

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157621	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2015
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NAME OF PROVIDER OR SUPPLIER  BETTER LIVING HOME HEALTH CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2040 WASHINGTON AVENUE EVANSVILLE, IN 47714
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G 0000  Bldg. 00	<p>This was a Federal home health recertification survey. This survey was extended.</p> <p>Survey Dates: August 10, 2015 to August 14, 2015</p> <p>Facility #: 012101</p> <p>Medicaid Vendor #: 15121011</p> <p>Facility unduplicated census: 59</p> <p>Records reviewed without home visit: 5</p> <p>Record reviews with home visits: 5</p> <p>Total records reviewed: 10</p> <p>Better Living Home Health Care is precluded from providing its own training and competency evaluation program for a period of 2 years beginning August 14, 2015 to August 14, 2017, for being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration and 484.55 Comprehensive Assessment of Patients.</p> <p>QA; LD, R.N.</p>	G 0000		
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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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G 0114  Bldg. 00	<p>484.10(e)(1(i-iii)) PATIENT LIABILITY FOR PAYMENT</p> <p>Before the care is initiated, the HHA must inform the patient, orally and in writing, of:</p> <p>(i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA;</p> <p>(ii) The charges for services that will not be covered by Medicare; and</p> <p>(iii) The charges that the individual may have to pay.</p> <p>Based on clinical record review and interview, the agency failed to inform the patient, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 9 of 10 records reviewed. (#1 - 6, 8 - 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/03/14. The Admission Service Agreement dated 06/03/14 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p> <p>2. Clinical record number 2, SOC 01/20/15. The Admission Service Agreement dated 01/20/15 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p>	G 0114	<p>The deficiency was corrected as follows: The Administrator notified client #1, orally and in writing, of the extent to which payment is expected from third party payers including Medicare and Medicaid. The Administrator reviewed the Admission Service Agreement and the Medicare Beneficiary Notice of consolidated billing for home health services and what that means to the beneficiary in terms of potential liability for payment, including actions the beneficiary might take that could result in liability for payment. The client was informed of charges not expected to be covered by Medicare or Medicaid. Charges that the client might have to pay were provided on a Letter of Authorization utilizing estimated dollar amounts based on planned services. Completed 08/28/15. The Administrator notified client #2, orally and in writing, of the extent to which</p>	08/28/2015
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	<p>3. Clinical record number 3, SOC 05/27/14. The Admission Service Agreement dated 05/27/14 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p> <p>4. Clinical record number 4, SOC 08/01/14. The Admission Service Agreement dated 08/01/14 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p> <p>5. Clinical record number 5, SOC 06/26/15. The Admission Service Agreement dated 06/26/15 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p> <p>6. Clinical record number 6, SOC 06/20/14. The Admission Service Agreement dated 06/20/14 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p> <p>7. Clinical record number 8, SOC 06/15/15. The Admission Service Agreement dated 06/15/15 failed to evidence the charges that may occur for services not covered by the insurance</p>		<p>payment is expected from third party payers including Medicare and Medicaid. The Administrator reviewed the Admission Service Agreement and the Medicare Beneficiary Notice of consolidated billing for home health services and what that means to the beneficiary in terms of potential liability for payment, including actions the beneficiary might take that could result in liability for payment. The client was informed of charges not expected to be covered by Medicare or Medicaid. Charges that the client might have to pay were provided on a Letter of Authorization utilizing estimated dollar amounts based on planned services. Completed 08/28/15. The Administrator notified client #3, orally and in writing, of the extent to which payment is expected from third party payers including Medicare and Medicaid. The Administrator reviewed the Admission Service Agreement and the Medicare Beneficiary Notice of consolidated billing for home health services and what that means to the beneficiary in terms of potential liability for payment, including actions the beneficiary might take that could result in liability for payment. The client was informed of charges not expected to be covered by Medicare or Medicaid. Charges that the client might have to pay were provided on a Letter of Authorization utilizing estimated dollar amounts based</p>		

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	<p>benefit.</p> <p>8. Clinical record number 9, SOC 04/21/15. The Admission Service Agreement dated 04/21/15 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p> <p>9. Clinical record number 10, SOC 02/05/15. The Admission Service Agreement dated 02/05/15 failed to evidence the charges that may occur for services not covered by the insurance benefit.</p> <p>11. The Administrator was interviewed on 08/13/15 at 10:30 AM. The Administrator stated he / she was not aware the Admission Service Agreement needed to include charges that may not be paid by the insurance benefit since most Medicare and Medicaid pays at a 100% and the agency could not bill the patient for outstanding balances.</p> <p>12. A policy titled Client Bill of Rights / Informed Consents, dated 03/2009, indicated "Prior to admission, the admitting clinician will provide information, written and / or verbal, to the client and / or family / caregiver on the following topics in language that can be reasonably expected to be understood</p>		<p>on planned services. Completed 08/28/15. Client # 4 was discharged in 2014. No payment liability was imposed. The Administrator notified the parent of client #5, orally and in writing, of the extent to which payment is expected from third party payers including Medicaid. The Client is not covered by Medicare. The Administrator reviewed the Admission Service Agreement and the Medicare Beneficiary Notice of consolidated billing for home health services and what that means to the beneficiary in terms of potential liability for payment, including actions the beneficiary might take that could result in liability for payment. The client's parent was informed of charges not expected to be covered by Medicaid. Charges that the client might have to pay were provided on a Letter of Authorization utilizing estimated dollar amounts based on planned services. Completed 08/28/15. The Administrator notified the parent of client #6, orally and in writing, of the extent to which payment is expected from third party payers including Medicaid. The Client is not covered by Medicare. The Administrator reviewed the Admission Service Agreement and the Medicare Beneficiary Notice of consolidated billing for home health services and what that means to the beneficiary in terms of potential liability for payment, including</p>	

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	<p>... Costs to be borne by the client, if any, for care and / or service ...</p> <p>13. A policy titled Patient Liability for Payment, dated 03/2009, indicated "Before care is initiated, the client will be informed orally and in writing, of the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, charges for services not covered by Medicare or Medicaid, and charges the client may have to pay."</p>		<p>actions the beneficiary might take that could result in liability for payment. The client's parent was informed of charges not expected to be covered by Medicaid. Charges that the client might have to pay were provided on a Letter of Authorization utilizing estimated dollar amounts based on planned services. Completed 08/26/15. Client # 8 was discharged in July, 2015. No liability imposed. Client # 9 was discharged in June, 2015. No liability imposed. The Administrator notified client #10, orally and in writing, of the extent to which payment is expected from third party payers including Medicaid. The Client is not covered by Medicare. The Administrator reviewed the Admission Service Agreement and the Medicare Beneficiary Notice of consolidated billing for home health services and what that means to the beneficiary in terms of potential liability for payment, including actions the beneficiary might take that could result in liability for payment. The client was informed of charges not expected to be covered by Medicaid. Charges that the client might have to pay were provided on a Letter of Authorization utilizing estimated dollar amounts based on planned services. Completed 08/28/15. <b>To prevent the deficiency from recurring:</b> The Administrator updated the agency's Patient</p>		

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			<p>Liability for Payment policy to require the charges the patient may have to pay to be represented to the client in dollar amounts based on planned services. Completed 08/28/15. The Administrator re-trained all RNs who conduct admissions regarding the responsibility to inform clients, prior to the initiation of care, orally and in writing of 1) the extent to which payment may be expected from Medicare, Medicaid, or any other federally funded or aided program known to the agency 2) any charges that will not be covered by Medicare, 3) the charges that the individual may have to pay The Administrator reviewed the entire Patient Liability for Payment policy with the admission nurses and educated them on the policy change. A monitoring program was implemented to review 100% of all admission documents for evidence of compliance. Elements for review include items 1-3 in the above paragraph, and evidence that potential charges were represented to clients in dollar amounts based on planned services. Admission documents will be reviewed weekly until 100% compliance is achieved for 12 consecutive weeks. Thereafter, 100% review will continue monthly until the total length of the monitoring program is at least 7 months and compliance remains at 100%.</p>	

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G 0121 Bldg. 00	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. A. Based on observation and policy review, and interview the agency failed to ensure staff cleaned equipment prior to placing in the nursing bag, failed to wear gloves during care, and failed to wash their hands after removing gloves, during	G 0121	The QA Manager is responsible for the monitoring program and reporting results to the Administrator. Any RN who fails to comply with agency policy and the requirements of this section of the POC will be re-trained before performing any additional admissions. Any RN who repeats non-compliance after re-training will be relieved of admission responsibilities. The Administrator is responsible for re-training and removal of nurses from admission responsibilities as necessary. The Administrator is responsible for overall implementation of the POC and ensuring that the plan results in sustained compliance. IDR is requested because we believe: 1. patient records contained evidence of compliance at the time of the survey; and 2. dollar amounts required by the surveyor for compliance are not required by regulation  <b>The deficiency was corrected as follows:</b> On 8/11/15 the Administrator re-educated Employee E on infection control policies and procedures including Universal Precautions, Handwashing, and	09/12/2015	

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	<p>care, and after care for 2 of 5 home visits observed. (# 1 and 2)</p> <p>B. Based on observation, clinical record and employee record review, and interview, the Licensed Practical Nurse (LPN) failed to follow agency policy and professional practice standards in relation to providing medication through a patient's gastric feeding tube without first checking residuals for 1 of 1 patient observed for administration of medications through a gastric tube. (# 6)</p> <p>Findings include:</p> <p>A 1. On 8/11/15 at 8:10 AM, Employee E was observed providing patient #1 with bathing and hygiene. During the care, employee E was observed cleaning the patient on the toilet with gloves on, removed the gloves and assisted the patient down into the bath tub. Employee E then grabbed the wash clothe and handed it to the patient. Employee E then was observed to washed the patient's back, hair, and beard then rinsed without gloves. Employee E proceeds to help the patient out of the bath tub and assist with drying the patient off, grabbed the patient clothes and placed them on the floor, then applied gloves without washing or sanitizing hands and continued to assist the patient with dressing, combing hair,</p>		<p>Nursing/Aide Bag Technique. Employee E demonstrated competency with handwashing and gloving, and described appropriate infection control procedures to follow when providing care. On 8/11/15 the Administrator re-educated Employee F on infection control policies and procedures including Universal Precautions, Handwashing, and Nursing Bag Technique. Employee F demonstrated competency with glove and handwashing procedures and described appropriate infection control procedures to follow when passing medications. Employee F demonstrated competency with bag technique, including cleaning equipment after assessing a client and before placing the equipment back in the bag. All patients may be affected. On 8/26/15, 9/2/15, 9/9/15, 9/10/15, 9/11/15, and 9/12/15 the Administrator and RN designees educated 100% of clinical employees on standards of practice and infection control including the following policies and procedures: Universal Precautions; Hand washing; Nursing/Aide Bag Technique. Proper handwashing, gloving and bag technique were demonstrated to the employees and all were successful in return demonstrations of the same skills. On 8/15/15 the Administrator reviewed agency</p>	

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	<p>and applying scented lotion to the patient facial area. Employee E assisted the patient back onto the toilet, took dirty linen to the laundry room, removed gloves, then assisted the patient with pulling his hair back. Employee E ran hands under the water without soap for less than 10 seconds then reapplied gloves, cleaned patient's buttocks from toileting, removed gloves and assisted the patient to the wheelchair. Employee then retrieved the patient's bandana and placed it around his head then pushed the wheelchair to the kitchen table. Employee then was observed retrieving a glass, retrieved a pitcher of fluids from the refrigerator to pour into the patient's glass, then applied hand sanitizer, then gloves and took the drink to the patient at the kitchen table.</p> <p>A 2. On 8/11/15 at 9:00 AM, Employee F was observed setting up the patient number 2's medication dispenser. Employee F was setting up medication cups then was observed to touch each pill that was placed into the medication cups. Employee F was then observed to go to her lab coat and retrieve her cell phone to look up a medication. After placing the phone on the table, Employee F proceeded to touch each pill and placing it in the medication cups without washing / sanitizing his / her hands. Upon</p>		<p>policy and procedure with employee j and instructed the employee to follow policy and procedure when administering medication through the G-tube. Employee J was provided with a manual of clinical nursing procedures and performance expectations for procedural compliance. Employee J's job description was reviewed, including the responsibility to follow agency policies and provide care according to the established Plan of Care. The Administrator placed Employee J on probationary status for no less than 12 weeks due to failure to follow agency policy on medication administration through a G-tube. The employee was instructed that failure to follow policies and procedures will result in termination. The Administrator is responsible for any additional disciplinary action. On 8/24/15 the Administrator installed an RN on the case to provide direct patient care, weekly in-home case management, assessment of LPN technical skills, and supervision of care provided by LPNs. It is the case manager's responsibility to provide in-home supervision and report findings to the Administrator on a weekly basis. Also on this date, employee J was observed by the Administrator and RN Case Manager to competently administer medication via the G-Tube in compliance with</p>		

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	<p>completion of filling the medication cups, Employee F was observed to retrieve stethoscope, blood pressure cuff and thermometer with sheath from the nursing bag. Upon completion, Employee F removes the sheath without gloves, places thermometer into the container and placed equipment back into the nursing bag without cleaning cleaning equipment or washing / sanitizing hands.</p> <p>A 3. The Director of Nursing was interviewed on 8/11/15 at 8:45 AM. The Director of Nursing stated that Employee E was one of their best home health aides and the employee was extremely nervous.</p> <p>A 4. The Administrator was interviewed on 8/13/15 at 11:00 AM. The Administrator stated that Employee F was a fairly new nurse and probably did not receive enough orientation prior to letting her be on her own in the field.</p> <p>A 5. A policy titled Universal Body Substance Precautions, dated 03/2009, indicated "Handwashing will be performed to prevent cross-contamination between patients / clients and personnel. Hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly before and after patient / client contact, if contaminated with body</p>		<p>agency policy and procedure. To ensure that other patients weren't at similar risk, all LPNs providing g-tube medications or any other specialized procedure were required to demonstrate procedural competency to the Administrator. Only two additional LPNs were providing any specialized procedures. LPN "A" demonstrated competency in administration of medication through a G-tube on 9/9/15 and LPN "B" demonstrated competency checking blood sugar with a Glucometer on 9/10/15. On 9/11/15 the Administrator assigned all LPNs on staff to an individual RN to serve as a mentor and to provide ongoing supervision and guidance. <b>To prevent the deficiency from recurring:</b> Monitoring for continued compliance will be achieved through a QA activity of weekly home visits to observe handwashing, gloving, bag technique, and universal precautions in the patient care setting. The Administrator and RN designees will observe 5% of the total number of clinical employees weekly for a minimum of 7 months or until 100% compliance is achieved, whichever is longer. The Administrator is responsible conducting, coordinating, and documenting in-home observations. The QA Manager is responsible for maintaining</p>				

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	<p>substances, before and after gloves are worn, and before preparing or eating food ... Gloves are to be worn by all agency staff when direct contact with any body substance is anticipated [blood, urine, pus, feces, saliva, drainage of any kind] ... gloves are to be worn when handling soiled linen ... Proper handwashing techniques should be prior to touching food ... "</p> <p>A 6. A policy titled Handwashing, dated 03/2009, indicated "Personnel providing care / service in the home setting will wash their hands ... after handling bed pans, urinals, catheters, linens, before and after gloves are used, before and after eating, after use of the toilet ... Using an approved antiseptic hand cleanser and towels or antiseptic towelettes ... dry hands with paper towels or clean cloth towel ... use this procedure only if water is not available."</p> <p>A 7. A policy titled Nursing Bag Technique, dated 03/2009, indicated "When the visit is completed, reusable equipment is cleaned using alcohol and / or soap and water ... hands are washed and equipment and supplies are returned to the bag, hands are washed prior to returning clean equipment to bag ... "</p>		<p>data, calculating and reporting compliance rates on a monthly basis. Any clinical employee who fails to demonstrate compliance with infection control policies (including handwashing, gloving, and bag technique) during provision of care will be re-trained before performing any additional client care. Any clinical employee who repeats non-compliance after re-training will be relieved of patient care responsibilities. The Administrator is responsible for re-training and removal of nurses from admission responsibilities. On 9/11/15 the Administrator implemented a policy requiring LPN supervision by an RN as often as necessary to insure safe and effective care, but in any event no less frequently than every 30 days. The Administrator is responsible for assigning and scheduling RNs for LPN supervisory visits. On 9/11/15 the Administrator added competency demonstration of specialized procedures to the orientation and education program for LPNs. The Administrator also developed an LPN assignment procedure requiring the identification of any specialized skills required on each case and documentation of how any LPN assigned to the case has demonstrated the skills necessary for safe and effective patient care. The LPN assignment document was implemented 9/11/15. The</p>		

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	<p>B 1. Clinical record number 6 included a plan of care established by a physician for the certification period of 06/15/15 to 08/13/15 with orders for skilled nursing six times a week for one week, seven times a week for seven weeks, then five times a week for one week up to 10 hours a day.</p> <p>a. Upon arrival on 08/11/15 at 2:00 PM, the patient was observed to be sitting up in his wheelchair with a tube starting at the feeding bag and ending to the patient's gastric tube from his abdomen. The tube feeding was running at a rate of 250 ml (milliliters) per hour. 2:10 PM, Employee J, LPN, was observed preparing to give the patient his medications through his gastric tube. Employee J stopped the tube feeding and indicated that she wasn't going to check for residual because the patient would "naturally" have residual since the patient was receiving tube feedings. The employee proceeded to flush the gastric tube with 20 ml of water, then proceeded giving the prescribed medications. Once the medication administration was completed, the employee reconnected the tube to the feeding bag and resumed the feeding.</p> <p>b. Upon review of the established plan of care, the skilled nursing</p>		<p>Administrator is responsible for ensuring that the procedure is followed. LPN competency and supervision monitoring was incorporated into the QA program on 9/11/15. Monitoring elements include 100% of LPN cases for supervisory visits, LPN orientation documents, LPN assignment procedure followed for each LPN assignment, and review of 100% of LPN nursing visits on a weekly basis to ensure that LPNs have been competency tested for any specialized care provided. Monitoring will continue until 100% compliance is achieved for at least 3 consecutive months or for 7 months, whichever is longer. The QA Manager is responsible for data collection and reporting to the Administrator. The Administrator is responsible for re-training and any necessary disciplinary action required based on QA findings.</p>		

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	<p>instructions indicated, "SN [skilled nurse]: Check placement of g-tube prn [as needed] dislodgement / occlusion via auscultation / aspiration before flush / RX [medication] administration."</p> <p>c. Upon review of communication notes between former Director of Nursing and Employee J, on 07/06/15 at 3:57 PM, the patient had gastric residuals of greater than 50 ml. The physician had been notified with return orders to hold for one hour if residuals are greater than 50 mls.</p> <p>B 2. Employee J employee record was reviewed on 08/14/15 at 3:00 PM. Employee J had a form titled "Giving Medicine Using G-Tube" in her file. The handout indicated "Sitting up, remove plug from G-Tube ... Attach syringe, pull back on the plunger and draw out some stomach contents. Push down on plunger and return the stomach contents. Flush G-Tube with 30 ml of water. Draw up the medicine into the syringe. Attach syringe and push down on the plunger to give the medicine ... "</p> <p>B 3. Employee A, Administrator / Registered Nurse, was interviewed on 08/13/15 at 3:10 PM. Employee A stated Employee J had been counceled on professional standards of gastrostomy tubes and checking placement in the past.</p>			

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G 0122 Bldg. 00	<p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION</p> <p>Based on observation, employee record review, public record review, policy review and interview, the agency failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency (See G123); the agency failed to ensure the state agency was notified of branch sites and /or branch was approved by the Centers for Medicare and Medicaid Services (CMS) prior to a location functioning as a branch for 1 of 1 agency (See G125); the agency failed to ensure qualified personnel for Director of Nursing per 410 Indiana Administrative Code 17-2-1-(d) for 1 of 1 agency (See G134); the Administrator failed to ensure public information materials was true and accurate for 1 of 1 agency (See G135); and the agency failed to ensure qualified person is authorized in writing to act in the absence of the administrator per 410 Indiana Administrative Code 17-2-1-(C) 8 and (d) for 1 of 1 agency (See G137).</p> <p>The cumulative effect of this systemic</p>	G 0122	<p>The management team is meeting several times a week to address the deficiencies cited in the survey and to design our plan for corrections and monitoring programs in a way that allows us to identify and correct all systemic problems With a new, highly qualified and experienced home health Administrator, we have the leadership and management capability to restore the agency to compliance with the standards within this condition The cumulative effect of the systemic problem resulting in being out of compliance with this condition is being addressed on the whole as well as in each individual citation below. G 123 On 8/27/15 The Administrator reviewed the agency policy on Administrative Control. The policy was updated to include putting employee names under their respective titles/positions on the organization chart from the President down to the patient. The HR manager added the names of all employees were to the OrganizationChart under their respective titles/positions from the President down to the patient. This corrective action was completed on 9/9/15 To</p>	09/13/2015

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	problem resulted in the agency being out of compliance with the Condition of Participation 484.14 Organization, Services, and Administration.		ensure continued compliance, the HRManager will update the Organization Chart with names under the titles/positions each time an RN, LPN, Home Health Aide, Physical Therapist, Occupational Therapist, Speech Therapist, or Administrative staff member is hired or terminated. The Administrator will monitor compliance weekly by comparing the Organizational Chart to the active employee roster. Monitoring will continue until 100% compliance is achieved for 3 consecutive months or for 7 months, whichever is longer. The Administrator is responsible for this corrective action and for ongoing monitoring. G 125 8/30/15 Administrator reviewed the State Regulations and definitions concerning Branch locations as well as the surveyor's guidance provided in the exit survey. 8/30/15 Better Living Brochures and Administrator Business Card removed from lobby by Administrator. 8/30/15 Applications for employment were removed from the table in the lobby by Administrator 9/10/15 Administrator's agent contacted IAHC for additional clarification activities that jeopardize the location's status as a drop-site. 9/13/15 All scheduling activities removed from the Princeton location under direct supervision of the Administrator. On 9/13/15 the Administrator		

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			<p>ensured that the location wasoperating only in accordance with guidance provided by 410 IAC 17-9-5, CMS, andthat provided by the surveyor during the exit conference: · Pick up and drop off paperwork · In-service location · Maintenance of a very limited amount of routine supplies · Location for brief exchanges of information among field staff · No staff assigned to the location · No advertising the location as part of the HHA · No agency services provided fromlocation · No advertising the location as part of the HHA 9/10/15 Administrator developed a policy to identify allowable andnon-allowable activities at the location; distributed policy to and educatedadministrative and professional staff on policy. 9/13/15 Initiated weekly monitoring of location to ensure that thelocation does not cross the line from drop site to branch. Administratoris responsible for monitoring. Monitoring will continue until such timethat the HHA discontinues using the location as a drop-site. G 134 On 8/15/15 the Administrator reviewed theFederal Standard 484.14 (c); G 134 requiring the Administrator to employqualified personnel and ensure adequate staff education and evaluations. On 8/15/15 the Administrator reviewed the Federal Standards for the Director ofNursing</p>	

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			<p>requiring the Administrator to employ a Director of Nursing whois a licensed physician or RN. On 8/15/15 The Administrator re-assigned the employee in orientation for theDON position. On 8/15/15 To ensure that qualified staff are employed throughout theorganization, the Administrator compared the required qualificationswith the qualifications documented in the personnel record for all currentemployees. No unqualified staff were identified. On 9/1/15 a qualified applicant was submitted to ISDH. The applicant wasapproved on 9/2/15.</p> <p>Effective 8/15/15: The Administrator and HR Manager will both review the qualificationrequirements for each new position and/or each vacated position prioerto posting the job. The HR manager will include position qualifications on the agency's HRrequisition for staff. The HR Manager will ensure that all applicant's considered for employment havedocumentation of meeting qualifications for the job. The Administrator and HR Manager will both compare applicantqualifications with position requirements prior to making an offer ofemployment. The Administrator is responsible for ensuring compliance with this plan. G 135 On 9/1/15 the Administrator reviewed theregulations at 484.14(c)</p>	

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			<p>outlining the responsibilities of the Administrator as related to ensuring the accuracy of public information materials and activities. On 9/1/15 the Administrator met with the web developer and internal IT support staff to educate them about regulatory requirements related to accuracy of public information materials. They were instructed that all changes to public information materials require oversight and approval from the Administrator in advance of the changes. Specific information was provided about accuracy regarding services offered, geographic areas served, names of administrative staff, physical location, telephone numbers, e-mail addresses, and other information that the general public may need in order to make decisions about obtaining home health care. The Administrator instructed the web developer and computer technician that there are currently no changes authorized to be made to the website and any future authorizations must be issued in writing and signed and dated by the Administrator in advance of any changes. Both verbalized understanding and agreed not to make changes to public information materials without advance written approval from the Administrator. The Administrator informed both</p>	

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			workers that any future release of inaccurate information will result in disciplinary action up to and including dismissal of the technician and termination of the contract with the web developer. The Administrator is responsible for any disciplinary action that may become necessary. On 9/1/15 the Operations Manager removed the website from public view. The name of the DON of Welcome Home was removed from the website. Homemaker and Attendant Care Services were removed from the list of services offered. All other identified inaccuracies were corrected and the website was placed back online on 9/2/2015. On 9/1/15 the Administrator reviewed the current brochure for inaccuracies. The 877 number listed on the brochure was dialed and answered by agency staff. No other inaccuracies were identified. On 9/1/15 the Administrator destroyed all outdated printed materials. <b>On 9/1/15 the Administrator developed a Public Information Policy addressing both the development of new printed and digital materials as well as the destruction and/or removal of outdated material.</b> On 9/1/15 The Administrator provided education for office staff regarding elements of public	

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			<p>information and the need for 100% accuracy. Allstaff were instructed to observe public information materials they encounter toensure accuracy and bring any questionable or outdated material to theAdministrator.</p> <p><b>Effective 9/1/15</b>the Administrator will access the website at least bi-weekly to ensure that theinformation on the site is accurate. This monitoring will continue for 7months. Effective 9/1/15 the Administrator will receive and approve all publicinformation material delivered to the agency prior to its release to thegeneral public.</p> <p><b>G 137 Actions taken tocorrect deficiency</b> On 8/15/15 the Administrator reviewed the Federal Standard 484.14 (c) G 137requiring the Administrator to ensure that a <b>qualified person isauthorized in writing to act in the absence of the administrator.</b> On 8/15 /15 the Administrator reviewed the AlternateAdministrator requiring the Administrator (and Alternate Administrator) tobe: <b>(a) a licensed physician; or (b) a registered nurse; or (c) a person with training and experience in health serviceadministration and at least 1 year of supervisory or administrativeexperience in home health care or related</b></p>	

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			<p><b>health programs.</b> On 8/15/15 the Administrator reviewed the Federal Standard 484.14 (c) G 134 requiring the Administrator to employ qualified personnel and ensure adequate staff education and evaluations. On 8/15/15 the Administrator reviewed the Federal Standards for the Director of Nursing requiring the Administrator to employ a Director of Nursing who is a licensed physician or RN. On 8/15/15 The Administrator re-assigned the employee in orientation for the DON position. On 8/15/15 To ensure that qualified staff are employed throughout the organization, the Administrator compared the required qualifications with the qualifications documented in the personnel record for all current employees. No unqualified staff were identified. 8/15/15 The Administrator received approval from the ISDH as the administrator. On 9/1/15 The Administrator submitted additional qualifying information to ISDH seeking approval of Joshua Ross as the Alternate Administrator. On 9/2/15 he was approved. The Administrator and HR Manager will both review the qualification requirements for each new position and/or each vacated position prior to posting the job. The HR manager will include position qualifications on the agency's HR requisition for staff.</p>	

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G 0123 Bldg. 00	<p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Based on record review and interview, the agency failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency.</p> <p>Finding included:</p> <p>1. On 8/10/15 at 11:30 AM, the organizational chart was requested. The organizational chart provided indicated</p>	G 0123	<p>The HR Manager will ensure that all applicant's considered for employment have documentation of meeting qualifications for the job. The Administrator and HR Manager will both compare applicant qualifications with position requirements prior to making an offer of employment. The Administrator is responsible for ensuring compliance with this plan. We are requesting an IDR for this condition for the reasons cited at individual Tags 123, 125, 134, and 137; should these citations be overturned, the condition would be invalid as well.</p> <p><b>The deficiency was corrected as follows:</b> On 8/27/15 The Administrator reviewed the agency policy on Administrative Control. The policy was updated to include putting employee names under their respective titles/positions on the organization chart from the President down to the patient. The HR manager added the names of all employees were to the Organization Chart under their respective titles/positions from the President down to the</p>	09/09/2015

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G 0125 Bldg. 00	<p>titles / positions but failed to include the name of employee under the title / position.</p> <p>2. A policy titled Administrative Control dated 03/2009, indicated "The Organizational chart defines lines of authority for the delegation of responsibility and accountability down to the patient care level ... "</p> <p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION All services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency. Based on observation, record review, and interview, the agency failed to ensure the state agency was notified of branch sites and /or branch was approved by the</p>	G 0125	<p>patient. This corrective action was completed on 9/9/15. <b>To prevent the deficiency from recurring:</b> To ensure continued compliance, the HR Manager will update the Organization Chart with names under the titles/positions each time an RN, LPN, Home Health Aide, Physical Therapist, Occupational Therapist, Speech Therapist, or Administrative staff member is hired or terminated. The Administrator will monitor compliance weekly by comparing the Organizational Chart to the active employee roster. Monitoring will continue until 100% compliance is achieved for 3 consecutive months or for 7 months, whichever is longer. The Administrator is responsible for this corrective action and for ongoing monitoring. We are filing an IDR because we believe the regulation requires delineation of lines of authority rather than enumeration of agency employees.</p> <p><b>Actions taken to correct deficiency:</b> 8/30/15 Administrator reviewed the State Regulations and definitions concerning Branch locations as</p>	09/13/2015			

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	<p>Centers for Medicare and Medicaid Services (CMS) prior to a location functioning as a branch for 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the Entrance Conference on 08/10/15 at 11:30 AM, the administrator stated the agency does not have a branch or drop-site but did have an office in Princeton, IN where payroll and scheduling is handled.</li> <li>2. On 8/11/15 at 1:20 PM, the location at 524 Hart St, Princeton, IN was observed. Upon entering the building, there was a table to the left that contained brochures of Better Living Home Health along with the administrator's business card. On the right, there was a table with clip boards and applications for employment attached. Walking past the two tables there was an office with two desks on the left where an employee was working at and an office to the right with a desk. Both areas had computers and file cabinets. The owner provided a tour of the office and indicated that the office on the left was where payroll / billing were managed and the office on the right was where scheduling was managed. The owner continued on with the tour and beyond the scheduling office was the nurses area where inservices and</li> </ol>		<p>well as the surveyor's guidance provided in the exit survey. 8/30/15 Better Living Brochures and Administrator Business Card removed from lobby by Administrator. 8/30/15 Applications for employment were removed from the table in the lobby by Administrator 9/10/15 Administrator's agent contacted IAHC for additional clarification activities that jeopardize the location's status as a drop-site. 9/13/15 All scheduling activities removed from the Princeton location under direct supervision of the Administrator. On 9/13/15 the Administrator ensured that the location was operating only in accordance with guidance provided by 410 IAC 17-9-5, CMS, and that provided by the surveyor during the exit conference: · Pick up and drop off paperwork · In-service location · Maintenance of a very limited amount of routine supplies · Location for brief exchanges of information among field staff · No staff assigned to the location · No advertising the location as part of the HHA · No agency services provided from location · No advertising the location as part of the HHA <b>Actions taken to prevent deficiency from recurring in the future:</b> 9/10/15 Administrator developed a policy to identify allowable and non-allowable activities at the location; distributed policy to and educated administrative and</p>	

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G 0134 Bldg. 00	<p>meetings with supervisors would take place. A computer, file cabinets, table and chairs was observed. Beyond the nursing area was a small kitchen area.</p> <p>3. On 8/12/15 at 10:00 AM, the administrator was interviewed and indicated she thought that as long as patient charts were not in the office, it was not considered a branch.</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on personnel record and policy review and interview, the agency failed to ensure qualified personnel for Director of Nursing per 410 Indiana Administrative Code 17-2-1-(d) for 1 of 1 agency.</p> <p>Finding include:</p> <p>1. The 410 Indiana Administrative Code 17-2-1-(d) indicated, "A physician or a registered nurse who has two (2) years of nursing experience, with at least one (1) year of supervisory or administrative experience, shall supervise and direct nursing and other therapeutic services."</p>	G 0134	<p>professional staff on policy. 9/13/15 Initiated weekly monitoring of location to ensure that the location does not cross the line from drop site to branch. Administrator is responsible for monitoring. Monitoring will continue until such time that the HHA discontinues using the location as a drop-site.</p> <p><b>Actions taken to correct deficiency:</b> On 8/15/15 the Administrator reviewed the Federal Standard 484.14 (c); G 134 requiring the Administrator to employ qualified personnel and ensure adequate staff education and evaluations. On 8/15/15 the Administrator reviewed the Federal Standards for the Director of Nursing requiring the Administrator to employ a Director of Nursing who is a licensed physician or RN. On 8/15/15 The Administrator re-assigned the employee in orientation for the DON position. On 8/15/15 To ensure that qualified staff are employed</p>	09/02/2015

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G 0135 Bldg. 00	<p>2. On 08/10/15 at 2:05 PM, Employee B, Registered Nurse, employee filed was reviewed.</p> <p>a. Employee B graduated from an Associates Degree Program became a licensed Registered Nurse on 07/22/14.</p> <p>b. Employee B was hired on 07/06/15 as the Marketing / Intake / Scheduling Manager / Director. On 07/19/15, Employee B was promoted to be the Director of Nursing.</p> <p>c. Employee B signed a Director of Clinical Services Job Description on 07/27/15. The qualifications indicated, "Has three to five years clinical nursing experience, an emphasis in home care nursing is preferred ... BSN (Bachelor of Science in Nursing) preferred.</p> <p>3. The Administrator was interviewed on 08/12/15 at 10:30 AM. The Administrator indicated she had forgotten the state required the Registered Nurse have two years of clinical experience.</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the</p>		<p>throughout the organization, the Administrator compared the required qualifications with the qualifications documented in the personnel record for all current employees. No unqualified staff were identified. On 9/1/15 a qualified applicant was submitted to ISDH. The applicant was approved on 9/2/15. <b>Actions taken to prevent deficiency from recurring:</b> Effective 8/15/15: The Administrator and HR Manager will both review the qualification requirements for each new position and/or each vacated position prior to posting the job. The HR manager will include position qualifications on the agency's HR requisition for staff. The HR Manager will ensure that all applicant's considered for employment have documentation of meeting qualifications for the job. The Administrator and HR Manager will both compare applicant qualifications with position requirements prior to making an offer of employment. The Administrator is responsible for ensuring compliance with this plan. We are requesting an IDR because: 1. At the time of the survey, the Supervising Nurse was qualified under Federal regulations and agency policy.</p>		

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	<p>supervising physician or registered nurse required under paragraph (d) of this section, ensures the accuracy of public information materials and activities.</p> <p>Based on record review, public information, and interview, the Administrator failed to ensure public information materials was true and accurate for 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 8/10/15, a brochure was provided with an Admission Folder by Employee B, Director of Nursing. The brochure indicated, "Better Living caregivers assist with the regular day-to-day activities of life including: Skilled Nursing Services, Home Health Aide Services, Therapy Services ... Toll free: 877-739-4408.</li> <li>On 8/11/15, a website <a href="http://betterlivinghomehealthcare.com">http://betterlivinghomehealthcare.com</a> was reviewed. The website indicated, "Better Living Caregivers assist with the regular day to day activities including: Skilled Nursing Services, Therapy Services, Home Health Aide Services, Attendant Care Services, Homemaker Services ... Our toll free number is 1-800-414-4428 ... Our staff included [Name of Employee], RN [Registered Nurse] Director of Nursing ... "</li> <li>On 8/12/15 at 10:00 AM, the</li> </ol>	G 0135	<p><b>Actions taken to correct deficiency</b> On 9/1/15 the Administrator reviewed the regulations at 484.14(c) outlining the responsibilities of the Administrator as related to ensuring the accuracy of public information materials and activities. On 9/1/15 the Administrator met with the web developer and internal IT support staff to educate them about regulatory requirements related to accuracy of public information materials. They were instructed that all changes to public information materials require oversight and approval from the Administrator in advance of the changes. Specific information was provided about accuracy regarding services offered, geographic area served, names of administrative staff, physical location, telephone numbers, e-mail addresses, and other information that the general public may need in order to made decisions about obtaining home health care. The Administrator instructed the web developer and computer technician that there are currently no changes authorized to be made to the website and any future authorizations must be issued in writing and signed and dated by the Administrator in advance of</p>	09/02/2015

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	<p>administrator was interviewed and stated that the website was incorrect with the toll free number, the employee listed is the Director of Nursing with their sister company, and the company does not provide attendant care or homemaker services. The administrator stated she / he was working with a new company for advertising.</p>		<p>any changes. Both verbalized understanding and agreed not to make changes to public information materials without advance written approval from the Administrator. The Administrator informed both workers that any future release of inaccurate information will result in disciplinary action up to and including dismissal of the technician and termination of the contract with the web developer. The Administrator is responsible for any disciplinary action that may become necessary. On 9/1/15 the Operations Manager removed the website from public view. The name of the DON of Welcome Home was removed from the website. Homemaker and Attendant Care Services were removed from the list of services offered. All other identified inaccuracies were corrected and the website was placed back online on 9/2/2015. On 9/1/15 the Administrator reviewed the current brochure for inaccuracies. The 877 number listed on the brochure was dialed and answered by agency staff. No other inaccuracies were identified. On 9/1/15 the Administrator destroyed all outdated printed materials. <b>On 9/1/15 the Administrator developed a Public Information Policy addressing both the development of new printed</b></p>	

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G 0137 Bldg. 00	<p>484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator. Based on personnel record and policy review and interview, the agency failed to ensure qualified person is authorized in writing to act in the absence of the administrator per 410 Indiana Administrative Code 17-2-1-(C) 8 and (d) for 1 of 1 agency.</p> <p>Finding include:</p>	G 0137	<p><b>and digital material as well as the destruction and/or removal of outdated material.</b> On 9/1/15 The Administrator provided education for office staff regarding elements of public information and the need for 100% accuracy. All staff were instructed to observe public information materials they encounter to ensure accuracy and bring any questionable or outdated material to the Administrator. <b>Actions taken to prevent deficiency from recurring: Effective 9/1/15</b> the Administrator will access the website at least bi-weekly to ensure that the information on the site is accurate. This monitoring will continue for 7 months. Effective 9/1/15 the Administrator will receive and approve all public information material delivered to the agency prior to its release to the general public.</p> <p><b>Actions taken to correct deficiency</b> On 8/15/15 the Administrator reviewed the Federal Standard 484.14 (c) G 137 requiring the Administrator to ensure that a <b>qualified person is authorized in writing to act in the absence of the administrator.</b> On 8/15 /15 the Administrator reviewed the Federal Standards for the</p>	09/02/2015

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	<p>1. The 410 Indiana Administrative Code 17-2-1-(C) 8 indicated, "Ensure that a qualified person is authorized in writing to act in the administrator's absence."</p> <p>2. The 410 Indiana Administrative Code 17-2-1-(d) indicated, "A physician or a registered nurse who has two (2) years of nursing experience, with at least one (1) year of supervisory or administrative experience, shall supervise and direct nursing and other therapeutic services."</p> <p>3. On 08/10/15 at 1:55 PM, Employee C, Operations's Director, employee file was reviewed.</p> <p style="padding-left: 40px;">a. Employee C graduated obtained a Bachelor's Degree in Business Administration in 2007.</p> <p style="padding-left: 40px;">b. Employee C's work history included Recruiting Manager from 5/07 to 5/08 for a former home health agency that was previously own by Employee A.</p> <p style="padding-left: 40px;">c. Employee C signed a job description as the "Operations Director / Human Resources / IT on 01/20/15.</p> <p>4. On 08/10/15 at 2:05 PM, Employee B, Registered Nurse, employee filed was reviewed.</p>		<p>Alternate Administrator requiring the Administrator (and Alternate Administrator) to be: <b>(a) a licensed physician; or (b) a registered nurse; or (c) a person with training and experience in health service administration and at least 1 year of supervisory or administrative experience in home health care or related health programs.</b> On 8/15/15 the Administrator reviewed the Federal Standard 484.14 (c) G 134 requiring the Administrator to employ qualified personnel and ensure adequate staff education and evaluations. On 8/15/15 the Administrator reviewed the Federal Standards for the Director of Nursing requiring the Administrator to employ a Director of Nursing who is a licensed physician or RN. On 8/15/15 The Administrator re-assigned the employee in orientation for the DON position. On 8/15/15 To ensure that qualified staff are employed throughout the organization, the Administrator compared the required qualifications with the qualifications documented in the personnel record for all current employees. No unqualified staff were identified. 8/15/15 The Administrator received approval from the ISDH as the administrator. On 9/1/15 The Administrator submitted additional qualifying information to ISDH seeking approval of Joshua</p>	

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	<p>a. Employee B graduated from an Associates Degree Program became a licensed Registered Nurse on 07/22/14.</p> <p>b. Employee B was hired on 07/06/15 as the Marketing / Intake / Scheduling Manager / Director. On 07/19/15, Employee B was promoted to be the Director of Nursing.</p> <p>c. Employee B signed a Director of Clinical Services Job Description on 07/27/15. The qualifications indicated, "Has three to five years clinical nursing experience, an emphasis in home care nursing is preferred ... BSN (Bachelor of Science in Nursing) preferred.</p> <p>5. Prior to the entrance conference on 08/10/15 at 10:35 AM, the Administrator provided a letter from the (ISDH) Indiana State Department of Health dated 07/28/15 indicating that the Administrator, himself / herself, and the chosen Alternate Administrator, was not qualified for the positions and indicated that he / she had not followed up with ISDH. The Administrator also indicated that he / she had not provided ISDH with Employee B's information as the Director of Nursing.</p> <p>6. The Administrator was interviewed on</p>		<p>Ross as the Alternate Administrator. On 9/2/15 he was approved <b>Actions taken to prevent deficiency from recurring:</b> The Administrator and HR Manager will both review the qualification requirements for each new position and/or each vacated position prior to posting the job. The HR manager will include position qualifications on the agency's HR requisition for staff. The HR Manager will ensure that all applicant's considered for employment have documentation of meeting qualifications for the job. The Administrator and HR Manager will both compare applicant qualifications with position requirements prior to making an offer of employment. The Administrator is responsible for ensuring compliance with this plan. We are requesting an IDR because on the days of the survey both the DON and Alternate Administrator were qualified for their positions under Federal Regulations and agency policy.</p>	

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G 0159 Bldg. 00	<p>08/10/15 at 3:00 PM. The Administrator stated Employee C, son of the Administrator and Owner, had taken an interest in the family business and was suppose to have been shadowing the former Administrator and learning how to run the business.</p> <p>7. The Administrator was interviewed on 08/12/15 at 10:30 AM. The Administrator indicated she had forgotten the state required the Registered Nurse have two years of clinical experience.</p> <p>484.18(a) PLAN OF CARE 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. Based on clinical record and policy review, the agency failed to ensure plans of care were revised and updated to include all diagnoses, all medications for 2 of 10 records reviewed (#1 and 4) and failed to ensure that a comprehensive</p>	G 0159	<p><b>Actions taken to correct deficiency r/t Pt. # 1&amp;4:</b> On 8/27/15 the Administrator reviewed the agency policies related to the establishment and ongoing development of the plan of care, following the plan of</p>	09/12/2015

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	<p>assessment was conducted within five days of the patients Medicaid Authorization for services for 1 of 7 Medicaid records reviewed. (# 5)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/03/14, included a plan of care established by the physician for the certification period 05/29/15 to 07/27/15 with primary diagnosis of cerebral palsy and secondary diagnoses of intellectual disability, epilepsy, chronic obstructive pulmonary disease, and depression.</p> <p>a. A faxed medication summary from the patient's physician dated 05/26/15, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, detrol 2 mg by mouth twice a day, hydroxyzine HCL 25 mg at bedtime as needed, ipratropium - albuterol 0.5 mg - 3 mg nebulization solution 1 unit three times a day, symbicort 160 mcg (micrograms) aerosol inhaler 2 puffs twice a day, metformin 50 mg daily, loperamide 2 mg, 2 tablets daily as needed, aspirin 81 mg daily, benzonate 200 mg every four hours as needed, vitamin D3 2,000 unit daily, aricept 5 mg every evening, docusate sodium 100 mg daily, multivitamin daily, and simvastatin 10 mg daily.</p>		<p>care, updating the plan of care, and medication review. No policy changes were needed. On 9/12/15 the Administrator met with the Administrative nursing staff and Case Managers to provide training and education on Case Management responsibilities as they relate to the establishment and ongoing development of the plan of care.</p> <p>9/8/15 RN Case Manager assigned to Patient # 1 contacted appropriate physicians to clarify medication, diagnoses, and treatment orders and to obtain any orders needed to fully update the plan of care and medication profile. Plans and profiles fully updated. Patient #4 was discharged a year prior to the survey so no patient- specific corrective action could be taken.</p> <p>9 /12/15 Since all clients could be affected RN Case Managers conducted a 100% review of their current caseloads to determine if other patients were affected by the failure to keep plans of care updated. One other instance of medication orders out of date was discovered and corrected on 9/11/15.</p> <p><b>Actions taken to prevent deficiency from recurring:</b> Effective 9/12/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 2 in 10 records or 20% is the baseline for a QA activity</p>	

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	<p>b. The 05/29/15 to 07/27/15 established plan of care indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, combivent 18/103 mcg / act every 6 hours as needed, hydroxyzine HCL 25 mg at bedtime as needed, docusate 100 mg daily, metformin 500 mg daily, milk of magnesia 30 mg daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime.</p> <p>c. The medication profile was initiated on 06/03/14, and provided only one date for drug regimen review of 07/23/15. The medication profile indicated advair diskus 250 / 50 mcg 1 puff twice a day, combivent 18/103 2 puffs twice a day, acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, docusate 100 mg daily, fluoxetine 10 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, hydroxyzine HCL 25 mg at bedtime as needed, multivitamin daily, naproxen 500 mg twice a day as needed, donepezil HCL (aricept) 5 mg at bedtime, simvastatin 10 mg daily, myebetriq ER 50 mg daily, trazadone 100 mg at bedtime, metformin 500 mg daily,</p>		<p>monitoring 100% of all records for compliance with updating diagnoses, medications, and other aspects of case management relevant to updating the plans of care. The QA Manager is responsible for collecting the raw data, calculating the compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months or 7 months, whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining. Increasing record review frequency, and/or disciplinary action based on QA findings. <b>Actions taken to correct deficiency related to Pt. #5:</b> 8/14/15 the Administrator reviewed patient record #5 to determine if a comprehensive assessment needed to be conducted. A comprehensive assessment had been conducted during the survey on 8/12/15. No additional assessments were made. On 8/27/15 the Administrator reviewed agency policies related to Comprehensive</p>	

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	<p>melatonin 3 mg two tabs at bedtime, tolterodine (detrol) 1 mg by mouth twice a day, multi - vitamin D3 2,000 unit daily, symbicort 160 / 4.5 two puffs twice a day, and mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed.</p> <p>d. The 07/28/15 to 09/25/15 established plan of care, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, advair diskus 250 / 50 mcg 1 puff twice a day, aspirin 81 mg daily, combivent 18/103 2 puffs twice a day, docusate 100 mg daily, donepezil HCL (aricept) 5 mg at bedtime, fluoxetine 10 mg daily, hydroxyzine HCL 25 mg at bedtime as needed, metformin 500 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, myebetriq ER 50 mg daily, mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, symbicort 160 / 4.5 two puffs twice a day, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime</p> <p>The medication section of the plan of care failed to be updated / revised with correct dosages and most current medications every 60 days and as needed and the plan of care failed to include the</p>		<p>Assessment of Patients. No policy changes were needed.</p> <p>9/4/15 The Administrator met with Administrative nurses and Case Managers, Admission and Assessment Nurses, and Intake Coordinator to provide training and education on the Comprehensive Assessment of Patients, specifically, the requirement to conduct a comprehensive assessment consistent with the patient's immediate needs, but no later than 5 days after the start of care.</p> <p>9/4/15 The Administrator discontinued the practice of using the date of the Initial Comprehensive Assessment as the SOC date in cases where the initiation of care will be delayed after the initial assessment until the PA is approved. <b>Actions taken to prevent deficiency from recurring:</b> On 9/8/15 the Administrator initiated a QA activity to monitor for continued compliance. The surveyor identified non-compliance rate of 1 in 7 records or 14% will be the baseline for monitoring 100% of all Admissions to determine if the comprehensive assessment was completed within 5 days of the SOC. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate and reporting it to the Administrator on a monthly basis. This activity will continue until a compliance rate of 100% is achieved for 3</p>				

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	<p>patient was a diabetic.</p> <p>2. Clinical record number 4 included a plan of care established by a physician for certification period 08/01/14 to 09/29/14.</p> <p>a. A skilled nurse visit note dated 08/27/14 indicated the patient had been prescribed Levaquin 250 mg by mouth daily for 7 days.</p> <p>b. A skilled nurse visit note dated 09/03/14 indicated the patient had been prescribed Aspirin 81 mg by mouth daily and Prednisone 10 mg by mouth daily for 10 days.</p> <p>c. A skilled nurse visit note dated 09/17/14 indicated the patient had been prescribed Keflex 500 mg by mouth twice a day for 10 days.</p> <p>The medication section of the plan of care failed to be updated / revised to include the new medications prescribed to the patient.</p> <p>3. A policy titled On-Going Assessment dated 03/2009 indicated, "Based on the findings of the reassessment, verbal orders are generated and forwarded to the physician as needed. The physician will be notified to verify any changes in</p>		<p>consecutive months, or 7 months whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained.</p>		

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	<p>medications, including over the counter medications, and / or treatment / interventions that require physician approval.</p> <p>4. Clinical record number 5, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15 with orders for skilled nursing "to begin once authorized."</p> <p>a. Review of the skilled nursing visit notes, the patient had an initial assessment dated 06/26/15. The next skilled nursing visit was 07/19/15. The 07/19/15 was a routine visit and not a comprehensive assessment.</p> <p>b. Review of the established plan of care, the start of care date indicated 06/26/15 and not the actual start of care date 07/19/15.</p> <p>2. Employee A, Administrator / Registered Nurse, was interview on 08/13/15 at 11:30 AM. Employee A stated skill nursing services started on 07/19/15 because the agency was waiting for authorization from Medicaid. The established plan of care was for reimbursement and prior authorization from Medicaid. Employee A stated he / she could not remember if the plan of</p>			

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G 0173 Bldg. 00	<p>care needed to be updated / revised once Medicaid was approved.</p> <p>3. A policy titled Client Plan of Care dated 03/2009, indicated "The RN ... promptly notifies the physician of any changes that suggests a need to modify the plan of care; Changes in the plan of care are documented through written and verbal orders ... The attending physician's recertification is obtained at intervals of at least once every 60 days and / or when the client's plan of care is reviewed and updated as appropriate. A CMS 485 is completed and forwarded to the physician for signature; When Better Living forwards the request for reimbursement to the intermediary, Better Living certifies that the requisite certification and recertifications have been made by the attending physician and are on file at Better Living."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and policy review, the agency failed to ensure plans of care were revised and updated to include all diagnoses, all medications for 2 of 10 records reviewed (#1 and 4) and</p>	G 0173	<p><b>Actions taken to correct deficiency</b> On 8/27/15 the Administrator reviewed the agency policies related to the establishment and ongoing development of the plan of care, following the plan of care,</p>	09/12/2015

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	<p>failed to ensure that a comprehensive assessment was conducted within five days of the patients Medicaid Authorization for services for 1 of 7 Medicaid records reviewed. (# 5)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/03/14, included a plan of care established by the physician for the certification period 05/29/15 to 07/27/15 with primary diagnosis of cerebral palsy and secondary diagnoses of intellectual disability, epilepsy, chronic obstructive pulmonary disease, and depression.</p> <p>a. A faxed medication summary from the patient's physician dated 05/26/15, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, detrol 2 mg by mouth twice a day, hydroxyzine HCL 25 mg at bedtime as needed, ipratropium - albuterol 0.5 mg - 3 mg nebulization solution 1 unit three times a day, symbicort 160 mcg (micrograms) aerosol inhaler 2 puffs twice a day, metformin 50 mg daily, loperamide 2 mg, 2 tablets daily as needed, aspirin 81 mg daily, benzonate 200 mg every four hours as needed, vitamin D3 2,000 unit daily, aricept 5 mg every evening, docusate sodium 100 mg daily, multivitamin daily, and simvastatin</p>		<p>updating the plan of care, and medication review. No policy changes were needed. On 9/12/15 the Administrator met with the Administrative nursing staff and Case Managers to provide training and education on Case Management responsibilities as they relate to the establishment and ongoing development of the plan of care, more specifically updating all diagnoses and medications. 9/8/15 RN Case Manager assigned to Patient # 1 contacted appropriate physicians to clarify medication, diagnoses, and treatment orders and to obtain any orders needed to fully update the plan of care and medication profile. Plans and profiles fully updated. Patient #4 was discharged a year prior to the survey so no patient- specific corrective action could be taken. 9 /12/15 Since all clients could be affected RN Case Managers conducted a 100% review of their current caseloads to determine if other patients were affected by the failure to keep plans of care updated. One other instance of medication orders out of date was discovered and corrected on 9/11/15.</p> <p><b>Actions taken to prevent deficiency from recurring:</b> Effective 9/12/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of</p>		

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	<p>10 mg daily.</p> <p>b. The 05/29/15 to 07/27/15 established plan of care indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, combivent 18/103 mcg / act every 6 hours as needed, hydroxyzine HCL 25 mg at bedtime as needed, docusate 100 mg daily, metformin 500 mg daily, milk of magnesia 30 mg daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime.</p> <p>c. The medication profile was initiated on 06/03/14, and provided only one date for drug regimen review of 07/23/15. The medication profile indicated advair diskus 250 / 50 mcg 1 puff twice a day, combivent 18/103 2 puffs twice a day, acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, docusate 100 mg daily, fluoxetine 10 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, hydroxyzine HCL 25 mg at bedtime as needed, multivitamin daily, naproxen 500 mg twice a day as needed, donepezil HCL (aricept) 5 mg at bedtime, simvastatin 10 mg daily, myebetriq ER 50 mg daily, trazadone 100</p>		<p>2 in 10 records or 20% is the baseline for a QA activity monitoring 100% of all records for compliance with updating diagnoses, medications, and other aspects of case management relevant to updating the plans of care. The QA Manager is responsible for collecting the raw data, calculating the compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months or 7 months, whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining. Increasing record review frequency, and/or disciplinary action based on QA findings. <b>Actions taken to correct deficiency</b> 8/14/15 the Administrator reviewed patient record #5 to determine if a comprehensive assessment needed to be conducted. A comprehensive assessment had been conducted during the survey on 8/12/15. No additional assessments will be made. On 8/27/15 the</p>				

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	<p>mg at bedtime, metformin 500 mg daily, melatonin 3 mg two tabs at bedtime, tolterodine (detrol) 1 mg by mouth twice a day, multi - vitamin D3 2,000 unit daily, symbicort 160 / 4.5 two puffs twice a day, and mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed.</p> <p>d. The 07/28/15 to 09/25/15 established plan of care, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, advair diskus 250 / 50 mcg 1 puff twice a day, aspirin 81 mg daily, combivent 18/103 2 puffs twice a day, docusate 100 mg daily, donepezil HCL (aricept) 5 mg at bedtime, fluoxetine 10 mg daily, hydroxyzine HCL 25 mg at bedtime as needed, metformin 500 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, myebetriq ER 50 mg daily, mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, symbicort 160 / 4.5 two puffs twice a day, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime</p> <p>The medication section of the plan of care failed to be updated / revised with correct dosages and most current medications every 60 days and as needed</p>		<p>Administrator reviewed agency policies related to Comprehensive Assessment of Patients. No policy changes were needed.</p> <p>9/4/15 The Administrator met with Administrative nurses and Case Managers, Admission and Assessment Nurses, and Intake Coordinator to provide training and education on the Comprehensive Assessment of Patients, specifically, the requirement to conduct a comprehensive assessment consistent with the patient's immediate needs, but no later than 5 days after the start of care.</p> <p>9/4/15 The Administrator discontinued the practice of using the date of the Initial Comprehensive Assessment as the SOC date in cases where the initiation of care will be delayed after the initial assessment until the PA is approved. <b>Actions taken to prevent deficiency from recurring:</b> On 9/8/15 the Administrator initiated a QA activity to monitor for continued compliance. The surveyor identified non-compliance rate of 1 in 7 records or 14% will be the baseline for monitoring 100% of all Admissions to determine if the comprehensive assessment was completed within 5 days of the SOC. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate and reporting it to the Administrator on a monthly basis. This activity will</p>	

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	<p>and the plan of care failed to include the patient was a diabetic.</p> <p>2. Clinical record number 4 included a plan of care established by a physician for certification period 08/01/14 to 09/29/14.</p> <p>a. A skilled nurse visit note dated 08/27/14 indicated the patient had been prescribed Levaquin 250 mg by mouth daily for 7 days.</p> <p>b. A skilled nurse visit note dated 09/03/14 indicated the patient had been prescribed Aspirin 81 mg by mouth daily and Prednisone 10 mg by mouth daily for 10 days.</p> <p>c. A skilled nurse visit note dated 09/17/14 indicated the patient had been prescribed Keflex 500 mg by mouth twice a day for 10 days.</p> <p>The medication section of the plan of care failed to be updated / revised to include the new medications prescribed to the patient.</p> <p>3. A policy titled On-Going Assessment dated 03/2009 indicated, "Based on the findings of the reassessment, verbal orders are generated and forwarded to the physician as needed. The physician will</p>		<p>continue until a compliance rate of 100% is achieved for 3 consecutive months, or 7 months whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained.</p>		

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	<p>be notified to verify any changes in medications, including over the counter medications, and / or treatment / interventions that require physician approval.</p> <p>4. Clinical record number 5, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15 with orders for skilled nursing "to begin once authorized."</p> <p>a. Review of the skilled nursing visit notes, the patient had an initial assessment dated 06/26/15. The next skilled nursing visit was 07/19/15. The 07/19/15 was a routine visit and not a comprehensive assessment.</p> <p>b. Review of the established plan of care, the start of care date indicated 06/26/15 and not the actual start of care date 07/19/15.</p> <p>2. Employee A, Administrator / Registered Nurse, was interview on 08/13/15 at 11:30 AM. Employee A stated skill nursing services started on 07/19/15 because the agency was waiting for authorization from Medicaid. The established plan of care was for reimbursement and prior authorization from Medicaid. Employee A stated he /</p>			

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G 0181 Bldg. 00	<p>she could not remember if the plan of care needed to be updated / revised once Medicaid was approved.</p> <p>3. A policy titled Client Plan of Care dated 03/2009, indicated "The RN ... promptly notifies the physician of any changes that suggests a need to modify the plan of care; Changes in the plan of care are documented through written and verbal orders ... The attending physician's recertification is obtained at intervals of at least once every 60 days and / or when the client's plan of care is reviewed and updated as appropriate. A CMS 485 is completed and forwarded to the physician for signature; When Better Living forwards the request for reimbursement to the intermediary, Better Living certifies that the requisite certification and recertifications have been made by the attending physician and are on file at Better Living."</p> <p>484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the physician and registered nurse in performing specialized procedures. Based on observation, clinical record and employee record review, and interview, the Licensed Practical Nurse (LPN) failed to follow agency policy and professional</p>	G 0181	<b>The deficiency was corrected as follows:</b> On 8/15/15 the Administrator reviewed agency policy and procedure with	09/11/2015

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	<p>practice standards in relation to providing medication through a patient's gastric feeding tube without first checking residuals for 1 of 1 patient observed for administration of medications through a gastric tube. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6 included a plan of care established by a physician for the certification period of 06/15/15 to 08/13/15 with orders for skilled nursing six times a week for one week, seven times a week for seven weeks, then five times a week for one week up to 10 hours a day.</p> <p>a. Upon arrival on 08/11/15 at 2:00 PM, the patient was observed to be sitting up in his wheelchair with a tube starting at the feeding bag and ending to the patient's gastric tube from his abdomen. The tube feeding was running at a rate of 250 ml (milliliters) per hour. 2:10 PM, Employee J, LPN, was observed preparing to give the patient his medications through his gastric tube. Employee J stopped the tube feeding and indicated that she wasn't going to check for residual because the patient would "naturally" have residual since the patient was receiving tube feedings. The employee proceeded to flush the gastric</p>		<p>employee j and instructed the employee to follow policy and procedure when administering medication through the G-tube. Employee J was provided with a manual of clinical nursing procedures and performance expectations for procedural compliance. Employee J's job description was reviewed, including the responsibility to follow agency policies and provide care according to the established Plan of Care. The Administrator placed Employee J on probationary status for no less than 12 weeks due to failure to follow agency policy on medication administration through a G-tube. The employee was instructed that failure to follow policies and procedures will result in termination. The Administrator is responsible for any additional disciplinary action. On 8/24/15 the Administrator installed an RN on the case to provide direct patient care, weekly in-home case management, assessment of LPN technical skills, and supervision of care provided by LPNs. It is the case manager's responsibility to provide in-home supervision and report findings to the Administrator on a weekly basis. Also on this date, employee J was observed by the Administrator and RN Case Manager to competently administer medication via the G-Tube in compliance with agency policy and procedure. To</p>	

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	<p>tube with 20 ml of water, then proceeded giving the prescribed medications. Once the medication administration was completed, the employee reconnected the tube to the feeding bag and resumed the feeding.</p> <p>b. Upon review of the established plan of care, the skilled nursing instructions indicated, "SN [skilled nurse]: Check placement of g-tube prn [as needed] dislodgement / occlusion via auscultation / aspiration before flush / RX [medication] administration."</p> <p>c. Upon review of communication notes between former Director of Nursing and Employee J, on 07/06/15 at 3:57 PM, the patient had gastric residuals of greater than 50 ml. The physician had been notified with return orders to hold for one hour if residuals are greater than 50 mls.</p> <p>2. Employee J employee record was reviewed on 08/14/15 at 3:00 PM. Employee J had a form titled "Giving Medicine Using G-Tube" in her file. The handout indicated "Sitting up, remove plug from G-Tube ... Attach syringe, pull back on the plunger and draw out some stomach contents. Push down on plunger and return the stomach contents. Flush G-Tube with 30 ml of water. Draw up the medicine into the syringe. Attach</p>		<p>ensure that other patients weren't at similar risk, all LPNs providing g-tube medications or any other specialized procedure were required to demonstrate procedural competency to the Administrator. Only two additional LPNs were providing any specialized procedures. LPN "A" demonstrated competency in administration of medication through a G-tube on 9/9/15 and LPN "B" demonstrated competency checking blood sugar with a Glucometer on 9/10/15. On 9/11/15 the Administrator assigned all LPNs on staff to an individual RN to serve as a mentor and to provide ongoing supervision and guidance. <b>To prevent the deficiency from recurring:</b> On 9/11/15 the Administrator implemented a policy requiring LPN supervision by an RN as often as necessary to insure safe and effective care, but in any event no less frequently than every 30 days. The Administrator is responsible for assigning and scheduling RNs for LPN supervisory visits. On 9/11/15 the Administrator added competency demonstration of specialized procedures to the orientation and education program for LPNs. The Administrator also developed an LPN assignment procedure requiring the identification of any specialized skills required on each case and documentation of how any LPN assigned to the</p>				

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G 0191  Bldg. 00	<p>syringe and push down on the plunger to give the medicine ... "</p> <p>3. Employee A, Administrator / Registered Nurse, was interviewed on 08/14/15 at 3:10 PM. Employee A stated Employee J had been counceled on professional standards of gastrostomy tubes and checking placement in the past.</p> <p>484.32(a) SUPERVISION OF PHYSICAL &amp; OCCUPATIONAL A physical therapy assistant or occupational therapy assistant assists in preparing clinical notes and progress reports. Based on clinical record and policy review, the agency failed to ensure the physical therapy assistant assessed the</p>	G 0191	<p>case has demonstrated the skills necessary for safe and effective patient care. The LPN assignment document was implemented 9/11/15. The Administrator is responsible for ensuring that the procedure is followed. LPN competency and supervision monitoring was incorporated into the QA program on 9/11/15. Monitoring elements include 100% of LPN cases for supervisory visits, LPN orientation documents, LPN assignment procedure followed for each LPN assignment, and review of 100% of LPN nursing visits on a weekly basis to ensure that LPNs have been competency tested for any specialized care provided. Monitoring will continue until 100% compliance is achieved for at least 3 consecutive months or for 7 months, whichever is longer. The QA Manager is responsible for data collection and reporting to the Administrator. The Administrator is responsible for re-training and any necessary disciplinary action required based on QA findings.</p> <p><b>Actions taken to correct deficiency</b> On 8/14/15 the Administrator contacted patient</p>	08/26/2015			

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	<p>patient for pain during therapy visits for 1 of 1 record reviewed with physical therapy assistance. (# 4)</p> <p>Findings include:</p> <p>1. Clinical record number 4 included a plan of care established by a physician for certification period 08/01/14 to 09/29/14 with order for physical therapy two times a week for five weeks, one time a week for two weeks.</p> <p>a. A Physical Therapy evaluation and plan of care dated 08/05/15 indicated the patient was having pain to the right shoulder and arm as well as the left side of the ribs at a pain level of four out of ten with ten meaning worst pain. The patient indicated pain would get as high as six out of ten with activity. The patient described her pain as dull / aching, sharp, interfered with sleep, and the patient was not able to tolerate cold management and pain medications.</p> <p>b. Employee O, physical therapy assistant was assigned to see the patient. On 08/19/14 and 09/02/14, Employee O indicated the patient was having pain but failed to complete the patient's pain intensity and / or characteristics of the patient's pain. On 08/06/14, 08/15/14, 08/25/14, and 08/26/14, Employee O did</p>		<p>#5 to inquire about the patient's pain, including intensity and characteristics. The patient indicated that the pain is currently well managed with medication and proper positioning. The patient verbalized that no changes to the plan of care are indicated to manage pain. On 8/14/15 the Administrator gave pain report to patient #5 RN Case Manager. Administrator re-educated the RN Case Manager agency policies re: Care Management and Care Coordination as well as the responsibility for Case Management for all patients, including those with therapy services only. Instructed that agency policy requires Case Managers to provide the same level of care coordination and case management for therapy only cases as they do for all other cases. On 8/26/15 the Administrator met with all RN Case Managers to review the agency policy on Care Management and Care Coordination. Case Managers were re-educated on their responsibilities for Case Management for all patients, including those with therapy only services. Instructed agency policy requires Case Managers to provide the same level of care coordination and case management for therapy only cases as they do for all other cases. 8/26/15 since all clients</p>				

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	<p>not complete the pain assessment on the visit notes. The pain assessment was left blank. On 08/11/14, 09/10/14, and 09/19/14, Employee O wrote N/A [not applicable] on the pain assessment. Employee O failed to properly assess the patient's pain during each visit.</p> <p>2. On 08/13/15 at 12:20 PM, the Administrator was interviewed and indicated the physical therapist should had assessed the patient's pain at each visit.</p> <p>3. A policy titled Therapy Services dated 03/2009 indicated, "The duties of the qualified therapist include ... assisting in developing the plan of care and making necessary revisions; ... directing the activities of any therapy assistant ... Duties of the qualified physical therapy assistant include performing services planned, delegated, and supervised by the therapist; preparing clinical notes and progress notes ... "</p>		<p>were at risk the Administrator reviewed the services of all active clients and found that there were no other therapy only cases active at the time. 8/26/15 the Administrator provided training to the supervisor of the Contract Provider regarding the following: Supervision requirements and standards for supervision · Care coordination requirements and standards for documentation · Standard of care for pain assessment and standards for documentation Agency policies on Therapy Services and Client Assessments · The implementation of 100% QA review of specific elements of therapy services to be described in the plan for QA review. · The potential for termination of the contract for therapy services if identified deficiencies do not improve. <b>Actions taken to prevent deficiency from recurring:</b> Effective 8/26/15 the Administer implemented a QA activity placing all Physical Therapy cases are under a 100% review to monitor the supervision of therapy assistants and appropriate documentation of assessments, including pain assessment. The QA Manager is responsible for conducting monthly reviews of 100% of all therapy cases for appropriate supervision, care coordination, and pain assessment. The QA Manager is responsible for gathering data, calculating</p>				

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G 0224 Bldg. 00	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review and interview, the agency failed to ensure a Registered Nurse establish a written plan of care in relation to a patient needing more than 1 visit from a home health aide in a 24 hour for 1 of 8 records reviewed for home health aide services. (# 3)</p> <p>Finding include:</p> <p>1. Clinical record number 3 evidence a plan of care established by the physician for the certification period of 05/22/15 to 07/20/15 with orders for home health</p>	G 0224	<p>compliance rates, and reporting results to Administrator. The Administrator is responsible for reporting results to Contract Providers and any necessary re-education/re-training and/or termination of the contract for therapy services if identified deficiencies do not improve. The monitoring activity will continue until 100% compliance with designated elements is achieved for 3 consecutive months, or 7 months, whichever is longer.</p> <p><b>The deficiency was corrected as follows:</b> 8/18/15 The Administrator and the RN Case Manager for client #3 developed home health aide plans of care for each instance of care in a 24 hour period. The Administrator delivered the care plans to the client's home and documented information about the multiple care plans in the staff communication notebook. 8/28/15 The Administrator changed the Aide care planning policy to include the requirement for a separate written aide care plan for each instance of care</p>	09/12/2015

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	<p>aide services two times a week for one week, seven times a week for eight weeks, and two times a week for one week for three hours in the morning and one hour in the evening. The clinical record was reviewed on 08/12/15, in which it revealed only one home health aide care plan and failed to indicate if the careplan was for AM or PM.</p> <p>2. Upon the exit conference on 08/14/15, the Administrator indicated she was not aware that a care plan needed to be developed for the home health aide for each visit if there were two visits in one day.</p> <p>3. A policy titled Home Health Aide Services, dated 03/09, indicated "The home health aide shall be provided with written instructions for patient care prepared by a Registered Nurse ... "</p> <p>4. A policy titled Home Health Aide Assignments, dated 03/09, indicated "The RN [Registered Nurse] / Case Manager is responsible for the assignment of the HHA [Home Health Aide], and the HHA care plan is developed by a registered nurse following assessment of the clients specific needs ... Is completed and reviewed with the HHA prior to start of HHA services ... "</p>		<p>occurring within a 24 hour period. On 8/29/15 the Administrator held a staff meeting with Case Managers and nurses who supervise aides to educate them on changes to the Aide Care Plan policy and their responsibility to develop Home Health Aide Care Plans for every instance of care in a 24 hour period. The nurses were instructed that when a patient needs more than one visit from a home health aide in a 24 hour period a written plan of care must be developed to specifically address the aide activities to occur at each visit. On 8/29/15 the Administrator held a staff meeting with HR and QA/Education Manager to ensure that this requirement is incorporated into RN training documents and is listed on the RN orientation checklist. 9/9/15 The Administrator assisted the RNs in identifying all patients who receive multiple aide visits in a 24 hour period, and in the development of new care plans to cover each instance of care. Home Health Aides were trained on the new policy of having multiple care plans in the home and determining which care plan to follow at each instance of care. Training took place over six different dates, including 8/26/15, 9/2/15, 9/9/15, 9/10/15, 9/11/15, and 9/12/15. 9/12/15 Administrator and Case Managers disseminated new care plans to all remaining affected</p>	

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			<p>clients. <b>To prevent the deficiency from recurring:</b></p> <p>9/12/15 the Administrator implemented a QA activity to monitor 100% of relevant patient records for the presence of aide care plans for each instance of care in a 24 hour period. Each case will be monitored every 60 days. The surveyor identified non-compliance rate of 1 in 8 records or 12% will be the baseline for the QA activity monitor. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate, and reporting to the Administrator every 60 days. This activity will continue until 100 % compliance is achieved for 3 consecutive months, or 7 months, whichever is greater. Staff retraining, increased frequency of record reviews, and/or disciplinary action will occur as needed to achieve compliance or restore compliance if the compliance rate drops back below 100%. The Administrator is responsible for determining individual needs for retraining, increased frequency of record reviews, or disciplinary action. The Administrator is responsible for implementing corrective actions as necessary. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained.</p>	

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G 0230  Bldg. 00	<p>484.36(d)(3) SUPERVISION</p> <p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure a Registered Nurse performed a supervisory visit with the home health aid for 1 of 6 records viewed with patients with home health aide services. (# 10)</p> <p>Findings include:</p> <p>1. Clinical record number 10, SOC (start of care) 02/05/15, included an established plan of care by a physician for the certification period of 06/05/15 to 08/03/15 with home health aide services.</p> <p>a. Review of the supervisory forms, the Registered Nurse made 2 consecutive unsupervised visits to the patient, without the home health aide on 07/02/15 and on 07/29/15.</p> <p>b. Review of the home health aide note dated 07/29/15, the home health aide</p>	G 0230	<p><b>The deficiency was corrected as follows:</b> On 8/18/15 the Administrator made an onsite supervisory visit to Patient #10 while the aide was providing care.</p> <p>On 8/21/15 a chart review of 100% of all patients receiving home health aide services only was conducted to ensure that a Registered Nurse had performed a supervisory visit within the last 60 days while the home health aide was providing care. No additional compliance issues were identified. On 8/25/15 the Administrator provided education for all agency RNs who provide aide supervision to re-educate them on the responsibility of the RN to perform an aide supervisory visit no less frequently than every 30 days for those clients receiving only home health aide services with every other supervisory visit occurring while the aide is furnishing services. <b>To prevent the deficiency from recurring:</b> 8/25/15 the</p>	08/25/2015

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	<p>was in the patient's home from 11:00 AM to 1:00 PM.</p> <p>c. Review of the skilled nursing visit note dated 07/29/15, the Registered nurse was in the patient's home from 09:45 AM to 10:50 AM. The agency failed to provide supervisory with the home health aide present in a 60 day period.</p> <p>2. Employee A, Administrator was interviewed on 08/13/15 at 3:45 PM. The Administrator indicated the home health aide needed to be present for one of the two supervisory visits.</p> <p>3. A policy titled Home Health Aide Supervision dated 03/2009, indicated "The Registered Nurse ... will make an onsite visit to the client's home no less frequently than every 30 days to those clients who only receive home health aide services, and every other supervisory visit must occur while the home health aide is providing client care ... "</p>		<p>Administrator implemented a Quality Assurance Activity to review of 100% of patients receiving home health aide services only to ensure that a supervisory visit is conducted at least every 30 days, and every 60 days while the aide is furnishing care. The surveyor identified non-compliance rate of 1 in 6 records or 17% will be the baseline for the QA activity. Data will be collected no less frequently than every 30 days and will continue until 100% compliance is achieved for at least 4 consecutive months, or 7 months, whichever is longer. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate, and reporting to the Administrator every 60 days. Staff retraining, increased frequency of record reviews, and/or disciplinary action will occur as needed to achieve compliance or restore compliance if the compliance rate drops back below 100%. The Administrator is responsible for determining individual needs for retraining, increased frequency of record reviews, or disciplinary action. The Administrator is responsible for implementing corrective actions as necessary. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained.</p>		

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G 0330  Bldg. 00	<p><b>484.55</b> <b>COMPREHENSIVE ASSESSMENT OF PATIENTS</b> 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 observation, clinical record review and interview, the agency failed to ensure that a comprehensive assessment was conducted within five days of the patients Medicaid Authorization for services for 1 of 7 Medicaid records reviewed (See G 334); failed to ensure plans of care were revised that included all medications for 2 of 10 records reviewed (See G 337); failed to ensure the Registered Nurse accurately assessed the patient upon recertification for 1 of 8 records reviewed that required a</p>	G 0330	The management team is meeting several times a week to address the deficiencies cited in the survey and to design our plan for corrections and monitoring programs in a way that allows us to identify and correct all systemic problems With a new, highly qualified and experienced home health Administrator, we have the leadership and management capability to restore the agency to compliance with the standards within this condition The cumulative effect of the systemic problem resulting in being out of	09/04/2015

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	<p>recertification (See G 339); failed to ensure the Registered Nurse accurately assessed the patient upon return from the hospital for 1 of 2 records reviewed of patients being hospitalized during a certification period (See G 340); and failed to ensure the physical therapist assessed the patient at discharge for 1 of 1 record reviewed with physical therapy assistance (See 341).</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.55 Comprehensive Assessment of Patients</p>		<p>compliance with this condition is being addressed on the whole as well as in each individual citation below. G334 8/14/15 the Administrator reviewed patient record #5 to determine if a comprehensive assessment needed to be conducted. A comprehensive assessment had been conducted during the survey on 8/12/15. No additional assessments were made to correct this deficiency. On 8/27/15 the Administrator reviewed agency policies related to Comprehensive Assessment of Patients. No policy changes were needed. 9/4/15 The Administrator met with Administrative nurses and Case Managers, Admission and Assessment Nurses, and Intake Coordinator to provide training and education on the Comprehensive Assessment of Patients, specifically, the requirement to conduct a comprehensive assessment consistent with the patient's immediate needs, but no later than 5 days after the start of care. 9/4/15 The Administrator discontinued the practice of using the date of the initial Comprehensive Assessment as the SOC date in cases where the initiation of care will be delayed after the initial assessment until the PA is approved. On 9/8/15 the Administrator initiated a QA activity to monitor for continued compliance. The surveyor</p>	

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			<p>identified non-compliance rate of 1 in 7 records or 14% will be the baseline for monitoring 100% of all Admissions to determine if the comprehensive assessment was completed within 5 days of the SOC. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate and reporting it to the Administrator on a monthly basis. This activity will continue until a compliance rate of 100% is achieved for 3 consecutive months, or 7 months whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained. G337 On 8/27/15 the Administrator reviewed the agency policies related to the drug regimen review, updating medication profiles, and establishment and ongoing development of the plan</p>	

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			<p>of care. No policy changes were needed. On 9/12/15 the Administrator met with the Administrative nursing staff and Case Managers to provide training and education on Case Management responsibilities as they relate to the establishment and ongoing development of the plan of care, more specifically to updating the medication portion of the plan of care as well as conducting an accurate drug regimen review. 9/8/15 RN Case Manager assigned to Patient # 1 contacted appropriate physicians to clarify medication orders and to obtain any orders needed to fully update the plan of care and medication profile. Plans and profiles fully updated. Patient #4 was discharged a year prior to the survey so no patient-specific corrective action could be taken. 9/12/15 Since all clients could be affected RN Case Managers conducted a 100% review of their current caseloads to determine if other patients were affected by the failure to keep medication orders up to date, conduct accurate drug regimen reviews, and update plans of care. One other instance of medication orders out of date was discovered and corrected on 9/11/15. Effective 9/12/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor</p>	

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			<p>identified non-compliance rate of 2 in 10 records or 20% is the baseline for a QA activity monitoring 100% of all records for compliance with updating medications on medication profiles and keeping plans of care updated with medication changes. The QA Manager is responsible for collecting raw data, calculating compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months, or 7 months, whichever is longer. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings.</p> <p>G339 On 8/26/15 the Administrator reviewed the agency policies related to Comprehensive Assessments at recertification of care. No needs for policy changes were identified. On 8/28/15 the Administrator conducted a complete and accurate comprehensive assessment on Client #10. The patient had no rectal bleeding. She was independent with ambulation and toileting. She was able to independently get a drink and</p>	

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			<p>crackers. Other ADLs were notobserved. The patient reported that she has "good days and baddays." On 9/4/15 the Administrator metwith the RN Case Managers and Admission and Assessment Nurses to providetraining and education on conducting highly accurate comprehensive assessments,and more specifically at the time of recertification. Comprehensive assessment forms both with and without the OASIS Data set were reviewed andnurses were instructed to fill each area of the assessment out as completelyand accurately as possible. Accuracy of ADL assessments were specificallyaddressed as well. On 9/11/15 the Administrator met with Employee G to evaluatetraining needs. Employee G was able to competently describe how to assessADL's and verbalize the appropriate answer to OASIS questions when given ascenario where nursing judgment is required. Employee G wasinstructed to prepare all comprehensive assessments and OASIS items withcare. Employee G feels confident and competent with Assessments and OASISitems. Employee G believes she scheduled too many assessments in oneday that may have contributed to inaccuracy. The Administratorwill approve all of Employee G's schedules in</p>	

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			<p>advance until such time that QAactivities show an improvement in her individual accuracy on ComprehensiveAssessments and OASIS items Effective 9/8/15 the Administratorestablished a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 1 in 8records or 13% is the baseline for a QA activity monitoring 100% ofall records for consistency and accuracy of comprehensive assessments atrecertification. The QA Manager is responsible for collecting raw data,calculating compliance rate and reporting data to the Administrator atleast every 30 days. This activity will continue until 100% compliance isachieved for 3 consecutive months, or 7 months, whichever is longer. Staff retraining, increasing record review frequency, and/or disciplinaryaction will occur as needed to achieve 100% compliance or to restorecompliance if it falls below 100%. The Administrator is responsiblefor initiating retraining, increasing record review frequency, and/ordisciplinary action based on QA findings.</p> <p>The Administrator is responsible foroverall compliance with the plan to correct this deficiency and to ensure thatcompliance is maintained. G340 On 8/26/15 the Administrator reviewedthe</p>	

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			agency policies related to Comprehensive Assessments at resumption of care. No needs for policy changes were identified. On 8/28/15 the Administrator conducted a complete and accurate comprehensive assessment on Client #10. The patient had no rectal bleeding. She was independent with ambulation and toileting. She was able to independently get a drink and crackers. Other ADLs were not observed. The patient reported that she has "good days and bad days." On 9/4/15 the Administrator met with the RN Case Managers and Admission and Assessment Nurses to provide training and education on conducting highly accurate comprehensive assessments, and more specifically at the time of resumption of care. Comprehensive assessment forms both with and without the OASIS Dataset were reviewed and nurses were instructed to fill each area of the assessment out as completely and accurately as possible. Accuracy of ADL assessments were specifically addressed as well. On 9/11/15 the Administrator met with Employee G to evaluate training needs. Employee G was able to competently describe how to assess ADL's and verbalize the appropriate answer to OASIS questions when given a scenario	

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			<p>where nursing judgment is required. Employee G was instructed to prepare all comprehensive assessments and OASIS items with care. Employee G feels confident and competent with Assessments and OASIS items. Employee G believes she scheduled too many assessments in one day that may have contributed to inaccuracy. The Administrator will approve all of Employee G's schedules in advance until such time that QA activities show an improvement in her individual accuracy on Comprehensive Assessments and OASIS items Effective 9/8/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 1 in 8 records or 13% is the baseline for a QA activity monitoring 100% of all records for consistency and accuracy of comprehensive assessments at resumption of care. The QA Manager is responsible for collecting raw data, calculating compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months, or 7 months, whichever is longer. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100%</p>	

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			<p>compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained. G341 Patient #4 was discharged a year prior to the survey so no patient-specific corrective action could be taken.</p> <p>8/26/15 since all clients were at risk the Administrator reviewed all PT services provided since 9/19/14 and found no additional instances of Comprehensive Assessments conducted by PTA's. On 8/26/15 the Administrator reviewed the Therapy Services Policy and Comprehensive Assessment at Discharge Policy and determined that no policy revisions were necessary. On 8/26/15 the Administrator met with all RN Case Managers to review the agency policies on Care Management, Care Coordination, and Comprehensive Assessments. Case Managers were re-educated on their responsibilities for Case Management for all patients, including those with therapy only services. Instructed agency policy requires Case Managers to provide the same level of care coordination and case</p>	

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			<p>management for therapyonly cases as they do for all other cases and should be reviewing theirtherapy only cases on a regular basis to identify concerns related to patientcare, and more specifically patient assessment. 8/26/15 the Administrator provided training tothe supervisor of the Contract Provider regarding the following: Agency policies on Therapy Services and Client Assessments</p> <ul style="list-style-type: none"> <li>* The requirement for comprehensive assessments to be updated andrevised at discharge</li> <li>* The qualifications for personnel conducting comprehensive assessments-- PTA not qualified.</li> <li>*The implementation of 100% QA review of specific elements of therapy services to be described in the plan for QA review.</li> <li>* The potential for termination of the contract fortherapy services if identified deficiencies do not improve. Effective 8/26/15 the Administer implementeda QA activity placing all Physical Therapy cases are under a 100% reviewto monitor the qualifications of any therapists conducting comprehensiveassessments and for evidence of care coordination involving the RN CaseManager. The QA Manager is responsible for gathering data, calculating compliance rates,and reporting results to Administrator monthly. The Administrator is responsible for reporting results to</li> </ul>	

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G 0334 Bldg. 00	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on observation, clinical record review and interview, the agency failed to ensure that a comprehensive assessment was conducted within five days of the patients Medicaid Authorization for services for 1 of 7 Medicaid records reviewed. (# 5)</p> <p>Findings include:</p> <p>1. Clinical record number 5, SOC (start of care) 06/26/15, included a plan of care established by the physician for the</p>	G 0334	<p>Contract Providers and any necessary re-education/re-training and/or termination of the contract for therapy services if identified deficiencies do not improve. The monitoring activity will continue until 100% compliance with both elements of review is achieved for 3 consecutive months, or 7 months, whichever is longer. We are requesting an IDR for this condition for the reasons cited at individual Tags 334, 339, and 340; should these citations be overturned, the condition might be as well.</p> <p><b>Actions taken to correct deficiency</b> 8/14/15 the Administrator reviewed patient record #5 to determine if a comprehensive assessment needed to be conducted. A comprehensive assessment had been conducted during the survey on 8/12/15. No additional assessments were made to correct this deficiency. On 8/27/15 the Administrator reviewed agency policies related to Comprehensive Assessment of Patients. No policy changes were needed.</p>	09/04/2015

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	<p>certification period 06/26/15 to 08/24/15 with orders for skilled nursing "to begin once authorized."</p> <p>Upon review of the skilled nursing visit notes, the patient had an initial assessment dated 06/26/15. The next skilled nursing visit was 07/19/15. The 07/19/15 was a routine visit and not a comprehensive assessment.</p> <p>2. Employee A, Administrator / Registered Nurse, was interview on 08/13/15 at 11:30 AM. Employee A stated skill nursing services started on 07/19/15 because the agency was waiting for authorization from Medicaid. Employee A stated he / she could not remember if another comprehensive assessment had to be made as well as another plan of care upon Medicaid approval.</p> <p>3. A policy titled Comprehensive Assessment dated 03/2009, indicated "The comprehensive assessment will be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care ... "</p>		<p>9/4/15 The Administrator met with Administrative nurses and Case Managers, Admission and Assessment Nurses, and Intake Coordinator to provide training and education on the Comprehensive Assessment of Patients, specifically, the requirement to conduct a comprehensive assessment consistent with the patient's immediate needs, but no later than 5 days after the start of care.</p> <p>9/4/15 The Administrator discontinued the practice of using the date of the Initial Comprehensive Assessment as the SOC date in cases where the initiation of care will be delayed after the initial assessment until the PA is approved. <b>Actions taken to prevent deficiency from recurring:</b> On 9/8/15 the Administrator initiated a QA activity to monitor for continued compliance. The surveyor identified non-compliance rate of 1 in 7 records or 14% will be the baseline for monitoring 100% of all Admissions to determine if the comprehensive assessment was completed within 5 days of the SOC. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate and reporting it to the Administrator on a monthly basis. This activity will continue until a compliance rate of 100% is achieved for 3 consecutive months, or 7 months whichever is longer. The</p>				

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G 0337 Bldg. 00	484.55(c) DRUG REGIMEN REVIEW 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. Based on clinical record and policy review, the agency failed to ensure the medication profile were revised and updated that included all medications for	G 0337	Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained. An IDR is requested because: A comprehensive assessment is not required in relation to Medicaid Authorization for services and a comprehensive assessment was completed on the SOC date.  <b>Actions taken to correct deficiency</b> On 8/27/15 the Administrator reviewed the agency policies related to the drug regimen review, updating	09/12/2015

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	<p>2 of 10 records reviewed. (# 1 and 4)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/03/14, included a plan of care established by the physician for the certification period 05/29/15 to 07/27/15 with primary diagnosis of cerebral palsy and secondary diagnoses of intellectual disability, epilepsy, chronic obstructive pulmonary disease, and depression.</p> <p>a. A faxed medication summary from the patient's physician dated 05/26/15, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, detrol 2 mg by mouth twice a day, hydroxyzine HCL 25 mg at bedtime as needed, ipratropium - albuterol 0.5 mg - 3 mg nebulization solution 1 unit three times a day, symbicort 160 mcg (micrograms) aerosol inhaler 2 puffs twice a day, metformin 50 mg daily, loperamide 2 mg, 2 tablets daily as needed, aspirin 81 mg daily, benzonate 200 mg every four hours as needed, vitamin D3 2,000 unit daily, aricept 5 mg every evening, docusate sodium 100 mg daily, multivitamin daily, and simvastatin 10 mg daily.</p> <p>b. The 05/29/15 to 07/27/15 established plan of care indicated the</p>		<p>medication profiles, and establishment and ongoing development of the plan of care. No policy changes were needed. On 9/12/15 the Administrator met with the Administrative nursing staff and Case Managers to provide training and education on Case Management responsibilities as they relate to the establishment and ongoing development of the plan of care, more specifically to updating the medication portion of the plan of care as well as conducting an accurate drug regimen review. 9/8/15 RN Case Manager assigned to Patient # 1 contacted appropriate physicians to clarify medication orders and to obtain any orders needed to fully update the plan of care and medication profile. Plans and profiles fully updated. Patient #4 was discharged a year prior to the survey so no patient- specific corrective action could be taken. 9 /12/15 Since all clients could be affected RN Case Managers conducted a 100% review of their current caseloads to determine if other patients were affected by the failure to keep medication orders up to date, conduct accurate drug regimen reviews, and update plans of care. One other instance of medication orders out of date was discovered and corrected on 9/11/15. <b>Actions taken to prevent deficiency from recurring:</b> Effective 9/12/15 the</p>	

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	<p>patient was to be taking acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, combivent 18/103 mcg / act every 6 hours as needed, hydroxyzine HCL 25 mg at bedtime as needed, docusate 100 mg daily, metformin 500 mg daily, milk of magnesia 30 mg daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime.</p> <p>c. The medication profile was initiated on 06/03/14 and only date indicated drug regimen review of 07/23/15 indicated the patient's medication regimen was advair diskus 250 / 50 mcg 1 puff twice a day, combivent 18/103 2 puffs twice a day, acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, docusate 100 mg daily, fluoxetine 10 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, hydroxyzine HCL 25 mg at bedtime as needed, multivitamin daily, naproxen 500 mg twice a day as needed, donepezil HCL (aricept) 5 mg at bedtime, simvastatin 10 mg daily, myebetriq ER 50 mg daily, trazadone 100 mg at bedtime, metformin 500 mg daily, melatonin 3 mg two tabs at bedtime, tolterodine (detrol) 1 mg by mouth twice</p>		<p>Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 2 in 10 records or 20% is the baseline for a QA activity monitoring 100% of all records for compliance with updating medications on medication profiles and keeping plans of care updated with medication changes. The QA Manager is responsible for collecting raw data, calculating compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months, or 7 months, whichever is longer. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings.</p>	

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	<p>a day, multi - vitamin D3 2,000 unit daily, symbicort 160 / 4.5 two puffs twice a day, and mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed.</p> <p>d. The 07/28/15 to 09/25/15 established plan of care indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, advair diskus 250 / 50 mcg 1 puff twice a day, aspirin 81 mg daily, combivent 18/103 2 puffs twice a day, docusate 100 mg daily, donepezil HCL (aricept) 5 mg at bedtime, fluoxetine 10 mg daily, hydroxyzine HCL 25 mg at bedtime as needed, metformin 500 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, myebetriq ER 50 mg daily, mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, symbicort 160 / 4.5 two puffs twice a day, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime</p> <p>The medication section of the plan of care failed to be updated / revised with correct dosages and most current medications and failed to include the patient was a diabetic.</p> <p>2. Clinical record number 4 included a</p>			

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	<p>plan of care established by a physician for certification period 08/01/14 to 09/29/14.</p> <p>a. A skilled nurse visit note dated 08/27/14 indicated the patient had been prescribed Levaquin 250 mg by mouth daily for 7 days.</p> <p>b. A skilled nurse visit note dated 09/03/14 indicated the patient had been prescribed Aspirin 81 mg by mouth daily and Prednisone 10 mg by mouth daily for 10 days.</p> <p>c. A skilled nurse visit note dated 09/17/14 indicated the patient had been prescribed Keflex 500 mg by mouth twice a day for 10 days.</p> <p>The medication section of the plan of care failed to be updated / revised to include the new medications prescribed to the patient.</p> <p>3. Employee A, Administrator, was interviewed on 08/13/15 at 3:45 PM. The Administrator indicated the medication profile should have been updated and reconciled with the physician.</p> <p>4. A policy titled Comprehensive Assessment dated 03/2009, indicated</p>			

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G 0339 Bldg. 00	<p>"The comprehensive assessment will 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>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 observation, clinical record review and interview, the agency failed to ensure the Registered Nurse accurately assessed the patient upon recertification for 1 of 8 records reviewed that required a recertification. (# 10)</p> <p>Findings include:</p> <p>1. Clinical record number 10 included a plan of care established by the physician for certification period of 08/04/15 to 10/02/15 with orders for a home health aide four times a week for one week then</p>	G 0339	<p><b>The deficiency was corrected as follows:</b> On 8/26/15 the Administrator reviewed the agency policies related to Comprehensive Assessments at recertification of care. No needs for policy changes were identified. On 8/28/15 the Administrator conducted a complete and accurate comprehensive assessment on Client #10. The patient had no rectal bleeding. She was independent with ambulation and toileting. She was able to independently get a drink and crackers. Other ADLs were not</p>	09/11/2015

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NAME OF PROVIDER OR SUPPLIER  BETTER LIVING HOME HEALTH CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2040 WASHINGTON AVENUE EVANSVILLE, IN 47714
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	<p>five times a week for eight weeks for two hours per visit to assist with personal care and activities of daily living. Patient primary diagnosis was joint pain with secondary diagnoses of ankylosing spondylitis, myalgia and myositis. Functional limitations included ambulation and dyspnea with minimal exertion.</p> <p>a. A visit was made to the patient's home on 08/12/15 at 11:00 AM. The patient had stated he / she was in the hospital recently for approximately a week due to blood loss through her rectum. The patient had indicated she was treated with antibiotics for approximately a week and returned home.</p> <p>b. Patient was observed getting up from the couch and walking to the bathroom at a slow pace. Employee G was observed assisting the patient with getting undressed and helping the patient to sit down into the bath tub. Employee G washed the patient's back, assisted the patient getting out of the bath tub, then proceeded to assist the patient with drying the body and putting clothes back on the upper and lower body.</p> <p>c. Review of the comprehensive assessment dated 07/30/15, the</p>		<p>observed. The patient reported that she has "good days and bad days." On 9/4/15 the Administrator met with the RN Case Managers and Admission and Assessment Nurses to provide training and education on conducting highly accurate comprehensive assessments, and more specifically at the time of recertification. Comprehensive assessment forms both with and without the OASIS Data set were reviewed and nurses were instructed to fill each area of the assessment out as completely and accurately as possible. Accuracy of ADL assessments were specifically addressed as well. On 9/11/15 the Administrator met with Employee G to evaluate training needs. Employee G was able to competently describe how to assess ADL's and verbalize the appropriate answer to OASIS questions when given a scenario where nursing judgment is required. Employee G was instructed to prepare all comprehensive assessments and OASIS items with care. Employee G feels confident and competent with Assessments and OASIS items. Employee G believes she scheduled too many assessments in one day that may have contributed to inaccuracy. The Administrator will approve all of Employee G's schedules in advance until such time that QA activities show an</p>	

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	<p>assessment failed to identify that the patient had rectal bleeding. Assessment of the activities of daily living indicated the patient was independent with dressing the upper and lower body, bathing, toilet transferring, and able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>2. Employee A, Administrator, was interviewed on 08/13/15 at 3:30 PM. Employee A indicated that he / she was surprised of the inaccurate assessment by Employee G due to the employee work history background. Employee A also indicated that Employee G was put out into the field too soon and did not have enough time for orientation due to staff turn-around and Employee G was needed out in the field.</p> <p>3. A policy titled Reassessments / Recertifications dated 03/2009, indicated "Each client is reassessed and the plan of care reviewed and revised when ... The client's condition improves or deteriorates, the client has a change in diagnoses, there is a significant change in the client's care environment and / or support system ... Documentation in the clinical record should support the assessment as well as the actions taken in response ... "</p>		<p>improvement in her individual accuracy on Comprehensive Assessments and OASIS items <b>To prevent the deficiency from recurring:</b> Effective 9/8/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 1 in 8 records or 13% is the baseline for a QA activity monitoring 100% of all records for consistency and accuracy of comprehensive assessments at recertification. The QA Manager is responsible for collecting raw data, calculating compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months, or 7 months, whichever is longer. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained. We are requesting an IDR because Per direction from CMS, the</p>		

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G 0340 Bldg. 00	<p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. Based on observation, clinical record review and interview, the agency failed to ensure the Registered Nurse accurately assessed the patient upon return from the hospital for 1 of 2 records reviewed of patients being hospitalized during a certification period. (# 10)</p> <p>Findings include:</p> <p>1. Clinical record number 10 included a plan of care established by the physician for certification period of 08/04/15 to 10/02/15 with orders for a home health aide four times a week for one week then five times a week for eight weeks for two hours per visit to assist with personal care and activities of daily living. Patient primary diagnosis was joint pain with secondary diagnoses of ankylosing spondylitis, myalgia and myositis. Functional limitations included ambulation and dyspnea with minimal</p>	G 0340	<p>assessments conducted on 7/30/15 were accurate as of the day of the assessment.</p> <p><b>The deficiency was corrected as follows:</b> On 8/26/15 the Administrator reviewed the agency policies related to Comprehensive Assessments at resumption of care. No needs for policy changes were identified. On 8/28/15 the Administrator conducted a complete and accurate comprehensive assessment on Client #10. The patient had no rectal bleeding. She was independent with ambulation and toileting. She was able to independently get a drink and crackers. Other ADLs were not observed. The patient reported that she has "good days and bad days." On 9/4/15 the Administrator met with the RN Case Managers and Admission and Assessment Nurses to provide training and education on conducting highly accurate comprehensive assessments, and more specifically at the time of resumption of care. Comprehensive</p>	09/11/2015

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	<p>exertion.</p> <p>a. A visit was made to the patient's home on 08/12/15 at 11:00 AM. The patient had stated he / she was in the hospital recently for approximately a week due to blood loss through her rectum. The patient had indicated she was treated with antibiotics for approximately a week and returned home.</p> <p>b. Patient was observed getting up from the couch and walking to the bathroom at a slow pace. Employee G was observed assisting the patient with getting undressed and helping the patient to sit down into the bath tub. Employee G washed the patient's back, assisted the patient getting out of the bath tub, then proceeded to assist the patient with drying the body and putting clothes back on the upper and lower body.</p> <p>c. Review of the comprehensive resumption of care assessment dated 07/29/15, the assessment failed to identify that the patient had rectal bleeding. Assessment of the activities of daily living indicated the patient was independent with grooming, dressing the upper and lower body, bathing, toilet transferring, toileting hygiene, transferring, ambulation / locomotion,</p>		<p>assessment forms both with and without the OASIS Data set were reviewed and nurses were instructed to fill each area of the assessment out as completely and accurately as possible. Accuracy of ADL assessments were specifically addressed as well. On 9/11/15 the Administrator met with Employee G to evaluate training needs. Employee G was able to competently describe how to assess ADL's and verbalize the appropriate answer to OASIS questions when given a scenario where nursing judgment is required. Employee G was instructed to prepare all comprehensive assessments and OASIS items with care. Employee G feels confident and competent with Assessments and OASIS items. Employee G believes she scheduled too many assessments in one day that may have contributed to inaccuracy. The Administrator will approve all of Employee G's schedules in advance until such time that QA activities show an improvement in her individual accuracy on Comprehensive Assessments and OASIS items</p> <p><b>To prevent the deficiency from recurring:</b> Effective 9/8/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 1 in 8 records or 13% is the baseline for a QA activity</p>		

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G 0341 Bldg. 00	<p>ability to plan and prepare light meals.</p> <p>2. Employee A, Administrator, was interviewed on 08/13/15 at 3:30 PM. Employee A indicated that he / she was surprised of the inaccurate assessment by Employee G due to the employee work history background. Employee A also indicated that Employee G was put out into the field too soon and did not have enough time for orientation due to staff turn-around and Employee G was needed out in the field.</p> <p>3. A policy titled Comprehensive Assessment dated 03/2009, indicated "to accurately reflect the patient's current health status including information that may be used to demonstrate the patient's progress toward achievement of desired outcomes ... "</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.</p>		<p>monitoring 100% of all records for consistency and accuracy of comprehensive assessments at resumption of care. The QA Manager is responsible for collecting raw data, calculating compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months, or 7 months, whichever is longer. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained. We are requesting an IDR because Per direction from CMS, the assessments conducted on 7/30/15 were accurate as of the day of the assessment.</p>	

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	<p>Based on clinical record and policy review, the agency failed to ensure the physical therapist assessed the patient at discharge for 1 of 2 record reviewed with physical therapy services. (# 4)</p> <p>Findings include:</p> <p>1. Clinical record number 4 included a plan of care established by a physician for certification period 08/01/14 to 09/29/14 with order for physical therapy two times a week for five weeks, one time a week for two weeks.</p> <p>A visit note dated 09/19/14 indicated that Employee O, a physical therapy assistant, seen the patient and performed a discharge assessment that included the Berg Balance Scale that had been done on 08/05/14 and on 09/04/14 by a physical therapy. The physical therapy discharge summary indicated the reason for discharge was that all goals had been met and expired. The comment section indicated the patient had met all goals established for the patient. The patient was independent with transfers, bed mobility, and ambulation as long as the patient was mindful of her oxygen tubing. The summary also indicated the patient was involved in the discharge planning, was provided with discharge instructions, and demonstrated understanding of</p>			G 0341	<p><b>Actions taken to correct deficiency Patient #4</b></p> <p>was discharged a year prior to the survey so no patient- specific corrective action could be taken. 8/26/15 since all clients were at risk the Administrator reviewed all PT services provided since 9/19/14 and found no additional instances of Comprehensive Assessments conducted by PTA's. On 8/26/15 the Administrator reviewed the Therapy Services Policy and Comprehensive Assessment at Discharge Policy and determined that no policy revisions were necessary. On 8/26/15 the Administrator met with all RN Case Managers to review the agency policies on Care Management, Care Coordination, and Comprehensive Assessments. Case Managers were re-educated on their responsibilities for Case Management for all patients, including those with therapy only services. Instructed agency policy requires Case Managers to provide the same level of care coordination and case management for therapy only cases as they do for all other cases and should be reviewing their therapy only cases on a regular basis to identify concerns related to patient care, and more specifically patient assessment. 8/26/15 the Administrator provided training to the supervisor of the Contract</p>		08/26/2015

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	<p>instructions that had been provided. Employee O signed the summary and a physical therapist co-signed the summary.</p> <p>2. On 08/13/15 at 12:20 PM, the Administrator was interviewed and indicated the physical therapist should had performed the discharge assessment of the patient upon discharge.</p> <p>3. A policy titled Therapy Services dated 03/2009 indicated, "The duties of the qualified therapist include ... assisting in developing the plan of care and making necessary revisions; reviewing the plan of care as often as the severity of the client's condition requires, but at least every two months ... directing the activities of any therapy assistant ... "</p>		<p>Provider regarding the following: Agency policies on Therapy Services and Client Assessments * The requirement for comprehensive assessments to be updated and revised at discharge * The qualifications for personnel conducting comprehensive assessments -- PTA not qualified. *The implementation of 100% QA review of specific elements of therapy services to be described in the plan for QA review. * The potential for termination of the contract for therapy services if identified deficiencies do not improve. <b>Actions taken to prevent deficiency from recurring:</b> Effective 8/26/15 the Administer implemented a QA activity placing all Physical Therapy cases are under a 100% review to monitor the qualifications of any therapists conducting comprehensive assessments and for evidence of care coordination involving the RN Case Manager. The QA Manager is responsible for gathering data, calculating compliance rates, and reporting results to Administrator monthly. The Administrator is responsible for reporting results to Contract Providers and any necessary re-education/re-training and/or termination of the contract for therapy services if identified deficiencies do not improve. The monitoring activity will continue until 100% compliance with both</p>		

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N 0000 Bldg. 00	<p>This was a State home health re-licensure survey. This survey was extended.</p> <p>Survey Dates: August10, 2015 to August 14, 2015</p> <p>Facility #: 012101</p> <p>Medicaid Vendor #: 15121011</p> <p>Facility unduplicated census: 59</p> <p>Records reviewed without home visit: 5</p> <p>Record reviews with home visits: 5</p> <p>Total records reviewed: 10</p> <p>QA; LD, R.N.</p>	N 0000	elements of review is achieved for 3 consecutive months, or 7 months, whichever is longer.	
N 0440 Bldg. 00	<p>410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and</p>			

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	<p>(2) readily identifiable.</p> <p>Based on record review and interview, the agency failed to ensure the Organizational Chart included the name of the employees under the title / position from the President down to the patient for 1 of 1 agency.</p> <p>Finding included:</p> <p>1. On 8/10/15 at 11:30 AM, the organizational chart was requested. The organizational chart provided indicated titles / positions but failed to include the name of employee under the title / position.</p> <p>2. A policy titled Administrative Control dated 03/2009, indicated "The Organizational chart defines lines of authority for the delegation of responsibility and accountability down to the patient care level ... "</p>	N 0440	<p><b>The deficiency was corrected as follows:</b> On 8/27/15 The Administrator reviewed the agency policy on Administrative Control. The policy was updated to include putting employee names under their respective titles/positions on the organization chart from the President down to the patient. The HR manager added the names of all employees were to the Organization Chart under their respective titles/positions from the President down to the patient. This corrective action was completed on 9/9/15. <b>To prevent the deficiency from recurring:</b> To ensure continued compliance, the HR Manager will update the Organization Chart with names under the titles/positions each time an RN, LPN, Home Health Aide, Physical Therapist, Occupational Therapist, Speech Therapist, or Administrative staff member is hired or terminated. The Administrator will monitor compliance weekly by comparing the Organizational Chart to the active employee roster. Monitoring will continue until 100% compliance is achieved for 3 consecutive months or for 7 months, whichever is longer. The Administrator is responsible for this corrective action and for ongoing monitoring. We are filing an IDR because we believe the regulation requires</p>	09/09/2015

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N 0446 Bldg. 00	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations.</p> <p>Based on personnel record and policy review and interview, the agency failed to ensure qualified personnel for Director of Nursing per 410 Indiana Administrative Code 17-2-1-(d) for 1 of 1 agency.</p> <p>Finding include:</p> <p>1. The 410 Indiana Administrative Code 17-2-1-(d) indicated, "A physician or a registered nurse who has two (2) years of nursing experience, with at least one (1) year of supervisory or administrative experience, shall supervise and direct nursing and other therapeutic services."</p> <p>2. On 08/10/15 at 2:05 PM, Employee B, Registered Nurse, employee filed was reviewed.</p> <p>a. Employee B graduated from an Associates Degree Program became a</p>	N 0446	<p>delineation of lines of authority rather than enumeration of agency employees.</p> <p>On 8/15 the Administrator reviewed the State Rule at 410 IAC 17-2-1(d) requiring the Supervising Nurse to have 2 years of nursing experience and 1 year of supervisory experience. On 8/15/15 The Administrator re-assigned the employee in orientation forthe DON position. On 8/15/15 To ensure that qualified staff are employed throughout theorganization, the Administrator compared the required qualificationswith the qualifications documented in the personnel record for all currentemployees. No unqualified staff were identified. On 9/1/15 a qualified applicant was submitted to the ISDH and was approved on 9/2/15</p> <p><b>Actions taken to preventdeficiency from recurring:</b> Effective 8/15/15:The Administrator and HR Manager will both review the qualificationrequirements for each</p>	09/02/2015

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N 0447 Bldg. 00	<p>licensed Registered Nurse on 07/22/14.</p> <p>b. Employee B was hired on 07/06/15 as the Marketing / Intake / Scheduling Manager / Director. On 07/19/15, Employee B was promoted to be the Director of Nursing.</p> <p>c. Employee B signed a Director of Clinical Services Job Description on 07/27/15. The qualifications indicated, "Has three to five years clinical nursing experience, an emphasis in home care nursing is preferred ... BSN (Bachelor of Science in Nursing) preferred.</p> <p>3. The Administrator was interviewed on 08/12/15 at 10:30 AM. The Administrator indicated she had forgotten the state required the Registered Nurse have two years of clinical experience.</p> <p>410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview, the Administrator failed to ensure public information materials was true and</p>	N 0447	<p>new position and/or each vacated position prior to posting the job. The HR manager will include position qualifications on the agency's HR requisition for staff. The HR Manager will ensure that all applicant's considered for employment have documentation of meeting qualifications for the job. The Administrator and HR Manager will both compare applicant qualifications with position requirements prior to making an offer of employment. The Administrator is responsible for ensuring compliance with this plan.</p> <p><b>Actions taken to correct deficiency</b> On 9/1/15 the Administrator reviewed the regulations at 484.14(c) outlining</p>	09/01/2015			

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	<p>accurate for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. On 8/10/15, a brochure was provided with an Admission Folder by Employee B, Director of Nursing. The brochure indicated, "Better Living caregivers assist with the regular day-to-day activities of life including: Skilled Nursing Services, Home Health Aide Services, Therapy Services ... Toll free: 877-739-4408.</p> <p>2. On 8/11/15, a website <a href="http://betterlivinghomehealthcare.com">http://betterlivinghomehealthcare.com</a> was reviewed. The website indicated, "Better Living Caregivers assist with the regular day to day activities including: Skilled Nursing Services, Therapy Services, Home Health Aide Services, Attendant Care Services, Homemaker Services ... Our toll free number is 1-800-414-4428 ... Our staff included [Name of Employee], RN [Registered Nurse] Director of Nursing ... "</p> <p>3. On 8/12/15 at 10:00 AM, the administrator was interviewed and stated that the website was incorrect with the toll free number, the employee listed is the Director of Nursing with their sister company, and the company does not provide attendant care or homemaker services. The administrator stated she /</p>		<p>the responsibilities of the Administrator as related to ensuring the accuracy of public information materials and activities. On 9/1/15 the Administrator met with the web developer and internal IT support staff to educate them about regulatory requirements related to accuracy of public information materials. They were instructed that all changes to public information materials require oversight and approval from the Administrator in advance of the changes. Specific information was provided about accuracy regarding services offered, geographic area served, names of administrative staff, physical location, telephone numbers, e-mail addresses, and other information that the general public may need in order to make decisions about obtaining home health care. The Administrator instructed the web developer and computer technician that there are currently no changes authorized to be made to the website and any future authorizations must be issued in writing and signed and dated by the Administrator in advance of any changes. Both verbalized understanding and agreed not to make changes to public information materials without advance written approval from the Administrator. The Administrator informed both workers that any future release of inaccurate</p>				

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	he was working with a new company for advertising.		information will result in disciplinary action up to and including dismissal of the technician and termination of the contract with the web developer. The Administrator is responsible for any disciplinary action that may become necessary. On 9/1/15 the Operations Manager removed the website from public view. The name of the DON of Welcome Home was removed from the website. Homemaker and Attendant Care Services were removed from the list of services offered. All other identified inaccuracies were corrected and the website was placed back online on 9/2/2015. On 9/1/15 the Administrator reviewed the current brochure for inaccuracies. The 877 number listed on the brochure was dialed and answered by agency staff. No other inaccuracies were identified. On 9/1/15 the Administrator destroyed all outdated printed materials. <b>On 9/1/15 the Administrator developed a Public Information Policy addressing both the development of new printed and digital material as well as the destruction and/or removal of outdated material.</b> On 9/1/15 The Administrator provided education for office staff regarding elements of public information and the need for 100% accuracy. All staff were	

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N 0451 Bldg. 00	<p>410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence.</p> <p>Based on personnel record and policy review and interview, the agency failed to ensure qualified person is authorized in writing to act in the absence of the administrator per 410 Indiana Administrative Code 17-2-1-(C) 8 and (d) for 1 of 1 agency.</p> <p>Finding include:</p>	N 0451	<p>instructed to observe public information materials they encounter to ensure accuracy and bring any questionable or outdated material to the Administrator. <b>Actions taken to prevent deficiency from recurring: Effective 9/1/15</b> the Administrator will access the website at least bi-weekly to ensure that the information on the site is accurate. This monitoring will continue for 7 months. Effective 9/1/15 the Administrator will receive and approve all public information material delivered to the agency prior to its release to the general public.</p> <p>On 8/15 the Administrator reviewed the regulation at 410 IAC 17-2-1(c) 8 and (d) requiring the agency to ensure that <b>a qualified person is authorized in writing to act in the absence of the administrator.</b> On 8/15 the Administrator reviewed the State Rules for the Alternate Administrator. The Administrator acknowledges and understands that the Alternate Administrator must be: <b>(a) any</b></p>	09/02/2015

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	<p>1. The 410 Indiana Administrative Code 17-2-1-(C) 8 indicated, "Ensure that a qualified person is authorized in writing to act in the administrator's absence."</p> <p>2. The 410 Indiana Administrative Code 17-2-1-(d) indicated, "A physician or a registered nurse who has two (2) years of nursing experience, with at least one (1) year of supervisory or administrative experience, shall supervise and direct nursing and other therapeutic services."</p> <p>3. On 08/10/15 at 1:55 PM, Employee C, Operations's Director, employee file was reviewed.</p> <p style="padding-left: 40px;">a. Employee C graduated obtained a Bachelor's Degree in Business Administration in 2007.</p> <p style="padding-left: 40px;">b. Employee C's work history included Recruiting Manager from 5/07 to 5/08 for a former home health agency that was previously own by Employee A.</p> <p style="padding-left: 40px;">c. Employee C signed a job description as the "Operations Director / Human Resources / IT on 01/20/15.</p> <p>4. On 08/10/15 at 2:05 PM, Employee B, Registered Nurse, employee filed was reviewed.</p>		<p><b>health care professional who has at least one (1) year of supervisory or administrative experience in health service, or (b) any other individual who has at least one (1) year of experience in health service administration or health service finance.</b> Additional qualifying information for Joshua Ross was submitted to ISDH on 09/01/15. Joshua Ross was approved on 09/02/15 On 8/15 the Administrator reviewed the State Rule at 410 IAC 17-2-1(d) requiring the Supervising Nurse to have 2 years of nursing experience and 1 year of supervisory experience. On 8/15/15 The Administrator re-assigned the employee in orientation forthe DON position. On 8/15/15 To ensure that qualified staff are employed throughout theorganization, the Administrator compared the required qualificationswith the qualifications documented in the personnel record for all currentemployees. No unqualified staff were identified. On 9/1/15 a qualified applicant was submitted to the ISDH and was approved on 9/2/15 <b>Actions taken to prevent deficiency fromrecurring:</b> As of 8/15/15 the Administrator and HR Manager will both review the qualificationrequirements for each new position and/or each vacated position priorto posting the job. The HR manager will include</p>		

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	<p>a. Employee B graduated from an Associates Degree Program became a licensed Registered Nurse on 07/22/14.</p> <p>b. Employee B was hired on 07/06/15 as the Marketing / Intake / Scheduling Manager / Director. On 07/19/15, Employee B was promoted to be the Director of Nursing.</p> <p>c. Employee B signed a Director of Clinical Services Job Description on 07/27/15. The qualifications indicated, "Has three to five years clinical nursing experience, an emphasis in home care nursing is preferred ... BSN (Bachelor of Science in Nursing) preferred.</p> <p>5. Prior to the entrance conference on 08/10/15 at 10:35 AM, the Administrator provided a letter from the (ISDH) Indiana State Department of Health dated 07/28/15 indicating that the Administrator, himself/ herself, and the chosen Alternate Administrator, was not qualified for the positions and indicated that he / she had not followed up with ISDH. The Administrator also indicated that he / she had not provided ISDH with Employee B's information as the Director of Nursing.</p> <p>6. The Administrator was interviewed on 08/10/15 at 3:00 PM. The Administrator</p>		<p>position qualifications on the agency's HRrequisition for staff. The HR Manager will ensure that all applicant's considered for employment have documentation of meeting qualifications for the job. The Administrator and HR Manager will both compare applicant qualifications with position requirements prior to making an offer of employment. The Administrator is responsible for ensuring compliance with this plan. We are requesting an IDR because Alternate Administrator was qualified for his position under State regulations at the time of the survey.</p>		

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N 0470 Bldg. 00	<p>stated Employee C, son of the Administrator and Owner, had taken an interest in the family business and was suppose to have been shadowing the former Administrator and learning how to run the business.</p> <p>7. The Administrator was interviewed on 08/12/15 at 10:30 AM. The Administrator indicated she had forgotten the state required the Registered Nurse have two years of clinical experience.</p> <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>A. Based on observation and policy review, and interview the agency failed to ensure staff cleaned equipment prior to placing in the nursing bag, failed to wear gloves during care, and failed to wash their hands after removing gloves, during care, and after care for 2 of 5 home visits observed. (# 1 and 2)</p> <p>B. Based on observation, clinical record and employee record review, and interview, the Licensed Practical Nurse (LPN) failed to follow agency policy and</p>	N 0470	<p><b>The deficiency was corrected as follows:</b> On 8/11/15 the Administrator re-educated Employee E on infection control policies and procedures including Universal Precautions, Handwashing, and Nursing/Aide Bag Technique. Employee E demonstrated competency with handwashing and gloving, and described appropriate infection control procedures to follow when providing care. On 8/11/15 the Administrator re-educated Employee F on infection control</p>	09/12/2015

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	<p>professional practice standards in relation to providing medication through a patient's gastric feeding tube without first checking residuals for 1 of 1 patient observed for administration of medications through a gastric tube. (# 6)</p> <p>Findings include:</p> <p>A 1. On 8/11/15 at 8:10 AM, Employee E was observed providing patient #1 with bathing and hygiene. During the care, employee E was observed cleaning the patient on the toilet with gloves on, removed the gloves and assisted the patient down into the bath tub. Employee E then grabbed the wash clothe and handed it to the patient. Employee E then was observed to washed the patient's back, hair, and beard then rinsed without gloves. Employee E proceeds to help the patient out of the bath tub and assist with drying the patient off, grabbed the patient clothes and placed them on the floor, then applied gloves without washing or sanitizing hands and continued to assist the patient with dressing, combing hair, and applying scented lotion to the patient facial area. Employee E assisted the patient back onto the toilet, took dirty linen to the laundry room, removed gloves, then assisted the patient with pulling his hair back. Employee E ran hands under the water without soap for</p>		<p>policies and procedures including Universal Precautions, Handwashing, and Nursing Bag Technique. Employee F demonstrated competency with glove and handwashing procedures and described appropriate infection control procedures to follow when passing medications. Employee F demonstrated competency with bag technique, including cleaning equipment after assessing a client and before placing the equipment back in the bag. All patients may be affected. On 8/26/15, 9/2/15, 9/9/15, 9/10/15, 9/11/15, and 9/12/15 the Administrator and RN designees educated 100% of clinical employees on standards of practice and infection control including the following policies and procedures: Universal Precautions; Hand washing; Nursing/Aide Bag Technique. Proper handwashing, gloving and bag technique were demonstrated to the employees and all were successful in return demonstrations of the same skills. On 8/15/15 the Administrator reviewed agency policy and procedure with employee j and instructed the employee to follow policy and procedure when administering medication through the G-tube. Employee J was provided with a manual of clinical nursing procedures and performance expectations for procedural</p>				

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	<p>less than 10 seconds then reapplied gloves, cleaned patient's buttocks from toileting, removed gloves and assisted the patient to the wheelchair. Employee then retrieved the patient's bandana and placed it around his head then pushed the wheelchair to the kitchen table.</p> <p>Employee then was observed retrieving a glass, retrieved a pitcher of fluids from the refrigerator to pour into the patient's glass, then applied hand sanitizer, then gloves and took the drink to the patient at the kitchen table.</p> <p>A 2. On 8/11/15 at 9:00 AM, Employee F was observed setting up the patient number 2's medication dispenser. Employee F was setting up medication cups then was observed to touch each pill that was placed into the medication cups. Employee F was then observed to go to her lab coat and retrieve her cell phone to look up a medication. After placing the phone on the table, Employee F proceeded to touch each pill and placing it in the medication cups without washing / sanitizing his / her hands. Upon completion of filling the medication cups, Employee F was observed to retrieve stethoscope, blood pressure cuff and thermometer with sheath from the nursing bag. Upon completion, Employee F removes the sheath without gloves, places thermometer into the</p>		<p>compliance. Employee J's job description was reviewed, including the responsibility to follow agency policies and provide care according to the established Plan of Care. The Administrator placed Employee J on probationary status for no less than 12 weeks due to failure to follow agency policy on medication administration through a G-tube. The employee was instructed that failure to follow policies and procedures will result in termination. The Administrator is responsible for any additional disciplinary action. On 8/24/15 the Administrator installed an RN on the case to provide direct patient care, weekly in-home case management, assessment of LPN technical skills, and supervision of care provided by LPNs. It is the case manager's responsibility to provide in-home supervision and report findings to the Administrator on a weekly basis. Also on this date, employee J was observed by the Administrator and RN Case Manager to competently administer medication via the G-Tube in compliance with agency policy and procedure. To ensure that other patients weren't at similar risk, all LPNs providing g-tube medications or any other specialized procedure were required to demonstrate procedural competency to the Administrator. Only two additional LPNs were providing</p>		

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	<p>container and placed equipment back into the nursing bag without cleaning cleaning equipment or washing / sanitizing hands.</p> <p>A 3. The Director of Nursing was interviewed on 8/11/15 at 8:45 AM. The Director of Nursing stated that Employee E was one of their best home health aides and the employee was extremely nervous.</p> <p>A 4. The Administrator was interviewed on 8/13/15 at 11:00 AM. The Administrator stated that Employee F was a fairly new nurse and probably did not receive enough orientation prior to letting her be on her own in the field.</p> <p>A 5. A policy titled Universal Body Substance Precautions, dated 03/2009, indicated "Handwashing will be performed to prevent cross-contamination between patients / clients and personnel. Hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly before and after patient / client contact, if contaminated with body substances, before and after gloves are worn, and before preparing or eating food ... Gloves are to be worn by all agency staff when direct contact with any body substance is anticipated [blood, urine, pus, feces, saliva, drainage of any kind] ... gloves are to be worn when handling</p>		<p>any specialized procedures. LPN "A" demonstrated competency in administration of medication through a G-tube on 9/9/15 and LPN "B" demonstrated competency checking blood sugar with a Glucometer on 9/10/15. On 9/11/15 the Administrator assigned all LPNs on staff to an individual RN to serve as a mentor and to provide ongoing supervision and guidance. <b>To prevent the deficiency from recurring:</b> Monitoring for continued compliance will be achieved through a QA activity of weekly home visits to observe handwashing, gloving, bag technique, and universal precautions in the patient care setting. The Administrator and RN designees will observe 5% of the total number of clinical employees weekly for a minimum of 7 months or until 100% compliance is achieved, whichever is longer. The Administrator is responsible conducting, coordinating, and documenting in-home observations. The QA Manager is responsible for maintaining data, calculating and reporting compliance rates on a monthly basis. Any clinical employee who fails to demonstrate compliance with infection control policies (including handwashing, gloving, and bag technique) during provision of care will be re-trained before performing any</p>				

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	<p>soiled linen ... Proper handwashing techniques should be prior to touching food ... "</p> <p>A 6. A policy titled Handwashing, dated 03/2009, indicated "Personnel providing care / service in the home setting will wash their hands ... after handling bed pans, urinals, catheters, linens, before and after gloves are used, before and after eating, after use of the toilet ... Using an approved antiseptic hand cleanser and towels or antiseptic towelettes ... dry hands with paper towels or clean cloth towel ... use this procedure only if water is not available."</p> <p>A 7. A policy titled Nursing Bag Technique, dated 03/2009, indicated "When the visit is completed, reusable equipment is cleaned using alcohol and / or soap and water ... hands are washed and equipment and supplies are returned to the bag, hands are washed prior to returning clean equipment to bag ... "</p> <p>B 1. Clinical record number 6 included a plan of care established by a physician for the certification period of 06/15/15 to 08/13/15 with orders for skilled nursing six times a week for one week, seven times a week for seven weeks, then five times a week for one week up to 10 hours</p>		<p>additional client care. Any clinical employee who repeats non-compliance after re-training will be relieved of patient care responsibilities. The Administrator is responsible for re-training and removal of nurses from admission responsibilities. On 9/11/15 the Administrator implemented a policy requiring LPN supervision by an RN as often as necessary to insure safe and effective care, but in any event no less frequently than every 30 days. The Administrator is responsible for assigning and scheduling RNs for LPN supervisory visits. On 9/11/15 the Administrator added competency demonstration of specialized procedures to the orientation and education program for LPNs. The Administrator also developed an LPN assignment procedure requiring the identification of any specialized skills required on each case and documentation of how any LPN assigned to the case has demonstrated the skills necessary for safe and effective patient care. The LPN assignment document was implemented 9/11/15. The Administrator is responsible for ensuring that the procedure is followed. LPN competency and supervision monitoring was incorporated into the QA program on 9/11/15. Monitoring elements include 100% of LPN cases for supervisory visits, LPN orientation documents, LPN assignment</p>	

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	<p>a day.</p> <p>a. Upon arrival on 08/11/15 at 2:00 PM, the patient was observed to be sitting up in his wheelchair with a tube starting at the feeding bag and ending to the patient's gastric tube from his abdomen. The tube feeding was running at a rate of 250 ml (milliliters) per hour. 2:10 PM, Employee J, LPN, was observed preparing to give the patient his medications through his gastric tube. Employee J stopped the tube feeding and indicated that she wasn't going to check for residual because the patient would "naturally" have residual since the patient was receiving tube feedings. The employee proceeded to flush the gastric tube with 20 ml of water, then proceeded giving the prescribed medications. Once the medication administration was completed, the employee reconnected the tube to the feeding bag and resumed the feeding.</p> <p>b. Upon review of the established plan of care, the skilled nursing instructions indicated, "SN [skilled nurse]: Check placement of g-tube prn [as needed] dislodgement / occlusion via auscultation / aspiration before flush / RX [medication] administration."</p> <p>c. Upon review of communication</p>		<p>procedure followed for each LPN assignment, and review of 100% of LPN nursing visits on a weekly basis to ensure that LPNs have been competency tested for any specialized care provided. Monitoring will continue until 100% compliance is achieved for at least 3 consecutive months or for 7 months, whichever is longer. The QA Manager is responsible for data collection and reporting to the Administrator. The Administrator is responsible for re-training and any necessary disciplinary action required based on QA findings.</p>	

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NAME OF PROVIDER OR SUPPLIER  BETTER LIVING HOME HEALTH CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2040 WASHINGTON AVENUE EVANSVILLE, IN 47714
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N 0524 Bldg. 00	<p>notes between former Director of Nursing and Employee J, on 07/06/15 at 3:57 PM, the patient had gastric residuals of greater than 50 ml. The physician had been notified with return orders to hold for one hour if residuals are greater than 50 mls.</p> <p>B 2. Employee J employee record was reviewed on 08/14/15 at 3:00 PM. Employee J had a form titled "Giving Medicine Using G-Tube" in her file. The handout indicated "Sitting up, remove plug from G-Tube ... Attach syringe, pull back on the plunger and draw out some stomach contents. Push down on plunger and return the stomach contents. Flush G-Tube with 30 ml of water. Draw up the medicine into the syringe. Attach syringe and push down on the plunger to give the medicine ... "</p> <p>B 3. Employee A, Administrator / Registered Nurse, was interviewed on 08/13/15 at 3:10 PM. Employee A stated Employee J had been counceled on professional standards of gastrostomy tubes and checking placement in the past.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p>			

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	<p>(A) Be developed in consultation with the home health agency staff.</p> <p>(B) Include all services to be provided if a skilled service is being provided.</p> <p>(B) Cover all pertinent diagnoses.</p> <p>(C) Include the following:</p> <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> <p>Based on clinical record and policy review, the agency failed to ensure plans of care were revised and updated to include all diagnoses, all medications for 2 of 10 records reviewed (#1 and 4) and failed to ensure that a comprehensive assessment was conducted within five days of the patients Medicaid Authorization for services for 1 of 7 Medicaid records reviewed. (# 5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1, SOC (start</li> </ol>	N 0524	<p><b>Actions taken to correct deficiency</b> On 8/27/15 the Administrator reviewed the agency policies related to the establishment and ongoing development of the plan of care, following the plan of care, updating the plan of care, and medication review. No policy changes were needed. On 9/12/15 the Administrator met with the Administrative nursing staff and Case Managers to provide training and education on Case Management responsibilities as they relate to the establishment and ongoing development of the plan of care, more specifically updating all</p>	09/12/2015

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	<p>of care) 06/03/14, included a plan of care established by the physician for the certification period 05/29/15 to 07/27/15 with primary diagnosis of cerebral palsy and secondary diagnoses of intellectual disability, epilepsy, chronic obstructive pulmonary disease, and depression.</p> <p>a. A faxed medication summary from the patient's physician dated 05/26/15, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, detrol 2 mg by mouth twice a day, hydroxyzine HCL 25 mg at bedtime as needed, ipratropium - albuterol 0.5 mg - 3 mg nebulization solution 1 unit three times a day, symbicort 160 mcg (micrograms) aerosol inhaler 2 puffs twice a day, metformin 50 mg daily, loperamide 2 mg, 2 tablets daily as needed, aspirin 81 mg daily, benzonate 200 mg every four hours as needed, vitamin D3 2,000 unit daily, aricept 5 mg every evening, docusate sodium 100 mg daily, multivitamin daily, and simvastatin 10 mg daily.</p> <p>b. The 05/29/15 to 07/27/15 established plan of care indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, combivent 18/103 mcg / act every 6 hours as needed, hydroxyzine HCL 25 mg at bedtime as</p>		<p>diagnoses and medications. 9/8/15 RN Case Manager assigned to Patient # 1 contacted appropriate physicians to clarify medication, diagnoses, and treatment orders and to obtain any orders needed to fully update the plan of care and medication profile. Plans and profiles fully updated. Patient #4 was discharged a year prior to the survey so no patient- specific corrective action could be taken. 9 /12/15 Since all clients could be affected RN Case Managers conducted a 100% review of their current caseloads to determine if other patients were affected by the failure to keep plans of care updated. One other instance of medication orders out of date was discovered and corrected on 9/11/15.</p> <p><b>Actions taken to prevent deficiency from recurring:</b> Effective 9/12/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 2 in 10 records or 20% is the baseline for a QA activity monitoring 100% of all records for compliance with updating diagnoses, medications, and other aspects of case management relevant to updating the plans of care. The QA Manager is responsible for collecting the raw data, calculating the compliance rate and reporting data to the</p>				

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	<p>needed, docusate 100 mg daily, metformin 500 mg daily, milk of magnesia 30 mg daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime.</p> <p>c. The medication profile was initiated on 06/03/14, and provided only one date for drug regimen review of 07/23/15. The medication profile indicated advair diskus 250 / 50 mcg 1 puff twice a day, combivent 18/103 2 puffs twice a day, acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, docusate 100 mg daily, fluoxetine 10 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, hydroxyzine HCL 25 mg at bedtime as needed, multivitamin daily, naproxen 500 mg twice a day as needed, donepezil HCL (aricept) 5 mg at bedtime, simvastatin 10 mg daily, mybetriq ER 50 mg daily, trazadone 100 mg at bedtime, metformin 500 mg daily, melatonin 3 mg two tabs at bedtime, tolterodine (detrol) 1 mg by mouth twice a day, multi - vitamin D3 2,000 unit daily, symbicort 160 / 4.5 two puffs twice a day, and mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed.</p> <p>d. The 07/28/15 to 09/25/15</p>		<p>Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months or 7 months, whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining. Increasing record review frequency, and/or disciplinary action based on QA findings. <b>Actions taken to correct deficiency</b> 8/14/15 the Administrator reviewed patient record #5 to determine if a comprehensive assessment needed to be conducted. A comprehensive assessment had been conducted during the survey on 8/12/15. No additional assessments will be made. On 8/27/15 the Administrator reviewed agency policies related to Comprehensive Assessment of Patients. No policy changes were needed. 9/4/15 The Administrator met with Administrative nurses and Case Managers, Admission and Assessment Nurses, and Intake Coordinator to provide training and education on the Comprehensive Assessment of Patients, specifically, the</p>				

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	<p>established plan of care, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, advair diskus 250 / 50 mcg 1 puff twice a day, aspirin 81 mg daily, combivent 18/103 2 puffs twice a day, docusate 100 mg daily, donepezil HCL (aricept) 5 mg at bedtime, fluoxetine 10 mg daily, hydroxyzine HCL 25 mg at bedtime as needed, metformin 500 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, myebetriq ER 50 mg daily, mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, symbicort 160 / 4.5 two puffs twice a day, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime</p> <p>The medication section of the plan of care failed to be updated / revised with correct dosages and most current medications every 60 days and as needed and the plan of care failed to include the patient was a diabetic.</p> <p>2. Clinical record number 4 included a plan of care established by a physician for certification period 08/01/14 to 09/29/14.</p> <p>a. A skilled nurse visit note dated</p>		<p>requirement to conduct a comprehensive assessment consistent with the patient's immediate needs, but no later than 5 days after the start of care.</p> <p>9/4/15 The Administrator discontinued the practice of using the date of the Initial Comprehensive Assessment as the SOC date in cases where the initiation of care will be delayed after the initial assessment until the PA is approved. <b>Actions taken to prevent deficiency from recurring:</b> On 9/8/15 the Administrator initiated a QA activity to monitor for continued compliance. The surveyor identified non-compliance rate of 1 in 7 records or 14% will be the baseline for monitoring 100% of all Admissions to determine if the comprehensive assessment was completed within 5 days of the SOC. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate and reporting it to the Administrator on a monthly basis. This activity will continue until a compliance rate of 100% is achieved for 3 consecutive months, or 7 months whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below</p>				

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	<p>08/27/14 indicated the patient had been prescribed Levaquin 250 mg by mouth daily for 7 days.</p> <p>b. A skilled nurse visit note dated 09/03/14 indicated the patient had been prescribed Aspirin 81 mg by mouth daily and Prednisone 10 mg by mouth daily for 10 days.</p> <p>c. A skilled nurse visit note dated 09/17/14 indicated the patient had been prescribed Keflex 500 mg by mouth twice a day for 10 days.</p> <p>The medication section of the plan of care failed to be updated / revised to include the new medications prescribed to the patient.</p> <p>3. A policy titled On-Going Assessment dated 03/2009 indicated, "Based on the findings of the reassessment, verbal orders are generated and forwarded to the physician as needed. The physician will be notified to verify any changes in medications, including over the counter medications, and / or treatment / interventions that require physician approval.</p> <p>4. Clinical record number 5, SOC (start of care) 06/26/15, included a plan of care established by the physician for the</p>		100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained.		

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	<p>certification period 06/26/15 to 08/24/15 with orders for skilled nursing "to begin once authorized."</p> <p>a. Review of the skilled nursing visit notes, the patient had an initial assessment dated 06/26/15. The next skilled nursing visit was 07/19/15. The 07/19/15 was a routine visit and not a comprehensive assessment.</p> <p>b. Review of the established plan of care, the start of care date indicated 06/26/15 and not the actual start of care date 07/19/15.</p> <p>2. Employee A, Administrator / Registered Nurse, was interview on 08/13/15 at 11:30 AM. Employee A stated skill nursing services started on 07/19/15 because the agency was waiting for authorization from Medicaid. The established plan of care was for reimbursement and prior authorization from Medicaid. Employee A stated he / she could not remember if the plan of care needed to be updated / revised once Medicaid was approved.</p> <p>3. A policy titled Client Plan of Care dated 03/2009, indicated "The RN ... promptly notifies the physician of any changes that suggests a need to modify the plan of care; Changes in the plan of</p>			

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N 0541 Bldg. 00	<p>care are documented through written and verbal orders ... The attending physician's recertification is obtained at intervals of at least once every 60 days and / or when the client's plan of care is reviewed and updated as appropriate. A CMS 485 is completed and forwarded to the physician for signature; When Better Living forwards the request for reimbursement to the intermediary, Better Living certifies that the requisite certification and recertifications have been made by the attending physician and are on file at Better Living."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, clinical record review and interview, the agency failed to ensure the patient was accurately assessed upon return from the hospital and upon recertification for 1 of 8 records reviewed that required a recertification. (# 10)  Findings include:  1. Clinical record number 10 included a</p>	N 0541	<p><b>The deficiency was corrected as follows:</b> On 8/26/15 the Administrator reviewed the agency policies related to Comprehensive Assessments at resumption of care. No needs for policy changes were identified. On 8/28/15 the Administrator conducted a complete and accurate comprehensive assessment on Client #10. The patient had no rectal bleeding. She was independent with ambulation and</p>	09/11/2015

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	<p>plan of care established by the physician for certification period of 08/04/15 to 10/02/15 with orders for a home health aide four times a week for one week then five times a week for eight weeks for two hours per visit to assist with personal care and activities of daily living. Patient primary diagnosis was joint pain with secondary diagnoses of ankylosing spondylitis, myalgia and myositis. Functional limitations included ambulation and dyspnea with minimal exertion.</p> <p>a. A visit was made to the patient's home on 08/12/15 at 11:00 AM. The patient had stated he / she was in the hospital recently for approximately a week due to blood loss through her rectum. The patient had indicated she was treated with antibiotics for approximately a week and returned home.</p> <p>b. Patient was observed getting up from the couch and walking to the bathroom at a slow pace. Employee G was observed assisting the patient with getting undressed and helping the patient to sit down into the bath tub. Employee G washed the patient's back, assisted the patient getting out of the bath tub, then proceeded to assist the patient with drying the body and putting clothes back</p>		<p>toileting. She was able to independently get a drink and crackers. Other ADLs were not observed. The patient reported that she has "good days and bad days." On 9/4/15 the Administrator met with the RN Case Managers and Admission and Assessment Nurses to provide training and education on conducting highly accurate comprehensive assessments, and more specifically at the time of resumption of care. Comprehensive assessment forms both with and without the OASIS Data set were reviewed and nurses were instructed to fill each area of the assessment out as completely and accurately as possible. Accuracy of ADL assessments were specifically addressed as well. On 9/11/15 the Administrator met with Employee G to evaluate training needs. Employee G was able to competently describe how to assess ADL's and verbalize the appropriate answer to OASIS questions when given a scenario where nursing judgment is required. Employee G was instructed to prepare all comprehensive assessments and OASIS items with care. Employee G feels confident and competent with Assessments and OASIS items. Employee G believes she scheduled too many assessments in one day that may have contributed</p>	

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	<p>on the upper and lower body.</p> <p>c. Review of the comprehensive resumption of care assessment dated 07/29/15, the assessment failed to identify that the patient had rectal bleeding. Assessment of the activities of daily living indicated the patient was independent with grooming, dressing the upper and lower body, bathing, toilet transferring, toileting hygiene, transferring, ambulation / locomotion, ability to plan and prepare light meals.</p> <p>d. Review of the comprehensive assessment dated 07/30/15, the assessment failed to identify that the patient had rectal bleeding. Assessment of the activities of daily living indicated the patient was independent with dressing the upper and lower body, bathing, toilet transferring, and able to bear weight and pivot during the transfer process but unable to transfer self.</p> <p>2. Employee A, Administrator, was interviewed on 08/13/15 at 3:30 PM. Employee A indicated that he / she was surprised of the inaccurate assessment by Employee G due to the employee work history background. Employee A also indicated that Employee G was put out into the field too soon and did not have enough time for orientation due to staff</p>		<p>to inaccuracy. The Administrator will approve all of Employee G's schedules in advance until such time that QA activities show an improvement in her individual accuracy on Comprehensive Assessments and OASIS items</p> <p><b>To prevent the deficiency from recurring:</b> Effective 9/8/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 1 in 8 records or 13% is the baseline for a QA activity monitoring 100% of all records for consistency and accuracy of comprehensive assessments at resumption of care. The QA Manager is responsible for collecting raw data, calculating compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months, or 7 months, whichever is longer. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to</p>	

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N 0542  Bldg. 00	<p>turn-around and Employee G was needed out in the field.</p> <p>3. A policy titled Reassessments / Recertifications dated 03/2009, indicated "Each client is reassessed and the plan of care reviewed and revised when ... The client's condition improves or deteriorates, the client has a change in diagnoses, there is a significant change in the client's care environment and / or support system ... Documentation in the clinical record should support the assessment as well as the actions taken in response ... "</p> <p>Based on observation, clinical record review and interview, the agency failed to ensure the Registered Nurse accurately for 1 of 2 records reviewed of patients being hospitalized during a certification period. (# 10)</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p>		correct this deficiency and to ensure that compliance is maintained. We are requesting an IDR because The assessments conducted on 7/30/15 were accurate as of the day of the assessment.				

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	<p>Based on clinical record and policy review, the agency failed to ensure plans of care were revised and updated to include all diagnoses, all medications for 2 of 10 records reviewed (#1 and 4) and failed to ensure that a comprehensive assessment was conducted within five days of the patients Medicaid Authorization for services for 1 of 7 Medicaid records reviewed. (# 5)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 06/03/14, included a plan of care established by the physician for the certification period 05/29/15 to 07/27/15 with primary diagnosis of cerebral palsy and secondary diagnoses of intellectual disability, epilepsy, chronic obstructive pulmonary disease, and depression.</p> <p>a. A faxed medication summary from the patient's physician dated 05/26/15, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, detrol 2 mg by mouth twice a day, hydroxyzine HCL 25 mg at bedtime as needed, ipratropium - albuterol 0.5 mg - 3 mg nebulization solution 1 unit three times a day, symbicort 160 mcg (micrograms) aerosol inhaler 2 puffs twice a day, metformin 50 mg daily, loperamide 2 mg, 2 tablets daily as</p>	N 0542	<p><b>Actions taken to correct deficiency</b> On 8/27/15 the Administrator reviewed the agency policies related to the establishment and ongoing development of the plan of care, following the plan of care, updating the plan of care, and medication review. No policy changes were needed. On 9/12/15 the Administrator met with the Administrative nursing staff and Case Managers to provide training and education on Case Management responsibilities as they relate to the establishment and ongoing development of the plan of care, more specifically updating all diagnoses and medications. 9/8/15 RN Case Manager assigned to Patient # 1 contacted appropriate physicians to clarify medication, diagnoses, and treatment orders and to obtain any orders needed to fully update the plan of care and medication profile. Plans and profiles fully updated. Patient #4 was discharged a year prior to the survey so no patient- specific corrective action could be taken. 9/12/15 Since all clients could be affected RN Case Managers conducted a 100% review of their current caseloads to determine if other patients were affected by the failure to keep plans of care updated. One other instance of medication orders out of date was discovered and corrected on 9/11/15.</p>	09/12/2015			

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	<p>needed, aspirin 81 mg daily, benzonate 200 mg every four hours as needed, vitamin D3 2,000 unit daily, aricept 5 mg every evening, docusate sodium 100 mg daily, multivitamin daily, and simvastatin 10 mg daily.</p> <p>b. The 05/29/15 to 07/27/15 established plan of care indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, combivent 18/103 mcg / act every 6 hours as needed, hydroxyzine HCL 25 mg at bedtime as needed, docusate 100 mg daily, metformin 500 mg daily, milk of magnesia 30 mg daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime.</p> <p>c. The medication profile was initiated on 06/03/14, and provided only one date for drug regimen review of 07/23/15. The medication profile indicated advair diskus 250 / 50 mcg 1 puff twice a day, combivent 18/103 2 puffs twice a day, acetaminophen 325 mg every four hours as needed, aspirin 81 mg daily, docusate 100 mg daily, fluoxetine 10 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, hydroxyzine HCL 25</p>		<p><b>Actions taken to prevent deficiency from recurring:</b> Effective 9/12/15 the Administrator established a QA activity to monitor ongoing compliance. The surveyor identified non-compliance rate of 2 in 10 records or 20% is the baseline for a QA activity monitoring 100% of all records for compliance with updating diagnoses, medications, and other aspects of case management relevant to updating the plans of care. The QA Manager is responsible for collecting the raw data, calculating the compliance rate and reporting data to the Administrator at least every 30 days. This activity will continue until 100% compliance is achieved for 3 consecutive months or 7 months, whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining. Increasing record review frequency, and/or disciplinary action based on QA findings. <b>Actions taken to correct deficiency</b> 8/14/15 the Administrator reviewed patient record #5 to determine if a</p>	

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	<p>mg at bedtime as needed, multivitamin daily, naproxen 500 mg twice a day as needed, donepezil HCL (aricept) 5 mg at bedtime, simvastatin 10 mg daily, myebetriq ER 50 mg daily, trazadone 100 mg at bedtime, metformin 500 mg daily, melatonin 3 mg two tabs at bedtime, tolterodine (detrol) 1 mg by mouth twice a day, multi - vitamin D3 2,000 unit daily, symbicort 160 / 4.5 two puffs twice a day, and mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed.</p> <p>d. The 07/28/15 to 09/25/15 established plan of care, indicated the patient was to be taking acetaminophen 325 mg every four hours as needed, advair diskus 250 / 50 mcg 1 puff twice a day, aspirin 81 mg daily, combivent 18/103 2 puffs twice a day, docusate 100 mg daily, donepezil HCL (aricept) 5 mg at bedtime, fluoxetine 10 mg daily, hydroxyzine HCL 25 mg at bedtime as needed, metformin 500 mg daily, milk of magnesia 30 mg / 30 ml daily as needed, multivitamin daily, multi - vitamin D3 2,000 unit daily, myebetriq ER 50 mg daily, mylanta 200 / 200 / 20 mg / 5 ml 30 ml every 6 hours as needed, naproxen 500 mg twice a day as needed, simvastatin 10 mg daily, symbicort 160 / 4.5 two puffs twice a day, tolterodine (detrol) 1 mg by mouth twice a day, and trazadone 100 mg at bedtime</p>		<p>comprehensive assessment needed to be conducted. A comprehensive assessment had been conducted during the survey on 8/12/15. No additional assessments will be made. On 8/27/15 the Administrator reviewed agency policies related to Comprehensive Assessment of Patients. No policy changes were needed. 9/4/15 The Administrator met with Administrative nurses and Case Managers, Admission and Assessment Nurses, and Intake Coordinator to provide training and education on the Comprehensive Assessment of Patients, specifically, the requirement to conduct a comprehensive assessment consistent with the patient's immediate needs, but no later than 5 days after the start of care. 9/4/15 The Administrator discontinued the practice of using the date of the Initial Comprehensive Assessment as the SOC date in cases where the initiation of care will be delayed after the initial assessment until the PA is approved. <b>Actions taken to prevent deficiency from recurring:</b> On 9/8/15 the Administrator initiated a QA activity to monitor for continued compliance. The surveyor identified non-compliance rate of 1 in 7 records or 14% will be the baseline for monitoring 100% of all Admissions to determine if the comprehensive assessment was</p>	

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	<p>The medication section of the plan of care failed to be updated / revised with correct dosages and most current medications every 60 days and as needed and the plan of care failed to include the patient was a diabetic.</p> <p>2. Clinical record number 4 included a plan of care established by a physician for certification period 08/01/14 to 09/29/14.</p> <p>a. A skilled nurse visit note dated 08/27/14 indicated the patient had been prescribed Levaquin 250 mg by mouth daily for 7 days.</p> <p>b. A skilled nurse visit note dated 09/03/14 indicated the patient had been prescribed Aspirin 81 mg by mouth daily and Prednisone 10 mg by mouth daily for 10 days.</p> <p>c. A skilled nurse visit note dated 09/17/14 indicated the patient had been prescribed Keflex 500 mg by mouth twice a day for 10 days.</p> <p>The medication section of the plan of care failed to be updated / revised to include the new medications prescribed to the patient.</p>		<p>completed within 5 days of the SOC. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate and reporting it to the Administrator on a monthly basis. This activity will continue until a compliance rate of 100% is achieved for 3 consecutive months, or 7 months whichever is longer. The Administrator is responsible for taking action on unexpected results. Staff retraining, increasing record review frequency, and/or disciplinary action will occur as needed to achieve 100% compliance or to restore compliance if it falls below 100%. The Administrator is responsible for initiating retraining, increasing record review frequency, and/or disciplinary action based on QA findings. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained.</p>		

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	<p>3. A policy titled On-Going Assessment dated 03/2009 indicated, "Based on the findings of the reassessment, verbal orders are generated and forwarded to the physician as needed. The physician will be notified to verify any changes in medications, including over the counter medications, and / or treatment / interventions that require physician approval.</p> <p>4. Clinical record number 5, SOC (start of care) 06/26/15, included a plan of care established by the physician for the certification period 06/26/15 to 08/24/15 with orders for skilled nursing "to begin once authorized."</p> <p>a. Review of the skilled nursing visit notes, the patient had an initial assessment dated 06/26/15. The next skilled nursing visit was 07/19/15. The 07/19/15 was a routine visit and not a comprehensive assessment.</p> <p>b. Review of the established plan of care, the start of care date indicated 06/26/15 and not the actual start of care date 07/19/15.</p> <p>2. Employee A, Administrator / Registered Nurse, was interview on 08/13/15 at 11:30 AM. Employee A stated skill nursing services started on</p>			

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N 0550 Bldg. 00	<p>07/19/15 because the agency was waiting for authorization from Medicaid. The established plan of care was for reimbursement and prior authorization from Medicaid. Employee A stated he / she could not remember if the plan of care needed to be updated / revised once Medicaid was approved.</p> <p>3. A policy titled Client Plan of Care dated 03/2009, indicated "The RN ... promptly notifies the physician of any changes that suggests a need to modify the plan of care; Changes in the plan of care are documented through written and verbal orders ... The attending physician's recertification is obtained at intervals of at least once every 60 days and / or when the client's plan of care is reviewed and updated as appropriate. A CMS 485 is completed and forwarded to the physician for signature; When Better Living forwards the request for reimbursement to the intermediary, Better Living certifies that the requisite certification and recertifications have been made by the attending physician and are on file at Better Living."</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for</p>			

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	<p>purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review and interview, the agency failed to ensure a Registered Nurse establish a written plan of care in relation to a patient needing more than 1 visit from a home health aide in a 24 hour for 1 of 8 records reviewed for home health aide services. (# 3)</p> <p>Finding include:</p> <ol style="list-style-type: none"> <li>Clinical record number 3 evidence a plan of care established by the physician for the certification period of 05/22/15 to 07/20/15 with orders for home health aide services two times a week for one week, seven times a week for eight weeks, and two times a week for one week for three hours in the morning and one hour in the evening. The clinical record was reviewed on 08/12/15, in which it revealed only one home health aide care plan and failed to indicate if the careplan was for AM or PM.</li> <li>Upon the exit conference on 08/14/15, the Administrator indicated she was not aware that a care plan needed to be developed for the home health aide for each visit if there were two visits in one</li> </ol>	N 0550	<p><b>The deficiency was corrected as follows:</b> 8/18/15 The Administrator and the RN Case Manager for client #3 developed home health aide plans of care for each instance of care in a 24 hour period. The Administrator delivered the care plans to the client's home and documented information about the multiple care plans in the staff communication notebook. 8/28/15 The Administrator changed the Aide care planning policy to include the requirement for a separate written aide care plan for each instance of care occurring within a 24 hour period. On 8/29/15 the Administrator held a staff meeting with Case Managers and nurses who supervise aides to educate them on changes to the Aide Care Plan policy and their responsibility to develop Home Health Aide Care Plans for every instance of care in a 24 hour period. The nurses were instructed that when a patient needs more than one visit from a home health aide in a 24 hour period a written plan of care must be developed to specifically address the aide activities to occur at each visit. On 8/29/15 the Administrator held a staff meeting with HR and</p>	09/12/2015

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	<p>day.</p> <p>3. A policy titled Home Health Aide Services, dated 03/09, indicated "The home health aide shall be provided with written instructions for patient care prepared by a Registered Nurse ... "</p> <p>4. A policy titled Home Health Aide Assignments, dated 03/09, indicated "The RN [Registered Nurse] / Case Manager is responsible for the assignment of the HHA [Home Health Aide], and the HHA care plan is developed by a registered nurse following assessment of the clients specific needs ... Is completed and reviewed with the HHA prior to start of HHA services ... "</p>		<p>QA/Education Manager to ensure that this requirement is incorporated into RN training documents and is listed on the RN orientation checklist. 9/9/15 The Administrator assisted the RNs in identifying all patients who receive multiple aide visits in a 24 hour period, and in the development of new care plans to cover each instance of care. Home Health Aides were trained on the new policy of having multiple care plans in the home and determining which care plan to follow at each instance of care. Training took place over six different dates, including 8/26/15, 9/2/15, 9/9/15, 9/10/15, 9/11/15, and 9/12/15. 9/12/15 Administrator and Case Managers disseminated new care plans to all remaining affected clients. <b>To prevent the deficiency from recurring:</b> 9/12/15 the Administrator implemented a QA activity to monitor 100% of relevant patient records for the presence of aide care plans for each instance of care in a 24 hour period. Each case will be monitored every 60 days. The surveyor identified non-compliance rate of 1 in 8 records or 12% will be the baseline for the QA activity monitor. The QA Manager is responsible for collecting the raw data, calculating the non-compliance rate, and reporting to the Administrator every 60 days. This activity will</p>				

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N 0555 Bldg. 00	410 IAC 17-14-1(a)(2)(C) Scope of Services Rule 14 Sec. 1(a) (2)(C) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (C) Assist the physician and/or registered nurse in performing specialized procedures. Based on observation, clinical record and employee record review, and interview, the Licensed Practical Nurse (LPN) failed to follow agency policy and professional practice standards in relation to providing medication through a patient's gastric feeding tube without first checking residuals for 1 of 1 patient observed for administration of medications through a	N 0555	continue until 100 % compliance is achieved for 3 consecutive months, or 7 months, whichever is greater. Staff retraining, increased frequency of record reviews, and/or disciplinary action will occur as needed to achieve compliance or restore compliance if the compliance rate drops back below 100%. The Administrator is responsible for determining individual needs for retraining, increased frequency of record reviews, or disciplinary action. The Administrator is responsible for implementing corrective actions as necessary. The Administrator is responsible for overall compliance with the plan to correct this deficiency and to ensure that compliance is maintained.  <b>The deficiency was corrected as follows:</b> On 8/15/15 the Administrator reviewed agency policy and procedure with employee j and instructed the employee to follow policy and procedure when administering medication through the G-tube. Employee J was provided with a manual of clinical nursing procedures and performance	09/11/2015

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	<p>gastric tube. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6 included a plan of care established by a physician for the certification period of 06/15/15 to 08/13/15 with orders for skilled nursing six times a week for one week, seven times a week for seven weeks, then five times a week for one week up to 10 hours a day.</p> <p>a. Upon arrival on 08/11/15 at 2:00 PM, the patient was observed to be sitting up in his wheelchair with a tube starting at the feeding bag and ending to the patient's gastric tube from his abdomen. The tube feeding was running at a rate of 250 ml (milliliters) per hour. 2:10 PM, Employee J, LPN, was observed preparing to give the patient his medications through his gastric tube. Employee J stopped the tube feeding and indicated that she wasn't going to check for residual because the patient would "naturally" have residual since the patient was receiving tube feedings. The employee proceeded to flush the gastric tube with 20 ml of water, then proceeded giving the prescribed medications. Once the medication administration was completed, the employee reconnected the tube to the feeding bag and resumed the</p>		<p>expectations for procedural compliance. Employee J's job description was reviewed, including the responsibility to follow agency policies and provide care according to the established Plan of Care. The Administrator placed Employee J on probationary status for no less than 12 weeks due to failure to follow agency policy on medication administration through a G-tube. The employee was instructed that failure to follow policies and procedures will result in termination. The Administrator is responsible for any additional disciplinary action. On 8/24/15 the Administrator installed an RN on the case to provide direct patient care, weekly in-home case management, assessment of LPN technical skills, and supervision of care provided by LPNs. It is the case manager's responsibility to provide in-home supervision and report findings to the Administrator on a weekly basis. Also on this date, employee J was observed by the Administrator and RN Case Manager to competently administer medication via the G-Tube in compliance with agency policy and procedure. To ensure that other patients weren't at similar risk, all LPNs providing g-tube medications or any other specialized procedure were required to demonstrate procedural competency to the Administrator. Only two</p>		

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	<p>feeding.</p> <p>b. Upon review of the established plan of care, the skilled nursing instructions indicated, "SN [skilled nurse]: Check placement of g-tube prn [as needed] dislodgement / occlusion via auscultation / aspiration before flush / RX [medication] administration."</p> <p>c. Upon review of communication notes between former Director of Nursing and Employee J, on 07/06/15 at 3:57 PM, the patient had gastric residuals of greater than 50 ml. The physician had been notified with return orders to hold for one hour if residuals are greater than 50 mls.</p> <p>2. Employee J employee record was reviewed on 08/14/15 at 3:00 PM. Employee J had a form titled "Giving Medicine Using G-Tube" in her file. The handout indicated "Sitting up, remove plug from G-Tube ... Attach syringe, pull back on the plunger and draw out some stomach contents. Push down on plunger and return the stomach contents. Flush G-Tube with 30 ml of water. Draw up the medicine into the syringe. Attach syringe and push down on the plunger to give the medicine ... "</p> <p>3. Employee A, Administrator / Registered Nurse, was interviewed on</p>		<p>additional LPNs were providing any specialized procedures. LPN "A" demonstrated competency in administration of medication through a G-tube on 9/9/15 and LPN "B" demonstrated competency checking blood sugar with a Glucometer on 9/10/15. On 9/11/15 the Administrator assigned all LPNs on staff to an individual RN to serve as a mentor and to provide ongoing supervision and guidance. <b>To prevent the deficiency from recurring:</b> On 9/11/15 the Administrator implemented a policy requiring LPN supervision by an RN as often as necessary to insure safe and effective care, but in any event no less frequently than every 30 days. The Administrator is responsible for assigning and scheduling RNs for LPN supervisory visits. On 9/11/15 the Administrator added competency demonstration of specialized procedures to the orientation and education program for LPNs. The Administrator also developed an LPN assignment procedure requiring the identification of any specialized skills required on each case and documentation of how any LPN assigned to the case has demonstrated the skills necessary for safe and effective patient care. The LPN assignment document was implemented 9/11/15. The Administrator is responsible for ensuring that the procedure is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157621	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2015
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	08/14/15 at 3:10 PM. Employee A stated Employee J had been counceled on professional standards of gastrostomy tubes and checking placement in the past.		followed. LPN competency and supervision monitoring was incorporated into the QA program on 9/11/15. Monitoring elements include 100% of LPN cases for supervisory visits, LPN orientation documents, LPN assignment procedure followed for each LPN assignment, and review of 100% of LPN nursing visits on a weekly basis to ensure that LPNs have been competency tested for any specialized care provided. Monitoring will continue until 100% compliance is achieved for at least 3 consecutive months or for 7 months, whichever is longer. The QA Manager is responsible for data collection and reporting to the Administrator. The Administrator is responsible for re-training and any necessary disciplinary action required based on QA findings.		