employee P] 09/26/2014" The plan of care failed to evidence the physicians verbal order for services was received by the registered nurse.</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee D stating, "SN eval for HHC services. PT eval et tx as indicated. "</p> <p>4. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 stating, "21. SNV 2-4/month x 2 months. ... PTV 2-3/week x 10 weeks." The plan of care failed to evidence the physicians verbal order for services was received by the registered nurse.</p> <p>The record contained a physicians verbal order dated 9/19/14 signed by employee F stating, "SN evaluation for recertification of HHC services. PT eval et tx as indicated. "</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000168	<p>5. On 10/16/14 at 12:30 PM, employee P indicated LPN's are case managers and there are 2, employees D and F. The employee indicated the case managers manage the patient's case, do verifications, and take physician's orders. The employee indicated the LPN's process the patients' care plans and then he/she co-signs them.</p> <p>6. he agency policy with a revision date of March 2005, titled "Physician Orders" states, "POLICY All medications, treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... Verbal orders may be taken by licensed personnel designated by the agency in accordance with applicable state and federal law and organization policy. ... SPECIAL INSTRUCTIONS ... 3. Verbal orders are accepted by authorized, licensed agency personnel in accordance with applicable law and agency policy. ..."</p> <p>484.30 SKILLED NURSING SERVICES Based on clinical record review, agency</p>	G000168	All staff will be educated and	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
	policy review, and interview, it was determined the agency failed to ensure the home health agency furnished skilled nursing services under the supervision of a registered nurse in 4 of 8 active patient records reviewed creating the potential to affect all 72 of the agency's patients (See G 169), failed to ensure the registered nurse included the patient's pain management on the plan of care and/or made necessary revisions and revised the plan of care to include the patient's foot soaks in 2 of 8 active patient records reviewed creating the potential to affect all 72 patients of the agency (See G 173), failed to ensure the registered nurse initiated appropriate preventative nursing procedures to address the patient's pain in 1 of 6 active patient records reviewed creating the potential to affect all 46 patients of the agency receiving skilled nursing services (See G 175), failed to ensure the registered nurse coordinated with the aide providing services and the physician to ensure the patient was receiving appropriate care in 1 of 6 active patient records reviewed of patients receiving skilled nursing services creating the potential to affect all patients of the agency receiving skilled nursing services (See G 176), and failed to ensure the licensed practical nurse did not function in the role of the registered nurse in 4 of 8 active patient records		in-serviced on updated Coordination of Patient Services policy. (see exhibit A and B G144) All staff also educated on reporting any change of condition immediately to the RN/Case manager. Educated on proper documentation, physician notification, and obtaining new orders. Staff educated of importance of adding any new orders to the Plan of Care. Home Health Aides educated on not implementing any new interventions without a physicians order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes to the Plan of Care. This will be tracked by employee log sheet initialed by supervising nurse. (see exhibit C G144) Compliance will be ensured by Director or designee through Case conference with office staff bi-weekly. Minutes will be kept for documentation. All staff will be in-serviced on current policy for pain management/intervention which states that pain is to be assessed at all visits.(See exhibit A and B G121) Staff also educated on where to address pain on all current visit and evaluation forms. (see exhibit C, D, E, F, and G G121) Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000169	<p>reviewed creating the potential to affect all patients of the agency (See G 179).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.30: Nursing Services.</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services by or under the supervision of a registered nurse. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the home health agency furnished skilled nursing services under the supervision of a registered nurse in 4 of 8 active patient records reviewed creating the potential to affect all patients of the agency. (#1, 2, 4, and 5)</p> <p>Findings include:</p>	G000169	<p>exhibit H G121) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care. This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission (see exhibit H G121) and weekly thereafter until 90% accuracy has been reached. This will be documented on calendar to be kept in chart. (See exhibit I G121) Once 90% accuracy has been maintained for 4 weeks Director of Nursing or designee will ensure that ongoing compliance is maintained through chart audits to be done every 60 days. (see exhibit J, K, and L G121)</p> <p>All clinical nurses educated/in-serviced on Federal and state regulation stating that the clinician performing initial assessment is to write the Plan of Care and to review before signing and sending to physician. (see exhibit A and B G166) This will be monitored by Medical Records/LPN through weekly verification. Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "21. SNV [skilled nursing visit] 1-3/month x [times] 2 months. ... PTV [physical therapy visits] 2-3/week x 4 weeks. Assess and or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers ... 23. Nurse's signature and Date of verbal SOC [start of care] where applicable: [employee F (LPN-licensed practical nurse) employee P (director of nursing)] 10/03/2014"</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that stated, "21. SNV 1-3/month x [times] 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. ... 23. Nurse's signature and Date of verbal SOC [start of care] where applicable: [employee F] [employee P] 09/26/2014"</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee F that stated, "SN [skilled nursing] evaluation for HHC [home health care] services. PT [physical therapy] eval et [and] tx [treat] as</p>		see exhibit C and D G166)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>indicated. "</p> <p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers. ... 23. Nurse's signature and Date of verbal SOC where applicable: [employee D (LPN)] [employee P] 09/26/2014"</p> <p>A. The record contained a physicians verbal order dated 9/26/14 signed by employee D that stated, "SN eval for HHC services. PT eval et tx as indicated. "</p> <p>B. The record evidenced a document dated 9/26/14 titled "Admission Oasis" signed by the registered nurse (employee I) stating, "(M1240 Has this patient had a formal pain assessment using a standardized pain assessment tool</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>(appropriate to the patient's ability to communicate the severity of pain)? [checked] 2 - Yes, and it indicates sever pain. ... "</p> <p>C. The record evidenced a document dated 9/26/14, signed by employee I, titled "Formal Pain Assessment" stating, "Do you ever experience pain? 'Yes if yes, continue' pain location 1 'knees' Onset of pain 'chronic' Intensity (0-10 scale) 4-5 Precipitating factors RA [rheumatoid arthritis], walking Control measures 'rest' 'medication' ... How long does the pain last? 'comes and goes' What is the pain preventing patient from doing? 'being more active'"</p> <p>D. The record evidenced a document dated 10/8/14 titled "Skilled Nursing Visit Note" signed by employee L (registered nurse) stating, "Nursing assessment and observation signs/symptoms ... PAIN Origin: 'RA [Rheumatoid Arthritis]' Location: 'knees' Duration: 'intermittent' Intensity: (0-10) '3-6'." The record failed to evidence the patient's pain was addressed at this visit.</p> <p>4. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 stating, "21. SNV 2-4/month x 2 months. ... PTV 2-3/week x 10 weeks. ... 23.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>Nurse's signature and date of verbal SOC where applicable: [employee F] [employee P] 09/19/2014."</p> <p>The record contained a physicians verbal order dated 9/19/14 signed by employee F stating, "SN evaluation for recertification of HHC services. PT eval et tx as indicated. "</p> <p>5. On 10/16/14 at 12:30 PM, employee P indicated LPN's are case managers and there are 2, employees D and F. The employee indicated the case managers manage the patient's case, do verifications, and take physician's orders. Employee P indicated the registered nurse does the visit and if there is need to contact the physician, the registered nurse calls the case manager and gives report and then the case manager contacts the physician. The employee indicated the LPN's process the patients' care plans and then he/she co-signs them.</p> <p>6. The agency policy with a revision date of May 2004 titled "Patient admission process" states, "SPECIAL INSTRUCTIONS ... 7. Each patient referred to the agency shall be evaluated by a registered nurse/therapist to determine the immediate care and support needs of the patient ... 10. The admission professional will: ... d.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000173	<p>Complete the assessment form, including OASIS data elements, plan of care/485, care plan if indicated, medication regime review, and additional documents, as required. The data gathered shall form the basis for the plan of care and care plan. ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the registered nurse included the patient's pain management on the plan of care and/or made necessary revisions and revised the plan of care to include the patient's foot soaks in 2 of 8 active patient records reviewed creating the potential to affect all 72 patients of the agency. (#4 and 5)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis.</p>	G000173	<p>All staff will be educated and in-serviced on updated Coordination of Patient Services policy. (see exhibit A and B G144) All staff also educated on reporting any change of condition immediately to the RN/Case manager. Educated on proper documentation, physician notification, and obtaining new orders. Staff educated of importance of adding any new orders to the Plan of Care. Home Health Aides educated on not implementing any new interventions without a physicians order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes to the Plan of Care. This will be tracked by employee log sheet initiated by supervising nurse.</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>A. The record evidenced a document dated 9/26/14 titled "Admission Oasis" signed by the registered nurse (employee I) that stated, "(M1240 Has this patient had a formal pain assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? [checked] 2 - Yes, and it indicates sever pain. ... " The plan of care failed to include pain management as a specific intervention on the plan of care.</p> <p>B. The record evidenced a document dated 9/26/14, signed by employee I, titled "Formal Pain Assessment" that stated, "Do you ever experience pain? 'Yes if yes, continue' pain location 1 'knees' Onset of pain 'chronic' Intensity (0-10 scale) 4-5 Precipitating factors RA [rheumatoid arthritis], walking Control measures 'rest' 'medication' ... How long does the pain last? 'comes and goes' What is the pain preventing patient from doing? 'being more active'" The plan of care failed to include pain management as a specific intervention on the plan of care.</p> <p>C. The record evidenced a document dated 9/29/14 titled "Physical Therapy Progress Notes" signed by employee U (physical therapy assistant) stating, "Type of visit: [checked] Re-visit ... Pain:</p>		(see exhibit C G144) Compliance will be ensured by Director or designee through Case conference with office staff bi-weekly. Minutes will be kept for documentation. All staff will be in-serviced on current policy for pain management/intervention which states that pain is to be assessed at all visits. (See exhibit A and B G121) Staff also educated on where to address pain on all current visit and evaluation forms. (see exhibit C, D, E,F, and G G121) Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see exhibit H G121) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care. This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission (see exhibit H G121) and weekly thereafter until 90% accuracy has been reached. This will be documented on calendar to be kept in chart. (See exhibit I G121) Once				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>location: 'L [left] knee' Rate: '6'/10." The plan of care failed to evidence the registered nurse had revised the plan of care to include pain management as a specific intervention.</p> <p>D. The record evidenced a document dated 10/6/14 titled "Physical Therapy Progress Notes" signed by employee U stating, "Type of visit: [checked] Re-visit ... Pain: Location: 'L Knee' Rate: '6'/10." The plan of care failed to evidence the registered nurse had revised the plan of care to include pain management as a specific intervention.</p> <p>E. The record evidenced a document dated 10/8/14 titled "Skilled Nursing Visit Note" signed by employee L (registered nurse) stating, "Nursing assessment and observation signs/symptoms ... PAIN Origin: 'RA [Rheumatoid Arthritis]' Location: 'knees' Duration: 'intermittent' Intensity: (0-10) '3-6'." The plan of care failed to evidence the registered nurse had revised the plan of care to include pain management as a specific intervention.</p> <p>F. On 10/20/14 at 12:10 PM, employee P (director of nursing) indicated the registered nurse documented the patient as having 'severe pain' on admission, therefore, pain would</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>be assessed on every visit and should have been listed as an intervention on the plan of care but was not.</p> <p>G. The agency policy with a revision date of May 2004 titled "Pain Assessment/Management" states, "POLICY All patients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. ... PURPOSE To support the patient's right to expect that pain will be recognized and addressed appropriately. To coordinate the efforts of all members of the team in effective pain management. To assess the effectiveness of interventions and strive for effective pain management. ... SPECIAL INSTRUCTIONS 1. Pain assessment is an integral part of the initial comprehensive assessment and the patient's right to expect appropriate assessment and management is explained and honored. If the patient has pain that interferes with activity or movement on a daily basis or is determines to be intractable, pain management will be a specific intervention on the plan of care. ... 3. Pain is assessed on every home visit and documented on a pain or symptom flow sheet. ... 5. The follow-up assessments will address effectiveness of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the pain management program and identify if there is a need for referral for additional or alternative therapy. If the established plan is ineffective and the pain management needs cannot be met within the agency pain management parameters, a referral will be made to an alternative provider. 6. Assessment of presence of pain and treatment/response will be incorporated into all agency assessment/reassessment tools."</p> <p>2. Clinical record #5, start of care 7/23/14, contained a plan of care with primary diagnosis as late effect cardiovascular disorder and a secondary diagnosis of Diabetes Mellitus for certification period 9/21 to 11/19/14.</p> <p>A. The record evidenced a skilled nursing visit dated 10/3/14 by employee M (registered nurse) stating, "Analysis / Intervention / Instructions / Patient Response ... 'Pt [patient] had a red area on the side of her left great toe [with] tiny pin point open area [with] tiny drop of red blood. area measured 0.3 cm [centimeter] (L) [length] x [by] 0.1 cm (W) [width]. area was red [and] a little swollen around toe. no drainage or odor. Pt afebrile, temp [temperature] - 96.5. area not tender to touch. Pt verb [verbalized] that [he/she] did not bump [his/her] toe. Pt verb that she already has</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>M.D. [medical doctor] appt [appointment] on Tuesday and would have toe checked at that time. Called [primary physician's name] office, spoke [with] [staff at physician's office] and informed her of pt's status of toe [and] pt's [next] appt, [and] if pt needed to come in sooner. [staff at physician's office] verb that she would send the message to the NP [nurse practitioner] d/t [due/to] [physician] not being in today [and] will call back [with] orders. [employee P (director of nursing)] called and informed of all the above. ... "</p> <p>B. The record evidenced a home health aide visit dated 10/9/14 by employee B (home health aide) stating, "Skin Care [checked] Comments: '[patient name] went to the dr and he checked out her left big toe nail and she was told to soak her feet in Epsom salt'."</p> <p>C. The record evidenced a home health aide visit dated 10/16/14 by employee B stating, "[check]soaked [patient's name] toe in Epsom salt because the dr told her it was infected and needed to soak."</p> <p>The record evidenced a home health aide care plan prepared by employee M on 9/19/14. The care plan failed to include soaking the patient's foot</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>in Epsom salt as a task to be performed by the home health aide.</p> <p>D. The record evidenced a skilled nursing visit dated 10/17/14 by employee J (registered nurse) stating, "SKIN ... 'reddened area on lateral aspect of [left] great toe near top of nail has lightened to pink. no tenderness on palpation. temp of are same as rest of foot, warm. client reports soaking [left] foot BID [two time per day] in warm [water]. Instructed to continue [with] soaking until completely healed.'"</p> <p>The record evidenced a home health aide supervisory visit note by employee J on 10/17/14 stating, "client requires aide for assistance with: 'bathing, grooming, dressing, transfers, assist [and] foot soaking until healed.' Are there any changes in client's condition medication changes, or physician visits? NO Care Coordination: [blank]."</p> <p>E: The plan of care failed to evidence it had been revised to include the foot soaks.</p> <p>F. On 10/21/14 at 9:47 AM, employee P indicated an update to the plan of care should have been made in regards to the assistance with foot soaks for the wound on the left great toe. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>employee indicated being unable to locate documentation to evidence the registered coordinated care with the physician, home health aide, or other personnel providing services to the patient.</p> <p>3. On 10/16/14 at 12:30 PM, employee P indicated Licensed Practical Nurses (LPN) are case managers and there are 2, employees D and F. The employee indicated the LPNs process the patients' care plans and then he/she co-signs them.</p> <p>4. The agency policy with a revision date of May 2004 titled "Skilled nursing services" states, "SPECIAL INSTRUCTIONS 1. The registered nurse: ... c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
G000175	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review, agency policy review and interview, the agency failed to ensure the registered nurse initiated appropriate preventative nursing procedures to address the patient's pain in 1 of 6 active patient records reviewed creating the potential to affect all 46 patients of the agency receiving skilled nursing services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis.</p> <p>A. The record evidenced a document dated 9/26/14 titled "Admission Oasis" signed by the registered nurse (employee I) that stated, "(M1240 Has this patient had a formal pain assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? [checked] 2 - Yes, and it indicates sever pain. ... " The plan of care failed to</p>	G000175	All staff will be in-serviced on current policy for pain management/intervention which states that pain is to be assessed at all visits. (See exhibit A and B G121) Staff also educated on where to address pain on all current visit and evaluation forms. (see exhibit C, D, E,F, and G G121) Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see exhibit H G121) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care.This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission(see exhibit H G121) and weekly thereafter until 90% accuracy has been reached.This will be documented on calendar to be kept in chart. (See exhibit I G121)	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>evidence the registered nurse initiated preventative nursing procedures to address the patient's pain.</p> <p>B. The record evidenced a document dated 9/26/14, signed by employee I, titled "Formal Pain Assessment" that stated, "Do you ever experience pain? 'Yes if yes, continue' pain location 1 'knees' Onset of pain 'chronic' Intensity (0-10 scale) 4-5 Precipitating factors RA [rheumatoid arthritis], walking Control measures 'rest' 'medication' ... How long does the pain last? 'comes and goes' What is the pain preventing patient from doing? 'being more active'" The plan of care failed to evidence the registered nurse initiated preventative nursing procedures to address the patient's pain.</p> <p>C. The record evidenced a document dated 10/8/14 titled "Skilled Nursing Visit Note" signed by employee L (registered nurse) stating, "Nursing assessment and observation signs/symptoms ... PAIN Origin: 'RA [Rheumatoid Arthritis]' Location: 'knees' Duration: 'intermittent' Intensity: (0-10) '3-6'." The plan of care failed to evidence the registered nurse initiated preventative nursing procedures to address the patient's pain.</p> <p>2. On 10/20/14 at 12:10 PM, employee P</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>(director of nursing) indicated the registered nurse documented the patient as having 'severe pain' on admission, therefore, pain would be assessed on every visit and should have been listed as an intervention on the plan of care but was not.</p> <p>3. The agency policy with a revision date of May 2004 titled "Pain Assessment / Management" states, "POLICY All patients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. The agency will work with the patient, family and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal."</p> <p>4. The agency policy with a revision date of May 2004 titled "Skilled nursing services" states, "POLICY Skilled nursing services will be provided by a registered nurse or a licensed practical / vocation nurse under the supervision of a registered nurse and in accordance with a medically approved plan of care (physician's orders). ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... d. Provides services requiring specialized nursing skill and initiates</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000176	<p>appropriate preventative and rehabilitative nursing procedures."</p> <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 clinical record review, agency policy review, and interview, the agency failed to ensure the registered nurse coordinated with the aide providing services and the physician to ensure the patient was receiving appropriate care in 1 of 6 active patient records reviewed of patients receiving skilled nursing services creating the potential to affect all patients of the agency receiving skilled nursing services. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care 7/23/14, contained a plan of care for the certification period 9/21 to 11/19/14 that identified the primary diagnosis as late effect cardiovascular disorder and a secondary diagnosis of Diabetes Mellitus and included orders for skilled nursing services 2-4 times per month to assess, monitor, and evaluate and home health</p>	G000176	<p>All staff will be educated and in-serviced on updated Coordination of Patient Services policy. (see exhibit A and B G144) All staff also educated on reporting any change of condition immediately to the RN/Case manager. Educated on proper documentation, physician notification, and obtaining new orders. Staff educated of importance of adding any new orders to the Plan of Care. Home Health Aides educated on not implementing any new interventions without a physicians order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes to the Plan of Care. This will be tracked by employee log sheet initialed by supervising nurse. (see exhibit C G144) Compliance will be ensured by Director or designee through Case conference with office staff</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>aide services 2-3 times per week to assist with activities of daily living, light housekeeping, personal care, and skin care.</p> <p>A. The record evidenced a skilled nursing visit dated 10/3/14 by employee M (registered nurse) stating, "Analysis / Intervention / Instructions / Patient Response ... 'Pt [patient] had a red area on the side of her left great toe [with] tiny pin point open area [with] tiny drop of red blood. area measured 0.3 cm [centimeter] (L) [length] x [by] 0.1 cm (W) [width]. area was red [and] a little swollen around toe. no drainage or odor. Pt afebrile, temp [temperature] - 96.5. area not tender to touch. Pt verb [verbalized] that [he/she] did not bump [his/her] toe. Pt verb that she already has M.D. [medical doctor] appt [appointment] on Tuesday and would have toe checked at that time. Called [primary physician's name] office, spoke [with] [staff at physician's office] and informed her of pt's status of toe [and] pt's [next] appt, [and] if pt needed to come in sooner. [staff at physician's office] verb that she would send the message to the NP [nurse practitioner] d/t [due/to] [physician] not being in today [and] will call back [with] orders. [employee P (director of nursing)] called and informed of all the above."</p>		bi-weekly. Minutes will be kept for documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>B. The record evidenced a home health aide visit dated 10/9/14 by employee B (home health aide) stating, "Skin Care [checked] Comments: '[patient name] went to the dr and he checked out her left big toe nail and she was told to soak her feet in Epsom salt'." The record failed to evidence the registered nurse had delegated this task to the aide.</p> <p>C. The record evidenced a home health aide visit dated 10/16/14 by employee B stating, "[check] soaked [patient's name] toe in Epsom salt because the dr told her it was infected and needed to soak."</p> <p>D. The record evidenced a skilled nursing visit dated 10/17/14 by employee J (registered nurse) stating, "SKIN ... 'reddened area on lateral aspect of [left] great toe near top of nail has lightened to pink. no tenderness on palpation. temp of are same as rest of foot, warm. client reports soaking [left] foot BID [two time per day] in warm [water]. Instructed to continue [with] soaking until completely healed.'"</p> <p>The record evidenced a home health aide supervisory visit note by employee J on 10/17/14 that stated,</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>"Client requires aide for assistance with: 'bathing, grooming, dressing, transfers, assist [and] foot soaking until healed.' Are there any changes in client's condition medication changes, or physician visits? NO Care Coordination: [blank]."</p> <p>2. On 10/21/14 at 9:47 AM, employee P indicated an update to the plan of care should have been made in regards to the assistance with foot soaks for the wound on the left great toe. The employee indicated being unable to locate documentation to evidence the registered nurse coordinated care with the physician, home health aide, or other personnel providing services to the patient.</p> <p>3. The agency policy with a revision date of May 2004, titled "Skilled nursing services" states, "POLICY Skilled nursing services will be provided by a registered nurse or a licensed practical / vocation nurse under the supervision of a registered nurse and in accordance with a medically approved plan of care (physician's orders). ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... b. regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the plan of care and necessary revisions and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>updates to the plan of care and care plan.</p> <p>d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs. f. counsels the patient and family/caregivers in meeting their needs."</p> <p>4. The agency policy with a revision date of May 2004, titled "Coordination of patient services" states, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may be done through formal care conferences, maintaining complete, current care plans; and written and verbal interaction. ... SPECIAL INSTRUCTIONS 1. All condition changes, missed visits, medication changes, or any concerns or questions involving a client should be reported immediately to the case manager during business hours. ... Each employee is responsible for documenting this care coordination, with both the field staff and the case manager documenting. ... 10. The case manager will identify provide communication to assure that all disciplines and departments are informed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000179	<p>of changes to plan and/or need for modification."</p> <p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes services in accordance with agency policy. Based on clinical record review, personnel file review, agency policy review, and interview, the agency failed to ensure the licensed practical nurse (LPN) did not function in the role of the registered nurse in 4 of 8 active patient records reviewed creating the potential to affect all patients of the agency. (#1, 2, 4, and 5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that identified the LPN obtained the verbal orders on the plan of care. The plan of care stated, "23. Nurse's signature and Date of verbal SOC [start of care] where applicable: [employee F (LPN-licensed practical nurse)] [employee P (director of nursing)] 10/03/2014" 2. Clinical record #2, start of care 	G000179	All clinical nurses educated/in-serviced on Federal and state regulation stating that the clinician performing initial assessment is to write the Plan of Care and to review before signing and sending to physician.(see exhibit A and B G166) This will be monitored by Medical Records/LPN through weekly verification. Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibit C and D G166) LPN's removed as case managers.	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that identified the LPN obtained the verbal orders of the plan of care. The plan of care stated, "23. Nurse's signature and Date of verbal SOC where applicable: [employee F] [employee P] 09/26/2014 ..."</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee F that stated, "SN [skilled nursing] evaluation for HHC [home health care] services. PT [physical therapy] eval et [and] tx [treat] as indicated."</p> <p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 that identified the LPN obtained the verbal orders on the plan of care. The plan of care states, "23. Nurse's signature and Date of verbal SOC where applicable: [employee D (LPN)] [employee P] 09/26/2014 ..."</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee D that states, "SN eval for HHC services. PT eval et tx as indicated."</p> <p>4. Clinical record #5, start of care</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 that identified the LPN obtained the verbal orders on the plan of care. The plan of care states, "23. Nurse's signature and date of verbal SOC where applicable: [employee F] [employee P] 09/19/2014."</p> <p>The record contained a physicians verbal order dated 9/19/14 signed by employee F that states, "SN evaluation for recertification of HHC services. PT eval et tx as indicated. "</p> <p>5. On 10/16/14 at 12:30 PM, employee P indicated LPN's are case managers and there are 2, employees D and F. The employee indicated the case managers manage the patient's case, do verifications, and take physician's orders. Employee P indicated the registered nurse does the visit and if there is need to contact the physician, the registered nurse calls the case manager and gives report and then the case manager contacts the physician. The employee indicated the LPN's process the patients' care plans and then he/she co-signs them.</p> <p>Employee file D evidenced a document signed and dated by the employee on 3/10/10 titled "Licensed Practical Nurse Licensed Vocational Nurse" that stated, "PURPOSE: Initial</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>job description STATEMENT OF RESPONSIBILITY: The LPN/LVN provides services in accordance with the policies and procedures of the agency under the supervision of a Registered Nurse and under the direction of a licensed physician. participates with the registered nurse in the assessment, planning, implementation, and evaluation of nursing care."</p> <p>6. The agency policy with a revision date of May 2004 titled "Skilled nursing services" states, "SPECIAL INSTRUCTIONS 1. The registered nurse: ... c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan."</p> <p>7. The agency policy with a revision date of May 2004 titled "Licensed Practical Nurse Supervision" states, "POLICY The agency shall provide Licensed practical nurse services under the direction and supervision of a registered professional nurse when services are indicated and ordered by the physician. ... PURPOSE To provide supervision of the licensed practical nurse as required by state/federal guidelines. ... SPECIAL INSTRUCTIONS 1. The case manager designated Registered Nurse will give the licensed practical nurse direction for patient care by way of the care plan ... 2.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000184	<p>... b. The case manager will review the LPN documentation and ensure that the care provided is following the established plan of care. Ongoing communication and direction of the LPN will be provided through the case manager. ... 5. The Case Manager or another staff Registered Nurse will be readily available by telephone should the Licensed Practical Nurse need assistance."</p> <p>484.32 THERAPY SERVICES</p> <p>Based on clinical record review, policy review, and interview, it was determined the agency failed to ensure the physical therapist evaluated the patient's level of function timely in 1 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy services (See G 186), failed to ensure the physical therapist consulted with the physical therapy assistant at least once each working day to review all patient's treatments in 6 of 6 active patient records</p>	G000184	All therapists will be educated/in-serviced on the updated Therapy services policy which states that therapy evaluations will be done within 5 days of admission to ensure compliance with plan of care. (see exhibit A and B) This will be monitored by medical records/LPN through weekly verification. Ongoing compliance will be ensured by Director or designee through charts audits to be done with all certification periods. (see exhibit C, D, and E) Therapists and assistants educated/in-serviced on the	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>reviewed of patients receiving physical therapy services (See G 188), failed to ensure the physical therapist supervised the physical therapist assistant in 6 of 6 active patient records reviewed of patients receiving physical therapy services (See G 190), and failed to ensure the physical therapy assistant participated in educating the patient and family on pain management in 1 of 6 active patient records reviewed of patients receiving physical therapy services (See G 192).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.32: Therapy Services.</p>		<p>importance of daily communication for all patients. (See exhibit A and B) Therapists and assistants will begin this by emailing detailed summaries of each patient on a daily basis. The supervising therapist will then sign these emails and they will be given to office to file in patient's chart within a timely manner. This will be ensured through weekly verification done by Medical records/LPN) Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibits C, D, and E) All staff will be in-serviced on current policyfor pain management/intervention which states that pain is to be assessed at all visits. (See exhibit A and B G121) Staff also educated on where to address pain on all current visit and evaluation forms. (see exhibit C, D, E,F, and G G121) Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see exhibit H G121) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care. This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission (see exhibit H G121) and weekly thereafter until 90% accuracy has</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
G000186	<p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on clinical record review, policy review, and interview, the agency failed to ensure the physical therapist evaluated the patient's level of function timely in 1 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy services. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 8/8 to 10/8/14 stating, "21. Orders for discipline and treatments ... SNV [skilled nursing visit] 1-2/month x [times] 2 months ... PTV [physical therapy visit] 2-3/week x 9 weeks. (beginning week 2) Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers... 23. Nurse's signature</p>	G000186	<p>been reached. This will be documented on calendar to be kept in chart. (See exhibit I G121)</p> <p>All therapists will be educated/in-serviced on the updated Therapy services policy which states that therapy evaluations will be done within 5 days of admission to ensure compliance with plan of care. (see exhibit A and B G184) This will be monitored by medical records/LPN through weekly verification. Ongoing compliance will be ensured by Director or designee through charts audits to be done with all certification periods. (see exhibit C, D, and E G184) All therapists and RN's in-serviced/educated on Federal/state regulation stating that the Case manager/RN is to co-sign and date all therapy orders to be sent to physician. Therapists and office nurses also educated on the importance of sending all patient evaluations to physicians. (see exhibit A and B) This will be ensured through weekly verification to be done by medical records/LPN. Ongoing compliance will be ensured by Director of designee through audits done every certification period.</p>	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>and date of verbal SOC [start of care] where applicable: [employee P (director of nursing)] 08/08/2014 ... "</p> <p>A. The record evidenced a document dated 8/15/14 titled "Physical Therapy Evaluation" signed by employee O (physical therapist).</p> <p>On 10/16/14 at 2:35 PM, employee P indicated the initial visit from the physical therapist was on 8/15/14.</p> <p>B. On 10/16/14 at 2:32 PM, employee P indicated the skilled nurse and physical therapist need to assess the patient within 48 hours of the start of care. The employee indicated being unable to provide documentation of why the physical therapy visit was not conducted until 8/15/14.</p> <p>2. The agency policy with a revision date of May 2004 titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members ... PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000188	<p>specific identified needs. ... SPECIAL INSTRUCTIONS ... 7. The patient, therapist, and other agency personnel shall participate in developing the plan of care"</p> <p>484.32 THERAPY SERVICES The qualified therapist advises and consults with the family and other agency personnel. Based on clinical record and document review, and interview, the agency failed to ensure the physical therapist consulted with the physical therapy assistant at least once each working day to review all patients' treatments in 6 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy. (#1, 2, 4, 5, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "21. SNV [skilled nursing visit] 1-3/month x</p>	G000188	<p>Therapists and assistants will be educated/in-serviced on the importance of daily communication for all patients. (See exhibit A and B G184)</p> <p>Therapists and assistants will begin this by emailing detailed summaries of each patient on a daily basis. The supervising therapist will then sign these emails and they will be given to office to file in patient's chart within a timely manner. This will be ensured through weekly verification done by Medical records/LPN) Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibits C, D, and E G184) All therapists will be in-serviced/educated on the</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>[times] 2 months. ... PTV [physical therapy visits] 2-3/week x 4 weeks. Assess and or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 8/15/14 and the physical therapy assistant conducted visits on 8/18, 8/19, 8/21, 8/25, 8/26, 8/28, 9/1, 9/3, 9/4, 9/8/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>B. The record evidenced the physical therapist conducted a visit on 9/9/14 and the physical therapist assistant conducted visits on 9/11, 9/15, 9/18, 9/22, 9/25, and 9/29/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for</p>		<p>importance of on-site supervisory visits for all patients receiving therapy to ensure proper care is being given by therapy assistants. (see exhibit A and B) On-site supervision will be done every 30 days going forward. (see exhibit C) This will be ensured through weekly verification done by Medical records/LPN. Ongoing compliance will be ensured by Director or designee through audits performed with each certification period. (see exhibit D and E)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>certification period 9/26 to 11/24/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted an initial visit on 9/27/14 and the physical therapist assistant conducted visits on 9/29, 9/30, 10/3, 10/6, 10/7, 10/9, 10/13, 10/14, and 10/16/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>instruct: ambulation training balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers." The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 9/27/14 and the physical therapist assistant conducted visits on 9/29, 10/3, 10/6, 10/10, and 10/17/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>B. On 10/17/14 at 11 AM, during a home visit, employee U (physical therapist assistant) indicated she contacts the physical therapist (employee Q) on Fridays through email but does not discuss all of the patients, only the ones that have concerns or does not seem to be progressing. The employee indicated the physical therapist has never made a visit during the time she is in the patient's home.</p> <p>4. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>stated, "21. SNV 2-4/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted a visit on 9/25/14 and the physical therapy assistant conducted visits on 9/29, 10/3, 10/7, 10/9, 10/13 and 10/16/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist.</p> <p>5. Clinical record #8, start of care 8/28/14, contained a plan of care for certification period 8/28 to 10/26/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>A. The record evidenced the physical therapist conducted an initial visit on 8/30/14 and the physical therapy assistant conducted visits on 9/3, 9/5, 9/8, 9/12, 9/15, 9/19, 9/22, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist.</p> <p>B. The record evidenced the physical therapist conducted a visit on 9/27/14 and the physical therapy assistant conducted visits on 9/29, 10/6, 10/10, 10/14, and 10/17/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>6. Clinical record #9, start of care 9/2/14, contained a plan of care for certification period 9/2 to 10/31/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, ROM, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The record evidenced the physical therapist conducted an initial visit on 9/2/14 and the physical therapy assistant conducted visits on 9/5, 9/8, 9/11, 9/15, 9/19, 9/23, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>7. On 10/16/14 at 12:55 PM, employee P (director of nursing) indicated there is no documentation of supervision of the physical therapy assistants. The employee indicated the physical therapy assistants do not consult with the physical therapists daily.</p> <p>8. The document titled "Physical Therapy Committee Laws and Regulations A compilation of the Indiana Code and Indiana Administrative Code 2013 Edition" states, "Rule 1. General Provisions ... 844 IAC 6-1-2 Definitions ... (g) Direct supervision means that the supervising physical therapist or physician at all times shall be available and at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant ...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000190	<p>With respect to the supervision of the physical therapist's assistants under IC 25-27-1-2(c), unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments."</p> <p>484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist.</p> <p>Based on clinical record and document review, and interview, the agency failed to ensure the physical therapy assistant was supervised by the physical therapist and consulted with the supervising physical therapist at least once each working day to review all patients' treatments in 6 of 6 active patient records</p>	G000190	<p>Therapists and assistants will be educated/in-service don the importance of daily communication for all patients. (See exhibit A and B G184) Therapists and assistants will begin this by emailing detailed summaries of each patient on a daily basis. The supervising therapist will then sign these</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy. (#1, 2, 4, 5, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "21. SNV [skilled nursing visit] 1-3/month x [times] 2 months. ... PTV [physical therapy visits] 2-3/week x 4 weeks. Assess and or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 8/15/14 and the physical therapy assistant conducted visits on 8/18, 8/19, 8/21, 8/25, 8/26, 8/28, 9/1, 9/3, 9/4, 9/8/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>B. The record evidenced the physical</p>		<p>emails and they will be given to office to file in patient's chart within a timely manner. This will be ensured through weekly verification done by Medical records/LPN) Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibits C, D, and E G184) All therapists will be in-serviced/educated on the importance of on-site supervisory visits for all patients receiving therapy to ensure proper care is being given by therapy assistants. (see exhibit A and B G188) On-site supervision will be done every 30 days going forward. (see exhibit C G188) This will be ensured through weekly verification done by Medical records/LPN. Ongoing compliance will be ensured by Director or designee through audits performed with each certification period. (see exhibit D and E G188)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>therapist conducted a visit on 9/9/14 and the physical therapist assistant conducted visits on 9/11, 9/15, 9/18, 9/22, 9/25, and 9/29/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted an initial visit on 9/27/14 and the physical therapist assistant conducted visits on 9/29, 9/30, 10/3, 10/6, 10/7, 10/9, 10/13, 10/14, and 10/16/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers." The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 9/27/14 and the physical therapist assistant conducted visits on 9/29, 10/3, 10/6, 10/10, and 10/17/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>B. On 10/17/14 at 11 AM, during a home visit, employee U (physical therapist assistant) indicated she contacts the physical therapist (employee Q) on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>Fridays through email but does not discuss all of the patients, only the ones that have concerns or does not seem to be progressing. The employee indicated the physical therapist has never made a visit during the time she is in the patient's home.</p> <p>4. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 that stated, "21. SNV 2-4/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted a visit on 9/25/14 and the physical therapy assistant conducted visits on 9/29, 10/3, 10/7, 10/9, 10/13 and 10/16/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist.</p> <p>5. Clinical record #8, start of care 8/28/14, contained a plan of care for certification period 8/28 to 10/26/14 that</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 8/30/14 and the physical therapy assistant conducted visits on 9/3, 9/5, 9/8, 9/12, 9/15, 9/19, 9/22, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist.</p> <p>B. The record evidenced the physical therapist conducted a visit on 9/27/14 and the physical therapy assistant conducted visits on 9/29, 10/6, 10/10, 10/14, and 10/17/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>6. Clinical record #9, start of care 9/2/14, contained a plan of care for certification</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>period 9/2 to 10/31/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, ROM, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted an initial visit on 9/2/14 and the physical therapy assistant conducted visits on 9/5, 9/8, 9/11, 9/15, 9/19, 9/23, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>7. On 10/16/14 at 12:55 PM, employee P (director of nursing) indicated there is no documentation of supervision of the physical therapy assistants. The employee indicated the physical therapy assistants do not consult with the physical therapists daily.</p> <p>8. The document titled "Physical Therapy Committee Laws and Regulations A compilation of the Indiana Code and Indiana Administrative</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000192	Code 2013 Edition" states, "Rule 1. General Provisions ... 844 IAC 6-1-2 Definitions ... (g) Direct supervision means that the supervising physical therapist or physician at all times shall be available and at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant ... With respect to the supervision of the physical therapist's assistants under IC 25-27-1-2(c), unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments." 484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL A physical therapy assistant or occupational therapy assistant participates in educating the patient and family, and in in-service programs. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the physical therapy assistant participated in educating the patient and family on pain management in 1 of 6 active patient records reviewed	G000192	All staff will be in-serviced on current policy for pain management/intervention which states that pain is to be assessed at all visits. (See exhibit A and B G121) Staff also educated on where to address pain on all current visit and evaluation forms.	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>of patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV [skilled nursing visits] 1-3/month x [times] 2 months. Assess / monitor / evaluate: ambulation, caregiver knowledge and compliance with medications, home safety, hydration status, mobility, patient knowledge and compliance with medications, patient knowledge and compliance with treatment, patient / caregiver knowledge and compliance with MD [medical doctor] follow up, safety issues within the home, signs and symptoms of infection, skin integrity, vital signs, provide treatment / intervention; pulse oximetry ... PTV [physical therapy visits] 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate:</p>		(see exhibit C, D, E,F, and G G121) Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see exhibit H G121) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care. This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission(see exhibit H G121) and weekly thereafter until 90% accuracy has been reached. This will be documented on calendar to be kept in chart. (See exhibit I G121)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>endurance, gait, home safety, mobility, strength, transfers." The plan of care failed to include pain management as a specific intervention on the plan of care and the record failed to evidence follow-up assessments to address effectiveness the pain management.</p> <p>A. The record evidenced a document dated 9/26/14 titled "Admission Oasis" signed by the registered nurse (employee I) that stated, "M1240 Has this patient had a formal pain assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? [checked] 2 - Yes, and it indicates severe pain. ... "</p> <p>B. The record evidenced a document dated 9/26/14, signed by employee I, titled "Formal Pain Assessment" that stated, "Do you ever experience pain? 'Yes if yes, continue' pain location 1 'knees' Onset of pain 'chronic' Intensity (0-10 scale) 4-5 Precipitating factors RA [rheumatoid arthritis], walking Control measures 'rest' 'medication' ... How long does the pain last? 'comes and goes' What is the pain preventing patient from doing? 'being more active'"</p> <p>C. The record evidenced a document dated 9/29/14 titled "Physical Therapy</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>Progress Notes" signed by employee U (physical therapy assistant) that stated, "Type of visit: [checked] Re-visit ... Pain: location: 'L [left] knee' Rate: '6/10.'" The record failed to evidence the patient's pain was addressed at this visit.</p> <p>D. The record evidenced a document dated 10/6/14 titled "Physical Therapy Progress Notes" signed by employee U that stated, "Type of visit: [checked] Re-visit ... Pain: Location: 'L Knee' Rate: '6/10.'" The record failed to evidence the patient's pain was addressed at this visit.</p> <p>2. On 10/20/14 at 12:10 PM, employee P (director of nursing) indicated the physical therapy assistant should have addressed the patient's pain at this visit.</p> <p>3. The agency policy with a revision date of May 2004 titled "Pain Assessment/Management" states, "POLICY All patients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. The agency will work with the patient, family and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>that goal. The plan will be reviewed and modified if the patient does not have pain relief. ... PURPOSE To support the patient's right to expect that pain will be recognized and addressed appropriately. To coordinate the efforts of all members of the team in effective pain management. To assess the effectiveness of interventions and strive for effective pain management. ... SPECIAL INSTRUCTIONS 1. Pain assessment is an integral part of the initial comprehensive assessment and the patient's right to expect appropriate assessment and management is explained and honored. If the patient has pain that interferes with activity or movement on a daily basis or is determines to be intractable, pain management will be a specific intervention on the plan of care. 2. The registered nurse or therapist completes the assessment. The assessment includes a measure of pain intensity and quality (character, frequency, location and duration). The patient's self report or report of family / caregiver is the primary indicator of pain and will identify the need for reassessment for pain management. 3. Pain is assessed on every home visit and documented on a pain or symptom flow sheet. ... 5. The follow-up assessments will address effectiveness of the pain management program and identify if</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
G000225	<p>there is a need for referral for additional or alternative therapy. If the established plan is ineffective and the pain management needs cannot be met within the agency pain management parameters, a referral will be made to an alternative provider. 6. Assessment of presence of pain and treatment/response will be incorporated into all agency assessment/reassessment tools."</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the home health aide only provided services that were ordered by the physician in the plan of care in 1 of 5 active patient records reviewed of patients receiving home health aide services creating the potential to affect all patients of the agency receiving home health aide services services. (#5) Findings include:</p>	G000225	All staff will be educated and in-serviced on updatedCoordination of Patient Services policy. (see exhibit A and B G144) All staff alsoeducated on reporting any change of condition immediately to the RN/Casemanager. Educated on proper documentation, physician notification, andobtaining new orders. Staff educated of importance of adding any new orders tothe Plan of Care. Home Health Aides educated on not	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>1. Clinical record #5, start of care 7/23/14, contained a plan of care for the certification period 9/21 to 11/19/14 that identified the primary diagnosis as late effect cardiovascular disorder and a secondary diagnosis of Diabetes Mellitus and included orders for skilled nursing services 2-4 times per month to assess, monitor, and evaluate and home health aide services 2-3 times per week to assist with activities of daily living, light housekeeping, personal care, and skin care.</p> <p>A. The record evidenced a skilled nursing visit dated 10/3/14 by employee M (registered nurse) stating, "Analysis / Intervention / Instructions / Patient Response ... 'Pt [patient] had a red area on the side of her left great toe [with] tiny pin point open area [with] tiny drop of red blood. area measured 0.3 cm [centimeter] (L) [length] x [by] 0.1 cm (W) [width]. area was red [and] a little swollen around toe. no drainage or odor. Pt afebrile, temp [temperature] - 96.5. area not tender to touch. Pt verb [verbalized] that [he/she] did not bump [his/her] toe. Pt verb that she already has M.D. [medical doctor] appt [appointment] on Tuesday and would have toe checked at that time. Called [primary physician's name] office, spoke</p>		<p>implementing any new interventions without a physicians order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes to the Plan of Care. This will be tracked by employee log sheet initialed by supervising nurse. (see exhibit C G144) Compliance will be ensured by Director or designee through Case conference with office staff bi-weekly. Minutes will be kept for documentation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>[with] [staff at physician's office] and informed her of pt's status of toe [and] pt's [next] appt, [and] if pt needed to come in sooner. [staff at physician's office] verb that she would send the message to the NP [nurse practitioner] d/t [due/to] [physician] not being in today [and] will call back [with] orders. [employee P (director of nursing)] called and informed of all the above. ... "</p> <p>B. The record evidenced a home health aide visit dated 10/9/14 by employee B (home health aide) stating, "Skin Care [checked] Comments: '[patient name] went to the dr and he checked out her left big toe nail and she was told to soak her feet in Epsom salt'." The record failed to evidence the registered nurse had delegated this task to the aide.</p> <p>C. The record evidenced a home health aide visit dated 10/16/14 by employee B stating, "[check] soaked [patient's name] toe in Epsom salt because the dr told her it was infected and needed to soak."</p> <p>D. The record evidenced a skilled nursing visit dated 10/17/14 by employee J (registered nurse) stating, "SKIN ... 'reddened area on lateral aspect of [left] great toe near top of nail has lightened to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>pink. no tenderness on palpation. temp of are same as rest of foot, warm. client reports soaking [left] foot BID [two time per day] in warm [water]. Instructed to continue [with] soaking until completely healed.'"</p> <p>The record evidenced a home health aide supervisory visit note by employee J on 10/17/14 that stated, "Client requires aide for assistance with: 'bathing, grooming, dressing, transfers, assist [and] foot soaking until healed.' Are there any changes in client's condition medication changes, or physician visits? NO Care Coordination: [blank]."</p> <p>2. On 10/21/14 at 9:47 AM, employee P indicated an update to the plan of care should have been made in regards to the assistance with foot soaks for the wound on the left great toe.</p> <p>3. The agency policy with a revision date of May 2004, titled "Skilled nursing services" states, "POLICY Skilled nursing services will be provided by a registered nurse or a licensed practical / vocation nurse under the supervision of a registered nurse and in accordance with a medically approved plan of care (physician's orders). ... SPECIAL INSTRUCTIONS 1. The registered</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>nurse: ... b. regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs. f. counsels the patient and family / caregivers in meeting their needs."</p> <p>4. The agency policy with a revised date of May 2004 titled, "Home Health Aide Services" states, "POLICY Home health aide services will be provided to appropriate patients on an intermittent, part-time or full-time basis, under the direct supervision of an agency registered nurse / therapist in accordance with a medically approved plan of care. ... SPECIAL INSTRUCTIONS ... 2. The nurse or therapist assesses the need for personal care services and includes there services in the physician plan of care (orders). A specific care plan is developed documenting the aide services to be provided. 3. The aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising nurse /</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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	
N000000	therapist." This visit was for a state home health relicensure survey. Survey dates: October 15, 16, 17, 20, and 21, 2014 Facility #: 005836 Medicaid #: 200118810A Surveyor: Tonya Tucker, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN October 30, 2014	N000000			
N000458	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(3) A copy of limited criminal history pursuant to IC 16-27-2.</p> <p>(4) A copy of current license, certification, or registration.</p> <p>(5) Annual performance evaluations.</p> <p>Based on personnel file review, policy review, and interview, the agency failed to ensure all personnel files contained a current license for 3 of 10 employee files reviewed with the potential to affect all 72 patient's of the agency. (employee Q)</p> <p>Findings include:</p> <p>1. The agency policy with a revision date of May, 2004, titled "License, Registration, or certification requirements" states, "POLICY If a position requires licensure, registration, or certification, it shall be the employee's responsibility to keep these documents current. ... A copy of the employee's current license certification shall be maintained in his/her personnel file."</p> <p>2. Personnel file Q, date of hire 4/1/13, evidenced a document titled "Indiana Online Licensing Person Information [employee Q] ... License Information ... License type: Physical Therapist ... Expiration Date: 6/30/2014." The record failed to evidence documentation of employee Q's current license status.</p> <p>3. On 10/21/14 at 3:35 PM, employee P</p>	N000458	Human Resources and office managers educated on personnel policies. (see exhibit A and B G141) All personnel charts will be reviewed and audited monthly to ensure compliance. (see exhibit C G141) Assistant Administrator or designee will be responsible to ensure compliance.	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000484	<p>(director of nursing) indicated being unaware the file for employee Q contained documentation of an expired license.</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 clinical record review, agency policy review, and interview, the agency failed to ensure the registered nurse coordinated with the aide providing services to ensure the patient was receiving appropriate care in 1 of 6 active patient records reviewed of patients receiving skilled nursing services creating the potential to affect all patients of the agency receiving skilled nursing services. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care 7/23/14, contained a plan of care for the certification period 9/21 to 11/19/14 that identified the primary diagnosis as late</p>	N000484	All staff will be educated and in-serviced on updated Coordination of Patient Services policy. (see exhibit A and B G144) All staff also educated on reporting any change of condition immediately to the RN/Case manager. Educated on proper documentation, physician notification, and obtaining new orders. Staff educated of importance of adding any new orders to the Plan of Care. Home Health Aides educated on not implementing any new interventions without a physicians order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>effect cardiovascular disorder and a secondary diagnosis of Diabetes Mellitus and included orders for skilled nursing services 2-4 times per month to assess, monitor, and evaluate and home health aide services 2-3 times per week to assist with activities of daily living, light housekeeping, personal care, and skin care.</p> <p>A. The record evidenced a skilled nursing visit dated 10/3/14 by employee M (registered nurse) stating, "Analysis / Intervention / Instructions / Patient Response ... 'Pt [patient] had a red area on the side of her left great toe [with] tiny pin point open area [with] tiny drop of red blood. area measured 0.3 cm [centimeter] (L) [length] x [by] 0.1 cm (W) [width]. area was red [and] a little swollen around toe. no drainage or odor. Pt afebrile, temp [temperature] - 96.5. area not tender to touch. Pt verb [verbalized] that [he/she] did not bump [his/her] toe. Pt verb that she already has M.D. [medical doctor] appt [appointment] on Tuesday and would have toe checked at that time. Called [primary physician's name] office, spoke [with] [staff at physician's office] and informed her of pt's status of toe [and] pt's [next] appt, [and] if pt needed to come in sooner. [staff at physician's office] verb that she would send the</p>		to the Plan of Care. This will be tracked by employee log sheet initialed by supervising nurse. (see exhibit C G144) Compliance will be ensured by Director or designee through Case conference with office staff bi-weekly. Minutes will be kept for documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>message to the NP [nurse practitioner] d/t [due/to] [physician] not being in today [and] will call back [with] orders. [employee P (director of nursing)] called and informed of all the above."</p> <p>B. The record evidenced a home health aide visit dated 10/9/14 by employee B (home health aide) stating, "Skin Care [checked] Comments: '[patient name] went to the dr and he checked out her left big toe nail and she was told to soak her feet in Epsom salt'." The record failed to evidence the registered nurse had delegated this task to the aide.</p> <p>C. The record evidenced a home health aide visit dated 10/16/14 by employee B stating, "[check] soaked [patient's name] toe in Epsom salt because the dr told her it was infected and needed to soak."</p> <p>D. The record evidenced a skilled nursing visit dated 10/17/14 by employee J (registered nurse) stating, "SKIN ... 'reddened area on lateral aspect of [left] great toe near top of nail has lightened to pink. no tenderness on palpation. temp of are same as rest of foot, warm. client reports soaking [left] foot BID [two time per day] in warm [water]. Instructed to continue [with] soaking until completely</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>healed.'"</p> <p>The record evidenced a home health aide supervisory visit note by employee J on 10/17/14 that stated, "Client requires aide for assistance with: 'bathing, grooming, dressing, transfers, assist [and] foot soaking until healed.' Are there any changes in client's condition medication changes, or physician visits? NO Care Coordination: [blank]."</p> <p>2. On 10/21/14 at 9:47 AM, employee P indicated an update to the plan of care should have been made in regards to the assistance with foot soaks for the wound on the left great toe. The employee indicated being unable to locate documentation to evidence the registered nurse coordinated care with the physician, home health aide, or other personnel providing services to the patient.</p> <p>3. The agency policy with a revision date of May 2004, titled "Skilled nursing services" states, "POLICY Skilled nursing services will be provided by a registered nurse or a licensed practical / vocation nurse under the supervision of a registered nurse and in accordance with a medically approved plan of care (physician's orders). ... SPECIAL</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>INSTRUCTIONS 1. The registered nurse: ... b. regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs. f. counsels the patient and family/caregivers in meeting their needs."</p> <p>4. The agency policy with a revision date of May 2004, titled "Coordination of patient services" states, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may be done through formal care conferences, maintaining complete, current care plans; and written and verbal interaction. ... SPECIAL INSTRUCTIONS 1. All condition changes, missed visits, medication changes, or any concerns or questions involving a client should be reported immediately to the case manager during business hours. ... Each employee is responsible for documenting this care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000518	<p>coordination, with both the field staff and the case manager documenting. ... 10. The case manager will identify provide communication to assure that all disciplines and departments are informed of changes to plan and/or need for modification."</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on document, policy, and clinical record review; observation; and interview, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, for 8 of 8 active clinical records reviewed creating the potential to affect all the agency's 72 current patients. (#1, 2, and 4-9)</p> <p>Findings include:</p> <p>1. The agency's admission packet, distributed at SOC (start of care), failed</p>	N000518	<p>All nurses will be in-serviced on updated Advanced Directives dated 7/1/13. (See exhibit A and B G110) All current patients received updated Advance Directives and signed form upon receipt. (See exhibit C G110) Current Advanced Directives added to all admission packets. Revised Advance Directives will be added to admission audit form with each admission. (See exhibit D G110) RN completing admission will be responsible for completing checklist and signing off and returning admission paperwork to office. Medical Records/LPN will be responsible for verifying that the checklist has</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>to include the updated state of Indiana advanced directives document, revised July 1, 2013.</p> <p>2. Clinical record #1, SOC 8/8/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p> <p>3. Clinical record #2, SOC 9/26/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p> <p>4. Clinical record #4, SOC 9/26/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 11:00 AM, a home visit was conducted for patient #4. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>5. Clinical record #5, SOC 7/23/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 1:30 PM, a home visit was conducted to patient #5. The patient's admission packet failed to evidence the Indiana Advanced</p>		<p>been completed and will then place the checklist in the patients chart. This will be done on all charts.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>Directives document revised July, 2013.</p> <p>6. Clinical record #6, SOC 12/06/13, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 10:00 AM, a home visit was conducted to patient #6. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>7. Clinical record #7, SOC 3/06/13, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 10/17/14 at 11:45 AM, a home visit was conducted to patient #7. The patient's admission packet failed to evidence the Indiana Advanced Directives document revised July, 2013.</p> <p>8. Clinical record #8, SOC 8/28/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p> <p>9. Clinical record #9, SOC 9/2/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was presented to the patient.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000522	<p>10. On 10/15/14 at 2:15 PM, employee P (director of nursing) indicated being unaware of the July, 2013 revision to the Indiana Advanced Directives document.</p> <p>11. The agency policy with a revised date of May, 2004, titled "Advance Directive Procedure" states, "POLICY The organization recognizes that all persons have a fundamental right to make decisions relating to their own care ... Valid advance directives will be followed to the extent permitted and required by law. ... SPECIAL INSTRUCTIONS 1. Provide the patient with written information as required by the Act. a. during the admissions process, the Registered Nurse/Therapist shall provide the patient with the following written information. This information must be given to the patient before care is provided."</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 review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 2 of 8 active patient records reviewed creating the potential to</p>	N000522	All staff educated and in-serviced on new missed visit policy that states all missed visits will be reported to physician within 7days. (see exhibit A and B G158) Staff also educated on the importance of notifying	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>affect all 72 patients of the agency. (#1 and #5)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, included a plan of care for the certification period of 8/8 to 10/8/14 with orders for skilled nursing 1-2 times per month for 2 months and physical therapy 2-3 times per week for nine weeks, beginning week 2. The record evidenced one physical therapy visit during week 2.</p> <p>On 10/16/14 at 2:35 PM, employee P (director of nursing) indicated there was a visit made on 8/15/14 for week 2.</p> <p>2. Clinical record #5, start of care 7/23/14, included a plan of care for the certification period of 9/21 to 11/19/14 with orders for skilled nursing 2-4 times per month for 2 months, physical therapy services 2-3 times per week for 10 weeks, and home health aide services 2-3 times per week for 10 weeks. The record evidenced one physical therapy visit during week 1.</p> <p>On 10/21/14 at 9:49 AM, employee P indicated being unable to locate a second physical therapy visit for week 1 of the new certification period.</p>		<p>supervising nurse of all missed visits and how to properly fill out missed visit form. (see exhibit C G158) This will be ensured by weekly verification done by medical records/LPN. Ongoing compliance will be ensured by Director or designee through audits to be done with each certification period. (See exhibits D, E, and F G158)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000524	<p>3. The agency policy with a revised date of May 2004, titled "Clinical documentation" states, "SPECIAL INSTRUCTIONS 1. All skilled services provided by nursing, therapy, or social services will be documented in the clinical record. ... 6. Services not provided and the reason for the missed visits will be documented and reported to the physician."</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. (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. Based on clinical record review and</p>	N000524	All staff educated/in-serviced on the federal/state regulation stating	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>agency policy review, the agency failed to ensure orders for therapy services included therapy modalities specifying length of treatment for 5 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency that receive therapy services. (#1, 2, 5, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "PTV [physical therapy visits] 2-3/week x 4 weeks. Assess and or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers." The plan of care failed to include the therapy modalities specifying length of treatment to be used.</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that stated, "PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program,</p>		<p>that all orders sent to physicians are to be signed and/or co-signed and dated by RN prior to sending to physician. (see exhibit A and B G161)This will be tracked through weekly verification by medical records/LPN.Ongoing compliance will be ensured by director or designee through audits done with each certification period. (see exhibit C, D, and E G161) All therapists and assistants educated/in-serviced on providing Home Exercise Programs to both clients and office to be kept in clients chart upon initial eval or by visit number three. (see exhibit A and B G161)This will be monitored by medical records/LPN through weekly verification and logged on therapy tracking form that is also to be kept in clients chart. (see exhibit F G161)On going compliance will be ensured through audits performed with each certification by Director of nursing or designee. (exhibit G, H, and I G161)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers." The plan of care failed to include the therapy modalities specifying length of treatment to be used.</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee F that stated, "PT [physical therapy] eval et [and] tx [treat] as indicated. "</p> <p>3. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 stating, "PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility" The plan of care failed to include the therapy modalities specifying length of treatment to be used.</p> <p>The record contained a physician's verbal order dated 9/19/14 signed by employee F stating, "PT eval et tx as indicated. "</p> <p>4. Clinical record #8, start of care 8/28/14, contained a plan of care for certification period 8/28 to 10/26/14</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>stating, "PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, strength, transfers" The plan of care failed to include the therapy modalities specifying length of treatment to be used.</p> <p>5. Clinical record #9, start of care 9/2/14, contained a plan of care for certification period 9/2 to 10/31/14 stating, "PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, ROM, strength, transfers" The plan of care failed to include the therapy modalities specifying length of treatment to be used.</p> <p>6. The agency policy with a revision date of May 2004 titled "Care Plans" states, "3. The care plan shall include, but not be limited to: a. Nursing diagnosis (es) / problems and needs identified. b. reasonable, measurable, and realistic goals as determined by the assessment and patient expectations. c. A list of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>specific interventions with plans for implementation. d. indicators for measuring goal achievement and identified time frames. 4. the physician plan of care may be used as a care plan if specific interventions are clearly identified for home care staff to address patient care needs. ... "</p> <p>7. The agency policy with a revision date of April 1999 titled "Therapy services" states, "SPECIAL INSTRUCTIONS ... 2. Physician orders will be obtained for the kind, type and intensity of therapy services. After the assessment is completed, the therapist will communicate specific treatments and modalities to be used. The therapist or the agency designee will obtain there verbal order from the physician for the specific modalities. 3. The therapist will consult and collaborate with the registered nurse who is the casemanager. The therapist will participate in implementing the physician's plan of care and evaluating patient progress. ... "</p> <p>8. The agency policy with a revision date of May 2004 titled "Plan of Care" states, "2. The plan of care shall be completed in full to include: ... c. type, frequency, and duration of all visits/services. d. specific procedures and modalities for therapy services."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on clinical record review, agency policy review, and interview, the agency failed to ensure the registered nurse included the patient's pain management on the plan of care and/or made necessary revisions and revised the plan of care to include the patient's foot soaks in 2 of 8 active patient records reviewed creating the potential to affect all 72 patients of the agency. (#4 and 5)</p> <p>Findings include:</p>	N000542	<p>All staff will be educated and in-serviced on updated Coordination of Patient Services policy. (see exhibit A and B G144) All staff also educated on reporting any change of condition immediately to the RN/Case manager. Educated on proper documentation, physician notification, and obtaining new orders. Staff educated of importance of adding any new orders to the Plan of Care. Home Health Aides educated on not implementing any new interventions without a physicians</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>1. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis.</p> <p>A. The record evidenced a document dated 9/26/14 titled "Admission Oasis" signed by the registered nurse (employee I) that stated, "(M1240 Has this patient had a formal pain assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? [checked] 2 - Yes, and it indicates sever pain. ... " The plan of care failed to include pain management as a specific intervention on the plan of care.</p> <p>B. The record evidenced a document dated 9/26/14, signed by employee I, titled "Formal Pain Assessment" that stated, "Do you ever experience pain? 'Yes if yes, continue' pain location 1 'knees' Onset of pain 'chronic' Intensity (0-10 scale) 4-5 Precipitating factors RA [rheumatoid arthritis], walking Control measures 'rest' 'medication' ... How long does the pain last? 'comes and goes' What is the pain preventing patient from doing? 'being more active'" The plan of care failed to include pain management as a specific intervention on</p>		<p>order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes to the Plan of Care. This will be tracked by employee log sheet initialed by supervising nurse. (see exhibit CG144) Compliance will be ensured by Director or designee through Case conference with office staff bi-weekly. Minutes will be kept for documentation. All staff will be in-serviced on current policy for pain management/intervention which states that pain is to be assessed at all visits.(See exhibit A and B G121) Staff also educated on where to address pain on all current visit and evaluation forms. (see exhibit C, D, E,F, and G G121)Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see exhibit H G121) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care. This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission (see exhibit H G121) and weekly thereafter until90% accuracy has been reached. This will be documented on calendar to be kept in chart. (See exhibit I G121)</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

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

	<p>the plan of care.</p> <p>C. The record evidenced a document dated 9/29/14 titled "Physical Therapy Progress Notes" signed by employee U (physical therapy assistant) stating, "Type of visit: [checked] Re-visit ... Pain: location: 'L [left] knee' Rate: '6/10.'" The plan of care failed to evidence the registered nurse had revised the plan of care to include pain management as a specific intervention.</p> <p>D. The record evidenced a document dated 10/6/14 titled "Physical Therapy Progress Notes" signed by employee U stating, "Type of visit: [checked] Re-visit ... Pain: Location: 'L Knee' Rate: '6/10.'" The plan of care failed to evidence the registered nurse had revised the plan of care to include pain management as a specific intervention.</p> <p>E. The record evidenced a document dated 10/8/14 titled "Skilled Nursing Visit Note" signed by employee L (registered nurse) stating, "Nursing assessment and observation signs/symptoms ... PAIN Origin: 'RA [Rheumatoid Arthritis]' Location: 'knees' Duration: 'intermittent' Intensity: (0-10) '3-6'." The plan of care failed to evidence the registered nurse had revised the plan of care to include pain management as a</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>specific intervention.</p> <p>F. On 10/20/14 at 12:10 PM, employee P (director of nursing) indicated the registered nurse documented the patient as having 'severe pain' on admission, therefore, pain would be assessed on every visit and should have been listed as an intervention on the plan of care but was not.</p> <p>G. The agency policy with a revision date of May 2004 titled "Pain Assessment/Management" states, "POLICY All patients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. ... PURPOSE To support the patient's right to expect that pain will be recognized and addressed appropriately. To coordinate the efforts of all members of the team in effective pain management. To assess the effectiveness of interventions and strive for effective pain management. ... SPECIAL INSTRUCTIONS 1. Pain assessment is an integral part of the initial comprehensive assessment and the patient's right to expect appropriate assessment and management is explained and honored. If the patient has pain that interferes with activity or movement on a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>daily basis or is determines to be intractable, pain management will be a specific intervention on the plan of care.</p> <p>... 3. Pain is assessed on every home visit and documented on a pain or symptom flow sheet. ... 5. The follow-up assessments will address effectiveness of the pain management program and identify if there is a need for referral for additional or alternative therapy. If the established plan is ineffective and the pain management needs cannot be met within the agency pain management parameters, a referral will be made to an alternative provider. 6. Assessment of presence of pain and treatment/response will be incorporated into all agency assessment/reassessment tools."</p> <p>2. Clinical record #5, start of care 7/23/14, contained a plan of care with primary diagnosis as late effect cardiovascular disorder and a secondary diagnosis of Diabetes Mellitus for certification period 9/21 to 11/19/14.</p> <p>A. The record evidenced a skilled nursing visit dated 10/3/14 by employee M (registered nurse) stating, "Analysis / Intervention / Instructions / Patient Response ... 'Pt [patient] had a red area on the side of her left great toe [with] tiny pin point open area [with] tiny drop of red blood. area measured 0.3 cm</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>[centimeter] (L) [length] x [by] 0.1 cm (W) [width]. area was red [and] a little swollen around toe. no drainage or odor. Pt afebrile, temp [temperature] - 96.5. area not tender to touch. Pt verb [verbalized] that [he/she] did not bump [his/her] toe. Pt verb that she already has M.D. [medical doctor] appt [appointment] on Tuesday and would have toe checked at that time. Called [primary physician's name] office, spoke [with] [staff at physician's office] and informed her of pt's status of toe [and] pt's [next] appt, [and] if pt needed to come in sooner. [staff at physician's office] verb that she would send the message to the NP [nurse practitioner] d/t [due/to] [physician] not being in today [and] will call back [with] orders. [employee P (director of nursing)] called and informed of all the above. "</p> <p>B. The record evidenced a home health aide visit dated 10/9/14 by employee B (home health aide) stating, "Skin Care [checked] Comments: '[patient name] went to the dr and he checked out her left big toe nail and she was told to soak her feet in Epsom salt'."</p> <p>C. The record evidenced a home health aide visit dated 10/16/14 by employee B stating, "[check]soaked [patient's name] toe in Epsom salt</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>because the dr told her it was infected and needed to soak."</p> <p>The record evidenced a home health aide care plan prepared by employee M on 9/19/14. The care plan failed to include soaking the patient's foot in Epsom salt as a task to be performed by the home health aide.</p> <p>D. The record evidenced a skilled nursing visit dated 10/17/14 by employee J (registered nurse) stating, "SKIN ... 'reddened area on lateral aspect of [left] great toe near top of nail has lightened to pink. no tenderness on palpation. temp of are same as rest of foot, warm. client reports soaking [left] foot BID [two time per day] in warm [water]. Instructed to continue [with] soaking until completely healed.'"</p> <p>The record evidenced a home health aide supervisory visit note by employee J on 10/17/14 stating, "client requires aide for assistance with: 'bathing, grooming, dressing, transfers, assist [and] foot soaking until healed.' Are there any changes in client's condition medication changes, or physician visits? NO Care Coordination: [blank]."</p> <p>E: The plan of care failed to evidence it had been revised to include the foot</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>soaks.</p> <p>F. On 10/21/14 at 9:47 AM, employee P indicated an update to the plan of care should have been made in regards to the assistance with foot soaks for the wound on the left great toe. The employee indicated being unable to locate documentation to evidence the registered coordinated care with the physician, home health aide, or other personnel providing services to the patient.</p> <p>3. On 10/16/14 at 12:30 PM, employee P indicated Licensed Practical Nurses (LPN) are case managers and there are 2, employees D and F. The employee indicated the LPNs process the patients' care plans and then he/she co-signs them.</p> <p>4. The agency policy with a revision date of May 2004 titled "Skilled nursing services" states, "SPECIAL INSTRUCTIONS 1. The registered nurse: ... c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
N000543	<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. Based on clinical record review, agency policy review and interview, the agency failed to ensure the registered nurse initiated appropriate preventative nursing procedures to address the patient's pain in 1 of 6 active patient records reviewed creating the potential to affect all 46 patients of the agency receiving skilled nursing services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis.</p> <p>A. The record evidenced a document dated 9/26/14 titled "Admission Oasis" signed by the registered nurse (employee I) that stated, "(M1240 Has this patient had a formal pain assessment using a standardized pain assessment tool</p>	N000543	All staff will be in-serviced on current policy for pain management/intervention which states that pain is to be assessed at all visits. (See exhibit A and B G121) Staff also educated on where to address pain on all current visit and evaluation forms. (see exhibit C, D, E,F, and G G121) Admitting Rn also educated on performing a Formal Pain Assessment on all patients upon all admissions. (see exhibit H G121) If pain is identified intervention will be implemented by field staff and will be documented and added to Plan of Care. This will be reviewed and monitored by medical records/LPN weekly and will be initialed where pain is documented. All charts will be audited upon admission(see exhibit H G121) and weekly thereafter until 90% accuracy has been reached. This will be documented on calendar to be kept in chart. (See exhibit I G121)	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>(appropriate to the patient's ability to communicate the severity of pain)? [checked] 2 - Yes, and it indicates sever pain. ... " The plan of care failed to evidence the registered nurse initiated preventative nursing procedures to address the patient's pain.</p> <p>B. The record evidenced a document dated 9/26/14, signed by employee I, titled "Formal Pain Assessment" that stated, "Do you ever experience pain? 'Yes if yes, continue' pain location l 'knees' Onset of pain 'chronic' Intensity (0-10 scale) 4-5 Precipitating factors RA [rheumatoid arthritis], walking Control measures 'rest' 'medication' ... How long does the pain last? 'comes and goes' What is the pain preventing patient from doing? 'being more active'" The plan of care failed to evidence the registered nurse initiated preventative nursing procedures to address the patient's pain.</p> <p>C. The record evidenced a document dated 10/8/14 titled "Skilled Nursing Visit Note" signed by employee L (registered nurse) stating, "Nursing assessment and observation signs/symptoms ... PAIN Origin: 'RA [Rheumatoid Arthritis]' Location: 'knees' Duration: 'intermittent' Intensity: (0-10) '3-6'." The plan of care failed to evidence the registered nurse initiated preventative</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>nursing procedures to address the patient's pain.</p> <p>2. On 10/20/14 at 12:10 PM, employee P (director of nursing) indicated the registered nurse documented the patient as having 'severe pain' on admission, therefore, pain would be assessed on every visit and should have been listed as an intervention on the plan of care but was not.</p> <p>3. The agency policy with a revision date of May 2004 titled "Pain Assessment / Management" states, "POLICY All patients admitted to the agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. The agency will work with the patient, family and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal."</p> <p>4. The agency policy with a revision date of May 2004 titled "Skilled nursing services" states, "POLICY Skilled nursing services will be provided by a registered nurse or a licensed practical / vocation nurse under the supervision of a registered nurse and in accordance with a medically approved plan of care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000545	<p>(physician's orders). ... SPECIAL INSTRUCTIONS 1. The registered nurse: ... d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures."</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 clinical record review, agency policy review, and interview, the agency failed to ensure the registered nurse coordinated with the aide providing services and the physician to ensure the patient was receiving appropriate care in 1 of 6 active patient records reviewed of patients receiving skilled nursing services creating the potential to affect all patients of the agency receiving skilled nursing services. (#5)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care 7/23/14, contained a plan of care for the certification period 9/21 to 11/19/14 that identified the primary diagnosis as late effect cardiovascular disorder and a</p>	N000545	<p>All staff will be educated and in-serviced on updated Coordination of Patient Services policy. (see exhibit A and B G144) All staff also educated on reporting any change of condition immediately to the RN/Case manager. Educated on proper documentation, physician notification, and obtaining new orders. Staff educated of importance of adding any new orders to the Plan of Care. Home Health Aides educated on not implementing any new interventions without a physicians order or under the direction of an RN or therapist. This will be ensured through weekly contact between each field employee and office staff to discuss any changes of condition or changes to the Plan of Care. This will be tracked by employee log sheet</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>secondary diagnosis of Diabetes Mellitus and included orders for skilled nursing services 2-4 times per month to assess, monitor, and evaluate and home health aide services 2-3 times per week to assist with activities of daily living, light housekeeping, personal care, and skin care.</p> <p>A. The record evidenced a skilled nursing visit dated 10/3/14 by employee M (registered nurse) stating, "Analysis / Intervention / Instructions / Patient Response ... 'Pt [patient] had a red area on the side of her left great toe [with] tiny pin point open area [with] tiny drop of red blood. area measured 0.3 cm [centimeter] (L) [length] x [by] 0.1 cm (W) [width]. area was red [and] a little swollen around toe. no drainage or odor. Pt afebrile, temp [temperature] - 96.5. area not tender to touch. Pt verb [verbalized] that [he/she] did not bump [his/her] toe. Pt verb that she already has M.D. [medical doctor] appt [appointment] on Tuesday and would have toe checked at that time. Called [primary physician's name] office, spoke [with] [staff at physician's office] and informed her of pt's status of toe [and] pt's [next] appt, [and] if pt needed to come in sooner. [staff at physician's office] verb that she would send the message to the NP [nurse practitioner] d/t</p>		<p>initialed by supervising nurse. (see exhibit C G144) Compliance will be ensured by Director or designee through Case conference with office staff bi-weekly. Minutes will be kept for documentation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>[due/to] [physician] not being in today [and] will call back [with] orders. [employee P (director of nursing)] called and informed of all the above. ... "</p> <p>B. The record evidenced a home health aide visit dated 10/9/14 by employee B (home health aide) stating, "Skin Care [checked] Comments: '[patient name] went to the dr and he checked out her left big toe nail and she was told to soak her feet in Epsom salt'." The record failed to evidence the registered nurse had delegated this task to the aide.</p> <p>C. The record evidenced a home health aide visit dated 10/16/14 by employee B stating, "[check] soaked [patient's name] toe in Epsom salt because the dr told her it was infected and needed to soak."</p> <p>D. The record evidenced a skilled nursing visit dated 10/17/14 by employee J (registered nurse) stating, "SKIN ... 'reddened area on lateral aspect of [left] great toe near top of nail has lightened to pink. no tenderness on palpation. temp of are same as rest of foot, warm. client reports soaking [left] foot BID [two time per day] in warm [water]. Instructed to continue [with] soaking until completely healed.' ... "</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The record evidenced a home health aide supervisory visit note by employee J on 10/17/14 that stated, "Client requires aide for assistance with: 'bathing, grooming, dressing, transfers, assist [and] foot soaking until healed.' Are there any changes in client's condition medication changes, or physician visits? NO Care Coordination: [blank]."</p> <p>2. On 10/21/14 at 9:47 AM, employee P indicated an update to the plan of care should have been made in regards to the assistance with foot soaks for the wound on the left great toe. The employee indicated being unable to locate documentation to evidence the registered nurse coordinated care with the physician, home health aide, or other personnel providing services to the patient.</p> <p>3. The agency policy with a revision date of May 2004, titled "Skilled nursing services" states, "POLICY Skilled nursing services will be provided by a registered nurse or a licensed practical / vocation nurse under the supervision of a registered nurse and in accordance with a medically approved plan of care (physician's orders). ... SPECIAL INSTRUCTIONS 1. The registered</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>nurse: ... b. regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. Informs the physician and other personnel of changes in the patient condition and needs. f. counsels the patient and family/caregivers in meeting their needs."</p> <p>4. The agency policy with a revision date of May 2004, titled "Coordination of patient services" states, "POLICY All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This may be done through formal care conferences, maintaining complete, current care plans; and written and verbal interaction. ... SPECIAL INSTRUCTIONS 1. All condition changes, missed visits, medication changes, or any concerns or questions involving a client should be reported immediately to the case manager during business hours. ... Each employee is responsible for documenting this care coordination, with both the field staff and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000553	<p>the case manager documenting. ... 10. The case manager will identify provide communication to assure that all disciplines and departments are informed of changes to plan and/or need for modification."</p> <p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies. Based on clinical record review, personnel file review, agency policy review, and interview, the agency failed to ensure the licensed practical nurse (LPN) did not function in the role of the registered nurse in 4 of 8 active patient records reviewed creating the potential to affect all patients of the agency. (#1, 2, 4, and 5)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that identified the</p>	N000553	All clinical nurses educated/in-serviced on Federal and state regulation stating that the clinician performing initial assessment is to write the Plan of Care and to review before signing and sending to physician.(see exhibit A and B G166) This will be monitored by Medical Records/LPN through weekly verification. Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibit C and D G166)	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>LPN obtained the verbal orders on the plan of care. The plan of care stated, "23. Nurse's signature and Date of verbal SOC [start of care] where applicable: [employee F (LPN-licensed practical nurse)] [employee P (director of nursing)] 10/03/2014"</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that identified the LPN obtained the verbal orders of the plan of care. The plan of care stated, "23. Nurse's signature and Date of verbal SOC where applicable: [employee F] [employee P] 09/26/2014"</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee F that stated, "SN [skilled nursing] evaluation for HHC [home health care] services. PT [physical therapy] eval et [and] tx [treat] as indicated. "</p> <p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 that identified the LPN obtained the verbal orders on the plan of care. The plan of care states, "23. Nurse's signature and Date of verbal SOC where applicable: [employee D (LPN)] [employee P]</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>09/26/2014"</p> <p>The record contained a physicians verbal order dated 9/26/14 signed by employee D that states, "SN eval for HHC services. PT eval et tx as indicated. "</p> <p>4. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 that identified the LPN obtained the verbal orders on the plan of care. The plan of care states, "23. Nurse's signature and date of verbal SOC where applicable: [employee F] [employee P] 09/19/2014."</p> <p>The record contained a physicians verbal order dated 9/19/14 signed by employee F that states, "SN evaluation for recertification of HHC services. PT eval et tx as indicated. "</p> <p>5. On 10/16/14 at 12:30 PM, employee P indicated LPN's are case managers and there are 2, employees D and F. The employee indicated the case managers manage the patient's case, do verifications, and take physician's orders. Employee P indicated the registered nurse does the visit and if there is need to contact the physician, the registered nurse calls the case manager and gives report and then the case manager contacts the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>physician. The employee indicated the LPN's process the patients' care plans and then he/she co-signs them.</p> <p>Employee file D evidenced a document signed and dated by the employee on 3/10/10 titled "Licensed Practical Nurse Licensed Vocational Nurse" that stated, "PURPOSE: Initial job description STATEMENT OF RESPONSIBILITY: The LPN/LVN provides services in accordance with the policies and procedures of the agency under the supervision of a Registered Nurse and under the direction of a licensed physician. participates with the registered nurse in the assessment, planning, implementation, and evaluation of nursing care."</p> <p>6. The agency policy with a revision date of May 2004 titled "Skilled nursing services" states, "SPECIAL INSTRUCTIONS 1. The registered nurse: ... c. Initiates the plan of care and necessary revisions and updates to the plan of care and care plan."</p> <p>7. The agency policy with a revision date of May 2004 titled "Licensed Practical Nurse Supervision" states, "POLICY The agency shall provide Licensed practical nurse services under the direction and supervision of a registered</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
N000564	<p>professional nurse when services are indicated and ordered by the physician. ... PURPOSE To provide supervision of the licensed practical nurse as required by state/federal guidelines. ... SPECIAL INSTRUCTIONS 1. The case manager designated Registered Nurse will give the licensed practical nurse direction for patient care by way of the care plan ... 2. ... b. The case manager will review the LPN documentation and ensure that the care provided is following the established plan of care. Ongoing communication and direction of the LPN will be provided through the case manager. ... 5. The Case Manager or another staff Registered Nurse will be readily available by telephone should the Licensed Practical Nurse need assistance."</p> <p>410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function; Based on clinical record review, policy review, and interview, the agency failed to ensure the physical therapist evaluated the patient's level of function timely in 1 of 6 active patient records reviewed of</p>	N000564	All therapists will be educated/in-serviced on the updated Therapy services policy which states that therapy evaluations will be done within 5 days of admission to ensure	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy services. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 8/8 to 10/8/14 stating, "21. Orders for discipline and treatments ... SNV [skilled nursing visit] 1-2/month x [times] 2 months ... PTV [physical therapy visit] 2-3/week x 9 weeks. (beginning week 2) Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers... 23. Nurse's signature and date of verbal SOC [start of care] where applicable: [employee P (director of nursing)] 08/08/2014 ... "</p> <p>A. The record evidenced a document dated 8/15/14 titled "Physical Therapy Evaluation" signed by employee O (physical therapist).</p> <p>On 10/16/14 at 2:35 PM, employee P indicated the initial visit from the physical therapist was on 8/15/14.</p>		<p>compliance with plan of care. (see exhibit A and B G184) This will be monitored by medical records/LPN through weekly verification. Ongoing compliance will be ensured by Director or designee through charts audits to be done with all certification periods. (see exhibit C, D, and E G184) All therapists and RN's in-serviced/educated on Federal/state regulation stating that the Case manager/RN is to co-sign and date all therapy orders to be sent to physician. Therapists and office nurses also educated on the importance of sending all patient evaluations to physicians. (see exhibit A and B) This will be ensured through weekly verification to be done by medical records/LPN. Ongoing compliance will be ensured by Director of designee through audits done every certification period.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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			
N000567	<p>B. On 10/16/14 at 2:32 PM, employee P indicated the skilled nurse and physical therapist need to assess the patient within 48 hours of the start of care. The employee indicated being unable to provide documentation of why the physical therapy visit was not conducted until 8/15/14.</p> <p>2. The agency policy with a revision date of May 2004 titled "Plan of Care" states, "POLICY Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members ... PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs. ... SPECIAL INSTRUCTIONS ... 7. The patient, therapist, and other agency personnel shall participate in developing the plan of care"</p> <p>410 IAC 17-14-1(c)(6) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on clinical record and document</p>	N000567	Therapists and assistants educated/in-serviced on the	11/20/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>review, and interview, the agency failed to ensure the physical therapist consulted with the physical therapy assistant at least once each working day to review all patients' treatments in 6 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy. (#1, 2, 4, 5, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "21. SNV [skilled nursing visit] 1-3/month x [times] 2 months. ... PTV [physical therapy visits] 2-3/week x 4 weeks. Assess and or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 8/15/14 and the physical therapy assistant conducted visits on 8/18, 8/19, 8/21, 8/25, 8/26, 8/28, 9/1, 9/3, 9/4, 9/8/14. The record failed to evidenced daily</p>		<p>importance of daily communication for all patients. (See exhibit A and B G184) Therapists and assistants will begin this by emailing detailed summaries of each patient on a daily basis. The supervising therapist will then sign these emails and they will be given to office to file in patient's chart within a timely manner. This will be ensured through weekly verification done by Medical records/LPN) Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibits C, D, and E G184) All therapists will be in-serviced/educated on the importance of on-site supervisory visits for all patients receiving therapy to ensure proper care is being given by therapy assistants. (see exhibit A and B G188) On-site supervision will be done every 30 days going forward. (see exhibit C G188) This will be ensured through weekly verification done by Medical records/LPN. Ongoing compliance will be ensured by Director or designee through audits performed with each certification period. (see exhibit D and E G188)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>B. The record evidenced the physical therapist conducted a visit on 9/9/14 and the physical therapist assistant conducted visits on 9/11, 9/15, 9/18, 9/22, 9/25, and 9/29/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted an initial visit on 9/27/14 and the physical therapist assistant conducted visits on 9/29, 9/30,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>10/3, 10/6, 10/7, 10/9, 10/13, 10/14, and 10/16/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers." The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 9/27/14 and the physical therapist assistant conducted visits on 9/29, 10/3, 10/6, 10/10, and 10/17/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>therapist on the patient's treatments.</p> <p>B. On 10/17/14 at 11 AM, during a home visit, employee U (physical therapist assistant) indicated she contacts the physical therapist (employee Q) on Fridays through email but does not discuss all of the patients, only the ones that have concerns or does not seem to be progressing. The employee indicated the physical therapist has never made a visit during the time she is in the patient's home.</p> <p>4. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 that stated, "21. SNV 2-4/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted a visit on 9/25/14 and the physical therapy assistant conducted visits on 9/29, 10/3, 10/7, 10/9, 10/13 and 10/16/14. The record failed to evidenced daily communication on these dates</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>between the physical therapy assistant and the physical therapist.</p> <p>5. Clinical record #8, start of care 8/28/14, contained a plan of care for certification period 8/28 to 10/26/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 8/30/14 and the physical therapy assistant conducted visits on 9/3, 9/5, 9/8, 9/12, 9/15, 9/19, 9/22, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist.</p> <p>B. The record evidenced the physical therapist conducted a visit on 9/27/14 and the physical therapy assistant conducted visits on 9/29, 10/6, 10/10, 10/14, and 10/17/14. The record failed to evidenced daily communication on these dates</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>6. Clinical record #9, start of care 9/2/14, contained a plan of care for certification period 9/2 to 10/31/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, ROM, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted an initial visit on 9/2/14 and the physical therapy assistant conducted visits on 9/5, 9/8, 9/11, 9/15, 9/19, 9/23, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>7. On 10/16/14 at 12:55 PM, employee P (director of nursing) indicated there is no documentation of supervision of the physical therapy assistants. The employee indicated the physical therapy assistants do not consult with the physical</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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
N000570	<p>therapists daily.</p> <p>8. The document titled "Physical Therapy Committee Laws and Regulations A compilation of the Indiana Code and Indiana Administrative Code 2013 Edition" states, "Rule 1. General Provisions ... 844 IAC 6-1-2 Definitions ... (g) Direct supervision means that the supervising physical therapist or physician at all times shall be available and at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant ... With respect to the supervision of the physical therapist's assistants under IC 25-27-1-2(c), unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments."</p> <p>410 IAC 17-14-1(d) Scope of Services Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>this rule the therapist may:</p> <p>(1) direct the activities of any therapy assistant; or</p> <p>(2) delegate duties and tasks to other individuals as appropriate.</p> <p>Based on clinical record and document review, and interview, the agency failed to ensure the physical therapy assistant was supervised by the physical therapist and consulted with the supervising physical therapist at least once each working day to review all patients' treatments in 6 of 6 active patient records reviewed of patients receiving physical therapy services creating the potential to affect all patients of the agency receiving physical therapy. (#1, 2, 4, 5, 8, and 9)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8/8/14, contained a plan of care for certification period 10/7 to 12/5/14 that stated, "21. SNV [skilled nursing visit] 1-3/month x [times] 2 months. ... PTV [physical therapy visits] 2-3/week x 4 weeks. Assess and or instruct: ambulation training, balance activities, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, gait, home safety, mobility, ROM [range of motion], strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p>	N000570	<p>Therapists and assistants will be educated/in-service don the importance of daily communication for all patients. (See exhibit A and B G184)</p> <p>Therapists and assistants will begin this by emailing detailed summaries of each patient on a daily basis. The supervising therapist will then sign these emails and they will be given to office to file in patient's chart within a timely manner. This will be ensured through weekly verification done by Medical records/LPN)Ongoing compliance will be ensured by Director or designee through audits done with each certification period. (see exhibits C, D, and E G184)</p> <p>All therapists will be in-serviced/educated on the importance of on-site supervisory visits for all patients receiving therapy to ensure proper care is being given by therapy assistants. (see exhibit A and B G188)</p> <p>On-site supervision will be done every 30 days going forward. (see exhibit C G188) This will be ensured through weekly verification done by Medical records/LPN. Ongoing compliance will be ensured by Director or designee through audits performed with each certification period. (see exhibit D</p>	11/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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>A. The record evidenced the physical therapist conducted an initial visit on 8/15/14 and the physical therapy assistant conducted visits on 8/18, 8/19, 8/21, 8/25, 8/26, 8/28, 9/1, 9/3, 9/4, 9/8/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>B. The record evidenced the physical therapist conducted a visit on 9/9/14 and the physical therapist assistant conducted visits on 9/11, 9/15, 9/18, 9/22, 9/25, and 9/29/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>2. Clinical record #2, start of care 9/26/14, contained a plan of care for certification period 9/26 to 11/24/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of</p>		and E G188)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted an initial visit on 9/27/14 and the physical therapist assistant conducted visits on 9/29, 9/30, 10/3, 10/6, 10/7, 10/9, 10/13, 10/14, and 10/16/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>3. Clinical record #4, start of care 9/26/14, evidenced a plan of care for certification period 9/26 - 11/24/14 with primary diagnosis as congestive heart failure and a secondary diagnosis of rheumatoid arthritis. The plan of care states, "21. Orders for discipline and treatments ... SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training balance activities, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility, strength, transfers." The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>9/27/14 and the physical therapist assistant conducted visits on 9/29, 10/3, 10/6, 10/10, and 10/17/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>B. On 10/17/14 at 11 AM, during a home visit, employee U (physical therapist assistant) indicated she contacts the physical therapist (employee Q) on Fridays through email but does not discuss all of the patients, only the ones that have concerns or does not seem to be progressing. The employee indicated the physical therapist has never made a visit during the time she is in the patient's home.</p> <p>4. Clinical record #5, start of care 7/23/14, contained a plan of care for certification period 9/21 to 11/19/14 that stated, "21. SNV 2-4/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, energy conservation, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: endurance, gait, home safety, mobility" The record failed to evidence supervision of the physical therapist assistant.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The record evidenced the physical therapist conducted a visit on 9/25/14 and the physical therapy assistant conducted visits on 9/29, 10/3, 10/7, 10/9, 10/13 and 10/16/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist.</p> <p>5. Clinical record #8, start of care 8/28/14, contained a plan of care for certification period 8/28 to 10/26/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 1-1/week x 1 week PTV 2-3/week x 9 weeks. Assess and/or instruct: ambulation training, balance activities, energy conservation, evaluation, home exercise program, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>A. The record evidenced the physical therapist conducted an initial visit on 8/30/14 and the physical therapy assistant conducted visits on 9/3, 9/5, 9/8, 9/12, 9/15, 9/19, 9/22, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580			
(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>B. The record evidenced the physical therapist conducted a visit on 9/27/14 and the physical therapy assistant conducted visits on 9/29, 10/6, 10/10, 10/14, and 10/17/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p> <p>6. Clinical record #9, start of care 9/2/14, contained a plan of care for certification period 9/2 to 10/31/14 that stated, "21. SNV 1-3/month x 2 months. ... PTV 2-3/week x 10 weeks. Assess and/or instruct: ambulation training, balance activities, evaluation, home exercise program, safety awareness, strengthening exercise, evaluate: adaptive equipment, endurance, gait, home safety, mobility, ROM, strength, transfers" The record failed to evidence supervision of the physical therapist assistant.</p> <p>The record evidenced the physical therapist conducted an initial visit on 9/2/14 and the physical therapy assistant conducted visits on 9/5, 9/8, 9/11, 9/15, 9/19, 9/23, and 9/26/14. The record failed to evidenced daily communication on these dates between the physical therapy assistant and the physical therapist on the patient's treatments.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580
---	--

(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>7. On 10/16/14 at 12:55 PM, employee P (director of nursing) indicated there is no documentation of supervision of the physical therapy assistants. The employee indicated the physical therapy assistants do not consult with the physical therapists daily.</p> <p>8. The document titled "Physical Therapy Committee Laws and Regulations A compilation of the Indiana Code and Indiana Administrative Code 2013 Edition" states, "Rule 1. General Provisions ... 844 IAC 6-1-2 Definitions ... (g) Direct supervision means that the supervising physical therapist or physician at all times shall be available and at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant ... With respect to the supervision of the physical therapist's assistants under IC 25-27-1-2(c), unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2014
NAME OF PROVIDER OR SUPPLIER HEALTH FORCE OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 334 N ENTERPRISE DR WARSAW, IN 46580		
(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	