

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K036	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
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NAME OF PROVIDER OR SUPPLIER MAXIM HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 233 QUARTERMASTER COURT JEFFERSONVILLE, IN 47130
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G 0000 Bldg. 00	<p>This was a survey for federal home health re-certification, The survey was partial extended</p> <p>Survey Dates: 2/16/2016 through 2/23/2016</p> <p>Medicaid Provider # 200484160C</p> <p>Census: unskilled 21 skilled : 21 total : 42</p> <p>Home visits: 5 Records Reviewed : 10</p> <p>QA: jlh 3/4/16</p>	G 0000		
G 0159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on record review and interview the agency failed to ensure all care,</p>	G 0159	<font	03/18/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>treatments and nutritional requirements were addressed in the plan of care for 4(# 1, 3, 7, 8) of 10 records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 included a plan of care established by the physician for the certification period 10/29/2015 through 12/27/2015. The plan of care, reviewed 2/16/2016 failed to include accurate nutritional risk based on a recent nutritional assessment for a patient receiving g-tube (gastrostomy) feedings. 2. Clinical record #3 included a plan of care established by the physician for the certification period 12/5/2015 through 2/2/2016. The plan of care, reviewed 2/19/2016 failed to include accurate nutritional risk based on a recent nutritional assessment for a patient receiving g-tube feedings. 3. Clinical record #7 included a plan of care established by the physician for the certification period 1/19/2016 through 3/18/2016. The plan of care, reviewed 2/22/2016 failed to include accurate nutritional risk based on the most recent nutritional assessment for a patient with a slow healing wound. 		<p>Director of Clinical Services re-educated all Clinical Supervisorson 2/29/16 on the requirement to ensure all care, treatments and nutritionalrequirements are addressed in the plan of care. This education includedre-education on company policy &#8220;Home Health Certifications and Plan of Care&#8221;.&nbsp;&nbsp; <p>Clinical record #1, #3, #7 will be reviewed and updated to include accurate nutritional risk by 3/18/16.

 Clinical record #8 will be reviewed and updated to include requirement for condom catheter while patient is sleeping by 3/18/16.
 10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence that the plan of care covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate item.

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G 0172 Bldg. 00	<p>4. Clinical record #8 included a plan of care established by the physician for the certification period 11/25/2015 through 1/23/2015. The plan of care, reviewed 2/23/2016 failed to indicate the patient required a condom catheter while sleeping. The record contained nursing notes dated 12/30/2015 through 1/3/2016 that evidenced the patient had a condom catheter to drainage while sleeping.</p> <p>5. In an interview February 2/23/2016 at 3:20 PM the administrator acknowledged that nutritional risk based on a recent nutritional risk assesment and all equipment, should be included in the plan of care.</p> <p>6. An agency policy titled, Home Health Certification and Plans of Care, dated 6/22/2015 states "The plan of care shall include, but not limited to all treatments medications and procedures...a summary of patient findings following each comprehensive assessment."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on observation, interview and record review the RN (registered nurse) failed to regularly re-evaluate the patients needs for 3 (#1, 2, and 6) observations</p>	G 0172	<p>color="#000000">The Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this alleged deficiency is corrected and will not recur.

 <i>By submitting this POC the agency does not admit the allegations in the survey report or that it violated any regulations.&nbsp; The agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies.&nbsp; The agency intends to request that this POC service as its Credible Allegation of Compliance.</i>
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 </p> <p>Directorof Clinical Services will in-service all Clinical Supervisors and&nbsp; Nursing staff,</p> </p>	03/23/2016			

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	<p>and 1(#7) records reviewed.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. During a home visit on 2/17/2016 at 945 AM, employee J, an RN was observed to administer a nebulizer treatment to patient #1. The RN failed to reassess the patients lungs following the treatment. 2. During a home visit on 2/18/2016 at 930 AM, employee M, an RN was observed to administer a nebulizer treatment to patient #2. The RN failed to reassess the patients lungs following the treatment. 3. During a home visit on 2/18/2016 at 230 PM, employee N, a licensed practical nurse (LPN) was observed to administer a nebulizer treatment to patient #6. The LPN failed to re-evaluate the patients lungs following the treatment. 4. Clinical record #7 was reviewed 2/22/2016, The record included orders to assess the colostomy stoma and report complications to the physician. The nursing notes dated 1/19/2016 through 1/29/2016 failed to evidence the nurse assessed of the type, size, color or output from the colostomy. 		<p>including nurses assigned topatients #1, #2, #6, and #7&nbsp; on therequirement to regularly re-evaluate the patient&#8217;s nursing needs, to includethe requirement to reassess patient lungs following a nebulizer treatment andrequirement to assess and document assessment of colostomy stoma to includetype, size, color and output from colostomy.&nbsp; This re-education will include company&nbsp; VNAA protocol titled &#8220;Respiratory System-Device, Nebulizer&#8221;
&nbsp;
Directorof Clinical Services provided re-education to employees J, M and N on companyVNAA protocol titled &#8220;Respiratory System-Device, Nebulizer&#8221; to includeauscultation and reassessment of patient lungs following a nebulizertreatment.&nbsp; This re-education wascompleted on</p>				

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	<p>5. On February 23 at 420 PM, the agency administrator agreed that an post treatment assessment should have been completed following nebulizer treatments, and that the evaluation of the colostomy for record #7 was incomplete.</p> <p>6. The agency's policy titled Respiratory System-Device: Nebulizer dated 9/12 stated "At conclusion of treatment, encourage coughing and expectoration of secretions. Reassess respiratory status. Auscultate lung sounds."</p>		<p>3.09.16.
 &nbsp;
 10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence that the nurse regularly re-evaluated the patient's nursing needs.
 &nbsp;
 5 home visits will be completed as part of the quarterly audit, which will include observation to ensure the assigned nurse regularly re-evaluates the patient's nursing needs to include reassessment of the patient lungs following a nebulizer treatment.
 &nbsp;
 The Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this alleged deficiency is corrected and will not recur.

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G 0176 Bldg. 00	<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 record review and observation, the Registered Nurse failed to ensure interventions were documented effectively for 1 (#7) of 10 clinical records reviewed.</p> <p>Findings Include:</p> <p>1. On 2/18/2016 employee L, an RN was observed to complete a dressing change for patient #7. The RN removed the old dressing, cleansed the wound with normal saline the applied a new dressing with aquacel and paper tape.</p> <p>2. Clinical record #7 included orders for dressing changes to bilateral gluteal</p>	G 0176	<p>submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies.</p> <p>The agency intends to request that this POC service as its Credible Allegation of Compliance.</p> <p>Director of Clinical Services will re-educate all Clinical Supervisors and Nursingstaff, including employee L and additional nursing staff assigned to patient#7, on the requirement to ensure interventions are documented effectively inthe clinical record, to include nursing care and type of dressing applied topatient wounds as well as type, size and appearance, and care provided forpatient colostomy stoma.</p> <p>Thisre-education will include company policy titled Patient/Client Record: Contentand Requirements;</p>	03/23/2016

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	<p>wounds. Nursing notes for patient #7, dated 1/9/2016 through 2/7/2016 were reviewed on 2/22/2016. The documentation failed to include the nursing care and type of dressing applied to the patient's wounds.</p> <p>3. Clinical record #7 included orders for colostomy care and to assess the stoma and report changes to the physician. Nursing notes for patient #7 dated 1/19/2016 through 1/29/2016 failed to document type, size and appearance and care provided, of the patient's colostomy stoma.</p> <p>3. An agency policy titled Patient/Client Record: Content and Requirements, dated 8/14/2015 stated " The patient/client record will contain sufficient information to ... accurately document care provided and outcome.</p>		<p>color="#000000">&nbsp;
 Directorof Clinical Services provided education to employee L on 2.26.16.&nbsp;This education included the requirement toensure accurate documentation for wound care, including all care provided andtype of dressing applied.
 &nbsp;
 10 clinical records, or 10% of all clinical records, whichever isgreater, will be audited quarterly for evidence that nursing interventionsare documented effectively in the clinical record, to include nursing care andtype of dressing applied to patient wounds as well as type, size andappearance, and care provided for patient colostomy stoma.&nbsp;&nbsp;
 &nbsp;
 TheDirector of Home Health Care services will be responsible for monitoring thesecorrective actions to ensure that this alleged deficiency is corrected and willnot recur.

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G 0239 Bldg. 00	<p>484.48(b) PROTECTION OF RECORDS Clinical record information is safeguarded against loss or unauthorized use. Based on record review and interview, the agency failed to ensure clinical record information was safeguarded against loss or unauthorized use for 1(#9).</p> <p>Findings include:</p> <p>1. Clinical record #9 was reviewed 2/19/2016 at 11:30 AM. The record contained photocopied clinical notes dated 11/11/2015 through 12/30/2015, admission consents, and advanced directive notification. The original documents were not available in the</p>			G 0239	<p>
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</p> <p>Directorof Clinical Services to educate all agency staff, including Clinical Supervisors, on the requirement to ensure the clinical record information is safeguarded against loss or unauthorized use and that the Medical Record mustmaintain the original admission consents, documentation, advanced directives information.This education will include company policy titled &#8220;Patient/Client Record Content and</p>		03/23/2016

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	<p>record.</p> <p>2. The administrator indicated on 2/19/2016 at 10:13 AM the original documents had been lost and the photocopied documents in the clinical record had been re-created from the patient's home folder.</p> <p>3. An agency policy titled Patient/Client Record Content and Requirements, dated 8/14/2015 stated A patient/client record will be maintained for each patient/client receiving care...All documents, forms related to the care and or services provided to the patient shall be maintained in the medical record...Initial paperwork and 12 months from the start of current certification period shall always be retained in the office.</p>		<p>Requirements&#8221;.
 &nbsp;
 All clinical records are stored in Medical Record cabinets, which are locked whennot in use.&nbsp;The Medical Record cabinetsare in a separate room which remains locked when not in use.&nbsp;Agency staff will ensure that the MedicalRecord cabinets and Medical Record room are locked when not in use.
 &nbsp;
 10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence for evidence that all documents, forms related to the care and/or services provided to the patient are maintained in the Medical Record and that the initial paperwork and 12 months from the start of the current certification period is retained in the office.
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G 0331 Bldg. 00	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on record review and interview, the registered nurse failed to ensure the initial assessment accurately and completely reflected the patient care needs for 1 (#7) of 10 records reviewed.</p> <p>Findings Include:</p>	G 0331	<p>not recur.

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</p> <p>Director of Clinical Services to re-educate all Clinical Supervisors on the requirementto ensure the initial assessment accurately and completely reflects patientcare needs to include the immediate care, service and support needs of the patient.&nbsp; <font</p>	03/22/2016

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	<p>1. Clinical record #7 was reviewed 2/22/2016, the record contained an initial nursing assessment completed 1/19/2016. The assessment failed to include the nurses assessment of the size, type, and appearance of the patient's colostomy stoma. The nurse assessed the patient's wounds as stage II.</p> <p>2. A document titled History and Physical dated 1/2/2015 completed by the patient's hospital physician indicates the patient had stage IV wounds.</p> <p>3. An agency policy titled Assessment, dated 8/14/2015 states, " The purpose of the initial assessment is to evaluate the immediate care, service and support needs of the patient.</p> <p>4. In an interview with the agency's administrator at 10:30 AM on 2/22/2016 it was agreed that the patient's wounds had been incorrectly assessed by the RN and that the assessment of the colostomy stoma was not complete.</p>		<p>color="#000000">This education will includecompany policy titled &#8220;Assessment&#8221;. &nbsp;
 &nbsp;
 Director of Clinical Service will re-educate all Clinical Supervisors on completing anaccurate wound assessment to include the nurse&#8217;s assessment on the size, type and appearance of the patients wound and ostomy stomas, as well as accurate assessment of wound stage.&nbsp;
 &nbsp;
 Clinical record #7 patient will be reassessed by assigned Clinical Supervisor to ensure that the assessment accurately reflects the size, type and appearance of the patient&#8217;s colostomy stoma as well as accurately reflects the status and assessment of the patient&#8217;s wound including accurate wound stage.
 &nbsp;
 10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence the initial assessment accuratelyand completely reflects patient care</p>		

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			<p>needs, to include the immediate care, service and support needs of the patient as well as evidence that an accurate wound assessment was completed to include the nurse's assessment on the size, type and appearance of the patients wound and ostomy stomas, as well as accurate assessment of wound stage.</p> <p>The Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this alleged deficiency is corrected and will not recur.</p> <p>By submitting this POC the agency does not admit the allegations in the survey report or that it violated any regulations.</p> <p>The agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies.</p> <p>The agency intends to request that this POC</p>	

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G 0338 Bldg. 00	<p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.</p> <p>Based on record review, the agency failed to ensure the comprehensive assessments included an accurate and thorough update of the patients health status for 4 (#1,3, 6, and 8) records reviewed.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, reviewed on 2/16/2016, included a comprehensive assessment dated 12/23/2015 completed by an RN, The assessment failed to include a nutritional risk assessment for the patient with a g-tube. 2. Clinical record #3, reviewed 2/19/2016, included a comprehensive assessment dated 1/29/2016, the assessment failed to include a nutritional risk assessment, and failed to include asthma, allergic rhinitis and a 	G 0338	<p>service as its Credible Allegation of Compliance.</p> <p>Director of Clinical Services will educate all Clinical Supervisors, including Clinical Supervisors assigned to patients #1, #3, #6 and #8, on the requirement that the comprehensive assessment must be updated and revised, including the administration of the OASIS, as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.</p> <p>This education will include company policy titled Assessment; Clinical record #1, patient will be reassessed by the Clinical Supervisor to ensure that an accurate nutritional risk assessment is completed and</p>	03/22/2016

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	<p>tracheostomy(opening in the windpipe) as disorders of the heart and respiratory system for the patient with these diagnoses.</p> <p>3. Clinical record #6, reviewed 2/23/2016 included a comprehensive assessment dated 12/21/2015, the assessment failed to identify rhinitis, asthma, chronic obstructive pulmonary disorder, and a tracheostomy under disorders of of the heart/respiratory system for the patient with these diagnises, failed to identify the patient's intermittent nebulizer treatments and failed to include a nutritional risk assessment for the patient with g-tube feedings.</p> <p>4. Clinical Record #8, reviewed 2/23/2016 included a comprehensive assessment dated 11/23/2015, The comprehensive assessment indicated "no problem" under musculoskeletal assessment and failed to include information about the patient's functional status for the patient with a diagnosis of R hemiplegia.</p> <p>5. An agency policy titled Assessment, dated 8/14/2015 states" The assessment shall be based on patient/client need or perceived need and functional status."</p>		<p>documented for this patient with a g-tube.
 &nbsp;
 Clinical record #3, patient will be reassessed by the Clinical Supervisor to ensure that an accurate nutritional risk assessment is completed and documented as well as to ensure the comprehensive assessment includes thepatient&#8217;s diagnoses of asthma, allergic rhinitis and tracheostomy for thispatient with diagnoses of disorders of the heart and respiratory system.
 &nbsp;
 Clinical record #6, patient will be reassessed by the Clinical Supervisor to ensure that an accurate comprehensive assessment identifies anddocuments rhinitis, asthma, chronic obstructive pulmonary disorder, and tracheostomy for this patient with diagnoses of the heart and respiratorysystem, to ensure that an accurate assessment identifies and documents patientnebulizer treatments and includes a nutritional risk assessment for thispatient with g-tube feedings.
 &nbsp;
 Clinical record #8, patient</p>	

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N 0000 Bldg. 00	<p>This was a survey for state relicensure, The survey was partial extended</p> <p>Survey Dates: 2/16/2016 through 2/23/2016</p> <p>Medicaid Provider # 200484160C</p> <p>Census: unskilled 21 skilled : 21 total : 42</p> <p>Home visits: 5 Records Reviwed : 10</p> <p>QA: jlh 3/4/16</p>	N 0000	<p>regulations.&nbsp; The agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies.&nbsp;The agency intends to request that this POC service as its Credible Allegation of Compliance.</p>	
N 0524 Bldg. 00	<p>410 IAC 17-13-1(a)(1) Patient Care</p> <p>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p>			

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	<p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <p>(i) Mental status.</p> <p>(ii) Types of services and equipment required.</p> <p>(iii) Frequency and duration of visits.</p> <p>(iv) Prognosis.</p> <p>(v) Rehabilitation potential.</p> <p>(vi) Functional limitations.</p> <p>(vii) Activities permitted.</p> <p>(viii) Nutritional requirements.</p> <p>(ix) Medications and treatments.</p> <p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on record review and interview the agency failed to ensure all care, treatments and nutritional requirements were addressed in the plan of care for 4(# 1, 3, 7, 8) of 10 records reviewed.</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care established by the physician for the certification period 10/29/2015 through 12/27/2015. The plan of care, reviewed 2/16/2016 failed to include accurate nutritional risk based on a recent nutritional assessment for a patient</p>	N 0524	<p><p> Director of Clinical Services re-educated all Clinical Supervisorson 2/29/16 on the requirement to ensure all care, treatments and nutritionalrequirements are addressed in the plan of care. This education includedre-education on company policy &#8220;Home Health Certifications and Plan of Care&#8221;.&nbsp;</p></p> <p><p>&nbsp;
 Clinical record #1, #3, #7 will be reviewed and updated to include accurate nutritional risk by</p>	03/18/2016	

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	<p>receiving g-tube (gastrostomy) feedings.</p> <p>2. Clinical record #3 included a plan of care established by the physician for the certification period 12/5/2015 through 2/2/2016. The plan of care, reviewed 2/19/2016 failed to include accurate nutritional risk based on a recent nutritional assessment for a patient receiving g-tube feedings.</p> <p>3. Clinical record #7 included a plan of care established by the physician for the certification period 1/19/2016 through 3/18/2016. The plan of care, reviewed 2/22/2016 failed to include accurate nutritional risk based on the most recent nutritional assessment for a patient with a slow healing wound.</p> <p>4. Clinical record #8 included a plan of care established by the physician for the certification period 11/25/2015 through 1/23/2015. The plan of care, reviewed 2/23/2016 failed to indicate the patient required a condom catheter while sleeping. The record contained nursing notes dated 12/30/2015 through 1/3/2016 that evidenced the patient had a condom catheter to drainage while sleeping.</p> <p>5. In an interview February 2/23/2016 at 320 PM the administrator acknowledged that nutritional risk based on a recent</p>		<p>3/18/16.

 Clinical record #8 will be reviewed and updated to include requirement for condom catheter while patient is sleeping by 3/18/16.
 10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence that the plan of care covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate item.

 The Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this alleged deficiency is corrected and will not recur.

 <i>By submitting this POC the agency does not admit the allegations in the survey report or that it violated any regulations.&nbsp; The agency is submitting this POC in response to its regulatory obligations and</p>		

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N 0540 Bldg. 00	<p>nutritional risk assesment and all equipment, should be included in the plan of care.</p> <p>6. An agency policy titled, Home Health Certification and Plans of Care, dated 6/22/2015 states "The plan of care shall include, but not limited to all treatments medications and procedures...a summary of patient findings following each comprehensive assessment."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on record review and interview, the registered nurse failed to ensure the initial assessment accurately and completely reflected the patient care needs for 1 (#7) of 10 records reviewed.</p> <p>Findings Include:</p> <p>1. Clinical record #7 was reviewed 2/22/2016, the record contained an initial nursing assessment completed 1/19/2016. The assessment failed to include the nurses assessment of the size, type, and appearance of the patient's colostomy</p>	N 0540	<p>commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies.</p> <p>The agency intends to request that this POC service as its Credible Allegation of Compliance.</p> <p>Director of Clinical Services to re-educate all Clinical Supervisors on the requirementto ensure the initial assessment accurately and completely reflects patient care needs to include the immediate care, service and support needs of thepatient. This education will includecompany policy titled &#8220;Assessment&#8221;. Assessment&#8221;.</p> <p>Director of</p>	03/22/2016	

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	<p>stoma. The nurse assessed the patient's wounds as stage II.</p> <p>2. A document titled History and Physical dated 1/2/2015 completed by the patient's hospital physician indicates the patient had stage IV wounds.</p> <p>3. An agency policy titled Assessment, dated 8/14/2015 states, " The purpose of the initial assessment is to evaluate the immediate care, service and support needs of the patient.</p> <p>4. In an interview with the agency's administrator at 10:30 AM on 2/22/2016 it was agreed that the patient's wounds had been incorrectly assessed by the RN and that the assessment of the colostomy stoma was not complete.</p>		<p>Clinical Service will re-educate all Clinical Supervisors on completing an accurate wound assessment to include the nurse's assessment on the size, type and appearance of the patients wound and ostomy stomas, as well as accurate assessment of wound stage.</p> <p>Clinical record #7 patient will be reassessed by assigned Clinical Supervisor to ensure that the assessment accurately reflects the size, type and appearance of the patient's colostomy stoma as well as accurately reflects the status and assessment of the patient's wound including accurate wound stage.</p> <p>10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence the initial assessment accurately and completely reflects patient care needs, to include the immediate care, service and support needs of the patient as well as evidence that an accurate wound assessment was completed to include the nurse's assessment on the size, type and appearance of the patients wound</p>	

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	<p>Based on record review and observation, the Registered Nurse failed to ensure interventions were and documented effectively for 1 (#7) of 10 clinical records reviewed.</p> <p>Findings Include:</p> <p>1. On 2/18/2016 employee L, an RN was observed to complete a dressing change for patient #7. The RN removed the old dressing, cleansed the wound with normal saline the applied a new dressing with aquacel and paper tape.</p> <p>2. Clinical record #7 included orders for dressing changes to bilateral gluteal wounds. Nursing notes for patient #7, dated 1/9/2016 through 2/7/2016 were reviewed on 2/22/2016. The documentation failed to include the nursing care and type of dressing applied to the patient's wounds.</p> <p>3. Clinical record #7 included orders for colostomy care and to assess the stoma and report changes to the physician. Nursing notes for patient #7 dated 1/19/2016 through 1/29/2016 failed to document type, size and appearance and care provided, to the patient's colostomy stoma.</p> <p>3. An agency policy titled Patient/Client</p>	N 0544	<p>Director of Clinical Services will re-educate all Clinical Supervisors and Nursing staff, including employee L and additional nursing staff assigned to patient #7, on the requirement to ensure interventions are documented effectively in the clinical record, to include nursing care and type of dressing applied to patient wounds as well as type, size and appearance, and care provided for patient colostomy stoma.</p> <p>This re-education will include company policy titled Patient/Client Record: Content and Requirements;</p> <p>Director of Clinical Services provided education to employee L on 2.26.16.</p> <p>This education included the requirement to ensure accurate documentation for wound care, including all care provided and type of dressing applied.</p> <p>10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence that nursing interventions are documented effectively in the clinical record, to include nursing</p>	03/23/2016	

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	<p>procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.</p> <p>Based on record review and interview, the agency failed to ensure clinical record information was safeguarded against loss or unauthorized use for 1(#9) of 10 clinical records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #9 was reviewed 2/19/2016 at 11:30 AM. The record contained photocopied clinical notes dated 11/11/2015 through 12/30/2015, admission consents, and advanced directive notification. The original documents were not available in the record. 2. The administrator indicated on 2/19/2016 at 10:13 AM the original documents had been lost and the photocopied documents in the clinical record had been re-created from the patient's home folder. 	N 0614	<p><p> Directorof Clinical Services to educate all agency staff, including ClinicalSupervisors, on the requirement to ensure the clinical record information issafeguarded against loss or unauthorized use and that the Medical Record mustmaintain the original admission consents, documentation, advanced directivesinformation&nbsp; This education will includecompany policy titled &#8220;Patient/Client Record Content and Requirements&#8221;.</p> > <p>
 All clinical records are stored in Medical Record cabinets, which are locked when not in use.&nbsp; The Medical Record cabinets are in a separate room which remains locked when not in use.&nbsp; Agency staff will ensure that the Medical Record cabinets and Medical Record room are locked when not in use.</p> <p><font</p>	03/23/2016

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	3. An agency policy titled Patient/Client Record Content and Requirements, dated 8/14/2015 stated A patient/client record will be maintained for each patient/client receiving care...All documents, forms related to the care and or services provided to the patient shall be maintained in the medical record...Initial paperwork and 12 months from the start of current certification period shall always be retained in the office.		color="#000000"> 10 clinical records, or 10% of all clinical records, whichever is greater, will be audited quarterly for evidence for evidence that all documents, forms related to the care and/or services provided to the patient are maintained in the Medical Record and that the initial paperwork and 12 months from the start of the current certification period is retained in the office.</p><p> The Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this alleged deficiency is corrected and will not recur. <i>By submitting this POC the agency does not admit the allegations in the survey report or that it violated any regulations. The agency is submitting this POC in response to its regulatory obligations and commitment to compliance. The agency further reserves the right to contrast any alleged findings, conclusions and deficiencies. The agency intends to request that this POC service as its Credible Allegation of Compliance.</i><i> </i> </p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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