

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2015
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NAME OF PROVIDER OR SUPPLIER 1ST CARE HOME HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 6100 N KEYSTONE SUITE 639 INDIANAPOLIS, IN 46220
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N 0000 Bldg. 00	<p>This was a home health agency state complaint investigation.</p> <p>Complaint #00163668: Substantiated: Related and unrelated deficiencies are cited.</p> <p>Survey dates: 7-15 and 7-16-2015</p> <p>Facility number 012788</p> <p>Medicaid Vendor #: 201139080</p> <p>Current Census: 209</p> <p>QR: JE 7/24/15</p>	N 0000	<p>Plan Of Correction is submitted as of 08/04/2015. For : This was a home health agency state complaint investigation. Complaint #00163668: Substantiated: Related and unrelated deficiencies are cited. Survey dates: 7-15 and 7-16-2015 Facility number 012788 Medicaid Vendor #: 201139080 Current Census: 209 QR: JE 7/24/15</p>	
N 0456 Bldg. 00	<p>410 IAC 17-12-1(e) Home health agency administration/management</p> <p>Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following:</p> <p>(1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care.</p> <p>(2) Resolve identified problems.</p>			

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

TITLE

(X6) DATE

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

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	<p>(3) Improve patient care.</p> <p>Based on review of agency quality assurance/performance improvement (QAPI) documents and interview, the administrator failed to ensure the agency QAPI program systematically monitored and evaluated the quality and appropriateness of patient care, and documented improvement in patient care for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. QAPI meeting minutes from 3-13-14 evidenced an agency goal for the QAPI program of "attain a good standing in the OASIS driven Medicare comparison for State and National Home Health Agencies. We have selected achieving a high standing in improvement in the percentage of patients who improve transferring in and out of bed and in the percentage of patients who improve in understanding their medications. We are continuing to emphasize teaching and documentation in these areas in an effort to achieve a high Medicare OASIS [OBQI] rating." The meeting minutes failed to evidence any objective data to measure the agency performance.</p> <p>2. QAPI meeting minutes from 6-19-14 evidenced an agency goal for the QAPI</p>	N 0456	<p>1.0456-- Administration will ensure the QAPI program systematically monitors and evaluates the quality and appropriateness of patient care and provides documented improvement in patient care.</p> <p>1. The Administrator is responsible to ensure that each quarter the Clinical Record Review Committee meets in accordance with policies 8.22 and 8.23 and completes the quarterly clinical chart audits. Audit results will be recorded in writing and forwarded to the QAPI committee for review.</p> <p>2. The DON will be responsible to oversee the chart audits during the Clinical Record Review Committee held quarterly and to spotcheck the medical records that were reviewed.</p> <p>3. All deficiencies noted in the 3/13/14, 06/19/14 and 03/31/15 QAPI minutes will trended and action plans developed presented to the Professional Advisory Committee for approval and implementation as appropriate.</p> <p>4. The DON will be responsible to complete a mandatory in-service for all clinical staff. The in-service will educate the staff as to the findings from the survey. Included in the in-service will be the following items:</p> <p>1. Appropriate principles required in clinical documentation</p> <p>2. Plan of Care to be completed, reviewed/at least every</p>	08/13/2015	

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	<p>program of "attain a good standing in the OASIS driven Medicare comparison for State and National Home Health Agencies. We have selected achieving a high standing in improvement in the percentage of patients who improve transferring in and out of bed and in the percentage of patients who improve in understanding their medications. We are continuing to emphasize teaching and documentation in these areas in an effort to achieve a high Medicare OASIS [OBQI] rating." The meeting minutes failed to evidence any objective data to measure the agency performance or determination of improvement in patient care.</p> <p>3. QAPI meeting minutes from 3-31-15, evidenced defined quality measures and objective data derived from chart audits and other agency documents. Item 15 "Plan of Care" was assessed as "No Issues."</p> <p>4. QAPI meeting minutes from 6-2-15, evidenced defined quality measures and objective data derived from chart audits and other agency documents. Item 15 "Plan of Care" was assessed as "No Issues."</p> <p>5. On 7-16-15 at 2:30 PM, the Nursing Supervisor, Employee D, indicated</p>		<p>60 days and as needed</p> <p>3.Any change in the 485 requires a verbal order to be written and forwarded to the physician for co-signature</p> <p>4.Coordination and Continuation of Care, that includes a minimum 60 day summary that is sent to the physician and care coordination documentation on each visit as appropriate</p> <p>5.The Case Manager is the leader of the patient team and must be in communication with the other disciplines each day</p> <p>6.Implementation of the Plan of Care and notification to the physician of any deviations</p> <p>7.Review of Action Plan specifics as a result of trends noted</p> <p>5.All action plan results will be reviewed for the next quarter and the findings will be compiled and presented to the QAPI committee for review and approval that the issue is resolved and/or exhibits a percentage of improvement set by the QAPI committee or the issue is not resolved and further education on a one on one basis is necessary with individuals that continue to violate the principles of documentation regarding this issue. The plan results, improvement shown or a recommendation for plan revision, from the action plan(s) quarterly review will be forwarded to the PAC. The PAC will be responsible to identify if the trend has been resolved and current</p>		

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N 0472 Bldg. 00	clinical record audits were not completed yet for the last 2 quarters. She indicated that many of the quality measures were derived from clinical record audits. When queried for the basis of the finding of Item 15, Plan of Care, of "No Issues" without clinical record audit results to analyze, the Nursing Supervisor indicated there were issues with patients' plans of care, such as lack of coordination of care, failure of clinicians to take action to get services authorized to meet the patients' needs, visits made without physician orders, and not providing visits as per the POC orders, that should have been addressed in the QAPI process but have not been addressed as of 7-16-15. 410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the		action is completed or to revise the plan including what actions will be changed and who will be responsible to implement and monitor the plan. The PAC will forward all recommendations to the Governing Body who will approve all new or revised action plans. All in-service's and individual counseling will be documented and placed into the personnel file of the staff involved by the DON. Individual counseling will be completed by the DON and a definitive time frame to display improvement that would indicate that the employees involved with the findings finally understand the issue and have demonstrated through their documentation improvement. The employees will need to demonstrate that their documentation is at a minimum displaying a 95% improvement. If the desired improvement is not met, the employee will continue the disciplinary counseling which may ultimately result in termination. 6. Time Frame for the Plan of Correction To Be Completed: 1. In-service to all clinicians will be completed by August 13, 2015		

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	<p>home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on review of agency quality assurance/performance improvement (QAPI) documents, and interview, the agency failed to ensure the agency QAPI program was maintained with current objective measures of clinical chart audits for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. QAPI meeting minutes from 3-13-14 evidenced an agency goal for the QAPI program of "attain a good standing in the OASIS driven Medicare comparison for State and National Home Health Agencies. We have selected achieving a high standing in improvement in the percentage of patients who improve transferring in and out of bed and in the percentage of patients who improve in understanding their medications. We are continuing to emphasize teaching and documentation in these areas in an effort to achieve a high Medicare OASIS [OBQI] rating." The meeting minutes failed to evidence any objective data to</p>	N 0472	<p>1.0472Agency is to ensure the QAPI program is maintained with objective measures.</p> <p>1. The Governing Body is responsible to ensure that each year the agency has identified, though the Professional Advisory Committee, which Quality Indicators will be followed for that year. This is in addition to any trended results from the quarterly chart audits. Once identified the QAPI committee will be responsible to monitor and trend the results related to the Quality Indicators identified each quarter. The indicator(s) will be documented in the PAC meeting meetings. Quarterly the results are reported back to the PAC with any recommendations for an action plan or revisions to a current plan. The PAC committee will make the recommendation to the Governing Body, as part of the action plan, the objective measures including the acceptable threshold for each problem requiring an action plan.</p> <p>2. When applicable, the QAPI will adapt and utilize "national</p>	08/13/2015

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	<p>measure the agency performance.</p> <p>2. QAPI meeting minutes from 6-19-14 evidenced an agency goal for the QAPI program of "attain a good standing in the OASIS driven Medicare comparison for State and National Home Health Agencies. We have selected achieving a high standing in improvement in the percentage of patients who improve transferring in and out of bed and in the percentage of patients who improve in understanding their medications. We are continuing to emphasize teaching and documentation in these areas in an effort to achieve a high Medicare OASIS [OBQI] rating." The meeting minutes failed to evidence any objective data to measure the agency performance or determination of improvement in patient care.</p> <p>3. QAPI meeting minutes from 3-31-15, evidenced defined quality measures and objective data derived from chart audits and other agency documents. Item 15 "Plan of Care" was assessed as "No Issues."</p> <p>4. QAPI meeting minutes from 6-2-15, evidenced defined quality measures and objective data derived from chart audits and other agency documents. Item 15 "Plan of Care" was assessed as "No</p>		<p>standards of care and/or best practices as defined by the various national groups in establishing goals for improvement and/or set their goals to attain based on principles of documentation, and quality care.</p> <p>3. These functions will be accomplished as outlined in Plan of Correction 0456 QAPI committee will have a specially called meeting in the month of August to go over the findings from the survey and an overview of the agency's Performance Improvement Plan, policy 8.1 and identify which Quality Indicators will be monitored for the remainder of 2015.</p> <p>4. Each indicator will include the following: Aspect, Indicator, Threshold, Sample, Datasource, Methodology and employee(s) responsible.</p> <p>5. The PAC committee will be responsible each meeting to review the status of the quality indicators and any issues will be reported to the Governing Body for intervention.</p>		

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	<p>Issues."</p> <p>5. On 7-16-15 at 2:30 PM, the Nursing Supervisor, Employee D, indicated clinical record audits were not completed yet for the last 2 quarters. She indicated that many of the quality measures were derived from clinical record audits. When queried for the basis of the finding of Item 15, Plan of Care, of "No Issues" without clinical record audit results to analyze, the Nursing Supervisor indicated there were issues with patients' plans of care, such as lack of coordination of care, failure of clinicians to take action to get services authorized to meet the patients' needs, visits made without physician orders, and not providing visits as per the POC orders, that should have been addressed in the QAPI process but have not been addressed as of 7-16-15.</p>			

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N 0476 Bldg. 00	<p>410 IAC 17-12-2(c) Q A and performance improvement Rule 12 Sec. 2(c) In all cases involving the provision of home health aide services the home health agency shall provide case management by a health care professional acting within the scope of his or her practice. Such case management shall include an initial home visit for assessment of a patient's needs to determine the type, appropriateness, and adequacy of requested service, and the development of the patient care plan.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure all home health aides were assigned by a registered nurse or therapist, in a therapy only case, and failed to ensure the home health aide (HHA) providing services did so with a written HHA plan of care and instruction as per agency policy for 1 of 2 clinical records reviewed with therapy only and HHA services (2).</p>	N 0476	<p>1.0476 –Cases involving a Home Health Aide, the Home Health Agency will provide casemanagement by a health care professional acting within the scope of his/herpractice. The Home Health Agency willprovide a Home Health Aide Care Plan and the Case Manager will review the AidePlan of Care prior to the aides first visit.</p> <p>1.When a Home Health Aide is ordered the RN case manager,along with the OT, will assess the patient, their home</p>	08/06/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Policy, "Case Management and Assignments", copyright 2015, 21st Century HCC, states "Purpose: To ensure efficient and effective care management ... Procedure: An RN or physical therapist will be assigned to each patient/client as the case manager .. orienting the assigned Agency staff members to the home care environment and tasks ... developing the Home Health Aide care plan with the patient/family." 2. CR 2, start of care 11-5-14, contained a plan of care (POC) for certification period (CP) 1-4 to 3-4-14 with orders for physical therapy (PT); occupational therapy, and orders for skilled nursing (SN) evaluations on 1-8 and 1-15-15. 3. CR 2 failed to evidence the HHA was assigned to the patient by the PT case manager. The CR failed to evidence a written HHA plan of care for the CP. 4. HHA visit note dated 2-2-15, evidenced the HHA assisted the patient to dress, performed skin care and perineal care, assisted to ambulate with a walker, and provided bladder and bowel incontinence assistance. 5. On 7-15-15, at 2:30 PM, the 		<p>environment and thefamily situation to determine their needs, the appropriateness and the adequacyof requested service and will complete a Home Health Aide Care Plan inconjunction with the patient and their family.</p> <ol style="list-style-type: none"> 2.Prior to the aides first visit, the Case Managerwill communicate with the Home Health Aide to review the following: <ol style="list-style-type: none"> 1.The needs of the patient 2.The home environment situation 3.The duties the aide is to perform and thefrequency 4.Patient issues or change in condition to reportto the supervisor 5.As needed be in patient's home to review certainassignment functions for clarity and to be certain aide is able to perform thevarious function. 3.The Case Manager will have necessary discussionswith the Home Health Aide for reporting purposes, changes in Care Plan and/or to discuss any issues that may arise. 4. Case Managers assigned to the Home Health Aidepersonnel, will review the patients' medical record at the SOC,Recertification, Resumption of Care and spot checked as needed by the ClinicalSupervisors to be certain the Care Plan is being followed, that there are nonew orders, the patient's needs have or have not changed and that thesupervisory 		

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N 0484	410 IAC 17-12-2(g) Administrator, indicated the PT was the case manager for CR 2 and case management did not comply with agency policy as CR 2 did not evidence the HHA had been assigned by the physical therapist case manager, did not evidence the HHA had been oriented to the home environment and tasks, and did not contain a written HHA plan of care.		visits are being done, at least every 14 days, as scheduled and that there are no Missed Visits. The aide care plan will be reviewed and revised as needed during each supervisory visit. If needs have changed she/he will check to be certain the appropriate orders have been written, the care plan adjusted and signed. The patient and the aide will be notified of any change to the care plan. This will be documented on the care plan. 5. The DON will provide a mandatory in-service for all Case Managers and Home Health Aides regarding the procedure for: 1. Assignment of Home Health Aides 2. How to Prepare a Home Health Aide Care Plan 3. How to Orient a Home Health Aide to the Home Environment 4. QA process for Home Health Aides and the Care Plan 5. QA process for evaluating the Case Manager when a HHA is on the case 6. How to document patient activity and treatments performed during the aide visit. 6. Time table for the in-service's to be held will be: 1. Home Health Aide – completed by August 6th 2. Case Managers – completed by August 6th	

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Bldg. 00	<p>Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on policy review, job description review, clinical record review, and interview, the agency failed to ensure all personnel providing services communicated with each other regarding patients' request for additional services for 1 of 4 clinical records reviewed (1) and failed to communicate patient's perineal rash and update medication profile with ointment patient used for 1 of 4 clinical records reviewed (2).</p> <p>Findings include:</p> <p>1. Policy "Care Plan", undated, states, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential. A care plan is started upon the initiation of service ... based upon the the plan of treatment and an assessment of the patient's needs, resources, family, and environment. Continuing evaluation and service</p>	N 0484	<p>1.0484– Personnel providing services shall maintain effective communication to assure that their efforts appropriately complement one another & support the objectives of the patient care and these communications and results of same will be documented in the patient's medical record or in the minutes of the case conference.</p> <p>1. The DON will complete a mandatory in-service with the clinical staff to explain the need for coordination of care between team members and the need that this communication be placed in the medical record &/or case conference minutes, and will be monitored by the clinical supervisors responsible to ensure that the communication is taking place and being documented appropriately, and that if improvement is not noted, this could result in individual counseling, which could result in termination as they continue through the disciplinary process.</p> <p>2. The Director of Nursing has discussed this deficiency with</p>	08/13/2015	

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	<p>modification is provided as indicated as an integral part of the ongoing provision of Agency services ... the patient's health needs, plans, and goals are considered by the coordinating nurse on an ongoing basis ... revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient/client ... regularly contact the attending physician to discuss patient's status, care plan, and to obtain medical orders and/or recommendations ... The clinical record will contain evidence of Agency staff communication ... and/or periodic case conference documentation."</p> <p>2. Agency job description of physical therapy assistant, copyright 2006, 21st CHCC, states responsibilities, "8. Consults with PT regarding the outcome of home visits and reports findings in written form."</p> <p>3. Agency job description for registered nurse, copyright 2015, 21st CHCC, states responsibilities, "Participate in the development and periodic revision of the physician's Plan of Treatment and processes change orders as needed."</p> <p>4. CR 1, start of care (SOC) 11-14-14, contained a plan of care (POC) for certification period (CP) 11-14-14 to 1-12-15 with orders for physical therapy</p>		<p>clinical staff individually regarding coordination of care, and case conferences. Staff has been instructed that coordination of care is required as necessary. All patients receiving care from the Agency are required to have a written case conference every 60 days which is documented in the patient record and the summary sent to the physician. Each discipline involved in the care of the patient will contribute to the summary. The Director of Nursing will participate in all case conferences for the next three months. These requirements of the case conference and summaries will be discussed at monthly staff meetings for the next six months. Then they will be discussed at quarterly staff meetings for an additional twelve months. Staff has been required to read the policies pertaining to care coordination and case conferences.</p> <p>3. The Director of Nursing will review all records monthly for coordination of care and inclusions of case conference for patients receiving care for more than one certification period. This will occur until there is 100% compliance. Then 10% of patient records will be reviewed quarterly on an ongoing basis to ensure continued compliance. Any noncompliance will be discussed with the individual staff members. Noncompliance with coordination of care or case</p>	

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	<p>(PT) 2w7 (2 times a week for 7 weeks) and 1w2 (1 time a week for 2 weeks). Patient diagnoses included abnormal gait, muscle weakness, diabetes mellitus, neuropathy, hypertension, urinary incontinence, fecal smearing, obesity, edema, long term use of insulin, and person living alone. The clinical record (CR) evidenced a visit note by physical therapy assistant (PTA), dated 11-19-14, with narrative, "Reports after being hospitalized that he/she no longer has an aide to help him/her out with meals and ADLs, or a nurse to help her with medication management; patient describes feeling as if her family wants her to go to a nursing home." The CR failed to evidence the patient's report to the PTA, which may have been a request for additional services, had been communicated to the Physical Therapist, the Nursing Supervisor, or any agency personnel. The agency case conference records failed to evidence coordination of care/case communication for CR 1 during the certification period.</p> <p>5. CR 2 , SOC 11-5-14, contained a POC for the CP 11-5-14 to 1-3-15 with orders for PT 2w8 (2 times a week for 8 weeks) and 1w1. The CR evidenced a physician's order for Skilled Nursing (SN) assessment/evaluation of home health care needs, dated 12-17-14.</p>		<p>conferences will be monitored by the Director of Nursing. Results will be forwarded to the QAPI quarterly with the trends reported to the PAC. The PAC members will determine what action in addition to staff education is required to achieve and maintain a 100% compliance. This may include increased clinical record reviews, additional in-services or disciplinary actions for specific staff members. The DON will be responsible for implementing any action plans that are developed by the PAC.</p> <p>4. QAPI committee will include this issue as one of their topics to monitor and report to the PAC the progress of improvement.</p> <p>5. Time table for the above will be as follows:</p> <p>1. In-service for all clinicians will be held August 13, 2015</p> <p>2. Clinical Review by Clinical Supervisors will be a part of their daily QA of clinical notes, with reporting to the DON of any infractions to this process on a daily basis, and Communication with the clinician immediately to correct the issue.</p> <p>3. Clinical Audit review of this process will be done quarterly in their regularly scheduled meetings, beginning in August, 2015.</p> <p>4. QAPI report will include the clinical audit findings for the second quarter of 2015 in the next meeting, which will be in August 2015.</p>	

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	<p>Registered Nurse (RN), performed an assessment. SN visit note evidenced under Pain Profile, "Patient has burning from yeast infection to peri area, patient reports she was having difficulty with application of ointment. Patient instructed on application of cream when caregiver not present, verbalized understanding ... Under Genitourinary, incontinence and urgency were checked ... Narrative "Patient assessed and with verbal prompts was able to apply cream to peri area. Patient voiced she felt she needed someone to complete for her, Instructed patient and caregiver on need for following application frequency as ordered due to risk open areas and continued excoriation, and refill of prescription. Both voiced understanding." The CR and agency case conference records failed to evidence coordination of care/case communication between the disciplines regarding the SN's findings or any coordination of care/case communication during the CP.</p> <p>6. On 7-15-15 at 2:30 PM, the Administrator indicated the physical therapy assistant narrative note of 11-19-14 should have been evaluated as a request for additional services, and CR 1 and CR 2 failed to evidence effective interchange of information and care</p>			

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N 0486 Bldg. 00	<p>coordination.</p> <p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure agency staff documented communication/coordination of care activities for 1 of 1 clinical records reviewed of patients receiving care from the agency and another agency (1).</p> <p>Findings include:</p> <p>1. Policy "Care Plan", undated, states "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential. The clinical record will contain evidence of Agency staff communication."</p> <p>2. On 7-15-15 at 2:30 PM, the Administrator indicated the CR 2 received personal services from another agency during the CP 1-4 to 3-4-15. Administrator indicated the CR did not</p>	N 0486	<p>1.0486 –Home Health Agency will ensure communication and coordination with any other healthprovider when both are providing services to a patient.</p> <p>1. During the admission visit, the admitting discipline will document information regarding any other health provider that is providing services to the patient. The information will include the name of the provider and the services being provided. The DON or designee responsible for auditing 100% the admission paperwork to screen the documentation for this information. If identified this information will be documented in the patient record for future reference. The following will be included in the audit:</p> <p>1. An agreement is in place between the agencies, if applicable</p> <p>2. Current and signed Plan of Care indicating what and by whom other services are being provided to the patient</p> <p>3. Evidence in the documentation of</p>	08/06/2015

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	<p>contain documentation of communication and coordination between the 2 agencies.</p> <p>3. Clinical record (CR) 2 , SOC 11-5-14, contained a plan of care for the certification period 1-4-15 to 3-4-15 with orders for physical therapy, occupational therapy, and skilled nursing evaluations on 1-8 and 1-15-15. The CR failed to evidence coordination of care between the agency and an outside agency performing personal services.</p>		<p>carecoordination and communication between agencies</p> <p>1.The DON will complete a mandatory in-servicewith the clinical staff to review the process for ensuring that the appropriatedocumentation is included in the clinical record when 1st Care andanother cooperating agency is providing services to the patient.</p> <p>2.The DON will re-educate the Case Managers regardingtheir responsibilities if another agency is also providing care/services to thepatient. The re-education will includethe following:</p> <p>1.The Case Manager will review the Care Plan andcommunicate with the other agency when any changes have been made, any issueswith personnel, and that the caregiver Is performing his/her duties as noted onthe Care Plan.</p> <p>2.Reporting any personnel issues to their ClinicalSupervisors.</p> <p>1.This issue will be incorporated into the quarterlyQAPI reporting process and will be an item that is reviewed by the clinicalrecord audit committee and report findings of same.</p> <p>2.Time table will be as follows:</p> <p>1.Clinical Supervisors in-service will be heldAugust 5, 2015</p> <p>2.Case Manager in-service will be held August 6,2015</p>	

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N 0520 Bldg. 00	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on job description review, policy review, clinical record review, and interview, the agency failed to ensure the patient's needs were met and addressed on the plan of care for 2 of 2 clinical records (CR) reviewed (1, 2).</p> <p>Findings include:</p> <p>1. CR 1, SOC 11-14-14, contained a plan of care (POC) for certification periods (CP) 11-14-14 to 1-12-15 with orders for physical therapy (PT) 2w7 (2 times a week for 7 weeks) and 1w2 (1 time a week for 2 weeks). The POC failed to evidence orders for any other services and the CR failed to evidence a request to the attending physician for additional services. Diagnoses were abnormality of gait, general muscle weakness, diabetes mellitus 2, neuropathy in diabetes, hypertension, urinary incontinence, fecal smearing, obesity, edema, personal history of fall, long term use of insulin, and person living alone. Employee SSS, RN, signed the POC verbal order for</p>	N 0520	<p>1.0520 –The Home Health Agency will accept patients based on the reasonable expectationthat the patient's health needs can be adequately met by the home health agencyin the patient's place of residence.</p> <p>1. The DON will complete a mandatory in-service for all clinicians, and administrative staff to review the need to determine all aspects of the need of the patient when performing the admitting SOC, during prescribed clinical visits and when performing the quality assessment of the findings of the clinicians involved with the care of the patient. The following will be reviewed:</p> <p>1. During the admission visit the clinician will determine the need for care and services and the type of care and services to be provided to the patient and whether or not the patient needs additional services not offered by the Agency.</p> <p>2. If the patient requires services not offered by the agency, the referral source and the physician will be notified so</p>	08/20/2015

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	<p>services on 11-14-15.</p> <p>A. CR 1, comprehensive assessment (CA) /SOC OASIS, dated 11-14-14, performed by physical therapist (PT), Employee EEE, evidenced the patient was 5' 2", 218 lbs; had urinary frequency, urgency, and incontinence day and night; fecal smearing; edema in ankles and feet; was a person living alone; had functional limitations of incontinence, ambulation, and dyspnea with minimal exertion, Braden Integumentary score of 15 -indicating at risk for skin breakdown; memory deficit - failure to recognize familiar persons/places, inability to recall recent events, significant memory loss, supervision required; impaired decision making - failure to perform usual (I) ADL's (Instrumental and Activities of Daily Living); required someone to assist to groom; required someone to help put on upper body clothing; undergarments, slacks, socks ... shoes; able to participate in bathing self in shower/tub, but requires presence of another throughout the bath for assistance/supervision; required someone to help maintain toileting hygiene and/or adjust clothing; able to walk only with the supervision or assistance of another person at all times; unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations; received no assistance</p>		<p>other arrangements can be made for the patient.</p> <p>3. When determining what is needed on the Plan of Care, the Case Manager must determine how best to meet the need and by whom, RN, PT, etc.</p> <p>4. Including all disciplines on the Plan of Care that are needed to meet the needs of the patient and monitor the coordination between the team members including the administrative staff, i.e., Clinical Supervisors.</p> <p>5. Case Managers will monitor the care to be certain that all ordered care is being given by the clinicians in a timely manner and reporting to Case Manager to ensure that the goals are progressing or have been met.</p> <p>6. A review of the scores on the Oasis and what they mean including the Braden Scale, TUG and the various responses included in the ADL section of the OASIS.</p> <p>2. The Clinical Supervisors will monitor all medical records during their daily quality assurance audit to determine if all clinicians (services) have been ordered and are performing the services as ordered.</p> <p>3. Clinical Supervisors will provide reports to the DON regarding this quality check on a daily basis and the DON will perform spot checks as a check and balance to the review.</p> <p>4. This will be incorporated into</p>	

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	<p>with ADL or IADLs from caregiver(s) other than home health agency staff; Timed Up and Go score of 29 (less than 10 normal, less than 14 not a falls risk, more than 14 increased risk for falls); needed some assistance with oral and injectable (insulin) medications; presented a fall risk; required assistance - no caregiver available for: ADL assistance, IADL assistance, medication administration, supervision and safety, and advocacy or facilitation of the patient's participation in appropriate medical care.</p> <p>B. CA/OASIS at SOC, dated 11-14-14, recommended orders for discipline and treatment, evidenced PT 2w7, 1w2. Additional orders PT for Thera Ex, Balance, Transfers, Gait training, and patient education. Physical therapy IADL interventions were therapist to instruct patient: to wear proper footwear when ambulating, to use prescribed assistive device (walker) when ambulating, to change positions slowly, remove clutter from patient's path, contact agency for increased dizziness or problems with balance, on importance of adequate lighting in patient area, to contact agency for any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. The</p>		<p>the QAPI program of quality measures and the committee will determine the monitoring process time table during their next regularly scheduled meeting.</p> <p>5. Timetable for the above activities:</p> <ol style="list-style-type: none"> 1. In-services will be completed by August 20, 2015. 2. Clinical Supervisors review will begin immediately with reporting same 	

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	<p>CA/OASIS evidenced a narrative comment by the PT, "[Patient] previously had attendant care services but was not receiving attendant care services at this time; client in search of a new attendant care provider."</p> <p>C. The record failed to evidence these needs were addressed by the agency and included in the POC.</p> <p>2. CR 2, SOC 11-5-14, contained a POC for the CP 11-5-14 to 1-3-15, with orders for PT 1w1; 2w8 (1 time a week for 1 week; 2 times a week for 8 weeks). The POC failed to evidence orders for any other services and the CR failed to evidence a request to the attending physician for additional services. Diagnoses were muscle weakness, abnormality of gait, chronic airway obstruction, senile dementia, benign hypertension, tachycardia, hearing loss, full incontinence feces, urinary incontinence, personal history of fall, and oxygen dependency. Employee SSS, RN, signed the POC verbal order for services on 11-5-14.</p> <p>A. CA/OASIS, dated 11-5-14 by PT, Employee EEE, evidenced patient lives alone with other persons in the home during nighttime; required support during transfer and and ambulation; had partially</p>			

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	<p>impaired vision - cannot see medication labels or newsprint; Braden Integumentary score of 18 (at risk); experiences shortness of breath at rest day or night; had urinary frequency, urgency, and incontinence day and night; had an inadequate diet; mental status of forgetful and disoriented; impaired decision making; impaired decision making, failure to perform usual (I) ADLs, inability to stop activities, jeopardizes safety through actions; must have someone assist with grooming; must have someone help put on upper body clothing, undergarments, slacks, socks, and shoes; must have someone help to maintain toileting, hygiene and/or adjust clothing; able to walk only with the supervision or assistance of another person at all times; unable to to prepare light meals on a regular basis due to physical, cognitive, or mental limitations; fall risk due to age 65+ (90), incontinence, environmental hazards, cognitive impairment, visual impairment, 3 or more co-existing diagnoses, prior history of falls within 3 months, and impaired functional mobility.</p> <p>B. CA/OASIS at SOC, dated 11-5-14, recommended orders for discipline and treatment, evidenced PT 1w1, 2w8. Additional orders PT for Thera Ex, Balance, Transfers, Gait training, and</p>			

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	<p>patient/family education. Physical therapy IADL interventions were therapist to instruct patient: to wear proper footwear when ambulating, to use prescribed assistive device (walker) when ambulating, to change positions slowly, remove throw rugs or use double-sided tape to secure rug in place, remove clutter from patient's path that may cause patient to trip, and instruct patient to use non-skid mats in tub/shower. The CA/OASIS evidenced a narrative comment by PT "Patient is a pleasantly confused 90 year old Caucasian female with significant history of COPD (chronic obstructive pulmonary disease) and multiple falls. Patient presents with dyspnea at rest and with minimal exertion, weakness, unsteadiness and overall decreased ability and safety with transfers and gait." The assessment identified the need for other appropriate services for CR 2 such as home health aide for ADL/IADL assistance to include assistance to bathroom for urgency, frequency, urinary incontinence and fecal incontinence, bathing, grooming, dressing upper/lower body, assistance with planning and preparing meals and snacks, assistance with ambulation, and maintaining a safe home environment.</p> <p>C. The record failed to evidence these needs were addressed by the agency</p>			

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N 0522 Bldg. 00	<p>and included in the POC.</p> <p>3. On 7-15-15 at 2:30 PM, the Administrator indicated the agency should have contacted the attending physician to consult and request order for additional services. The CA/OASIS data for CR 1 and CR 2 evidenced the patient's needs for additional HHA services for assistance with ADL/ IADLs.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure patient's visits were made in accordance with physician plan of care orders for 1 of 4 clinical records reviewed (1); and failed to ensure all visits made were on the order of a physician for 1 of 4 clinical records reviewed (2).</p> <p>Findings include:</p> <p>1. Policy "Care Plan", undated, states, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual</p>	N 0522	<p>1.0522 –Medical care shall follow a written medical Plan of Care in which all orders onthe Plan of Care have been reviewed by the physician and approved by thephysician.</p> <p>1.The Director of Nursing will provide anin-service to all staff regarding policy requirements that the plan of caremust be followed in accordance with physician orders and any deviations fromthe plan of care is communicated to the physician with an interim orderobtained as appropriate.</p> <p>2.Each staff will review the plan of care with thephysician at the completion of the admission visit by the admittingdiscipline. This will be documented inthe clinical</p>	08/13/2015

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	<p>patient/client situation as needed, a care plan is essential. A care plan is started upon the initiation of service by the RN (registered nurse) or PT (physical therapist) based upon the the plan of treatment and an assessment of the patient's needs, resources, family, and environment. ... regularly contact the attending physician to discuss patient's status, care plan, and to obtain medical orders and/or recommendations ... The clinical record will contain evidence of Agency staff communication ... and/or periodic case conference documentation."</p> <p>2. Agency policy "Case management and Assignments", undated, states, "To ensure efficient and effective care management ... Agency staff ... obtaining and implementing physician orders when applicable."</p> <p>3. Clinical Record (CR) 1, start of care (SOC) 11-14-14, contained a plan of care (POC) for certification period (CP) 11-14-14 to 1-12-15 with orders for physical therapy (PT) 2w7 (2 times a week for 7 weeks) and 1w2 (1 time a week for 2 weeks). For the week of 11-30 to 12-6-14, the CR evidenced 1 visit by a PTA on 12-5-14. The CR failed to evidence a 2nd visit made by PT services that week, and the record failed to evidence the physician had been notified</p>		<p>record. The DON or designee will audit 100% of all admission paperwork to ensure compliance until a 100% threshold has been met for 3 months then the audit amount will be decrease to 10% of all admission paperwork quarterly as long as the threshold remains at 100%. Any deficiencies found will be reported to the DON for immediate correction with the responsible discipline. This will be added as a quality measure which will be reported quarterly to the QAPI committee to demonstrate improvement.</p> <p>3. The plan of care, once created, will be sent to the physician for co-signature indicating approval of the plan of care. The DON or designee will track all 485 and/or orders that are sent to the physician for co-signature. A log will be used to document what and when the documents were sent and when they are returned. The DON or designee will monitor the log weekly for any document that has not been returned with a signature less than 30 days. Any deficiencies found will be reported to the DON for immediate intervention. The DON will spot check the log monthly to ensure ongoing compliance.</p> <p>4. The DON will re-educate the staff that they are required to follow the plan of care without deviation. Required changes must be discussed with the physician who must be contacted</p>	

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NAME OF PROVIDER OR SUPPLIER 1ST CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 6100 N KEYSTONE SUITE 639 INDIANAPOLIS, IN 46220		
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	<p>of the missed visit.</p> <p>5. CR 2, SOC 11-5-14, contained a plan of care for certification period 1-4-15 to 3-4-15 with orders for PT 2 times a week for 8 weeks; occupational therapy beginning 1-13-15 for 1w8 (1 time a week for 8 weeks) and physician orders for skilled nursing (SN) evaluations on 1-8 and 1-15-15. The POC failed to evidence a physician order for HHA services for the certification period. The CR evidenced a HHA visit was made on 2-2-15. The CR evidenced SN visits on 1-22. The POC failed to evidence a physician order for this SN visit.</p> <p>6. On 7-15-15 at 2:30 PM, the Administrator indicated CR 1 physical therapy visits were not as per the physician orders on the plan of care, and CR 2 failed to evidence a physician's order for HHA visit made 2-2-15 and SN visit made 1-22.</p>		<p>to update the plan of care and provide a new order. All staff havebeen provided with a copy of Policy 2.8 Care Plan and they have verbalized understanding of the policy. Clinical Supervisors willinclude on a daily basis in their quality checking to determine that the Planof Care is being followed and there is an order for every service being done onthe Plan of Care. Clinical Supervisors will report theirfindings daily to the DON for tracking purposes and any follow-up that isneeded.</p> <p>5.The Director of Nursing will review all created 485swith the registered nurse or therapy professional prior to the 485 being sentto the physician for signature. These requirements will be reviewed by theDirector of Nursing at weekly staff meetings for one month for understandingand adherence. Then they will bereviewed by the Director of Nursing at monthly staff meetings for six months toassure understanding and adherence. Thereafter they will be reviewed by the Director of Nursing torunderstanding and adherence at quarterly staff meetings on an ongoingbasis.</p> <p>6.All clinical staff has attended the above in-servicesas verified by the signed attendance sheet(s).</p> <p>7.Ongoing 10% of patient records will be reviewedquarterly on an ongoing basis to ensure continued compliance. Any</p>		

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			<p>noncompliance will be discussed by the Director of Nursing with the individual involved. If specific clinical staff continues to be non-compliant, they will be placed on a progressive corrective action plan which will include coaching to progress towards improvement. The above plan will be discussed with the QAPI Committee. They will discuss the monitoring plan at their quarterly meetings and will determine what actions are needed to achieve and maintain 100% compliance. This includes increased clinical record reviews, increased in-service education, continued individual counseling, or discipline of specific staff. This deficiency will be discussed with the Professional Advisory Committee whose members will have the opportunity to make further recommendations. The action plan for this deficiency will be brought before the Governing Body. They will be kept informed of the progress toward 100% compliance that we are monitoring.</p> <p>8. Time table for the above is as follows:</p> <ol style="list-style-type: none"> 1. In-service for all clinicians and administrative staff will be completed by August 13, 2015. 2. Clinical Supervisors review and reporting will begin immediately and this shall be an on-going part of their quality check daily. 	

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	<p>following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on job description review, policy review, clinical record review, and interview, the agency failed to ensure the registered nurse revised plan of care to include all medications used by the patient for 1 of 4 clinical records reviewed; failed to ensure the plan of care was revised to include physician order for all skilled nursing visits made for 1 of 4 clinical records reviewed; and failed to ensure the data obtained from the therapist's start of care comprehensive assessment/OASIS was utilized to develop the plan of care for 2 of 2 clinical records (CR) reviewed of therapy only cases at start of care (1, 2).</p> <p>Findings include:</p> <p>Regarding update of plan of care</p> <p>1. Job description of registered nurse (RN), copyright 2015, 21st Century HCC, states, "Participate in the development and periodic revision of the physician's Plan of Treatment and processes change orders as needed."</p> <p>2. Policy, "Medication Profile", copyright 2015, 21st Century HCC, states</p>	N 0542	<p>1.0542 –Except where services are limited to therapy only, the registered nurse shall initiate the Plan of Care and any necessary revisions.</p> <p>1.The DON will complete a mandatory in-service for all clinicians and administrative staff, to review policies 2.7 Assessment and 2.8 CarePlan which states the RN will perform the initial assessment but when the patient physician has ordered only therapy services, the appropriate therapist (physical therapist, occupational therapist, or speech-language pathologist) may perform the initial assessment. Each clinician will be provided with a copy of these 2 policies.</p> <p>2.The DON or designee will review 100% of the referrals to ensure that the correct discipline has been assigned for the admission visit and creation of the plan of care.</p> <p>3.Weekly the DON will review the admission schedule to ensure that the correct discipline was assigned for the admission visit, admitted the patient timely and developed the plan of care. Any deficiencies found will have immediate follow up by the DON with the individuals involved.</p> <p>4.All audit results will be forwarded to the QAPI committee</p>	08/13/2015			

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	<p>under purpose, "To ensure all patients/clients have a current list of medications .. The plan of care will demonstrate the patient/client current medication regimen."</p> <p>3. Clinical record (CR) 2, SOC 11-5-14, contained a plan of care (POC) for certification period (CP) 11-5-14 to 1-3-15 with order for skilled nursing (SN) evaluation dated 12-17-14. SN visit note, Employee QQQ, RN, dated 12-18-14, evidenced under Pain Profile "patient has burning from yeast infection to peri area, [Patient] was having difficulty with application of [unidentified] ointment. Patient instructed on application of cream when caregiver not present, verbalized understanding." Under Narrative & Teaching "Patient assessed and with verbal prompts was able to apply cream to peri area. Pt [patient] voiced she felt she needed someone to complete for her. Instructed patient and caregiver on need for following application frequency as ordered due to risk open areas and continued excoriation, and refill of prescription. Both voiced understanding."</p> <p>A. The plan of care failed to evidence the registered nurse had revised the plan of care with an order for the</p>		<p>where they will be trended on a quarterly basis and an action plan recommended to the PAC committee as appropriate. Any plan developed by the PAC will be reviewed with the DON who will be responsible for implementation and ongoing monitoring of the plan.</p> <p>5. Time table for the above is as follows:</p> <p>1. Mandated in-service will be completed by August 13, 2015</p> <p>2. All reports will be presented at the next regularly scheduled QAPI meeting.</p> <p>3. A determination will be made by the QAPI committee as to whether or not the results of the daily QA review demonstrates enough improvement to either stop the process, revise the process or continue the process as described.</p> <p>4. The QAPI committee will forward results including any recommendations for an action plan to the PAC for follow up as appropriate.</p>	

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	<p>unidentified ointment.</p> <p>Regarding lack of physician order for visit made</p> <p>B. CR 2 contained a plan of care for certification period 1-4-15 to 3-4-15 with orders for PT; occupational therapy, and orders for skilled nursing (SN) evaluations on 1-8 and 1-15-15. The CR evidenced a SN visit, by Employee QQQ, RN, was made on 1-22-15. The CR failed to evidence the registered nurse had revised the plan of care to include an order for additional SN visits after 1-15-15.</p> <p>4. Policy "Care Plan", undated, states, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential. A care plan is started upon the initiation of service by the RN (registered nurse) or PT (physical therapist) based upon the the plan of treatment and an assessment of the patient's needs, resources, family, and environment. Continuing evaluation and service modification is provided as indicated as an integral part of the ongoing provision of Agency services ... the patient's health needs, plans, and</p>			

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	<p>goals are considered by the coordinating nurse on an ongoing basis ... revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient/client ... regularly contact the attending physician to discuss patient's status, care plan, and to obtain medical orders and/or recommendations ... The clinical record will contain evidence of Agency staff communication ... and/or periodic case conference documentation."</p> <p>Related to including data from the assessment to complete and revise the plan of care.</p> <p>5. CR 1, SOC 11-14-14, contained a plan of care (POC) for certification periods (CP) 11-14-14 to 1-12-15 with orders for physical therapy (PT) 2w7 (2 times a week for 7 weeks) and 1w2 (1 time a week for 2 weeks). The POC failed to evidence orders for any other services and the CR failed to evidence a request to the attending physician for additional services. Diagnoses were abnormality of gait, general muscle weakness, diabetes mellitus 2, neuropathy in diabetes, hypertension, urinary incontinence, fecal smearing, obesity, edema, personal history of fall, long term use of insulin, and person living alone. Employee SSS, RN, signed the POC verbal order for services on 11-14-15.</p>			

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	<p>A. CR 1, comprehensive assessment (CA) /SOC OASIS, dated 11-14-14, performed by physical therapist (PT), Employee EEE, evidenced the patient was 5' 2", 218 lbs; had urinary frequency, urgency, and incontinence day and night; fecal smearing; edema in ankles and feet; was a person living alone; had functional limitations of incontinence, ambulation, and dyspnea with minimal exertion, Braden Integumentary score of 15 -indicating at risk for skin breakdown; memory deficit - failure to recognize familiar persons/places, inability to recall recent events, significant memory loss, supervision required; impaired decision making - failure to perform usual (I) ADL's (Instrumental and Activities of Daily Living); required someone to assist to groom; required someone to help put on upper body clothing; undergarments, slacks, socks ... shoes; able to participate in bathing self in shower/tub, but requires presence of another throughout the bath for assistance/supervision; required someone to help maintain toileting hygiene and/or adjust clothing; able to walk only with the supervision or assistance of another person at all times; unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations; received no assistance with ADL or IADLs from caregiver(s)</p>			

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	<p>other than home health agency staff; Timed Up and Go score of 29 (less than 10 normal, less than 14 not a falls risk, more than 14 increased risk for falls); needed some assistance with oral and injectable (insulin) medications; presented a fall risk; required assistance - no caregiver available for: ADL assistance, IADL assistance, medication administration, supervision and safety, and advocacy or facilitation of the patient's participation in appropriate medical care.</p> <p>B. CA/OASIS at SOC, dated 11-14-14, recommended orders for discipline and treatment, evidenced PT 2w7, 1w2. Additional orders PT for Thera Ex, Balance, Transfers, Gait training, and patient education. Physical therapy IADL interventions were therapist to instruct patient: to wear proper footwear when ambulating, to use prescribed assistive device (walker) when ambulating, to change positions slowly, remove clutter from patient's path, contact agency for increased dizziness or problems with balance, on importance of adequate lighting in patient area, to contact agency for any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. The CA/OASIS evidenced a narrative</p>			

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	<p>comment by the PT, "[Patient] previously had attendant care services but was not receiving attendant care services at this time; client in search of a new attendant care provider."</p> <p>C. The record failed to evidence the registered nurse included to data from the assessment to include home health aide services on the plan of care.</p> <p>6. CR 2, SOC 11-5-14, contained a POC for the CP 11-5-14 to 1-3-15, with orders for PT 1w1; 2w8 (1 time a week for 1 week; 2 times a week for 8 weeks). The POC failed to evidence orders for any other services and the CR failed to evidence a request to the attending physician for additional services. Diagnoses were muscle weakness, abnormality of gait, chronic airway obstruction, senile dementia, benign hypertension, tachycardia, hearing loss, full incontinence feces, urinary incontinence, personal history of fall, and oxygen dependency. Employee SSS, RN, signed the POC verbal order for services on 11-5-14.</p> <p>A. CA/OASIS, dated 11-5-14 by PT, Employee EEE, evidenced patient lives alone with other persons in the home during nighttime; required support during transfer and and ambulation; had partially</p>			

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	<p>impaired vision - cannot see medication labels or newsprint; Braden Integumentary score of 18 (at risk); experiences shortness of breath at rest day or night; had urinary frequency, urgency, and incontinence day and night; had an inadequate diet; mental status of forgetful and disoriented; impaired decision making; impaired decision making, failure to perform usual (I) ADLs, inability to stop activities, jeopardizes safety through actions; must have someone assist with grooming; must have someone help put on upper body clothing, undergarments, slacks, socks, and shoes; must have someone help to maintain toileting, hygiene and/or adjust clothing; able to walk only with the supervision or assistance of another person at all times; unable to to prepare light meals on a regular basis due to physical, cognitive, or mental limitations; fall risk due to age 65+ (90), incontinence, environmental hazards, cognitive impairment, visual impairment, 3 or more co-existing diagnoses, prior history of falls within 3 months, and impaired functional mobility.</p> <p>B. CA/OASIS at SOC, dated 11-5-14, recommended orders for discipline and treatment, evidenced PT 1w1, 2w8. Additional orders PT for Thera Ex, Balance, Transfers, Gait training, and</p>			

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	<p>patient/family education. Physical therapy IADL interventions were therapist to instruct patient: to wear proper footwear when ambulating, to use prescribed assistive device (walker) when ambulating, to change positions slowly, remove throw rugs or use double-sided tape to secure rug in place, remove clutter from patient's path that may cause patient to trip, and instruct patient to use non-skid mats in tub/shower. The PT failed to use the data from the comprehensive assessment/OASIS as a basis to identify the need for other appropriate services for CR 2 such as home health aide for ADL/IADL assistance to include assistance to bathroom for urgency, frequency, urinary incontinence and fecal incontinence, bathing, grooming, dressing upper/lower body, assistance with planning and preparing meals and snacks, assistance with ambulation, and maintaining a safe home environment. The CA/OASIS evidenced a narrative comment by PT "Patient is a pleasantly confused 90 year old Caucasian female with significant history of COPD (chronic obstructive pulmonary disease) and multiple falls. Patient presents with dyspnea at rest and with minimal exertion, weakness, unsteadiness and overall decreased ability and safety with transfers and gait."</p>			

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N 0565 Bldg. 00	<p>C. The record failed to evidence the registered nurse included to data from the assessment to include home health aide services on the plan of care.</p> <p>7. On 7-15-15 at 2:30 PM, the Administrator indicated CR 2 evidenced only oxygen on the plan of care medication orders and medication profile for CP 11-5-14 to 1-3-15; the SN should have revised the plan of care to include the ointment used by the patient; the clinical record lacked a physician's order for SN visit on 1-22-15; CR1 and CR 2 should have had HHA services identified as a need earlier and the agency should have contacted the attending physician to consult and request order for additional services. The CA/OASIS data for CR 1 and CR 2 evidenced the patient's needs for additional HHA services for assistance with ADL/ IADLs.</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary);</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the case manager made</p>	N 0565	1.0565-- Therapists acting as a Case Manager will obtain any and all orders for services and will add them to the Plan of	08/13/2015

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	<p>appropriate revisions to the plan of care by obtaining physician orders for all visits made for 1 of 4 clinical records reviewed (2).</p> <p>Findings include:</p> <p>1. Policy "Case management and Assignments", undated, states, "To ensure efficient and effective care management ... Agency staff ... obtaining and implementing physician orders when applicable."</p> <p>2. Clinical record (CR) 2, SOC 11-5-14, contained a plan of care for certification period 1-4-15 to 3-4-15 with orders for physical therapy (PT); occupational therapy, and orders for skilled nursing (SN) evaluations on 1-8 and 1-15-15. The CR failed to evidence a physician order for HHA services for the certification period. The CR evidenced a HHA visit was made on 2-2-15.</p> <p>3. On 7-15-15 at 2:30 PM, Administrator indicated CR 2 lacked an order for HHA services and the PT was the case manager.</p>		<p>Care as ordered by the physician.</p> <p>1. The DON will complete a mandatory in-service for the therapists to review all the principles of the development and maintenance of a Plan of Care in accordance with policies 2.8 Care Plan and 2.9 Service Policies. A copy of the policies will be provided to each therapist.</p> <p>2. Points of emphasis will be that all disciplines serving the patient must have an order on the POC and this includes the HHA. If the therapist is acting as the Case Manager, it will be the responsibility of the therapist to monitor services and obtain additional physician orders as necessary to revise or update the plan of care(s) that they are case managing.</p> <p>3. Daily the Clinical Supervisors will complete their QA process and will report immediately to the DON any deficiencies identified. The DON will be responsible to any follow up that is needed.</p> <p>4. All audit results will be forwarded to the QAPI committee where they will be trended on a quarterly basis and an action plan recommended to the PAC committee as appropriate. Any plan developed by the PAC will be reviewed with the DON who will be responsible for implementation and ongoing monitoring of the plan.</p> <p>5. Time table for the above to be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/16/2015
NAME OF PROVIDER OR SUPPLIER 1ST CARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 6100 N KEYSTONE SUITE 639 INDIANAPOLIS, IN 46220		
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			<p>accomplished will be as follows:</p> <ol style="list-style-type: none"> 1. In-service will be completed by August 13, 2015. 2. Clinical Supervisors will begin incorporating this into daily schedule immediately. 3. Reporting findings to the QAPI will be done at the next regularly scheduled meeting. 4. A determination will be made by the QAPI committee as to whether or not the findings of the daily QA review demonstrate enough improvement to either stop the review process, revise the process or continue as described. 5. The QAPI committee will forward results including any recommendations to the PAC for follow up as appropriate. 		