

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2013
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NAME OF PROVIDER OR SUPPLIER CARE FORCE ONE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2440 BROADWAY ANDERSON, IN 46012
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G000000	<p>This visit was a home health federal recertification survey.</p> <p>Date of survey: October 29, 30, and 31, 2013</p> <p>Facility #: 012380</p> <p>Medicaid #: 201000300</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor Shannon Pietraszewski, RN PH Nurse Surveyor in training</p> <p>Census by Service Type</p> <p>Skilled Patients 36 Home Health Aide Patients 8 Personal Service Only Patients 0 Total 44</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 5, 2013</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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G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on policy review and observation, the agency failed to ensure a Registered Nurse and Home Health Aides followed the agency's policy for hand washing for 3 of 5 patients observed during a home visit with the potential to affect all patients of the agency. (Employees C, D, and A)</p> <p>The Findings included:</p> <ol style="list-style-type: none"> On 10/30/13, Employee C, home health aide, was observed during the home visit from 11:00 AM to 12:00 PM not washing her hands prior to accessing supplies from the work bag and prior to the application of gloves before Patient 3's bed bath. On 10/31/2013, Employee D, home health aide, was observed during the home visit from 10:00 AM to 11:10 AM not washing her hands prior to accessing supplies from the work bag and prior to the application of gloves before Patient 4's bed bath. On 10/31/2013, Employee A, Director 	G000121	G 121 The Nursing Supervisor will inservice HHA staff on the agency policies "Bag technique" and "Infection control" to include hand washing. It will be understood by all employees that the use of hand sanitizer alone is not acceptable per our policies. This will be completed by all employees prior to 11-15-13. The Nursing Supervisor will be responsible for monitoring this corrective action during supervisory visits to ensure that it does not reoccur.	11/15/2013			

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	<p>of Nursing, was observed during the home visit from 11:40 AM. to 1:30 PM washing her hands prior to accessing supplies from the work bag. Employee A did not wash her hands prior to the application of gloves and after the removal of Patient 5's soiled wound dressing. Employee C, Home Health Aide, did not wash her hands prior to accessing supplies from the work bag and prior to the application of gloves before assisting Employee A with Patient 5's wound dressing. Employee C did not wash her hands or change gloves after picking up items off the floor. Employee C did not wash her hands prior to the application of gloves before Patient 5's bed bath.</p> <p>4. A policy titled "Bag Technique" approved 5/31/13 states, "Employees should wash their hands prior to accessing supplies from the bag with the exception of the hand soap and paper towels."</p> <p>5. A policy titled "Infection Control" approved 4/15/13 states, "Staff will wash their hands with liquid antibacterial soap and warm water, scrubbing all surfaces of the hands, for at least 20 seconds. Antibacterial hand rinse may be used in the absence of running water ... Staff should wash their hands before and after patient contact, upon removal of gloves,</p>			

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	before and after invasive procedures, after handling soiled or contaminated materials."			

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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. Based on clinical record and policy review and interview, the agency failed to ensure care followed the most current written plan of care in 4 of 10 records reviewed with the potential to affect all 44 patients. (1, 3, 5 and 10) Findings: 1. Clinical record 1, start of care (SOC) 2/20/13, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One certification period dated 8/28/13 through 10/26/13 with skilled nursing orders and home health aide and one certification period dated 10/15/13 through 12/13/13 with physician orders home health aide 4 times a week for 1 week, 7 times a week for 7 weeks, and 6 times a week for 1 week for 2 hours each visit. The clinical record evidenced the 2 hour visits were made, plus 3 additional visits per day 7 days a week for total of 8 hours a day on 10/16/13, 10/17/13, 10/18/13, 10/19/13, 10/20/13, 10/21/13,</p>	G000158	G 158 The Administrator will ensure that all orders for services related to patient care regardless of funding source will be combined onto a single plan of care by 11-8-13. The Administrator will be responsible for monitoring this corrective action during the audit process to ensure that it does not reoccur.	11/08/2013			

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	<p>10/22/13, 10/23/13, 10/24/13, and 10/25/13.</p> <p>2. Clinical record 3, SOC 3/12/12, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One certification period dated 7/31/13 through 9/28/13 with skilled nursing orders and one certification period dated 9/3/13 through 11/1/13 with orders for home health aide 4 visits a week for 1 week and 5 visits a week for 8 weeks for 2 hours each visit. The clinical record evidenced the visits were made as ordered and the skilled nurse made visits 3 times a week for 3 hours each on 9/4/13, 9/5/13, 9/9/13, 9/11/13, 9/13/13, 9/16/13, 9/18/13, 9/20/13, 9/23/13, 9/25/13, and 9/27/13.</p> <p>3. Clinical record 5, start of care (SOC) 2/25/13, evidenced physician orders for the certification period 8/31/13 through 10/29/13 for RN (Registered Nurse) one time a month for two months for supervision of home health aide (HHA) and one prn (as needed) visit the last 5 days of the certification for recertification. The HHA services were to be provided 10 hours each week for 9 weeks and homemaking services 5 hours each week. The record evidenced a RN provided</p>			

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	<p>services two times a week on week 2 through 9 for wound care, HHA services exceeded 10 hours on week 2 through 9, and Patient #5 received four hours of HHA services on week 1 and eight hours on week 10.</p> <p>On 10/31/13 at 4:30 p.m., Employee #A, Director of Nursing, indicated under Medicaid, the patient received SN (Skilled Nursing) twice a week and 14 hours of HHA services a week. Under Medicaid Waiver A & D, the patient received 10 hours of HHA services and 5 hours of Homemaker services per week.</p> <p>4. Clinical record 10, SOC 1/28/13, evidenced physician orders for the certification period 9/25/13 through 11/23/13 for skilled nursing 0 times a week for 1 week and 1 time a week for 8 weeks. The physician orders did not evidence wound care instructions. The clinical record evidenced wound care was performed 10/2/13.</p> <p>On 10/31/13 at 4 PM, the Director of Nursing indicated the plan of care did not have wound care orders at the beginning of the certification period.</p> <p>5. A policy titled "Plan of Care", Effective: 5-31-11, states, "3. The Plan of Care will include physician orders for: ...</p>				

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	<p>Medications and treatments ..."</p> <p>6. On 10/29/13 at 1 PM, the Administrator, Employee B, and the Director of Nursing, Employee A, indicated that as they find new funding sources for more services they make new plans of care with overlapping certification periods and have the physicians sign them as new orders.</p>				

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G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure each patient only had a single plan of care that was accurate and contained all the patient's orders for 3 for 3 charts reviewed of patients with multiple payer sources with the potential to affect all 11 patients with multiple payer sources. (1, 3, and 5)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 2/20/13, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One plan of care for the certification period dated 8/28/13 through 10/26/13 had orders for skilled nursing and home health aide and one plan of care for the certification period dated 10/15/13</p>	G000159	G 159 The Administrator will ensure that all orders for services related to patient care regardless of funding source will be combined onto a single plan of care by 11-8-13. The Administrator will be responsible for monitoring this corrective action during the audit process to ensure that it does not reoccur.	11/08/2013	

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	<p>through 12/13/13 had orders for home health aide services.</p> <p>2. Clinical record 3, SOC 3/12/12, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One plan of care for the certification period dated 7/31/13 through 9/28/13 included orders for skilled nursing and one plan of care for the certification period dated 9/3/13 through 11/1/13 with orders for home health aide services.</p> <p>3. Clinical record 5, SOC 2/25/13, failed to evidence a single plan of care that contained all the patient's orders and failed to evidence a correct SOC date. The record evidenced two different plans of care (POC) for two different payer sources, two different certification periods, and two different primary diagnoses. The Medicaid A & D POC for the certification period dated 8/31/13 through 10/29/13 included a start of care date of 2/25/13, primary diagnosis of Pneumonia, skilled nursing orders for one time a month for two months for supervisory visits with one prn (as needed) visit for recertification, home health aide orders for up to 10 hours each week for 9 weeks, and homemaker orders</p>						

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	<p>5 hours per week. The Medicaid POC for the certification period dated 7/18/13 through 9/15/13 included a start of care date of 3/20/13, primary diagnosis of "Pressure Ulcer St (stage) II, skilled nursing orders for one time a week for week 1 then two times a week for 8 weeks, and home health aide orders for up to 14 hours per week.</p> <p>On 10/31/13 at 4:30 p.m., Employee A, Director of Nursing, and Employee B, Administrator, indicated Patient 5 was originally admitted in January of 2013 and was later discharged. Patient 5 was readmitted on March 4, 2013, with Medicaid A & D services and March 20, 2013, with Medicaid services. Employee B indicated she had always used two different POCs when the patient had two different payer sources and the secretary did not know how to change the start of care date in the computer. Employee A indicated diagnoses for both POCs should have been the same.</p> <p>4. On 10/29/13 at 1 PM, the Administrator, Employee B, and the Director of Nursing, Employee A, indicated that as they find new funding sources for more services they make new plans of care with overlapping certification periods and have the physicians sign them as new orders.</p>						

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	<p>5. A policy titled " Plan of Care", effective: 5-31-11, states, "1. Home health services are furnished to clients under the physician's certification that the services are medically required for the client. A copy of the plan of care will be maintained in the patient's clinical record. ... 7. All changes in the plan of care are documented through written and signed physician orders."</p>			

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G000225	<p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on observation, interview, and policy review, the agency failed to ensure Home Health Aides was not administering a medicated powder to patients for 1 of 5 patients observed which had the potential to affect all patients who received services from home health aides. (4)</p> <p>The Findings included:</p> <ol style="list-style-type: none"> 1. On 10/31/2013 Employee D, home health aide, was observed on a home visit from 10:00 AM to 11:10 AM applying a medicated powder to Patient 4's groin and buttocks area. Employee#D indicated she was checked off on her skills evaluation to apply the powder. 2. On 10/31/13 at 4:30 p.m., Employee A, Director of Nursing, indicated Employee D had not been checked off on this task and Home Health Aides were not allowed to apply medicated powder to patients. 3. A policy titled "Medication Assistance" approved on 5/31/13 states, 	G000225	G 225 The Nursing Supervisor will ensure that Employee D and all other Home Health Aides are inserviced with regard to helping patients with self-administration of medications by 11-15-13. Home Health Aides will demonstrate a clear understanding of their duties and limitations with regard to patient Medications. The Nursing Supervisor will be responsible for monitoring this corrective action during supervisory visits to ensure that it does not reoccur.	11/15/2013			

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	"Assistance with medication is defined as ancillary aid needed by a client to self-administer medication ... Ancillary aid does <u>not</u> include: A. Administration of any medication by injection, inhalation, ingestion or any other means."			

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G000332	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT 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. Based on clinical record and policy review and interview, the agency failed to ensure the physician's referral was made prior to the start of care and that the initial assessment visit was within 48 hours of the physician's referral in 5 of 10 clinical records reviewed with the potential to affect all new patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Clinical record 1, start of care (SOC) and comprehensive assessment dated 2/20/13, evidenced a referral dated 3/1/13, after the SOC. The record failed to evidence a referral prior to the SOC and an initial assessment visit within 48 hours of the referral. 2. Clinical record 3, SOC and comprehensive assessment dated 3/12/12, evidenced a referral dated 2/1/13. The record failed to evidence an initial assessment visit was completed within 48 hours of referral. 3. Clinical record 4, SOC and comprehensive assessment dated 4/22/13, evidenced a referral dated 9/19/13, 5 	G000332	G332 The Administrator will ensure that the data entry clerk is properly trained in correctly inputting the SOC date in box 2 of the patients 485. The Administrator will be responsible for monitoring this corrective action. This will be monitored as part of our audit process to ensure this error does not reoccur. It will be corrected by 11-15-13.	11/15/2013	

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	<p>months after the start of care. The record failed to evidence a referral prior to the SOC and an initial assessment visit within 48 hours of the referral.</p> <p>4. Clinical record 7, SOC and comprehensive assessment dated 10/8/12, failed to evidence a referral for services of any date.</p> <p>5. Clinical record 8, SOC and comprehensive assessment dated 7/30/13, evidenced a referral dated 9/6/10, after the start of care. The record failed to evidence a referral prior to the SOC and an initial assessment visit within 48 hours of the referral.</p> <p>6. On 10/31/13 at 4 PM, the Administrator indicated the person who does the referrals had not been properly trained and the referrals were incorrect in the clinical record.</p> <p>7. A policy titled "Client Assessment", Effective: 5-31-11, states, "The client is contacted within 24 hours of the referral order and the client assessment / evaluation is completed within 72 hours of the referral order." It is unclear if this policy refers to the initial assessment visit. If so, the policy is not congruent with federal regulations.</p>			

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NAME OF PROVIDER OR SUPPLIER CARE FORCE ONE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2440 BROADWAY ANDERSON, IN 46012
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N000000	<p>This visit was a home health state licensure survey.</p> <p>Date of survey: October 29, 30, and 31, 2013</p> <p>Facility #: 012380</p> <p>Medicaid #: 201000300</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor Shannon Pietraszewski, RN PH Nurse Surveyor in training</p> <p>Census by Service Type</p> <p>Skilled Patients 36 Home Health Aide Patients 8 Personal Service Only Patients 0 Total 44</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 5, 2013</p>	N000000					

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N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on policy review and observation, the agency failed to ensure a Registered Nurse and Home Health Aides followed the agency's policy for hand washing for 3 of 5 patients observed during a home visit with the potential to affect all patients of the agency. (Employees C, D, and A)</p> <p>The Findings included:</p> <ol style="list-style-type: none"> 1. On 10/30/13, Employee C, home health aide, was observed during the home visit from 11:00 AM to 12:00 PM not washing her hands prior to accessing supplies from the work bag and prior to the application of gloves before Patient 3's bed bath. 2. On 10/31/2013, Employee D, home health aide, was observed during the home visit from 10:00 AM to 11:10 AM not washing her hands prior to accessing supplies from the work bag and prior to the application of gloves before Patient 4's bed bath. 3. On 10/31/2013, Employee A, Director 	N000470	N470 The Nursing Supervisor will inservice HHA staff on the agency policies "Bag technique" and "Infection control" to include hand washing. It will be understood by all employees that the use of hand sanitizer alone is not acceptable per our policies. This will be completed by all employees prior to 11-15-13. The Nursing Supervisor will be responsible for monitoring this corrective action during supervisory visits to ensure that it does not reoccur.	11/15/2013			

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	<p>of Nursing, was observed during the home visit from 11:40 AM. to 1:30 PM washing her hands prior to accessing supplies from the work bag. Employee A did not wash her hands prior to the application of gloves and after the removal of Patient 5's soiled wound dressing. Employee C, Home Health Aide, did not wash her hands prior to accessing supplies from the work bag and prior to the application of gloves before assisting Employee A with Patient 5's wound dressing. Employee C did not wash her hands or change gloves after picking up items off the floor. Employee C did not wash her hands prior to the application of gloves before Patient 5's bed bath.</p> <p>4. A policy titled "Bag Technique" approved 5/31/13 states, "Employees should wash their hands prior to accessing supplies from the bag with the exception of the hand soap and paper towels."</p> <p>5. A policy titled "Infection Control" approved 4/15/13 states, "Staff will wash their hands with liquid antibacterial soap and warm water, scrubbing all surfaces of the hands, for at least 20 seconds. Antibacterial hand rinse may be used in the absence of running water ... Staff should wash their hands before and after patient contact, upon removal of gloves,</p>			

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	before and after invasive procedures, after handling soiled or contaminated materials."			

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N000522 SS=D	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review and interview, the agency failed to ensure care followed the most current written plan of care in 4 of 10 records reviewed with the potential to affect all 44 patients. (1, 3, 5 and 10)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 2/20/13, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One certification period dated 8/28/13 through 10/26/13 with skilled nursing orders and home health aide and one certification period dated 10/15/13 through 12/13/13 with physician orders home health aide 4 times a week for 1 week, 7 times a week for 7 weeks, and 6 times a week for 1 week for 2 hours each visit. The clinical record evidenced the 2 hour visits were made, plus 3 additional visits per day 7 days a week for total of 8 hours a day on 10/16/13, 10/17/13, 10/18/13, 10/19/13, 10/20/13, 10/21/13,</p>	N000522	N 522 The Administrator will ensure that all orders for services related to patient care regardless of funding source will be combined onto a single plan of care by 11-8-13. The Administrator will be responsible for monitoring this corrective action during the audit process to ensure that it does not reoccur.	11/08/2013			

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	<p>10/22/13, 10/23/13, 10/24/13, and 10/25/13.</p> <p>2. Clinical record 3, SOC 3/12/12, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One certification period dated 7/31/13 through 9/28/13 with skilled nursing orders and one certification period dated 9/3/13 through 11/1/13 with orders for home health aide 4 visits a week for 1 week and 5 visits a week for 8 weeks for 2 hours each visit. The clinical record evidenced the visits were made as ordered and the skilled nurse made visits 3 times a week for 3 hours each on 9/4/13, 9/5/13, 9/9/13, 9/11/13, 9/13/13, 9/16/13, 9/18/13, 9/20/13, 9/23/13, 9/25/13, and 9/27/13.</p> <p>3. Clinical record 5, start of care (SOC) 2/25/13, evidenced physician orders for the certification period 8/31/13 through 10/29/13 for RN (Registered Nurse) one time a month for two months for supervision of home health aide (HHA) and one prn (as needed) visit the last 5 days of the certification for recertification. The HHA services were to be provided 10 hours each week for 9 weeks and homemaking services 5 hours each week. The record evidenced a RN provided</p>						

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	<p>services two times a week on week 2 through 9 for wound care, HHA services exceeded 10 hours on week 2 through 9, and Patient #5 received four hours of HHA services on week 1 and eight hours on week 10.</p> <p>On 10/31/13 at 4:30 p.m., Employee #A, Director of Nursing, indicated under Medicaid, the patient received SN (Skilled Nursing) twice a week and 14 hours of HHA services a week. Under Medicaid Waiver A & D, the patient received 10 hours of HHA services and 5 hours of Homemaker services per week.</p> <p>4. Clinical record 10, SOC 1/28/13, evidenced physician orders for the certification period 9/25/13 through 11/23/13 for skilled nursing 0 times a week for 1 week and 1 time a week for 8 weeks. The physician orders did not evidence wound care instructions. The clinical record evidenced wound care was performed 10/2/13.</p> <p>On 10/31/13 at 4 PM, the Director of Nursing indicated the plan of care did not have wound care orders at the beginning of the certification period.</p> <p>5. A policy titled "Plan of Care", Effective: 5-31-11, states, "3. The Plan of Care will include physician orders for: ...</p>			

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	<p>Medications and treatments ..."</p> <p>6. On 10/29/13 at 1 PM, the Administrator, Employee B, and the Director of Nursing, Employee A, indicated that as they find new funding sources for more services they make new plans of care with overlapping certification periods and have the physicians sign them as new orders.</p>			
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N000524 SS=D	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record and policy review and interview, the agency failed to ensure each patient only had a single plan of care that was accurate and contained all the patient's orders for 3 for 3 charts reviewed of patients with multiple payer sources with the potential to affect all 11 patients with multiple payer sources. (1, 3, and 5)</p> <p>Findings:</p>	N000524	N 524 The Administrator will ensure that all orders for services related to patient care regardless of funding source will be combined onto a single plan of care by 11-8-13. The Administrator will be responsible for monitoring this corrective action during the audit process to ensure that it does not reoccur.	11/08/2013			

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	<p>1. Clinical record 1, start of care (SOC) 2/20/13, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One plan of care for the certification period dated 8/28/13 through 10/26/13 had orders for skilled nursing and home health aide and one plan of care for the certification period dated 10/15/13 through 12/13/13 had orders for home health aide services.</p> <p>2. Clinical record 3, SOC 3/12/12, failed to evidence a single plan of care that contained all the patient's orders. The record evidenced 2 different plans of care for two different payer sources and two different certification periods. One plan of care for the certification period dated 7/31/13 through 9/28/13 included orders for skilled nursing and one plan of care for the certification period dated 9/3/13 through 11/1/13 with orders for home health aide services.</p> <p>3. Clinical record 5, SOC 2/25/13, failed to evidence a single plan of care that contained all the patient's orders and failed to evidence a correct SOC date. The record evidenced two different plans of care (POC) for two different payer sources, two different certification</p>						

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	<p>periods, and two different primary diagnoses. The Medicaid A & D POC for the certification period dated 8/31/13 through 10/29/13 included a start of care date of 2/25/13, primary diagnosis of Pneumonia, skilled nursing orders for one time a month for two months for supervisory visits with one prn (as needed) visit for recertification, home health aide orders for up to 10 hours each week for 9 weeks, and homemaker orders 5 hours per week. The Medicaid POC for the certification period dated 7/18/13 through 9/15/13 included a start of care date of 3/20/13, primary diagnosis of "Pressure Ulcer St (stage) II, skilled nursing orders for one time a week for week 1 then two times a week for 8 weeks, and home health aide orders for up to 14 hours per week.</p> <p>On 10/31/13 at 4:30 p.m., Employee A, Director of Nursing, and Employee B, Administrator, indicated Patient 5 was originally admitted in January of 2013 and was later discharged. Patient 5 was readmitted on March 4, 2013, with Medicaid A & D services and March 20, 2013, with Medicaid services. Employee B indicated she had always used two different POCs when the patient had two different payer sources and the secretary did not know how to change the start of care date in the computer. Employee A</p>						

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	<p>indicated diagnoses for both POCs should have been the same.</p> <p>4. On 10/29/13 at 1 PM, the Administrator, Employee B, and the Director of Nursing, Employee A, indicated that as they find new funding sources for more services they make new plans of care with overlapping certification periods and have the physicians sign them as new orders.</p> <p>5. A policy titled " Plan of Care", effective: 5-31-11, states, "1. Home health services are furnished to clients under the physician's certification that the services are medically required for the client. A copy of the plan of care will be maintained in the patient's clinical record. ... 7. All changes in the plan of care are documented through written and signed physician orders."</p>				