

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/17/2013
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NAME OF PROVIDER OR SUPPLIER  CENTRAL HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5699 E 71ST ST STE 1A INDIANAPOLIS, IN 46220
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G000000	<p>This visit was a Home Health federal recertification survey. This was an extended survey.</p> <p>Survey Dates: May 14 - 17, 2013 Extended Survey Dates: May 16 - 17, 2013</p> <p>Facility Number: 004997</p> <p>Medicaid Number: 200811610</p> <p>Surveyors: Eric Moran, BSN, RN, Public Health Nurse Surveyor, Team Leader Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 159 Home Health Aide Only: 11 Personal Care Only: 0 Total: 170</p> <p>Sample: RR w/HV: 5 RR w/o HV: 8 Total: 13</p> <p>Central Home Health Services, Inc is precluded from providing its own</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.

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	<p>home health aide training and competency evaluation program for a period of 2 years beginning May 23, 2013, to May 23, 2015, due to being found out of compliance with the Conditions of Participation 42 CFR 484.18: Acceptance of patients, plan of care and medical supervision and 484.55: Comprehensive Assessment of Patients.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 23 2013</p>				

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G000141	<p><b>484.14(e)</b> <b>PERSONNEL POLICIES</b> Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>Based on policy review, personnel file review, and interview, the agency failed to ensure personnel policies related to criminal history documents and home health aide registry were followed for 1 of 9 HHA files reviewed for criminal history (CC) and for 3 of 12 HHA files reviewed for registry documentation with the potential to affect all patients (V, Z, CC).</p> <p>Findings include:</p> <p>1. Related to criminal history</p> <p>A. The undated policy titled "Personnel Records" policy number D-180 states, "The personnel record for an employee will include, but not be limited to: ... criminal history and background checks as required by law ... updated license/certifications ... Physical exams."</p> <p>B. The undated policy titled "Criminal Disclosure" policy number D-190 states, "In Indiana, a home health agency may</p>	G000141	The Administrator has instructed the staff on the regulation of applying for a criminal background check within three days of first patient contact. The Administrator has in-serviced the staff on the process and need to have all home health aides registered or determined to be on the home health registry, in good standing, prior to first patient contact. All home health aides are now on the home health aide registry and are in good standing. An audit tool has been developed and 100% of the personnel files have been audited for compliance with criminal background checks within 3 days of first patient contact. The personnel file audit tool will be utilized with every new hire to ensure that they have a criminal background check done within three days of first patient contact, and that the home health aide is on the registry and in good standing prior to first patient contact. The Administrator will be responsible for monitoring the corrective actions to ensure that this deficiency does not recur.	06/14/2013	

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	<p>not employ a person to provide services in a patient's temporary or permanent residence for more than three (3) business days without applying for that person's limited criminal history."</p> <p>C. Personnel file CC, home health aide (HHA), date of hire 2/18/13, contained a initial patient contact and HHA job description dated 2/18/13 and a limited criminal history dated on 3/11/13.</p> <p>D. On 5/17/13 at 3:40 PM, employee H, Administrator, indicated employee CC's criminal history was not within 3 business days of initial patient contact date.</p> <p>2. Related to home health aide registry</p> <p>A. The undated policy titled "License, registration, or certification requirements" policy number D-200 states, "If a position requires licensure, registration, or certification, it shall be the employee's responsibility to provide copies of these documents to the Agency on a timely basis prior to expiration ... The agency will track the expiration dates of employee's licenses, registrations, or certifications to ensure that copies are received timely. Those employees who do not provide copies of</p>			

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	<p>these documents to the Agency by the expiration date will not be allowed to work until such time as they comply with this policy."</p> <p>B. Personnel file V, date of hire 1/19/12, contained a CNA licensure issued on 1/12/93. The personnel file failed to evidence a HHA registration.</p> <p>C. Personnel file Z, date of hire 7/20/12, contained a CNA licensure issued on 3/23/12. The personnel file failed to evidence a HHA registration.</p> <p>D. Personnel file CC, date of hire 2/18/13, contained a CNA licensure issued on 9/17/11. The personnel file failed to evidence a HHA registration.</p> <p>E. During an interview on 5/17/13 at 3:41 PM, employee H, Administrator, indicated employees V, Z, and CC were Certified Nurse Aides and were not registered as HHAs.</p>			

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G000143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure coordination of care occurred with the physician for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>The undated policy titled "Plan of Care" policy number C-580 states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</li> <li>The undated policy titled "Coordination of Patient Services and</li> </ol>	G000143	<p>The Administrator, DON and RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. An RN homecare consultant has been hired to assist with on going education and oversight. On-going case conferences will occur at regularly scheduled intervals. Skilled care documentation will be reviewed</p>	06/15/2013

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	<p>Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p> <p>A. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was</p>		by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.				

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	<p>transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>			

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G000156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on policy review, record review, and interview, it was determined the home health agency failed to ensure visits and treatments were made in accordance with the plan of care in 3 of 13 clinical records reviewed with the potential to affect all patients of the agency (See G 158), failed to ensure the physician was notified regarding changes in the patient's condition for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency (See G 164); and failed to ensure blood was drawn as ordered by the physician for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency (See G 165).</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	<p>The Administrator, DON and RN consultant have in-serviced the professional staff on following the POC, ensuring that all treatments be provided as outlined on the POC with appropriate follow up. That all missed visits be documented on a missed visit report and all changes in patient condition be reported promptly to the physician. 100% of the Skilled nursing charts have been audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by the DON for compliance with the POC and proper notification of changes in condition. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	06/15/2013	

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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.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure visits and treatments were made in accordance with the plan of care in 3 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#3, 9, and 11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Clinical Documentation" policy number C-680 states, "Services not provided and the reason for the missed visits will be documented and reported to the physician."</li> <li>Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to facilitate access to a glucometer and to inform the physician of any changes in the patient's medical condition warranting intervention.</li> </ol>	G000158	<p>The Administrator, DON and RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. An RN homecare consultant has been hired to assist with education and oversight. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. On-going case conferences will occur at regularly scheduled intervals.</p>	06/15/2013	

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	<p>A. The Nursing start of care assessment completed by employee A, Registered Nurse (RN) , dated 2/2/13 states, "Problems/Needs: DM [Diabetes Mellitus] with change in medication. Interventions: 1. SN [skilled nurse] assist in getting a glucose monitor."</p> <p>B. A Nursing progress note completed by employee A, RN, dated 2/2/13 states, "[Patient] is a type 2 DM. [Patient] diabetic medication was recently changed from Janovia to Amaryl. [Patient] recently moved to the [senior living center] ... [Patient] states [patient] lost [their] blood glucose meter during the move."</p> <p>C. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to St. Vincent's Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS</p>		Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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	<p>[blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, low blood sugar, or need for a glucometer.</p> <p>During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p> <p>D. A Skilled Nursing Progress Note completed by employee A, RN on 2/20/13 states, "Pt still does not have a glucose monitor. This nurse called the office of [physician]. Was told by [staff at physician office] that the meter was being shipped yesterday or today and pt should receive it by end of wk [week]." Review of the record also failed to evidence any labs were drawn at this visit as ordered.</p> <p>E. A Skilled Nursing Progress Note completed by employee A, RN on 2/26/13 states, "Pt states [patient] has a glucose monitor (temp) [temporary]</p>				

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	<p>until [the patient's] arrives."</p> <p>J. During an interview on 5/16/13 at 1:10 PM, employee H, Administrator, was asked by the surveyor why it took the RN 18 days for the first attempt to obtain a glucometer. Employee H, Administrator, indicated the RN should have obtained the glucometer as soon as possible.</p> <p>3. Clinical record #3, start of care 4/25/13, contained a home health certification and plan of care dated 4/25/13 to 6/23/13 with orders for SN to assess and evaluate for vital signs. The SN visited the patient on 5/1/13 and 5/8/13. The record failed to evidence respirations were documented during each visit.</p> <p>During an interview on 5/16/13 at 10:10 AM, employee C, Supervising Nurse, indicated that when the plan of care says to take vital signs, the vital signs should include blood pressure, pulse, respirations, temperature, and pain. The RN indicated respirations should have been taken.</p> <p>4. Clinical record #9, start of care 4/6/13, contained a home health certification and plan of care dated</p>						

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	<p>4/6/13 to 6/4/13 with orders for physical therapy (PT) 1 to 2 visits a week for 9 weeks. The record failed to evidence any PT visits were made the week of 4/14/13. No missed visit notes were found in the record.</p> <p>During an interview on 5/17/13 at 3:40 PM, employee H, Administrator, indicated there was a missed PT visit for the week of 4/14/13 to 4/20/13.</p>			

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G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>The undated policy titled "Plan of Care" policy number C-580 states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</li> <li>The undated policy titled "Coordination of Patient Services and</li> </ol>	G000164	<p>The Administrator, DON and RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. An RN homecare consultant has been hired to assist with education and oversight. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. On-going case conferences will occur at regularly scheduled intervals. Skilled care documentation will be reviewed by the DON for</p>	06/15/2013			

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	<p>Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p> <p>A. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was</p>		<p>compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>				

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	<p>transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>			

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G000165	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure blood was drawn as ordered by the physician for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Skilled Nursing Services" policy number C-200 states, "Skilled nursing services will be provided by a Registered Nurse or a Licensed Practical/Vocational Nurse under the supervision of a Registered Nurse and in accordance with a medically approved Plan of Care."</li> <li>The undated policy titled "Physician Orders" policy number C-635 states, "All medications, treatments and services provided to patients must be ordered by a physician."</li> <li>Clinical record #11, start of care 2/2/13, contained a home health</li> </ol>	G000165	The Administrator, DON and RN consultant have in-serviced the professional staff on following the POC, ensuring that all treatments be provided as outlined on the POC with appropriate follow up. That all missed visits be documented on a missed visit report and all changes in patient condition be reported promptly to the physician. 100% of the Skilled nursing charts have been audited for the above deficiencies and have been addressed with the appropriate professional. An RN homecare consultant has been hired to assist with education and oversight. The clinical documentation will be reviewed by the DON for compliance with the POC and proper notification of changes in condition. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.	06/15/2013

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	<p>certification and plan of care dated 2/2/13-4/2/13. Review of the record evidenced the following:</p> <p>A. A document titled "Nursing Orders/Referrals" dated 2/19/13 states "Nursing Orders: please draw for TSH, T3, and Free T4 at next visit."</p> <p>B. A Skilled Nursing Progress Note completed by employee A, registered nurse (RN), on 2/20/13 failed to evidence any labs were drawn at this visit as ordered.</p> <p>C. A Skilled Nursing Progress Note completed by employee A, RN, on 2/26/13 states, "Blood drawn for T3, T4 free and TSH."</p> <p>D. A Skilled Nursing Progress Note completed by employee A, RN, on 2/27/13 states, "Received call from Mid America Lab - Stated Spec [specimen] was in the wrong type of tube and needed to be redrawn."</p> <p>E. A Skilled Nursing Progress note completed by employee A, RN on 2/28/13 states, "Labs were redrawn (R [right] antecubital) and taken to lab."</p> <p>4. During an interview on 5/16/13 at</p>			

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	1:10 PM, employee H, Administrator, indicated lab draws should have been completed at the visit on 2/20/13. The administrator further indicated orders should have been received for the redraw that was performed on 2/28/13.			

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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on record review and interview, the home health agency failed to ensure skilled nursing visits and treatments were provided as ordered on the plan of care in 2 of 13 clinical records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (#3 and #11)</p> <p>Findings include:</p> <p>1. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to facilitate access to a glucometer and to inform the physician of any changes in the patient's medical condition warranting intervention.</p> <p>A. The Nursing start of care assessment completed by employee A, Registered Nurse (RN) , dated 2/2/13 states, "Problems/Needs: DM [Diabetes Mellitus} with change in medication. Interventions: 1. SN [skilled nurse] assist in getting a glucose monitor."</p>	G000170	<p>The Administrator, DON and RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care and performing all skills and treatment indicated on the POC -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. An RN homecare consultant has been hired to assist with education and oversight. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. On-going case conferences will occur at regularly scheduled intervals. Skilled care documentation will be reviewed by the DON for</p>	06/15/2013	

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	<p>B. A Nursing progress note completed by employee A, RN, dated 2/2/13 states, "[Patient] is a type 2 DM. [Patient] diabetic medication was recently changed from Janovia to Amaryl. [Patient] recently moved to the [senior living center] ... [Patient] states [patient] lost [their] blood glucose meter during the move."</p> <p>C. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to St. Vincent's Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>Review of the record failed to</p>		<p>compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>				

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	<p>evidence the physician was notified of the patient fall, hospitalization, low blood sugar, or need for a glucometer.</p> <p>During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p> <p>D. A Skilled Nursing Progress Note completed by employee A, RN on 2/20/13 states, "Pt still does not have a glucose monitor. This nurse called the office of [physician]. Was told by [staff at physician office] that the meter was being shipped yesterday or today and pt should receive it by end of wk [week]." Review of the record also failed to evidence any labs were drawn at this visit as ordered.</p> <p>E. A Skilled Nursing Progress Note completed by employee A, RN on 2/26/13 states, "Pt states [patient] has a glucose monitor (temp) [temporary] until [the patient's] arrives."</p> <p>J. During an interview on 5/16/13 at 1:10 PM, employee H, Administrator, was asked by the surveyor why it took the RN 18 days for the first attempt to obtain a glucometer. Employee H, Administrator, indicated the RN</p>			

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	<p>should have obtained the glucometer as soon as possible.</p> <p>2. Clinical record #3, start of care 4/25/13, contained a home health certification and plan of care dated 4/25/13 to 6/23/13 with orders for SN to assess and evaluate for vital signs. Review of the record evidenced the SN visited the patient on 5/1/13 and 5/8/13. The record failed to evidence respirations were documented during each visit.</p> <p>During an interview on 5/16/13 at 10:10 AM, employee C, Supervising Nurse, indicated that when the plan of care says to take vital signs, the vital signs should include blood pressure, pulse, respirations, temperature, and pain. The RN indicated respirations should have been taken.</p>			

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G000175	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>Based on record review and interview, the home health agency failed to ensure the registered nurse intervened timely to help the patient obtain a new glucometer for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <p>1. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to facilitate access to a glucometer.</p> <p>A. The Nursing start of care assessment completed by employee A, Registered Nurse (RN), dated 2/2/13 states, "Problems/Needs: DM [Diabetes Mellitus] with change in medication. Interventions: 1. SN [skilled nurse] assist in getting a glucose monitor."</p> <p>B. A Nursing progress note completed by employee A, RN, dated 2/2/13 states, "[Patient] is a type 2</p>	G000175	The Administrator, DON and RN consultant have in-serviced the staff on following the plan of care and providing all care and treatments ordered in a timely manner and follow up needs. 100% of the skilled nursing clinical records have been audited and individual instruction and education has been given to the case manager concerning deficits in the documentation. Travel charts have been created for the case managers to use so they have the tools necessary with them during skilled visits to ensure that the POC and treatments ordered are carried out. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly to ensure compliance with the POC, treatments and needed follow up. The DON will be responsible for monitoring the corrective actions to ensure this deficiency does not recur.	06/15/2013	

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	<p>DM. [Patient] diabetic medication was recently changed from Janovia to Amaryl. [Patient] recently moved to the [senior living center] ... [Patient] states [patient] lost [their] blood glucose meter during the move."</p> <p>C. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states ... [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>D. A Skilled Nursing Progress Note completed by employee A, RN on 2/20/13 states, "Pt still does not have a glucose monitor. This nurse called the office of [physician]. Was told by [staff at physician office] that the meter was being shipped yesterday or today and pt should receive it by end of wk [week]."</p> <p>E. A Skilled Nursing Progress Note completed by employee A, RN on 2/26/13 states, "Pt states [patient] has a glucose monitor (temp) [temporary] until [the patient's] arrives."</p>				

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	2. During an interview on 5/16/13 at 1:10 PM, employee H, Administrator, was asked why it took the RN 18 days for the first attempt to obtain a glucometer. Employee H, Administrator, indicated the RN should have obtained the glucometer as soon as possible.			

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G000176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the registered nurse coordinated services and notified the physician of changes in the patient's condition for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>2. The undated policy titled "Plan of Care" policy number C-580 states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</li> </ol>	G000176	The Administrator, DON and RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. An RN homecare consultant has been hired to assist with education and oversight. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. On-going case conferences will occur at regularly scheduled intervals.	06/15/2013			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>3. The undated policy titled "Coordination of Patient Services and Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p> <p>A. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell</p>		<p>Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>				

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	<p>4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>				

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G000330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on policy review, clinical record review, and interview, it was determined the agency failed to ensure the Registered Nurse (RN) made an initial assessment visit within forty-eight hours of a physician referral or on the physician-ordered start of care date for 2 of 13 clinical records reviewed and with the potential to affect all the agency's new admissions (See G 332), failed to ensure the medication profile was updated at least every 60 days and</p>	G000330	The Administrator, DON and RN consultant have provided in-servicing to the staff on proper timing of the SOC comprehensive assessment with oasis elements, recertification assessment that includes an updated within the five day window prior to the new certification period. Also addressed, the necessity for a follow-up assessment with any major decline/significant change in patient condition. The skilled clinical nursing records have been audited for these timelines of assessment and all associated	06/15/2013	

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	<p>included medication changes in 2 of 13 clinical records reviewed with the potential to affect all patients at this agency (See G 337), failed to ensure the comprehensive assessment was updated and revised after a major decline in the patient's health status in 1 of 13 clinical records reviewed with the potential to affect all patients of the agency (See G 338), and failed to ensure the Registered Nurse (RN) updated the comprehensive reassessment during the last five days of the certification period and before completing a new plan of care in 1 of 13 clinical records reviewed with the potential to affect all the patients of the agency receiving services longer than 60 days (See G 339).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 484.55: Comprehensive Assessment of Patients.</p>		<p>reviews. Individual instruction has been provided for those staff that were found to have a deficit in the clinical record with these assessment time-lines. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly to monitor for correct assessment timelines. The DON will review all documentation to ensure all comprehensive assessment timelines are met. All referrals will be reviewed a that the time of referral and the DON will ensure patient is contacted and staff is assigned and scheduled to see the patient within the 48 hour timeline. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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G000332	<p><b>484.55(a)(1)</b> <b>INITIAL ASSESSMENT VISIT</b> The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Registered Nurse (RN) made an initial assessment visit within forty-eight hours of a physician referral or on the physician-ordered start of care date (SOC) for 2 of 13 clinical records reviewed and with the potential to affect all the agency's new admissions. (#1, #7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Initial Home Visit To Evaluate For Admission" policy number C-140 undated states,"3. Initial assessments are to be performed within 48 hours of referral, within 48 hours of the patient's return to home, per documented patient / family request or the physician ordered start of care date."</li> <li>Clinical record #1, start of care (SOC) 4/4/13, contained a document titled "Consult Requisition" with a physician order for the RN to evaluate and treat the patient written on 3/29/13. The record failed to evidence the initial</li> </ol>	G000332	The DON, Administrator and RN consultant have provided in-servicing to the staff on the necessity of the initial comprehensive assessment to be done within 48 hours of the referral, or physician ordered SOC. 100% of the skilled charts have been audited for this deficiency and individual education has been provided to those staff who have not complied. The DON will review all incoming referrals and ensure that the patient is called and the initial assessment visit occurs within the first 48 hours or physician ordered start of care date. These visits will be scheduled with the appropriate professional staff and monitored for completion within the 48 hour window. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly to ensure compliance with this regulation. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	06/15/2013

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	<p>assessment visit had been completed.</p> <p>Document titled "Nursing Start of Care Assessment" completed on 4/4/13 had a Date of Referral on 3/29/13.</p> <p>During an interview on 5/16/13 at 10:10 AM, employee H, Administrator, indicated that the Initial Assessment should have been completed within 48 hours of the referral date.</p> <p>3. Clinical record #7, SOC 12/20/12, contained a document titled "Admission Referral Job Sheet" with a referral date of 12/12/12. The record failed to evidence an initial assessment visit was made within 48 hours of the referral date. The record evidenced the RN completed the Comprehensive Assessment on 12/20/12.</p> <p>During an interview on 5/16/13 at 10:20 AM, employee H, Administrator, indicated that the Initial or Comprehensive Assessment needed to be completed within 48 hours of the referral date.</p>			

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G000337	<p><b>484.55(c) DRUG REGIMEN REVIEW</b></p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the medication profile was updated at least every 60 days and included medication changes in 2 of 13 clinical records reviewed with the potential to affect all patients at this agency. (#5, #8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Medication Profile" policy number C-700 undated states,"5. If the physician changes the medication orders, the Nurse must add newly ordered drugs or medication changes to the Medication Profile ... 10. The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication."</li> <li>Clinical record #5, start of care 4/10/13, included a Home Health</li> </ol>	G000337	<p>The DON has in-serviced the staff on the required review and update of the medication profile every 60 days and when the medication regime has changed. 100% of the skilled nursing clinical records have been audited for compliance with this regulation. The DON will review all documentation to ensure that the medication profile has been updated appropriately. 10% of the clinical records will be audited quarterly to ensure the medication profile has been updated appropriately. An RN homecare consultant has been hired to assist with education and oversight. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>	06/15/2013	

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	<p>Certification and Plan of Care for the certification period from 4/10/13 to 6/8/13. The document titled "Nursing Progress Notes For Home Health Care" dated 4/22/13 indicated the patient was seen by the physician on 4/19/13, and the patient's insulin sliding scale increased to moderate dosing. The "Medication Profile" was last reviewed and signed off by employee C, Supervising Nurse, on 4/10/13. Another document titled "Skilled Nurse Visit Note" dated 4/22/13 was blank under the 'New Meds' section. The medication profile failed to evidence updated sliding scale insulin orders prescribed on 4/19/13.</p> <p>During an interview on 5/16/13 at 10:00 AM, employee C, Supervising Nurse, indicated the Medication Profile should have been updated.</p> <p>3. Clinical record #8, start of care 3/16/12, included a Home Health Certification and Plan of Care for the certification period from 5/10/13 to 7/8/13. The "Medication Profile" was reviewed and signed off by employee D, Registered Nurse, on 5/16/12, and the document failed to evidence a signature of review until 1/15/13.</p>			

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	During an interview on 5/16/13 at 10:10 AM, employee C, Supervising Nurse, indicated the Medication Profile should have been updated every certification period.			

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G000338	<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 policy review and record review, the home health agency failed to ensure the comprehensive assessment was updated and revised after a major decline in the patient's health status in 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <p>1. The undated policy titled "Comprehensive Patient Reassessments/updates, resumption of care, SCIC, and Transfer OASIS for Skilled Patients" policy number C-155 states, "The comprehensive assessment will be updated and revised as often as the patient's condition warrants due to major decline or improvement in health status .. Patients are reassessed to determine their response to care, when significant changes occur in their condition, their diagnosis, in their</p>	G000338	The Administrator, DON and RN consultant have provided in-servicing to the staff on proper timing of the SOC comprehensive assessment with oasis elements, recertification assessment that includes an updated within the five day window prior to the new certification period. Also addressed, the necessity for a follow-up assessment with any major decline/significant change in patient condition. The skilled clinical nursing records have been audited for these timelines of assessment and all associated reviews. Individual instruction has been provided for those staff that were found to have a deficit in the clinical record with these assessment time-lines. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly to monitor for correct assessment timelines. The DON will review all documentation to ensure all comprehensive assessment timelines are met. All referrals will be reviewed a that the time of referral and the DON will ensure patient is contacted	06/15/2013			

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	<p>environment or support system that affect the plan of care, and when they are released from the hospital."</p> <p>2. Clinical record #11, start of care 2/2/13, contained a Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low." The record failed to evidence a comprehensive assessment was completed for the decline in the patient's condition.</p>		and staff is assigned and scheduled to see the patient within the 48 hour timeline. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.				

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G000339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review and interview, the agency failed to ensure the Registered Nurse (RN) updated the comprehensive reassessment during the last five days of the certification period and before completing a new plan of care in 1 of 13 clinical records reviewed with the potential to affect all the patients of the agency receiving services longer than 60 days. (#7)</p> <p>Findings include:</p> <p>1. Clinical record #7, start of care 12/20/12, included a Home Health Certification and Plan of Care for the certification period from 4/19/13 to 6/17/13. The document titled "Comprehensive Assessment" and the document titled "60 Day's Summary" were completed on 4/11/13 by employee D, RN. The next recertification</p>	G000339	The Administrator, DON and RN consultant have provided in-servicing to the staff on proper timing of the SOC comprehensive assessment with oasis elements, recertification assessment that includes an updated within the five day window prior to the new certification period. Also addressed, the necessity for a follow-up assessment with any major decline/significant change in patient condition. The skilled clinical nursing records have been audited for these timelines of assessment and all associated reviews. Individual instruction has been provided for those staff that were found to have a deficit in the clinical record with these assessment time-lines. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly to monitor for correct assessment timelines. The DON will review all documentation to ensure all comprehensive assessment timelines are met. All	06/15/2013			

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	<p>period began on 4/19/13.</p> <p>2. During an interview on 5/16/13 at 10:13 AM, employee H, Administrator, indicated the Comprehensive Assessment and 60 Day Summary were completed too early.</p>		<p>referrals will be reviewed a that the time of referral and the DON will ensure patient is contacted and staff is assigned and scheduled to see the patient within the 48 hour timeline. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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N000000	<p>This visit was a Home Health state licensure survey.</p> <p>Survey Dates: May 14 - 17, 2013</p> <p>Facility Number: 004997</p> <p>Surveyors: Eric Moran, BSN, RN, Public Health Nurse Surveyor, Team Leader Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 159 Home Health Aide Only: 11 Personal Care Only: 0 Total: 170</p> <p>Sample: RR w/HV: 5 RR w/o HV: 8 Total: 13</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 23 2013</p>	N000000					

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N000458	<p>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:</p> <ol style="list-style-type: none"> <li>(1) Receipt of job description.</li> <li>(2) Qualifications.</li> <li>(3) A copy of limited criminal history pursuant to IC 16-27-2.</li> <li>(4) A copy of current license, certification, or registration.</li> <li>(5) Annual performance evaluations.</li> </ol> <p>Based on policy review, personnel file review, and interview, the agency failed to ensure a criminal history was applied for within 3 business days of initial patient contact for 1 of 9 home health aide records reviewed for criminal history checks (CC) with the potential to affect all patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The undated policy titled "Criminal Disclosure" policy number D-190 states, "In Indiana, a home health agency may not employ a person to provide services in a patient's temporary or permanent</li> </ol>	N000458	The Administrator has instructed the staff on the regulation of applying for a criminal background check within three days of first patient contact. The staff will ensure that a criminal background check is applied for within or before the first patient contact. A personnel audit tool is in place and 100% of new hire files have been audited for compliance with applying for a criminal history. The audit tool will be used on all future hires and a tracking tool is in place to ensure compliance with the criminal background checks regulation. The Administrator will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.	06/14/2013

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	<p>residence for more than three (3) business days without applying for that person's limited criminal history."</p> <p>2. Personnel file CC, home health aide (HHA), date of hire 2/18/13, contained a initial patient contact and HHA job description dated 2/18/13 and a limited criminal history dated on 3/11/13.</p> <p>3. On 5/17/13 at 3:40 PM, employee H, Administrator, indicated employee CC's criminal history was not within 3 business days of initial patient contact date.</p>			

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N000462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review and interview, the agency failed to ensure all employees had a physical exam no more than 180 days prior to first patient contact for 2 of 9 home health aide files reviewed for physical exam documentation (S, Z) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file S, date of hire 3/23/12 and first patient contact 3/23/12, evidenced a document titled "Health Assessment" that was not completed until 4/26/12, after first patient contact.</li> <li>2. Personnel file Z, date of hire 7/20/12 and first patient contact 8/22/12, evidenced a document titled "Health Assessment" that was not completed until 9/6/12, after first patient contact.</li> </ol>	N000462	The Administrator has instructed the staff on the regulation that states an employee who have direct patient contact must have a physical examination no more than 180 days prior to first patient contact. A personnel audit tool is in place and 100% of new hire files have been audited for compliance with a physical 180 days or less prior to first patient contact. A tracking process has been developed to ensure compliance with this regulation. the Administrator will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.	06/14/2013			

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	3. During an interview on 5/17/13 at 3:42 PM, employee H, Administrator, verified the documents titled "Health Assessment" for employee S and employee Z were completed after the first patient contact date.			

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N000484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure coordination of care occurred with the physician for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>2. The undated policy titled "Plan of Care" policy number C-580 states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of</li> </ol>	N000484	<p>The Administrator, DON and consulting RN have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. On-going case conferences will occur at regularly scheduled intervals. Skilled care</p>	06/15/2013	

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	<p>Care."</p> <p>3. The undated policy titled "Coordination of Patient Services and Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p> <p>A. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13</p>		documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. A homecare RN consultant has been hired to help monitor and provide continued education and oversight. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.		

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	<p>states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>			
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N000522	<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:</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure visits and treatments were made in accordance with the plan of care in 3 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#3, 9, and 11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Clinical Documentation" policy number C-680 states, "Services not provided and the reason for the missed visits will be documented and reported to the physician."</li> <li>Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to facilitate access to a glucometer and to inform the physician of any changes in the patient's medical condition warranting intervention.</li> </ol>	N000522	<p>The Administrator, DON and RN consultant have in-serviced the professional staff on following the POC, ensuring that all treatments be provided as outlined on the POC with appropriate follow up. That all missed visits be documented on a missed visit report and all changes in patient condition be reported promptly to the physician. 100% of the Skilled nursing charts have been audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by the DON for compliance with the POC and proper notification of changes in condition. A homecare RN consultant has been hired to help monitor and provide continued education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	06/15/2013

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	<p>A. The Nursing start of care assessment completed by employee A, Registered Nurse (RN) , dated 2/2/13 states, "Problems/Needs: DM [Diabetes Mellitus} with change in medication. Interventions: 1. SN [skilled nurse] assist in getting a glucose monitor."</p> <p>B. A Nursing progress note completed by employee A, RN, dated 2/2/13 states, "[Patient] is a type 2 DM. [Patient] diabetic medication was recently changed from Janovia to Amaryl. [Patient] recently moved to the [senior living center] ... [Patient] states [patient] lost [their] blood glucose meter during the move."</p> <p>C. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to St. Vincent's Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS</p>			

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	<p>[blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, low blood sugar, or need for a glucometer.</p> <p>During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p> <p>D. A Skilled Nursing Progress Note completed by employee A, RN on 2/20/13 states, "Pt still does not have a glucose monitor. This nurse called the office of [physician]. Was told by [staff at physician office] that the meter was being shipped yesterday or today and pt should receive it by end of wk [week]." Review of the record also failed to evidence any labs were drawn at this visit as ordered.</p> <p>E. A Skilled Nursing Progress Note completed by employee A, RN on 2/26/13 states, "Pt states [patient] has a glucose monitor (temp) [temporary]</p>				

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	<p>until [the patient's] arrives."</p> <p>J. During an interview on 5/16/13 at 1:10 PM, employee H, Administrator, was asked by the surveyor why it took the RN 18 days for the first attempt to obtain a glucometer. Employee H, Administrator, indicated the RN should have obtained the glucometer as soon as possible.</p> <p>3. Clinical record #3, start of care 4/25/13, contained a home health certification and plan of care dated 4/25/13 to 6/23/13 with orders for SN to assess and evaluate for vital signs. The SN visited the patient on 5/1/13 and 5/8/13. The record failed to evidence respirations were documented during each visit.</p> <p>During an interview on 5/16/13 at 10:10 AM, employee C, Supervising Nurse, indicated that when the plan of care says to take vital signs, the vital signs should include blood pressure, pulse, respirations, temperature, and pain. The RN indicated respirations should have been taken.</p> <p>4. Clinical record #9, start of care 4/6/13, contained a home health certification and plan of care dated</p>				

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	<p>4/6/13 to 6/4/13 with orders for physical therapy (PT) 1 to 2 visits a week for 9 weeks. The record failed to evidence any PT visits were made the week of 4/14/13. No missed visit notes were found in the record.</p> <p>During an interview on 5/17/13 at 3:40 PM, employee H, Administrator, indicated there was a missed PT visit for the week of 4/14/13 to 4/20/13.</p>			

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>The undated policy titled "Plan of Care" policy number C-580 states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</li> </ol>	N000527	The Administrator, DON and RN consultant have in-serviced the staff the necessity to notify the physician promptly of any changes in the patient condition that would indicate a need to alter the POC. 100% of the Skilled nursing clinical records have been audited and education provided to the individual nurse on the POC and notification of changes in patient condition to the physician that would create the need for change in the original plan of care. The clinical documentation will be reviewed by the DON for compliance with the policy to notify the physician of any significant change in patient condition. A homecare RN consultant has been hired to help monitor and provide continued education and oversight. 10% of the clinical records will be audited quarterly for compliance with the notification of the physician of patient change in condition. The DON will be responsible for the monitoring the corrective actions to ensure the deficiency does not recur.	06/15/2013			

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	<p>3. The undated policy titled "Coordination of Patient Services and Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p> <p>A. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell</p>				

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	<p>4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>			

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N000532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>The undated policy titled "Plan of Care" policy number C-580 states, "Professional staff shall promptly alert</li> </ol>	N000532	The Administrator, DON and RN consultant have in-serviced the staff the necessity to notify the physician promptly of any changes in the patient condition that would indicate a need to alter the POC. 100% of the Skilled nursing clinical records have been audited and education provided to the individual nurse on the POC and notification of changes in patient condition to the physician that would create the need for change in the original plan of care. A homecare RN consultant has been hired to help monitor and provide continued education and oversight. The clinical documentation will be reviewed by the DON for compliance with the policy to notify the physician of any significant change in patient condition. 10% of the clinical records will be audited quarterly for compliance with the notification of the physician of patient change in condition. The DON will be responsible for the monitoring the corrective actions	06/15/2013			

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	<p>the physician to any changes that suggest a need to alter the Plan of Care."</p> <p>3. The undated policy titled "Coordination of Patient Services and Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p> <p>A. A Skilled Nursing Progress Note</p>		to ensure the deficiency does not recur.				

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	<p>completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>			

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on record review and interview, the home health agency failed to ensure skilled nursing visits and treatments were provided as ordered on the plan of care in 2 of 13 clinical records reviewed with the potential to affect all patients of the agency who receive skilled nursing services. (#3 and #11)</p> <p>Findings include:</p> <p>1. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to facilitate access to a glucometer and to inform the physician of any changes in the patient's medical condition warranting intervention.</p> <p>A. The Nursing start of care assessment completed by employee A, Registered Nurse (RN) , dated 2/2/13 states, "Problems/Needs: DM [Diabetes Mellitus} with change in medication. Interventions: 1. SN</p>	N000537	The Administrator, DON and RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. A homecare RN consultant has been hired to help monitor and provide continued education and oversight. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. On-going case conferences will occur at regularly scheduled intervals.	06/15/2013			

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	<p>[skilled nurse] assist in getting a glucose monitor."</p> <p>B. A Nursing progress note completed by employee A, RN, dated 2/2/13 states, "[Patient] is a type 2 DM. [Patient] diabetic medication was recently changed from Janovia to Amaryl. [Patient] recently moved to the [senior living center] ... [Patient] states [patient] lost [their] blood glucose meter during the move."</p> <p>C. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to St. Vincent's Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p>		<p>Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>	

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	<p>Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, low blood sugar, or need for a glucometer.</p> <p>During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p> <p>D. A Skilled Nursing Progress Note completed by employee A, RN on 2/20/13 states, "Pt still does not have a glucose monitor. This nurse called the office of [physician]. Was told by [staff at physician office] that the meter was being shipped yesterday or today and pt should receive it by end of wk [week]." Review of the record also failed to evidence any labs were drawn at this visit as ordered.</p> <p>E. A Skilled Nursing Progress Note completed by employee A, RN on 2/26/13 states, "Pt states [patient] has a glucose monitor (temp) [temporary] until [the patient's] arrives."</p> <p>J. During an interview on 5/16/13 at 1:10 PM, employee H, Administrator, was asked by the surveyor why it took the RN 18 days for the first attempt to</p>						

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	<p>obtain a glucometer. Employee H, Administrator, indicated the RN should have obtained the glucometer as soon as possible.</p> <p>2. Clinical record #3, start of care 4/25/13, contained a home health certification and plan of care dated 4/25/13 to 6/23/13 with orders for SN to assess and evaluate for vital signs. Review of the record evidenced the SN visited the patient on 5/1/13 and 5/8/13. The record failed to evidence respirations were documented during each visit.</p> <p>During an interview on 5/16/13 at 10:10 AM, employee C, Supervising Nurse, indicated that when the plan of care says to take vital signs, the vital signs should include blood pressure, pulse, respirations, temperature, and pain. The RN indicated respirations should have been taken.</p>				

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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.</p> <p>Based on record review and interview, the home health agency failed to ensure the registered nurse intervened timely to help the patient obtain a new glucometer for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <p>1. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to facilitate access to a glucometer.</p> <p>A. The Nursing start of care assessment completed by employee A, Registered Nurse (RN), dated 2/2/13 states, "Problems/Needs: DM [Diabetes Mellitus] with change in medication. Interventions: 1. SN [skilled nurse] assist in getting a glucose monitor."</p>	N000543	The DON, administrator and RN consultant have educated the staff on the need to follow the POC and to ensure appropriate preventive nursing procedure are planned and executed in a timely manner to ensure the well being of the patient. Instructed to seek assistance from the DON and during case conferences if problems are arising with the implementation of the nursing care plan. 100% of the skilled nursing charts have been audited to determine the establishment of a nursing care plan and the timely execution of that plan. The individual nurses have had instruction and education on the development of a nursing care plan and the need to execute this plan in an expeditious manner to ensure preventive measures are in place as soon as possible. Regularly scheduled case conferencing has been established. A homecare RN consultant has been hired to help monitor and provide continued education and oversight. 10% of the clinical records will be audited quarterly to ensure compliance with this regulation. Continued	06/15/2013	

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	<p>B. A Nursing progress note completed by employee A, RN, dated 2/2/13 states, "[Patient] is a type 2 DM. [Patient] diabetic medication was recently changed from Janovia to Amaryl. [Patient] recently moved to the [senior living center] ... [Patient] states [patient] lost [their] blood glucose meter during the move."</p> <p>C. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states ... [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>D. A Skilled Nursing Progress Note completed by employee A, RN on 2/20/13 states, "Pt still does not have a glucose monitor. This nurse called the office of [physician]. Was told by [staff at physician office] that the meter was being shipped yesterday or today and pt should receive it by end of wk [week]."</p> <p>E. A Skilled Nursing Progress Note completed by employee A, RN on</p>		<p>case conferencing and education will be provided. The DON will be responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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	<p>2/26/13 states, "Pt states [patient] has a glucose monitor (temp) [temporary] until [the patient's] arrives.</p> <p>2. During an interview on 5/16/13 at 1:10 PM, employee H, Administrator, was asked why it took the RN 18 days for the first attempt to obtain a glucometer. Employee H, Administrator, indicated the RN should have obtained the glucometer as soon as possible.</p>			

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N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the registered nurse coordinated services with the physician for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>The undated policy titled "Plan of Care" policy number C-580 states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</li> </ol>	N000545	<p>The Administrator, DON RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. A homecare RN consultant has been hired to help monitor and provide continued education and oversight. On-going case conferences will occur at regularly</p>	06/15/2013

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NAME OF PROVIDER OR SUPPLIER  CENTRAL HOME HEALTH SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5699 E 71ST ST STE 1A INDIANAPOLIS, IN 46220		
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	<p>3. The undated policy titled "Coordination of Patient Services and Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p> <p>A. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell</p>		<p>scheduled intervals. Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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	<p>4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>				

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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the registered nurse notified the physician of changes in the patient's condition for 1 of 13 clinical records reviewed with the potential to affect all patients of the agency. (#11)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The undated policy titled "Skilled Nursing Services" policy number C-200 states, "The Registered Nurse ... Regularly reevaluates the patient needs, and coordinates the necessary services ... Informs the physician and other personnel of changes in the patient condition and needs."</li> <li>2. The undated policy titled "Plan of</li> </ol>	N000546	<p>The Administrator, DON and RN consultant have conducted in-services with all nursing staff to address the regulations, policies and procedures on the following: -Following the established plan of care -Evaluating and re-evaluating the patient's on-going needs and notifying the physician and any other involved personnel of changes in the patient's condition or needs. -The need of changes in condition to be reported promptly and case conferences to be conducted to address any problems and needs of the patient. Travel Charts have been developed that include all necessary documents including the POC 100% of the records that include skilled nursing services have been audited with education provided to the nursing staff on deficiencies noted. A homecare RN consultant has been hired to help monitor and provide continued education and</p>	06/15/2013			

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	<p>Care" policy number C-580 states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."</p> <p>3. The undated policy titled "Coordination of Patient Services and Clinical Summary" policy number C-360 states, "Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed."</p> <p>4. The undated policy titled "Medical Supervision" policy number C-645 states, "Physician will be contacted when any of the following occurs: condition changes ... Agency Responsibilities include: Prompt reporting of a change in patient condition ... timely notification of change in condition."</p> <p>5. Clinical record #11, start of care 2/2/13, contained a home health certification and plan of care dated 2/2/13-4/2/13 with orders for Skilled Nursing to inform the physician of any changes in the patient's medical condition warranting intervention. Review of the record evidenced the following:</p>		oversight. A regularly scheduled case conference meeting has been established to conference and coordinate patient care and discuss patient needs. On-going case conferences will occur at regularly scheduled intervals. Skilled care documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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	<p>A. A Skilled Nursing Progress Note completed by employee A, Registered Nurse (RN) on 2/16/13 states, "Pt [patient] states [patient] fell 4x [4 times] and was found on the floor of [patient] apt [apartment] on 2/13/13. States [patient] was transported to [name of] Hosp. [Hospital]. Pt returned home on the 14th. Attempted to see pt on the 15th. [Patient] told this nurse on the phone that [patient] did not feel well and doesn't want nurse to come. Daughter was notified ... Pt states [patient] still does not have a glucose monitor ... Pt states [patient] BS [blood sugar] was 34 when [patient] was taken to the hospital. [Patient] also stated that [patient] frequently gets dizzy first thing in the morning and [patient] thinks [patient] BS is low."</p> <p>B. Review of the record failed to evidence the physician was notified of the patient fall, hospitalization, or low blood sugar.</p> <p>6. During an interview on 5/16/13 at 1:00 PM with employee H, Administrator, indicated there was no documentation in the record that the physician was notified.</p>			
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N000597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on policy review, personnel file review, and interview, the agency failed to ensure home health aides (HHA) were entered on and in good standing on the state aide registry for 3 of 12 HHA files reviewed for registry documentation with the potential to affect all patients receiving HHA services. (V, Z, CC)</p> <p>Findings include:</p> <p>1. The undated policy titled "License, registration, or certification requirements" policy number D-200 states, "If a position requires licensure, registration, or certification, it shall be the employee's responsibility to provide copies of these documents to the Agency on a timely basis prior to expiration ... The agency will track the expiration dates of employee's licenses, registrations, or certifications to ensure that copies are received timely. Those employees who do not provide copies of these documents to the Agency by the expiration date will not be allowed to work until such time as they comply with</p>	N000597	The Administrator has instructed the staff on the regulation of placing and/or ensuring that the home-health aides are placed on the registration site and are in good standing prior to first patient contact. All aide personnel files have been audited to determine that they are on the aide registry and are in good standing. A tracking tool is in place to track and check the aide registry to ensure that they are placed on the registry prior to first patient contact. All home health aides are now on the home health aide registry and in good standing. The Administrator will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.	06/03/2013

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	<p>this policy."</p> <p>2. Personnel file V, date of hire 1/19/12, contained a CNA licensure issued on 1/12/93. The personnel file failed to evidence a HHA registration.</p> <p>3. Personnel file Z, date of hire 7/20/12, contained a CNA licensure issued on 3/23/12. The personnel file failed to evidence a HHA registration.</p> <p>4. Personnel file CC, date of hire 2/18/13, contained a CNA licensure issued on 9/17/11. The personnel file failed to evidence a HHA registration.</p> <p>5. During an interview on 5/17/13 at 3:41 PM, employee H, Administrator, indicated employees V, Z, and CC were Certified Nurse Aides and were not registered as HHAs.</p>			

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