

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2014
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NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1521 S 3RD ST TERRE HAUTE, IN 47802
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G000000	<p>This was a home health Federal recertification survey that resulted in an extended survey on 06/17/14.</p> <p>Survey Dates: June 16 - 19, 2014.</p> <p>Facility #: 012338</p> <p>Medicaid Vendor #: 201018830</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 16</p> <p>Guardian Home Health is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 06/16/14 due to being found out of compliance with Conditions of Participation 42 CFR 484.10 Patient Rights, 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision, 484.30: Skilled Nursing Services, 484.36 Home Health Aide Services, and 484.48: Clinical Records.</p> <p>The Administrator and the Director of Nursing were informed of this preclusion during the exit conference held at this</p>	G000000		
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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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G000100	<p>agency on 06/16/14 at 4:15 PM.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 1, 2014</p> <p>Based on clinical record, document, and policy review and interview, it was determined the agency failed to investigate a complaint made by a patient regarding treatment and care furnished by a home health aide for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services by the home health agency (See G 106); failed to investigate a complaint made by a patient regarding treatment and care furnished by a home health aide for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services by the home health agency (See G 107); failed to ensure a patient representatives was informed in advance about the care to be furnished in regards to medication administration orally and in writing for 2 of 10 records reviewed creating the potential to affect all patients who were</p>	G000100	<p>The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may</p>	07/16/2014

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	<p>receiving medication administration by a home health aide (See G 108); failed to ensure patients were provided the current Indiana Advance Directives and agency policy regarding Advance Directives in 10 of 10 records reviewed creating the potential to affect all 16 patients receiving home health services (See G 110); failed to inform patients the extent to which payment for the home health agency service may be expected from the payer source and the extent to which payment may be required from the patient for 5 of 10 records reviewed creating the potential to affect all 16 patients receiving services from the home health agency (See G 113); and failed to ensure patients were informed orally and in writing of the extent to which payment may be expected from any Federally funded or aided program, the charges for services that will not be covered, and the charges that the individual may have to pay for 5 of 10 records reviewed creating the potential to affect all 16 patient's receiving services from the home health agency (See G 114).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.10 Patient Rights.</p>		<p>consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: All Clients will receive the effective May 2004 and revised July 1, 2013 State of Indiana Advanced</p>		

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			<p>Directives document & the agencies policies regarding advanced directives. All admission folders will have the outdated version removed and the current, July 1, 2013, version in place with the agencies policies on advanced directives. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: The Client shall be informed at every admission what services will be covered by their particular pay source and what will not be covered by their particular pay source via a new form created by the agency which will state these items and require Client signature for documentation of notification of this information. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has enrolled in the Indiana Medicaid for Providers e-mail notification program for Banners, Bulletins, Newsletters, IHCP Notices, Web Interchange Notices, EDI Notices and Advisor</p>		

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G000106	<p>484.10(b)(4) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.</p> <p>Based on clinical record and policy review and interview, the agency failed to investigate a complaint made by a patient regarding treatment and care furnished by a home health aide for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services by the home health agency. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, start of care 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times a week for 9 weeks to assist with bathing,</p>	G000106	<p>FSSA Newsletters. The Administrative assistant will enroll as well. The Executive Director will be responsible for reviewing updates. The Executive director and the administrative assistant will meet quarterly to review updates.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: In the case of discharge, the agency will provide the Physician, who signs the Plan of Care for the Client, with the reason(s) for the requested discharge and obtain, at the minimum, a verbal order for discharge, prior to providing the Client with a 5 day notice of intent to discharge from the agencies services.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be</p>	07/16/2014	

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	<p>grooming, meal preparation, light housekeeping, laundry, and errands. The patient was discharged on 04/28/14.</p> <p>a. A skilled nursing note written by the ADON (Alternate Director of Nursing) dated 04/23/14 stated the ADON had spoken with the DON (Director of Nursing) and discussed continued issues of non-compliance with medications, visits, and constant changes in schedules. The ADON explained to the DON that the patient had stated one of their employees was fired from another home health agency for stealing and apparently was accusing one of the staff members of being on drugs. The note stated the DON instructed the ADON to send a 5 - day notice of discharge and the ADON sent the letter via mail that day.</p> <p>b. An undated discharge letter was evidenced in the clinical record with an effective date of discharge on 04/28/14.</p> <p>c. A skilled nursing note written by the ADON dated 04/28/14 stated a discharge order was sent to the medical doctor on that day.</p> <p>d. A physician order for discharge was written and faxed on 04/28/14. The order was faxed back to the agency</p>		<p>audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: All grievances will be investigated according to current policy. The agency will in-service all employees on possible grievances and include this list in the "Patient Rights" portion of the agencies orientation of all employees. The list will include but not be limited to the possible grievances of complaints regarding staff. The agency will in-service all employees on the current grievance policy & procedure which will outline required time frame constraints for responding and documenting of the grievance procedure.</p> <p>The Administrator will be required to note every grievance filed in the agencies Grievance log.</p> <p>The Grievance log will be audited quarterly.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	

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	<p>signed on 04/29/14.</p> <p>2. The clinical record and the agency grievance and complaint book failed to indicate if the complaint was investigated. The clinical record and the agency grievance / complaint book failed to evidence earlier / previous complaints and investigations that the patient had since admission.</p> <p>3. The Alternate Director of Nursing indicated on 06/18/14 at 3:05 PM that she felt the complaint "held credence due to the patient's personality" and the aide was pregnant. The Administrator indicated the patient was a difficult patient and they had problems staffing for the patient and felt they could not meet her needs.</p> <p>4. A policy titled "Clients Rights and Responsibilities" dated 01/01/10 stated, "The Agency will investigate complaints made by the Client and / or his / her family or legal representative. Every effort will be made to resolve issues or concerns.</p> <p>5. A policy titled "Client Complaints and Grievances" dated 12/22/10 stated, "All complaints will be investigated within in then (10) days of receipt; the entire process from receipt of complaint through resolution will not exceed thirty</p>						

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G000107	<p>(30) days. Resolution action (s) will be documented and the client will be informed to ensure his / her agreement. The Administrator, Director of Nursing, or Assistant Director of Nursing will investigate all complaints and all information related to the complaint will be recorded on the complaint form and logged within 24 hours of receipt. The Administrator, Director of Nursing, or designee will initiate investigation within the same time period ... Clients will be allowed to voice grievances without fear of reprisal ... "</p> <p>484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on clinical record and policy review and interview, the agency failed to investigate a complaint made by a patient regarding treatment and care furnished by a home health aide for 1 of</p>	G000107	The Executive Director has in-serviced nursing staff on the following corrective action: In the case of discharge, the agency will provide the Physician, who signs the	07/16/2014			

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	<p>10 records reviewed creating the potential to affect all 16 patients receiving services by the home health agency. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, start of care 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry, and errands.</p> <p>A skilled nursing note written by the ADON (Alternate Director of Nursing) dated 04/23/14 stated the ADON had spoken with the DON (Director of Nursing) an discussed continued issues of non-compliance with medications, visits, and constant changes in schedules. The ADON explained to the DON that the patient had stated one of their employees was fired from another home health agency for stealing and apparently was accusing one of the staff members being on drugs.</p> <p>2. The clinical record and the agency grievance and complaint book failed to indicate if the complaint was</p>		<p>Plan of Care for the Client, with the reason(s) for the requested discharge and obtain, at the minimum, a verbal order for discharge, prior to providing the Client with a 5 day notice of intent to discharge from the agencies services.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: All grievances will be investigated according to current policy. The agency will in-service all employees on possible grievances and include this list in the "Patient Rights" portion of the agencies orientation of all employees. The list will include but not be limited to the possible grievances of complaints regarding staff. The agency will in-service all employees on the current grievance policy & procedure which will outline required time frame constraints for responding and documenting of the grievance procedure.</p> <p>The Administrator will be required to note every grievance filed in the</p>	

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	<p>investigated. The clinical record and the agency grievance / complaint book failed to evidence earlier / previous complaints and investigations that the patient had since admission.</p> <p>3. The Alternate Director of Nursing indicated on 06/18/14 at 3:05 PM that she felt the complaint "held credence due to the patient's personality" and the aide was pregnant.</p> <p>4. A policy titled "Clients Rights and Responsibilities" dated 01/01/10 stated, "The Agency will investigate complaints made by the Client and / or his / her family or legal representative. Every effort will be made to resolve issues or concerns.</p> <p>5. A policy titled "Client Complaints and Grievances" dated 12/22/10 stated, "All complaints will be investigated within in then (10) days of receipt; the entire process from receipt of complaint through resolution will not exceed thirty (30) days. Resolution action (s) will be documented and the client will be informed to ensure his / her agreement. The Administrator, Director of Nursing, or Assistant Director of Nursing will investigate all complaints and all information related to the complaint will be recorded on the complaint form and</p>		<p>agencys Grievance log.</p> <p>The Grievance log will be audited quarterly.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>				

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G000108	<p>logged within 24 hours of receipt. The Administrator, Director of Nursing, or designee will initiate investigation within the same time period ... "</p> <p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record and document review and interview, the agency failed to ensure a patient representatives was informed in advance about the care to be furnished in regard to medication administration orally and in writing for 2 of 10 records reviewed creating the potential to affect all patients who was receiving medication administration by a home health aide. (#2 and 4)</p> <p>Findings include:</p>	G000108	The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and	07/16/2014

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	<p>1. 410 IAC 17-9-20 "Medication Assistance" defined Sec. 20. "Medication Assistance means the provision of assistance: (1) through providing reminders or cues to take medications, the opening of pre-set medication containers, and providing assistance in the handling or ingesting of noncontrolled substances medication, including eye drops, herbs, supplements, and over-the-counter medication; and (2) to an individual who is unable to accomplish the task due to an impairment and who is: (A) competent and has directed the services; or (B) incompetent and has the services directed by a competent individual who may consent to health care for the impaired individual."</p> <p>2. Clinical record number 2, SOC (start of care) 01/09/12, included a plan of care established by the physician for 04/28/14 to 06/26/14 for home health aide services 8 hours a day, 3 to 5 days a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision.</p> <p>a. The clinical record evidenced a medication administration schedule for the months of January, February, March, April, and May, 2014. The dates and times are initialed by employee A, home health aide.</p>		<p>providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual.</p> <p>The Director of Home Health</p>	

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	<p>b. The clinical record failed to evidence the patient representative was informed in advance about the administration of medication by a home health aide.</p> <p>3. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician dated 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up and home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks for bathing, grooming, meal prep, meal prep, medication assistance, and supervision.</p> <p>a. The clinical record evidenced a medication administration schedule for the months of March, April, and May, 2014. The dates and times were initialed by employees A and D, home health aides.</p> <p>b. The clinical record failed to evidence the patient representative was informed in advance about the administration of medication to be provided by a home health aide.</p> <p>4. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at</p>		<p>Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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G000110	<p>3:00 PM.</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record, policy, and document review and interview, the agency failed to ensure patients were provided the current Indiana Advance Directives, including a description of applicable State law, and agency policy of Advance Directives in 10 of 10 records reviewed creating the potential to affect all 16 patients receiving home health services (# 1 - 10).</p> <p>Findings include</p> <p>1. The admission package given to the</p>	G000110	<p>The Executive Director has in-serviced staff on the following corrective action: All Clients will receive the effective May 2004 and revised July 1, 2013 State of Indiana Advanced Directives document & the agencies policies regarding advanced directives. All admission folders will have the outdated version removed and the current, July 1, 2013, version in place with the agencies policies on advanced directives.</p> <p>The Director of Home Health Services will be responsible for</p>	07/16/2014

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	<p>patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana Advanced Directives and agency policy in the admission folder that was distributed to the patients at the start of care (SOC).</p> <p>2. Clinical record number 1, SOC 04/09/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>3. Clinical record number 2, SOC 01/09/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>4. Clinical record number 3, SOC 03/15/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>5. Clinical record number 4, SOC 03/05/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana</p>		<p>monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has enrolled in the Indiana Medicaid for Providers e-mail notification program for Banners, Bulletins, Newsletters, IHCP Notices, Web Interchange Notices, EDI Notices and Advisor FSSA Newsletters. The Administrative assistant will enroll as well.</p> <p>The Executive Director will be responsible for reviewing updates.</p> <p>The Executive director and the administrative assistant will meet quarterly to review updates.</p> <p>21) The Executive Director has in-serviced staff on the following corrective action: all skilled nursing and staff who are responsible for scheduling that no visit outside the frequency & duration specifically outlined in the Plan of Care for each Client will be made without a minimum of a verbal order from the physician signing the Plan of Care to provide such visit. This will include extra visits being requested as PRN at the time of the initial Plan of Care and Prior Authorization request.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not</p>	

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	<p>Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>6. Clinical record number 5, SOC 04/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record number 6, SOC 02/10/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>8. Clinical record number 7, SOC 04/23/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>9. Clinical record number 8, SOC 02/03/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance</p>		<p>recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>directives. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record number 9, SOC 12/12/11, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>11. Clinical record number 10, SOC 05/13/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>12. The Administrator and the Director of Nursing indicated on 06/19/14 at 04:00 PM they were not aware of the updated version of the advance directors nor were they aware of the need to include the agency policies regarding advance directives in the admission packet.</p> <p>13. A policy titled "Advance Directives" dated 05/2010 stated "The Admitting RN [Registered Nurse] will present the Indiana State Department of Health Advance Directive brochure to all adult Clients at the time of admission. The RN</p>				

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G000113	<p>will inform the Client about the Agency's policies regarding Advance Directives ... "</p> <p>484.10(e)(1) PATIENT LIABILITY FOR PAYMENT The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.</p> <p>Based on clinical record review and interview, the agency failed to inform patients the extent to which payment for the home health agency service may be expected from the payer source and the extent to which payment may be required from the patient for 5 of 10 records reviewed creating the potential to affect all 16 patients receiving services from the home health agency. (# 1, 5, 6, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/09/14, included a plan of care established by the physician for 04/09/14 to 06/07/14. Review of the "Admission Service Agreement Home Health" dated 04/28/14 failed to evidence liability of payment for home health services.</p>	G000113	<p>The Executive Director has in-serviced staff on the following corrective action: The Client shall be informed at every admission what services will be covered by their particular pay source and what will not be covered by their particular pay source via a new form created by the agency which will state these items and require Client signature for documentation of notification of this information.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has enrolled</p>	07/16/2014

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	<p>2. Clinical record number 5, SOC 03/15/12, included a plan of care established by the physician for 03/05/14 to 05/03/14. Review of the "Admission Service Agreement Home Health" dated 04/08/14 failed to evidence liability of payment for home health services.</p> <p>3. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14. Review of the "Admission Service Agreement Home Health" dated 02/07/14, included a check mark in the "Medicare fee for service [Projected 100 % covered]." The clinical record failed to evidence that Medicaid was the prospective payer for home health services.</p> <p>4. Clinical record 7, SOC 04/23/14, included a plan of care established by the physician for 04/23/14 to 06/21/14. Review of the "Admission Service Agreement Home Health" dated 04/08/14 failed to evidence liability of payment for home health services.</p> <p>5. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 02/03/14 to 04/03/14. Review of the "Admission Service Agreement Home Health" dated 01/17/14</p>		<p>in the Indiana Medicaid for Providers e-mail notification program for Banners, Bulletins, Newsletters, IHCP Notices, Web Interchange Notices, EDI Notices and Advisor FSSA Newsletters. The Administrative assistant will enroll as well.</p> <p>The Executive Director will be responsible for reviewing updates.</p> <p>The Executive director and the administrative assistant will meet quarterly to review updates.</p>	

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G000114	<p>included a check mark in the "Medicare fee for service [Projected 100 % covered]." The clinical record failed to evidence that Medicaid was the prospective payer for home health services.</p> <p>6. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay.</p> <p>Based on clinical record review and interview, the agency failed to ensure patients was informed orally and in writing of the extent to which payment may be expected from any Federally funded or aided program, the charges for services that will not be covered, and the charges the individual may have to pay for 5 of 10 records reviewed creating the</p>	G000114	The Executive Director has in-serviced staff on the following corrective action: The Client shall be informed at every admission what services will be covered by their particular pay source and what will not be covered by their particular pay source via a new form created by the agency which will state these items and require Client signature for documentation of notification of	07/19/2014

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	<p>potential to affect all 16 patient's receiving services from the home health agency. (# 1, 5, 6, 7, and 8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1, SOC (start of care) 04/09/14, included a plan of care established by the physician for 04/09/14 to 06/07/14. Review of the "Admission Service Agreement Home Health" dated 04/28/14 failed to evidence liability of payment for home health services. 2. Clinical record number 5, SOC 03/15/12, included a plan of care established by the physician for 03/05/14 to 05/03/14. Review of the "Admission Service Agreement Home Health" dated 04/08/14 failed to evidence liability of payment for home health services. 3. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14. Review of the "Admission Service Agreement Home Health" dated 02/07/14, included a check mark in the "Medicare fee for service [Projected 100 % covered]." The clinical record failed to evidence that Medicaid was the prospective payer for home health services. 		<p>this information.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has enrolled in the Indiana Medicaid for Providers e-mail notification program for Banners, Bulletins, Newsletters, IHCP Notices, Web Interchange Notices, EDI Notices and Advisor FSSA Newsletters. The Administrative assistant will enroll as well.</p> <p>The Executive Director will be responsible for reviewing updates.</p> <p>The Executive director and the administrative assistant will meet quarterly to review updates.</p>	

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G000141	<p>4. Clinical record 7, SOC 04/23/14, included a plan of care established by the physician for 04/23/14 to 06/21/14. Review of the "Admission Service Agreement Home Health" dated 04/08/14 failed to evidence liability of payment for home health services.</p> <p>5. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 02/03/14 to 04/03/14. Review of the "Admission Service Agreement Home Health" dated 01/17/14 included a check mark in the "Medicare fee for service [Projected 100 % covered]." The clinical record failed to evidence that Medicaid was the prospective payer for home health services.</p> <p>6. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current.</p>			

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	<p>Based on personnel record and policy review and interview, the agency failed to ensure personnel policies were followed for 3 of 5 home health aide files reviewed with the potential to affect all patients receiving home health aide services. (Employee A, E, and F)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A policy titled "Employee Initial and Annual TB Testing" dated 03/07/12 stated, "The Agency will ensure that all employees, persons providing care on behalf of the agency, and contractors having direct patient care are evaluated for tuberculosis and will ensure that appropriate documentation is maintained ... TB screening by the Mantoux method will be repeated annually for employees with a negative history of tuberculosis and a negative history of tuberculin testing." 2. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "Guardian Home Health will only utilize Home Health Aides [HHA] who have satisfactorily demonstrated the ability to perform the duties and the responsibilities required for their position. All HHA employed by the Agency will meet the requirements of the State of Indiana (410 IAC 17 - 4 -1) 	G000141	<p>Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p>	07/19/2014

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	<p>and centers for Medicare and Medicaid Services [CMS] Condition of Participation ... After hire and prior to providing direct client care services, a HHA will have successfully completed evaluation program conducted by the agency. Evaluation will consist of two elements, observation of the HHA's performance or the required skills / tasks conducted with a patient / client and written examination ... Upon a HHA's successful completion of the competency evaluation, the Agency will submit the Indiana Home Health Aide Registry Application ... to the state ... "</p> <p>3. Personnel record F, a home health aide, date of hire 11/08/11, failed to evidence a negative skin test within 1 year of when the last PPD had been administered.</p> <p>4. Personnel record A, a home health aide, date of hire 11/06/13 and first patient contact 11/06/13, failed to evidence a written competency test and that the aide was on the state aide registry.</p> <p>5. Personnel record E, a home health aide, date of hire 10/29/13 and first patient contact 10/31/13, failed to evidence a written competency test and that the aide was on the state aide</p>			

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G000156	<p>registry.</p> <p>6. The Administrator / Director of Nursing indicated on 06/19/14 at 3:00 PM that she had spoken with Employee F and the employee was aware that a yearly PPD was needed but she had yet to get it done.</p> <p>7. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM that she thought employee A and E was registered home health aides and was not able to locate the written examination.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure care and services had been provided in accordance with physician orders in 2 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency (See G 158); failed to ensure plans of care included all medications, treatments, and services in 8 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency (See G 159); failed to</p>	G000156	<p>The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that</p>	07/16/2014

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	<p>ensure the physician was notified of a changes in condition related to falls, fractures, wounds, and pain for 5 of 10 records creating the potential to affect all 16 patients currently receiving care from the home health agency (See G 164); and failed to ensure verbal orders were written by the registered nurse for 2 of 10 records reviewed creating the potential to affect all 16 patients receiving home health services (See G 166).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18 Acceptance of patients, plan of care & medical supervision.</p>		<p>deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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			<p>The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Director of Home Health services will provide in-service to all administrative and skilled nursing staff outlining the requirement that after any fall or decline in physical ability, a request will be made for a physical therapy evaluation through the physician signing the Plan of Care for the Client.</p>	

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			<p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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			<p>The Executive Director has in-serviced nursing staff on the following corrective action: to obtain a complete set of vital signs at any visit to the home of a Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: Wound monitoring. The Physician signing the Plan of Care and the Physician directing wound care services, if the Client should be receiving care through another Physician, will be notified within 24 hours if the Registered Nurse finds a decline in wound healing. Otherwise, the Physician signing the Plan of Care and the Physician directing wound care services will be notified of wound status no less than every 60 days via the Physicians 60 day summary or by a Physicians update.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to</p>	

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure care and services had been provided in accordance with physician orders in 2 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency. (# 4 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/05/14, included a plan of care established by the physician 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up and home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks.</p> <p>a. The clinical record evidenced extra skilled nursing visits during the weeks of 03/09/14 and 03/23/14 and two</p>	G000158	<p>ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans</p>	07/19/2014

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	<p>extra visits the weeks of 04/06/14, 04/13/14, 04/20/14, and 06/04/14. The clinical record failed to evidence orders for the extra nursing visits.</p> <p>b. The clinical record failed to evidence a minimum of 5 home health aide visits during the week of 03/05/14 (1 visit made) and the week of 03/16/14 (2 visits made). The clinical record failed to evidence orders for a change in the number of home health aide visits.</p> <p>2. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry, and errands.</p> <p>a. The clinical record failed to evidence a skilled nurse visit the weeks of 02/16/14, 03/02/14, 03/16/14, 03/30/14, and 03/13/14. Two skilled nursing visits were made the week of 03/23/14.</p> <p>b. The clinical record failed to evidence at least 3 home health aide visits the week of 02/16/14.</p>		<p>of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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	<p>3. The Alternate Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>4. A policy titled "Physician Communication and Orders" dated 08/18/10 stated, "All communication with a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care."</p> <p>5. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly</p>				

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G000159	<p>inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all medications, treatments, and services in 8 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency. (# 1, 2, 3, 5, 6, 8, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/09/14, included a plan of care established by the physician for 04/09/14</p>	G000159	<p>The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: Agency policy will change requiring an Initial</p>	07/19/2014

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	<p>to 06/07/14 for home health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry and errands.</p> <p>a. An OASIS Assessment dated 06/03/14 stated the patient's had a 14 French foley catheter inserted to the urostomy stoma and that a family member irrigates the catheter twice a day. The plan of care failed to evidence the type and size of the foley catheter; the type, amount, and frequency of irrigation; and the maintenance of the catheter.</p> <p>b. A physician's progress note dated 04/15/14 stated the patient takes Docusate Sodium 100 mg (milligrams) capsules three times a day. An OASIS Assessment dated 06/03/14 stated "takes 3 softeners" for bowel movement and constipation. The plan of care failed to evidence the Docusate Sodium 100 mg capsules in the medication section of the plan of care.</p> <p>c. A physician's progress note dated 04/15/14 stated the patient had allergies of Cipro, Iodine, Metformin, Ampicillin, and Vitamin B. The plan of care failed to evidence Cipro, Iodine, Metformin, and Ampicillin in the allergy section of the plan of care.</p>		<p>Assessment being performed prior to the Start of Care Date rather than a Comprehensive Assessment. The Start of Care date will be the initiation of staffing for services provided by the agency after a pay source such as Medicaid PA is obtained, unless the Physician has ordered/indicated a specific Start of Care date which will be used and staffing will begin on the indicated date. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours. The Director of Home Health Services</p>				

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	<p>d. An OASIS Assessment dated 06/03/14 stated "no raw veggies" under the diet section of the assessment. The plan of care failed to evidence the no raw vegetables under the diet section of the plan of care and care plan.</p> <p>2. Clinical record number 2, SOC 01/09/12, included a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinent care, medication assistance and supervision due to MR (mentally retardation) status. An OASIS Assessment dated 05/13/14 stated the patient was receiving services with an outside agency. The plan of care failed to evidence the agency and type of services being provided to the patient.</p> <p>3. Clinical record number 3, SOC 03/15/12, included a plan of care established by a physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 for home health aide 2 to 4 hours per day 4 to 6 days a week for 9 weeks. The plan of care failed to include specific home health aide duties and services.</p> <p>A physician's order dated 10/13/12</p>		<p>will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that de</p> <p>The Executive Director has in-serviced staff on the following corrective action: incidents</p>	

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	<p>stated vital sign parameters of systolic blood pressure less than 90 or greater than 140, diastolic blood pressure less than 60 or greater than 90, heart rate less than 60 or greater than 110, oral temperature greater than 101, respirations less than 11 or greater than 26, and pain greater than 8 on a 10 point scale. The plan of care failed to evidence the vital sign parameters.</p> <p>4. Clinical record number 5, SOC 04/28/14, included a plan of care established by a physician for 04/28/14 to 06/26/14 for home health aide services 2 hours a day, 3 days a week for 9 weeks assisting the patient with "bathing only."</p> <p>a. A physician order dated 04/01/14 stated Area 7 requested the home health agency to assist the patient with bathing, meal prep, and errands. Review of the home health aide care plan stated that the home health aide was to assist with application of TED hose, assist with hygiene and grooming, and vital sign parameters to be used to notify the case manager. The plan of care failed to include the application of TED hose, specific bathing, assistance with hygiene and grooming, meal prep, errands, and vital sign parameters.</p> <p>b. A start of care assessment was</p>		<p>requiring reporting and the incident reporting procedure, including the correct forms to use. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME, orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p>				

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	<p>obtained on 04/08/14. A nursing note dated 04/28/14 stated that the plan of care was received signed by the physician on 04/28/14 and the prior authorization was sent to Medicaid on 04/28/14. A reassessment was obtained on 05/15/14. Home Health Aide services started on 05/26/14 per patient request. The plan of care failed to evidence the correct start of care and certification dates based on the 05/15/14 reassessment.</p> <p>5. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician 02/10/14 to 04/10/14 for skilled nursing 1 hour every other week for 7 weeks for medication set up and home health aide 2 - 4 hours a day, 3 - 5 days a week for 9 weeks for bathing, grooming, meal prep, light housekeeping, laundry, and errands. The home health aide care plan evidenced vital sign parameters to notify the registered nurse. The plan of care failed to include the vital sign parameters.</p> <p>a. The OASIS Comprehensive Admission Assessment dated 02/07/14 stated the patient was receiving homemaker services from another agency. A nursing note dated 04/29/14 indicated the patient was receiving homemaker services from another agency. The plan of care failed to</p>		<p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>evidence the patient was receiving services from an outside agency.</p> <p>b. A follow up Comprehensive assessment for recertification was completed by an RN (Registered Nurse) on 04/09/14. The clinical record failed to evidence a revised plan of care for the certification period of 04/11/14 to 06/09/14.</p> <p>6. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 06/03/14 to 08/01/14 for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medication and home health aide services 204 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry and errands. The clinical record evidenced homemaker visits were provided on 06/01/14, 06/03/14, and 06/05/14. The plan of care failed to include homemaker services.</p> <p>7. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week, for 9 weeks.</p>						

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NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1521 S 3RD ST TERRE HAUTE, IN 47802
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	<p>a. An FSSA assessment dated 09/26/13 stated the patient's family member monitored the patient's coumadin levels each week and adjusted dosages as needed. The registered nurse failed to monitor / follow the patient's coumadin levels and adjust dosages on the medication profile as needed. The assessment also indicated that the physician had reduced the frequency of the patient's aspirin from twice a day to once a day. The plan of care continued to evidence the patient was receiving aspirin twice a day.</p> <p>b. The 10/02/13 to 11/30/14, 12/01/13 to 01/29/14, 01/30/14 to 03/30/14, 03/31/13 to 05/28/14, and 05/30/14 to 07/28/14 plans of care failed to evidence the patient was having routine protime levels performed. A faxed medication list dated 01/28/14 stated the patient's current dosage of coumadin was 1 mg (milligrams). The coumadin dosage on the plan of care remained at 2.5 mg.</p> <p>c. The clinical record evidenced visit notes that the patient was receiving home health aide and attendant care services. The plan of care failed to evidence that the patient was receiving attendant care services.</p>			

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	<p>d. A physician's order dated 10/3/12 stated vital sign parameters of systolic blood pressure less than 90 and greater than 140, diastolic blood pressure less than 60 and greater than 90, pulse less than 60 and greater than 110, temperature greater than 101, and respirations less than 11 and greater than 26. The 03/31/14 to 05/28/14 and 05/29/14 to 07/27/14 plans of care failed to evidence vital sign parameters.</p> <p>8. A clinical record number 10, SOC 05/13/13, included a plan of care established by a physician for 03/09/14 to 05/07/14. A faxed medication list dated 01/10/14 stated the patient was receiving Detrol 5 mg three times a day. The plan of care failed to evidence the updated / current frequency of the medication.</p> <p>9. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>10. A policy titled "Client Plan of Care" dated 05/23/11 stated "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or</p>						

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G000164	<p>environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</p> <p>11. A policy titled "Physician Communication and Orders" dated 08/18/10 stated "Physician order must include the following information: Name of Client, specific orders for treatments, frequency, and special instructions if applicable; the discipline, e.g. skilled nurse, home health aide, therapist, required to carry out the orders; If a medication order, the name of the medication, dosage, route, frequency, and start and stop date if applicable ... "</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record review and</p>	G000164	The Executive Director has in-serviced staff on the following	07/19/2014

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	<p>interview, the agency failed to ensure the physician was notified of a changes in condition related to falls, fractures, wounds, and pain for 4 of 10 records reviewed creating the potential to affect all 16 patients currently receiving care from the home health agency. (# 2, 3, 8, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 02/27/14 to 04/27/14 and 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included, but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p> <p>A hospital discharge summary dated 05/23/14 stated the patient was discharged home with Fluconazole 150 mg (milligrams) weekly. Below the discharged medications, the summary stated the patient was had a "critical" reaction to Fluconazole. A skilled nursing notes dated 05/20/14, 06/03/14,</p>		<p>corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician</p>	

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	<p>and 06/11/14 stated the patient had a rash to the buttock / peri area with a raised area on the right buttock. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>2. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 with orders for home health aide services.</p> <p>a. A nursing note dated 02/03/14 stated a staff member had informed the Alternate Director of Nursing that she had to lower the patient to the floor because as she was in another room, she had heard the patient yelling for help and found the patient "hanging" out of his chair. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>b. A nursing note dated 02/28/14 stated that the patient was assessed and had an open wound on the scrotum measuring 0.5 inches in diameter and 0.3 cm (centimeters) deep draining small amount of bloody drainage. The clinical record failed to evidence the physician was notified of the findings.</p> <p>c. A nursing note dated 05/02/14 stated the patient was assessed and had</p>		<p>or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>purple feet that was cool to touch, no pedal pulses, and an open area on the right great toe that was draining serous drainage. The clinical record failed to evidence the physician was notified of the findings.</p> <p>d. A faxed "Physician Update" dated 05/27/14 stated during a home health aide supervisory visit on 05/23/14, the case manager observed the patient to have had a blister measuring 3 inches in diameter with a 1/2 inch open area in the center of the blister located on the patient's left thigh. The patient had told the case manager that he had spilled hot food in his lap. The Case Manager, a Registered Nurse, failed to notify the physician in a timely manner.</p> <p>3. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14 with orders for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medications and home health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry and errands. The patient's diagnoses included, but were not limited to, cerebral artery occlusion, right hemiparesis, and aphasia.</p>			

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	<p>A skilled nursing visit note dated 03/31/14 stated the patient had a blood pressure of 166 / 100. The clinical record failed to evidence the physician had been notified.</p> <p>6. Clinical record number 10, SOC 05/13/13 evidenced a plan of care dated 03/09/14 to 05/07/14 with orders for home health aide services.</p> <p>a. A skilled nursing note dated 08/09/13 stated that a staff employee had notified the agency of the patient fall that resulted in a trip to the emergency room on 08/08/13 which resulted in a dislocated elbow. The clinical record failed to evidence the physician was notified of the patient's fall and injury.</p> <p>b. A comprehensive recertification assessment dated 11/15/13 stated that the patient was complaining of an unsteady gait and frequent falls. The clinical record failed to notify the physician of the patient's falls.</p> <p>c. A comprehensive recertification assessment dated 03/05/14 stated that the patient had fallen a couple of times in the house and had increased shortness of breath with minimal exertion. The patient had complained of sternum pain around the scar tissue area. The</p>				

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	<p>registered nurse instructed the patient to notify the physician. The clinical record failed to evidence the physician had been notified of the patient's falls and symptoms.</p> <p>d. The Alternate Director of Nursing indicated on 06/19/14 at 3:00 PM the physician had not been notified.</p> <p>8. A policy titled "Physician Communication and Orders" dated 08/18/10 stated, "All communication with a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care.</p> <p>9. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care</p>				

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G000166	<p>services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on clinical record review and interview, the agency failed to ensure verbal orders were written by the registered nurse for 2 of 10 records reviewed creating the potential to affect all 16 patients receiving home health services. (# 4 and 8)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/05/14, included a plan of care established by the physician for 03/05/14 to 05/03/14 with orders for skilled nursing 1 hour every other week for medication set up and home health aide 6</p>	G000166	The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on	07/19/2014			

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	<p>to 8 hours a day, 5 to 7 days a week for 9 weeks.</p> <p>A nursing communication note dated 03/04/14 stated that the Alternate Director of Nursing had received an order from the physician to assess and admit the patient as appropriate for services. The clinical record failed to evidence a verbal physician order for services.</p> <p>2. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14.</p> <p>A skilled nursing note dated 04/28/14 stated the patient's son would take over setting up the medications and administering the medications and insulin. The clinical record evidenced an order discontinuing skilled nursing services on 06/03/14. The clinical record failed to evidence the order was written in a timely manner.</p> <p>3. The Alternate Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>4. A policy titled "Physician Communication and Orders" dated 08/18/10 stated "All communication with</p>		<p>the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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G000168	<p>a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care.</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to ensure the Registered Nurse provided care and services in accordance with physician orders in 2 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency (See G 170); failed to ensure the Registered Nurse completely reassessed a patient's vital signs during each skilled nursing visit for 1 of 10 records reviewed and failed to reassess patient wounds for 3 of 3 records reviewed of patients with wounds creating the potential to affect all 16 patients receiving services within the agency (See G 172); failed to ensure the Registered Nurse revised the plans of care to include all medications,</p>	G000168	<p>The Executive Director has in-serviced nursing staff on the following corrective action: to obtain a complete set of vital signs at any visit to the home of a Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: Wound monitoring. The Physician signing the Plan of Care and the Physician directing wound care services, if the Client should be receiving care</p>	07/16/2014			

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	<p>treatments, and services in 8 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency (See G 173); failed to ensure the Registered Nurse furnished skilled nursing services for 3 of 3 records reviewed of patients with wounds creating the potential to affect all patients who were receiving wound care within the agency (See G 174); failed to ensure the Registered Nurse referred a patient for therapy services due to falls, unsteady gait, and shortness of breath with minimal exertions for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services with the agency (See G 175); and failed to ensure the Registered Nurse notified the physician of a change in condition related to falls, fractures, wounds, and pain for 5 of 10 records creating the potential to affect all 16 patients currently receiving care from the home health agency (See G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.30 Skilled nursing services.</p>		<p>through another Physician, will be notified within 24 hours if the Registered Nurse finds a decline in wound healing. Otherwise, the Physician signing the Plan of Care and the Physician directing wound care services will be notified of wound status no less than every 60 days via the Physicians 60 day summary or by a Physicians update. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: on what constitutes a "change in condition". This in-service will include the current policy on "change in condition". Instruction will be that all employees are responsible for reporting any change of condition to a Registered Nurse. The Registered Nurse receiving the report of a change in condition or observing a change in condition will assess the change and notify the Physician signing the Plan of Care within 24 hours of the report or observed change in condition. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	

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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the Registered Nurse provided care and services in accordance with physician orders in 2 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency. (# 4 and 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record number 4, SOC (start of care) 03/05/14, included a plan of care established by the physician 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up. <p>The clinical record evidenced extra skilled nursing visits during the weeks of 03/09/14 and 03/23/14. Two extra visits were made the weeks of 04/06/14, 04/13/14, 04/20/14, and 06/04/14. The clinical record failed to evidence orders for the extra nursing visits.</p> <ol style="list-style-type: none"> Clinical record number 6, SOC 	G000170	<p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: on what constitutes a "change in condition". This in-service will include the current policy on "change in condition". Instruction will be that all employees are responsible for reporting any change of condition to a Registered Nurse. The Registered Nurse receiving the report of a change in condition or observing a change in condition will assess the change and notify the Physician signing the Plan of Care within 24 hours of the report or observed change in condition.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	07/19/2014

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	<p>02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14 with orders for skilled nursing services 1 hour every other week for 7 weeks to set up medications.</p> <p>The clinical record failed to evidence a skilled nurse visit the weeks of 02/16/14, 03/02/14, 03/16/14, 03/30/14, and 03/13/14. Two killed nursing visits were made the week of 03/23/14.</p> <p>3. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>4. A policy titled "Physician Communication and Orders" dated 08/18/10 stated "All communication with a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care.</p>				

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G000172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse reassess a patient's vital signs during each skilled nursing visit for 1 of 10 records reviewed (# 8) and failed to reassess patient wounds for 3 of 3 records reviewed of patients with wounds (# 6, 9, and 10) creating the potential to affect all 16 patients receiving services within the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, start of care (SOC) 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services. A 30 day Comprehensive assessment dated 05/14/14 provided a wound measurement to the right heel. The clinical record failed to evidence any further measurements after 05/14/14. 2. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14 for 	G000172	<p>The Executive Director has in-serviced nursing staff on the following corrective action: to obtain a complete set of vital signs at any visit to the home of a Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: Wound monitoring. The Physician signing the Plan of Care and the Physician directing wound care services, if the Client should be receiving care through another Physician, will be notified within 24 hours if the Registered Nurse finds a decline in wound healing. Otherwise, the Physician signing the Plan of Care and the Physician directing wound care services will be notified of</p>	07/19/2014
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	<p>skilled nursing nursing services 1 hour every other week for 9 weeks to set up medication. The patient's diagnoses included, but were not limited to, cerebral artery occlusion, right hemiparesis, and aphasia.</p> <p>a. A skilled nursing visit note dated 02/10/14 failed to evidence that a blood pressure had been obtained.</p> <p>b. Four (4) skilled nursing visit notes dated 02/03/14, 02/05/14, 02/06/14, and 02/11/14 failed to evidence that a blood pressure, pulse, respirations, and temperature had been obtained.</p> <p>c. A skilled nursing visit note dated 02/13/14 failed to evidence blood pressure had been obtained and that the cardio, respiratory, neuro, and genitourinary had been assessed.</p> <p>d. A skilled nursing visit note dated 04/14/14 failed to evidence blood pressure, pulse, respirations, and temperature had been obtained and that the digestive / nutrition had been assessed.</p> <p>3. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to</p>		<p>wound status no less than every 60 days via the Physicians 60 day summary or by a Physicians update.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>		

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	<p>05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week, for 9 weeks.</p> <p>a. A comprehensive recertification assessment dated 01/24/14 had stated that the patient's caregiver had indicated the patient had an area on the buttocks that was open but no drainage. The registered nurse did not assess the patient's wound.</p> <p>b. A comprehensive recertification assessment dated 03/25/14 stated that the patient's bilateral heels were broken down with eschar approximately 2.5 cm (centimeters) in diameter, the coccyx wound was healing and there were no open areas, and the right inner thigh was broken down with a small amount of bloody drainage. The clinical record failed to evidence the registered nursing routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration.</p> <p>c. A nursing supervisory visit note dated 04/22/14 stated that the patient's heels were assessed and the left heel had a large black scab approximately 1 1/2 inches in diameter, the right heel had a smaller black scab approximately 3/4 inch in diameter, and back of the right leg above the heel had an open area approximately 1/2 inch in diameter</p>						

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	<p>draining a small amount of serous drainage. The clinical record failed to evidence that the registered nurse routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration.</p> <p>d. A comprehensive recertification assessment dated 05/29/14 stated the doctor was contacted by a family member due to the foul smelling drainage from the left heel wound. The "black scab was loosening around the edges." The note stated the right heel could possibly be infected as well as 2 pressure areas. The right heel was approximately 1 inch, tan and classified as a stage III. The right ankle was approximately 2 inches and classified as a stage III. The family member was asked to notify the agency if the doctor calls back with instructions / prescriptions. The left heel was approximately 2 inches, scant purulent drainage with slough, foul odor, and classified as a stage III; the left ankle was not measured and classified as a stage II; and the back of the right ankle / heel was not measured and classified as a stage II. The clinical record failed to evidence the registered nursing routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration.</p>			

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G000173	<p>4. Clinical record number 10, SOC 12/13/13, included a plan of care established by the physician for the certification period 12/13/13 to 01/16/14 with orders for skilled nursing 7 days a week for 2 months for daily dressing changes. An Admission Assessment dated 12/13/13 provided a wound measurement to an ulcer of the lower extremity. The clinical record failed to evidence any further measurement after 12/13/13.</p> <p>5. The Director of Nursing indicated on 06/06/14 at 11:00 AM that wound measurements should had been done weekly and she had already identified this was a problem within the agency.</p> <p>6. An undated policy titled "Wound Care Management" stated "Documentation of wounds must include type of wound, measurements, including length, depth, and width, description of the wound bed, surrounding area, undermining, staging, color, odor, and estimated amount of drainage ... wound status or measurements will be documented by the RN and / or LPN ..."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE</p>						

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	<p>The registered nurse initiates the plan of care and necessary revisions.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the Registered Nurse updated the plan of care to include all medications, treatments, and services in 8 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency. (# 1, 3, 5, 6, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/09/14, included a plan of care established by the physician for 04/09/14 to 06/07/14 for home health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry and errands.</p> <p>a. An OASIS Assessment dated 06/03/14 stated the patient's had a 14 French foley catheter inserted to the urostomy stoma and that a family member irrigates the catheter twice a day. The plan of care failed to evidence the type and size of the foley catheter; the type, amount, and frequency of irrigation; and the maintenance of the catheter.</p>	G000173	<p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME, orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	07/19/2014

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	<p>b. A physician's progress note dated 04/15/14 stated the patient takes Docusate Sodium 100 mg (milligrams) capsules three times a day. An OASIS Assessment dated 06/03/14 stated "takes 3 softeners" for bowel movement and constipation. The plan of care failed to evidence the Docusate Sodium 100 mg capsules in the medication section of the plan of care.</p> <p>c. A physician's progress note dated 04/15/14 stated the patient had allergies of Cipro, Iodine, Metformin, Ampicillin, and Vitamin B. The plan of care failed to evidence Cipro, Iodine, Metformin, and Ampicillin in the allergy section of the plan of care.</p> <p>d. An OASIS Assessment dated 06/03/14 stated "no raw veggies" under the diet section of the assessment. The plan of care failed to evidence the no raw vegetables under the diet section of the plan of care and care plan.</p> <p>2. Clinical record number 2, SOC 01/09/12, included a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinent care,</p>		<p>The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>medication assistance and supervision due to MR (mentally retardation) status. An OASIS Assessment dated 05/13/14 stated the patient was receiving services with an outside agency. The plan of care failed to evidence the agency and type of services being provided to the patient.</p> <p>3. Clinical record number 3, SOC 03/15/12, included a plan of care established by a physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 for home health aide 2 to 4 hours per day 4 to 6 days a week for 9 weeks. The plan of care failed to include specific home health aide duties and services.</p> <p>A physician's order dated 10/13/12 stated vital sign parameters of systolic blood pressure less than 90 or greater than 140, diastolic blood pressure less than 60 or greater than 90, heart rate less than 60 or greater than 110, oral temperature greater than 101, respirations less than 11 or greater than 26, and pain greater than 8 on a 10 point scale. The plan of care failed to evidence the vital sign parameters.</p> <p>4. Clinical record number 5, SOC 04/28/14, included a plan of care established by a physician for 04/28/14 to 06/26/14 for home health aide services 2 hours a day, 3 days a week for 9 weeks</p>						

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	<p>assisting the patient with "bathing only."</p> <p>a. A physician order dated 04/01/14 stated Area 7 requested the home health agency to assist the patient with bathing, meal prep, and errands. Review of the home health aide care plan stated that the home health aide was to assist with application of TED hose, assist with hygiene and grooming, and vital sign parameters to be used to notify the case manager. The plan of care failed to include the application of TED hose, specific bathing, assistance with hygiene and grooming, meal prep, errands, and vital sign parameters.</p> <p>b. A start of care assessment was obtained on 04/08/14. A nursing note dated 04/28/14 stated that the plan of care was received signed by the physician on 04/28/14 and the prior authorization was sent to Medicaid on 04/28/14. A reassessment was obtained on 05/15/14. Home Health Aide services started on 05/26/14 per patient request. The plan of care failed to evidence the correct start of care and certification dates based on the 05/15/14 reassessment.</p> <p>5. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician 02/10/14 to 04/10/14 for skilled nursing 1 hour every</p>						

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	<p>other week for 7 weeks for medication set up and home health aide 2 - 4 hours a day, 3 - 5 days a week for 9 weeks for bathing, grooming, meal prep, light housekeeping, laundry, and errands. The home health aide care plan evidenced vital sign parameters to notify the registered nurse. The plan of care failed to include the vital sign parameters.</p> <p>a. The OASIS Comprehensive Admission Assessment dated 02/07/14 stated the patient was receiving homemaker services from another agency. A nursing note dated 04/29/14 indicated the patient was receiving homemaker services from another agency. The plan of care failed to evidence the patient was receiving services from an outside agency.</p> <p>b. A follow up Comprehensive assessment for recertification was completed by an RN (Registered Nurse) on 04/09/14. The clinical record failed to evidence a revised plan of care for the certification period of 04/11/14 to 06/09/14.</p> <p>6. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 06/03/14 to 08/01/14 for skilled nursing nursing services 1 hour every other week for 9 weeks to set up</p>						

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	<p>medication and home health aide services 204 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry and errands. The clinical record evidenced homemaker visits were provided on 06/01/14, 06/03/14, and 06/05/14. The plan of care failed to include homemaker services.</p> <p>7. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week, for 9 weeks.</p> <p>a. An FSSA assessment dated 09/26/13 stated the patient's family member monitored the patient's coumadin levels each week and adjusted dosages as needed. The registered nurse failed to monitor / follow the patient's coumadin levels and adjust dosages on the medication profile as needed. The assessment also indicated that the physician had reduced the frequency of the patient's aspirin from twice a day to once a day. The plan of care continued to evidence the patient was receiving aspirin twice a day.</p> <p>b. The 10/02/13 to 11/30/14,</p>			

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	<p>12/01/13 to 01/29/14, 01/30/14 to 03/30/14, 03/31/13 to 05/28/14, and 05/30/14 to 07/28/14 plans of care failed to evidence the patient was having routine protime levels performed. A faxed medication list dated 01/28/14 stated the patient's current dosage of coumadin was 1 mg (milligrams). The coumadin dosage on the plan of care remained at 2.5 mg.</p> <p>c. The clinical record evidenced visit notes that the patient was receiving home health aide and attendant care services. The plan of care failed to evidence that the patient was receiving attendant care services.</p> <p>d. A physician's order dated 10/3/12 stated vital sign parameters of systolic blood pressure less than 90 and greater than 140, diastolic blood pressure less than 60 and greater than 90, pulse less than 60 and greater than 110, temperature greater than 101, and respirations less than 11 and greater than 26. The 03/31/14 to 05/28/14 and 05/29/14 to 07/27/14 plans of care failed to evidence vital sign parameters.</p> <p>8. A clinical record number 10, SOC 05/13/13, included a plan of care established by a physician for 03/09/14 to 05/07/14. A faxed medication list dated</p>			

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	<p>01/10/14 stated the patient was receiving Detrol 5 mg three times a day. The plan of care failed to evidence the updated / current frequency of the medication.</p> <p>9. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>10. A policy titled "Client Plan of Care" dated 05/23/11 stated "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</p> <p>11. A policy titled "Physician Communication and Orders" dated 08/18/10 stated "Physician order must include the following information: Name of Client, specific orders for treatments, frequency, and special instructions if</p>				

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G000174	<p>applicable; the discipline, e.g. skilled nurse, home health aide, therapist, required to carry out the orders; If a medication order, the name of the medication, dosage, route, frequency, and start and stop date if applicable ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse furnished skilled nursing services for 3 of 3 records reviewed of patients with wounds creating the potential to affect all patients who were receiving wound care within the agency. (# 6, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 6, start of care (SOC) 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services. A 30 day Comprehensive assessment dated 05/14/14 provided a wound measurement to the right heel. The clinical record failed to evidence any further measurements after 05/14/14.</p>	G000174	<p>The Executive Director has in-serviced nursing staff on the following corrective action: Wound monitoring. The Physician signing the Plan of Care and the Physician directing wound care services, if the Client should be receiving care through another Physician, will be notified within 24 hours if the Registered Nurse finds a decline in wound healing. Otherwise, the Physician signing the Plan of Care and the Physician directing wound care services will be notified of wound status no less than every 60 days via the Physicians 60 day summary or by a Physicians update. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	07/19/2014

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	<p>2. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week, for 9 weeks.</p> <p>a. A comprehensive recertification assessment dated 01/24/14 stated the patient's caregiver had indicated the patient had an area on the buttocks that was open but no drainage. The registered nurse did not assess the patient's wound.</p> <p>b. A comprehensive recertification assessment dated 03/25/14 stated that the patient's bilateral heels were broken down with eschar approximately 2.5 cm (centimeters) in diameter, the coccyx wound was healing and there were no open areas, and the right inner thigh was broken down with a small amount of bloody drainage. The clinical record failed to evidence the registered nurse routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration. The registered nurse failed to notify the physician of the deterioration and obtain treatment orders.</p> <p>c. A nursing supervisory visit note</p>		<p>The Executive Director has in-serviced staff on the following corrective action: Agency policy will change requiring an Initial Assessment being performed prior to the Start of Care Date rather than a Comprehensive Assessment. The Start of Care date will be the initiation of staffing for services provided by the agency after a pay source such as Medicaid PA is obtained, unless the Physician has ordered/indicated a specific Start of Care date which will be used and staffing will begin on the indicated date.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for</p>	

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	<p>dated 04/22/14 stated that the patient's heels were assessed and the left heel had a large black scab approximately 1 1/2 inches in diameter, the right heel had a smaller black scab approximately 3/4 inch in diameter, and back of the right leg above the heel had an open area approximately 1/2 inch in diameter draining small amount of serous drainage. The clinical record failed to evidence that the registered nursing routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration. The registered nurse failed to notify the physician of the deterioration and obtain treatment orders.</p> <p>d. A comprehensive recertification assessment dated 05/29/14 stated the doctor was contacted by a family member due to the foul smelling drainage from the left heel wound. The "black scab was loosening around the edges." The note stated the right heel could have possibly be infected as well as 2 pressure areas. The right heel was approximately 1 inch, tan, and classified as a stage III. The right ankle was approximately 2 inches and classified as a stage III. The family member was asked to notify the agency if the doctor called back with instructions / prescriptions. The left heel was approximately 2 inches; scant purulent</p>		<p>evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary</p>	

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	<p>drainage with slough, foul odor, and classified as a stage III; the left ankle was not measured and classified as a stage II; and the back of the right ankle / heel was not measured and classified as a stage II. The clinical record failed to evidence that the registered nursing routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration. The registered nurse failed to notify the physician of the deterioration and obtain treatment orders.</p> <p>3. Clinical record number 10, SOC 12/13/13, included a plan of care established by the physician for the certification period 12/13/13 to 01/16/14 with orders for skilled nursing 7 days a week for 2 months for daily dressing changes. An Admission Assessment dated 12/13/13 provided a wound measurement to an ulcer of the lower extremity. The clinical record failed to evidence any further measurement after 12/13/13.</p> <p>4. The Director of Nursing indicated on 06/06/14 at 11:00 AM that wound measurements should had been done weekly and she had already identified this was a problem within the agency.</p> <p>5. An undated policy titled "Wound Care Management" stated,</p>		<p>services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: on what constitutes a "change in condition". This in-service will include the current policy on "change in condition". Instruction will be that all employees are responsible for reporting any change of condition to a Registered Nurse. The Registered Nurse receiving the report of a change in condition or observing a change in condition will assess the change and notify the Physician signing the Plan of Care within 24 hours of the report or observed change in condition.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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G000175	<p>"Documentation of wounds must include type of wound, measurements, including length, depth, and width, description of the wound bed, surrounding area, undermining, staging, color, odor and estimated amount of drainage ... wound status or measurements will be documented by the RN and / or LPN ..."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record and policy review and interview, the Registered Nurse failed to ensure a patient be referred for therapy services due to falls and shortness of breath with minimal exertions for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services with the agency. (# 10)</p> <p>Findings include:</p> <p>1. Clinical record number 10, start of care 05/13/13 evidenced a plan of care dated 03/09/14 to 05/07/14 with orders for home health aide services.</p> <p>a. A skilled nursing note dated</p>	G000175	<p>Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for</p>	07/19/2014

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	<p>08/09/13 stated that a staff employee had notified the agency of the patient's fall that resulted in a trip to the emergency room on 08/08/13 which resulted in a dislocated elbow. The registered nurse failed to obtain a referral for physical therapy assessment.</p> <p>b. A comprehensive recertification assessment dated 11/15/13 stated that the patient was complaining of an unsteady gait and frequent falls. The registered nurse failed to obtain a referral for physical therapy assessment.</p> <p>c. A comprehensive recertification assessment dated 03/05/14 stated that the patient had fallen a couple of times in the house and increased shortness of breath with minimal exertion. The registered nurse failed to obtain a referral for physical therapy assessment.</p> <p>2. The Alternate Director of Nursing indicated on 06/19/14 at 3:00 PM that the physician had not been notified to obtain a referral for physical therapy assessment.</p> <p>3. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate</p>		<p>monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Director of Home Health services will provide in-service to all administrative and skilled nursing staff outlining the requirement that after any fall or decline in physical ability, a request will be made for a physical therapy evaluation through the physician signing the Plan of Care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification</p>	

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G000176	<p>changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse notified the physician of a changes in condition related to falls, fractures, wounds, and pain for 5 of 10 records reviewed creating the potential to affect all 16 patients currently receiving care from the home health agency. (# 2, 3, 6, 8, and 10)</p>	G000176	<p>will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: on what constitutes a "change in condition". This in-service will include the current policy on "change in condition". Instruction will be that all employees are responsible for reporting any change of condition to a Registered Nurse. The Registered Nurse receiving the report of a</p>	07/19/2014			

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	<p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 02/27/14 to 04/27/14 and 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included, but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p> <p>A hospital discharge summary dated 05/23/14 stated the patient was discharged home with Fluconazole 150 mg (milligrams) weekly. Below the discharged medications, the summary stated the patient was had a "critical" reaction to Fluconazole. A skilled nursing notes dated 05/20/14, 06/03/14, and 06/11/14 stated the patient had a rash to the buttock / peri area with a raised area on the right buttock. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>2. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14</p>		<p>change in condition or observing a change in condition will assess the change and notify the Physician signing the Plan of Care within 24 hours of the report or observed change in condition.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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	<p>to 05/03/14 and 05/04/14 to 07/02/14 with orders for home health aide services.</p> <p>a. A nursing note dated 02/03/14 stated a staff member had informed the Alternate Director of Nursing that she had to lower the patient to the floor because as she was in another room, she had heard the patient yelling for help and found the patient "hanging" out of his chair. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>b. A nursing note dated 02/28/14 stated that the patient was assessed and had an open wound on the scrotum measuring 0.5 inches in diameter and 0.3 cm (centimeters) deep draining small amount of bloody drainage. The clinical record failed to evidence the physician was notified of the findings.</p> <p>c. A nursing note dated 05/02/14 stated the patient was assessed and had purple feet that was cool to touch, no pedal pulses, and an open area on the right great toe that was draining serous drainage. The clinical record failed to evidence the physician was notified of the findings.</p> <p>d. A faxed "Physician Update" dated 05/27/14 stated during a home health aide</p>				

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	<p>supervisory visit on 05/23/14, the case manager observed the patient to have had a blister measuring 3 inches in diameter with a 1/2 inch open area in the center of the blister located on the patient's left thigh. The patient had told the case manager that he had spilled hot food in his lap. The Case Manager, a Registered Nurse, failed to notify the physician in a timely manner.</p> <p>3. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14 with orders for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medications and home health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry and errands. The patient's diagnoses included, but were not limited to, cerebral artery occlusion, right hemiparesis, and aphasia.</p> <p>A skilled nursing visit note dated 03/31/14 stated the patient had a blood pressure of 166 / 100. The clinical record failed to evidence the physician had been notified.</p> <p>6. Clinical record number 10, SOC 05/13/13 evidenced a plan of care dated 03/09/14 to 05/07/14 with orders for</p>						

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	<p>home health aide services.</p> <p>a. A skilled nursing note dated 08/09/13 stated that a staff employee had notified the agency of the patient fall that resulted in a trip to the emergency room on 08/08/13 which resulted in a dislocated elbow. The clinical record failed to evidence the physician was notified of the patient's fall and injury.</p> <p>b. A comprehensive recertification assessment dated 11/15/13 stated that the patient was complaining of an unsteady gait and frequent falls. The clinical record failed to notify the physician of the patient's falls.</p> <p>c. A comprehensive recertification assessment dated 03/05/14 stated that the patient had fallen a couple of times in the house and had increased shortness of breath with minimal exertion. The patient had complained of sternum pain around the scar tissue area. The registered nurse instructed the patient to notify the physician. The clinical record failed to evidence the physician had been notified of the patient's falls and symptoms.</p> <p>d. The Alternate Director of Nursing indicated on 06/19/14 at 3:00 PM the physician had not been notified.</p>						

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G000202	484.36 8. A policy titled "Physician Communication and Orders" dated 08/18/10 stated, "All communication with a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care. 9. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "						

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	<p>HOME HEALTH AIDE SERVICES</p> <p>Based on clinical record review and interview, it was determined the agency failed to ensure home health aides had completed a competency evaluation for 2 of 8 home health aide records reviewed with the potential to affect all patents receiving aide services from employees A and E (See G 212), failed to ensure the home health aide care plan was updated with correct parameters for 2 of 10 records reviewed creating the potential to affect all patients receiving home health aide services (See G 224), failed to ensure the home health aide provided services that were within the aide's scope of practice for 3 of 10 records reviewed creating the potential to affect all 16 patient's receiving services with the agency (See G 225), and failed to ensure the Registered Nurse make an on-site visit to the patient's home no less frequently than every 2 weeks for 2 of 10 records reviewed creating the potential to affect all patients receiving skilled and home health aide services (See G 229).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.36 Home health aide services.</p>	G000202	<p>Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 10% of all employee records will be audited quarterly for evidence that deficiencies don't recur. All training and education required prior to a home health aide providing care to a client, to include classroom/theory education, practical/hands on training and competency review through demonstration of skills/tasks/duties and written competency exam will be provided through contract by an educational facility or Registered Nurse not employed by the agency. Upon successful completion of this training and</p>	07/16/2014			

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			<p>competency review, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: current policy on the time frames for completing Initial Assessments, Admission Assessments, Recertification Assessments, Resumption of Care Assessments and Supervisory visits.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and</p>	

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			<p>immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain</p>	

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G000212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on personnel record and policy review and interview, the agency failed to ensure home health aides had completed a competency evaluation for 2 of 5 home health aide records reviewed with the potential to affect all patents receiving aide services from employees A and E. (Employee A and E)</p> <p>Findings include:</p>	G000212	<p>consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the</p>	07/16/2014

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	<p>1. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "Guardian Home Health will only utilize Home Health Aides [HHA] who have satisfactorily demonstrated the ability to perform the duties and the responsibilities required for their position. All HHA employed by the Agency will meet the requirements of the State of Indiana (410 IAC 17 - 4 - 1) and centers for Medicare and Medicaid Services [CMS] Condition of Participation ... After hire and prior to providing direct client care services, a HHA will have successfully completed an evaluation program conducted by the agency. Evaluation will consist of two elements, observation of the HHA's performance or the required skills / tasks conducted with a patient / client and written examination ... Upon a HHA's successful completion of the competency evaluation, the Agency will submit the Indiana Home Health Aide Registry Application ... to the state ... "</p> <p>2. Personnel record A, a home health aide, date of hire 11/06/13 and first patient contact 11/06/13, failed to evidence a written competency test and that the aide was on the state aide registry.</p>		<p>employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>All training and education required prior to a home health aide providing care to a client, to include classroom/theory education, practical/hands on training and competency review through demonstration of skills/tasks/duties and written competency exam will be provided through contract by an educational facility or Registered Nurse not employed by the agency . Upon successful completion of this training and competency review, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services.</p> <p>All new employees will have this verified by the administrative</p>	

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G000224	<p>3. Personnel record E, a home health aide, date of hire 10/29/13 and first patient contact 10/31/13, failed to evidence a written competency test and that the aide was on the state aide registry.</p> <p>4. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM that she thought employees A and E were registered home health aides and was not able to locate the written examination.</p> <p>484.36(c)(1) ASSIGNMENT & 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. Based on clinical record review and interview, the agency failed to ensure the home health aide care plan was updated with correct parameters for 2 of 10 records reviewed creating the potential to affect all patients receiving home health aide services. (# 8 and 9)</p> <p>Findings include:</p> <p>1. Clinical record 8, SOC 02/03/14,</p>	G000224	<p>assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will</p>	07/19/2014

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	<p>included a plan of care established by the physician for 06/03/14 to 08/01/14 for skilled nursing services 1 hour every other week for 9 weeks to set up medication and home health aide services 2-4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry, and errands.</p> <p>The plan of care evidenced vital sign parameters of systolic blood pressure of less than 90 or greater than 110, diastolic blood pressure of less than 60 or greater than 100, pulse less than 60 or greater than 110, respirations less than 11 or greater than 26. The home health aide care plan evidenced vital sign parameters of systolic blood pressure less than 100 or greater than 140, diastolic blood pressure less than 60 or greater than 100, and respirations greater than 26. The clinical record failed to evidence an updated home health aide care plan with correct vital sign parameters.</p> <p>2. Clinical record number 9, SOC 12/12/11, included plans of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week for 9 weeks.</p>		<p>be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME, orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow</p>	

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G000225	<p>A physician's order dated 10/3/12 stated vital sign parameters as follows: systolic blood pressure less than 90 and greater than 140, diastolic blood pressure less than 60 and greater than 90, pulse less than 60 and greater than 110, temperature greater than 101, respirations less than 11 and greater than 26. The home health aide care plan continued to state vital sign parameters as follows: systolic blood pressure less than 90 and greater than 100, diastolic blood pressure less than 60 and greater than 90. No respirations or pulse parameters were written. The clinical record failed to evidence an updated home health aide care plan with correct vital sign parameters.</p> <p>3. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of</p>		<p>sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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	<p>care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the home health aide provided services that were within the aide's scope of practice for 3 of 10 records reviewed (# 2, 3, and 4) creating the potential to affect all patients receiving home health aide services within the agency.</p> <p>Findings include:</p> <p>1. A policy titled "Home Health Aide Medication Assistance with Medications" dated 01/01/10 stated "An HHA [home health aide] cannot provide assistance with medication to a Client with an alteration in mental status which includes confusion or lack of orientation, unless the services to be provided are directed by a competent individual who may consent to health care for the impaired individual [IC 6-18-2-28.5] ... Assistance with medications is defined to include ... providing assistance in the handling or ingesting of non - controlled substance medications; including eye drops, herbs, supplements and over - the - counter medications ... a HHA may apply topical medications to intact, unbroken skin surfaces ... "</p> <p>2. A policy titled "Home Health Aide Training, Evaluation, and Supervision"</p>	G000225	<p>The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the</p>	07/19/2014	

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	<p>dated 08/26/10 stated, "Eight [8] of the 12 required hours of in-service education will be in any eight of the following subject areas ... Medication assistance, any other tasks that the home health agency may choose to have the home health aide perform ... "</p> <p>3. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p> <p>a. One of two home health aide care plans stated, "hydrocolloid dressing to right buttock - change when soiled." The second care plan stated, "Notify Dr. [doctor] if pain not controlled with meds [medications]." The dressing change and notification of the MD are out of the scope of practice for a home health aide.</p> <p>b. The home health aide care plan stated to notify the registered nurse and</p>		<p>impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. All training and education required prior to a home health aide providing care to a client, to include classroom/theory education, practical/hands on training and competency review through demonstration of skills/tasks/duties and written competency exam will be provided through contract by an educational facility or Registered Nurse not employed by the agency . Upon successful completion of this training and competency review, the agency will ensure the home health aide has submitted the Indiana Home</p>	

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	<p>hold blood pressure medications for blood pressures less than 90/60 and greater than 160/100. A home health a visit note dated 12/17/14 stated that the patient had a blood pressure of 88/58 and stated, "med held at 11:00 PM." A home health aide visit note dated 12/31/13 stated the patient had a blood pressure of 80/53 and stated a blood pressure medication of clonidine was held by the home health aide. Administration and holding of medications is not within the scope of practice of a home health aide.</p> <p>c. A home health aide visit note dated 06/05/14 stated the home health aide notified the Alternate Director of Nursing of pain the patient was having. The Alternate Director of Nursing instructed the home health aide to give the patient a narcotic pain medication of Hydrocodone. Administration of medications is not within the scope of practice of a home health aide.</p> <p>d. The clinical record evidenced a medication administration schedule for the months of January, February, March, April, and May, 2014. Medications that was being administered routinely was Reglan (stomach medication), Inderal (blood pressure medication), Docusate Sodium (stool softener), Gas X, and Clonidine (blood pressure medication).</p>		<p>Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: the scope of practice of a home health aide. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a</p>	

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	<p>In December 2013 and January 2014, medications included Hydrocodone as needed (narcotic pain medication), Tramadol as needed (non-narcotic pain medication), Levaquin (an antibiotic that the patient had a history of an allergy to medication), and Levothyroxine (thyroid medication). The dates and times of administration are initialed by employee A, a home health aide. The clinical and employee record failed to evidence the employee was educated and trained on administering medications and the signs and symptoms of adverse / allergic reactions to medications. Administration of medications is not within the scope of practice of a home health aide.</p> <p>4. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 for home health aide services. A home health aide care plan with a revision date of 05/02/14 stated "MACE tx [treatment] every morning [manual ante grade colonic enema]." This treatment is not within the scope of practice of a home health aide.</p> <p>5. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician for 03/05/14 to 05/03/14 home health aide 6 to 8 hours</p>		<p>Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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G000229	<p>a day, 5 to 7 days a week for 9 weeks. The clinical record evidenced a medication administration schedule for the months of March, April, and May, 2014. Medications that were being administered routinely was Loratidine, Synthroid, Valporic Acid, Cogentin, Zyprexa, and Hiblicens. The dates and times are initialed by employees A and E, home health aides. The clinical and employee record failed to evidence that the employee was educated and trained on administering medications and the signs and symptoms of adverse / allergic reactions to medications. Administration of medications is not within the scope of practice of a home health aide.</p> <p>6. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM there was no written directives to administer medications and the home health aides were being told to perform this task without consent from the family or proper training.</p>						

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	<p>SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse made an on-site visit to the patient's home no less frequently than every 2 weeks for 2 of 10 records reviewed creating the potential to affect all patients receiving skilled and home health aide services. (# 2 and 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. <p>The clinical record evidenced supervisory visits on 04/22/14, 05/20/14, and 06/03/14.</p> <ol style="list-style-type: none"> 2. Clinical record number 6, SOC 02/07/14, evidenced a plan of care established by the physician for 02/07/14 	G000229	<p>The Executive Director has in-serviced nursing staff on the following corrective action: current policy on the time frames for completing Initial Assessments, Admission Assessments, Recertification Assessments, Resumption of Care Assessments and Supervisory visits.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	07/19/2014

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G000235	<p>484.48 CLINICAL RECORDS</p> <p>to 04/07/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry, and errands.</p> <p>The clinical record evidenced supervisory visits on 03/05/14 and 03/26/14.</p> <p>3. The Alternate Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>4. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "If a Client is receiving skilled services as well as aide services, the HHA [home health aide] will be supervised by a qualified Registered Nurse at least every 2 weeks, whether on site while the HHA is present or when the HHA is not present."</p>				

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	<p>Based on clinical record review and interview, it was determined the agency failed to ensure clinical records contained accurate information and signed and dated verbal orders for 4 of 10 records reviewed creating the potential to affect all 16 current patients receiving services. (See G 236)</p> <p>The cumulative effect of these systemic problems resulted in the agency being out of compliance with the Condition of Participation 484.48: Clinical Records.</p>	G000235	<p>The Executive Director has in-serviced nursing staff on the following corrective action: In the case of discharge, the agency will provide the Physician, who signs the Plan of Care for the Client, with the reason(s) for the requested discharge and obtain, at the minimum, a verbal order for discharge, prior to providing the Client with a 5 day notice of intent to discharge from the agencies services. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the</p>	07/16/2014	

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			<p>home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director will in-service skilled nursing on the procedure for filling out all forms contained in the admission packet including the Consent & Agreement of Services form which contains the pay source for services. Included in the admission packet is the OASIS and Aide Care Plan form which identify the services to be provided to the Client. In-service education will include the instruction the Client must be informed and agree to the services that will be provided.</p> <p>Informed consent and agreement to services will be validated by the Client or their appointed designee signing the OASIS assessment and the Consent & Agreement of Services form.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	

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			<p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the</p>	

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G000236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure clinical records contained accurate information and signed and dated verbal orders for 4 of 10 records reviewed creating the potential to affect all 16</p>	G000236	<p>change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: In the case of discharge, the agency will provide the Physician, who signs the Plan of Care for the Client, with the reason(s) for the requested</p>	07/16/2014

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	<p>current patients receiving services. (# 1, 2, 3, and 4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1, SOC (start of care) 04/09/14, included plans of care established by the physician dated 04/09/14 to 06/07/14 and 06/08/14 to 08/16/14. The plans of care failed to evidence a nurse's signature and date of the verbal start of care 2. Clinical record number 2, SOC 01/09/12, evidenced a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. <ol style="list-style-type: none"> a. A physician order dated 01/31/14 stated to hold blood pressure medications for blood pressure of less than 90/60 and to notify the office for blood pressures greater than 160 /100. b. A home health aide care plan dated 05/16/14 stated the call parameters for the patient's vital signs was for Temperature greater than 100, blood 		<p>discharge and obtain, at the minimum, a verbal order for discharge, prior to providing the Client with a 5 day notice of intent to discharge from the agencies services.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care</p>	

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	<p>pressure greater than 140/90 and less than 90/60, pulse greater than 120 and less than 60, and respirations less than 11 and greater than 29. In a box next to the checking of vital signs, the parameters state blood pressure less than 100/60 and greater than 160/ 90 and greater than 101 for Temperature.</p> <p>3. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14. The plans of care stated that the patient was taking 150 mg (milligrams) of Wellbutrin daily. The medication profile stated the patient was taking 100 mg of Welbutrin.</p> <p>a. A physician's order dated 10/13/12 stated vital sign parameters of systolic blood pressure less than 90 or greater than 140, diastolic blood pressure less than 60 or greater than 90, heart rate less than 60 or greater than 110, oral temperature greater than 101, respirations less than 11 or greater than 26.</p> <p>b. A home health aide care plan states vital sign parameters for blood pressure was greater than 160 / 90 or less than 100 / 60, heart rate greater than 126, and respirations greater than 26.</p>		<p>for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director will in-service skilled nursing on the procedure for filling out all forms contained in the admission packet including the Consent & Agreement of Services form which contains the pay source for services. Included in the admission packet is the OASIS and Aide Care Plan form which identify the services to be provided to the Client. In-service education will include the instruction the Client must be informed and agree to the services that will be provided. Informed consent and agreement to services will be validated by the Client or their appointed designee signing the OASIS assessment and the Consent & Agreement of Services form.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: The</p>	

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	<p>4. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician dated 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up and home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks.</p> <p>a. The medication profile stated the patient was receiving 250 mg of Valporic Acid three times a day and Zyprexa 10 mg three times a day.</p> <p>b. The medication administration record for March stated Valporic Acid 250 mg three times a day and Zyprexa 10 mg three times a day was given on March 11 and 12th. A new medication record for March 13 to 31st, April, and May 2014 stated Valporic Acid was 500 mg three times a day and Zyprexa 5 mg three times a day. The clinical record failed to evidence orders in regards to the change of dosages in both medications.</p>		<p>agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will</p>	

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G000337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure discharge medications after hospitalization was reconciled with the primary physician upon resumption of care for 1 of 10 records reviewed (# 2), failed to ensure the medication profile had start dates of medications for 6 of 10 records reviewed (# 2, 3, 4, 6, 8, and 9), failed to ensure the medication profile correctly reflected patients actual medications taken for 3 of 10 records reviewed (# 1, 2, and 6), and failed to ensure the medication profile listed all medication allergies for 1 of 10 records</p>	G000337	<p>include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will</p>	07/16/2014

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	<p>reviewed (# 1) creating the potential to affect all 16 patients who are receiving services in the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/09/14, included a plan of care established by the physician for 04/09/14 to 06/07/14.</p> <p style="padding-left: 40px;">a. A physician's progress note dated 04/15/14 stated the patient had allergies of Cipro, Iodine, Metformin, Ampicillin, and Vitamin B. The medication profile failed to evidence Cipro, Iodine, Metformin, and Ampicillin in the allergy section.</p> <p style="padding-left: 40px;">b. A physician's progress note dated 04/15/14 stated the patient takes Docusate Sodium 100 mg (milligrams) capsules three times a day. An OASIS Assessment dated 06/03/14 stated "takes 3 softners" for bowel movement and constipation. The clinical record failed to evidence the medication profile was updated to this medication.</p> <p>2. Clinical record number 2, SOC 01/09/12, included a plan of care that was established by a physician for 04/28/14 to 06/26/14.</p>		<p>include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to</p>	

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	<p>a. The clinical record evidenced the patient was hospitalized on 05/12/14. The patient's discharge paper stated the patient was to take Levothyroxine 25 mcg (micrograms) 1 tablet by mouth every morning upon wakening (new medication), Vasolex three times a day (new treatment), acetaminophen 650 mg (milligrams) 1 tablet by mouth every 6 hours as needed (changed medication), levofloxacin 500 mg by mouth daily (new medication), and lactaid 9,000 units after any dairy as needed (changed medication). The medication profile continued to display lactaid 3,000 units 1 tablet by mouth as needed with milk products, tramadol 50 mg 1 tab by mouth three times a day (every 8 hours), hydrocolloid dressing to the right buttock as directed, polybacitracin to the right buttock twice a day as needed for pressure ulcer, miralax 2 tablespoon daily as needed, A & D ointment to the right blister / pressure ulcer, and Tylenol 500 mg 1 by mouth as needed. The clinical record failed to evidence the primary care physician was notified of the discharge medications from the hospital.</p> <p>b. The medication profile last updated on 05/16/14 failed to evidence a start date for Ferrous Sulfate, Pantoprazole Sodium, Lisinopril, and Tylenol.</p>		<p>set parameters, values outside the parameters will be provided to the Physician within 24 hours.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>c. The medication list faxed by the physician's office dated 05/23/14 included Tylenol extra strength 500 mg 1 every 6 hours (max 6 tablets), Tylenol Arthritis 650 mg 1 tablet every 4 to 6 hours as needed (max 5 then at the bottom of the page 3000 mg max was handwritten), Miralax powder 1 tablespoon in 8 ounces of water twice a day, Ketoconazole 2% shampoo daily, Ultec hydrocolloid dressing daily, Norco 5/325 mg 1 tab every 4 to 6 hours as needed for pain, Fluconazole 150 mg 1 tablet weekly, and Tramadol 50 mg 1 by mouth as needed for pain. The clinical record failed to evidence that the medication profile was updated to include these medications and treatments.</p> <p>3. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14. The medication profile failed to evidence a start date for Oxybutin, Zoloft, Macrobid, Doxycycline, Welbutrin, Multi-Vitamin, and Calcium.</p> <p>4. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician for 03/05/14 to 05/03/14. The medication profile failed to evidence a start date for</p>			

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	<p>Loratidine, Synthroid, Valporic Acid, Cognentin, Zyprexa, Hiblicens, Bactroban, Benedryl, Ibuprofen, Ativan, Acetaminophen, and Ribivin.</p> <p>5. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14. The medication profile dated 02/07/14 and 03/28/14 failed to evidence start dates for Klor - Con, Cymbalta, Ritalin, Niaspan, Nystatin Cream, Mag Ox, Diflunisal, Naproxen, Norco, Colace, Prozac, Lisinopril, Zantac, Vitamin D, Humulin U, Bitamin B6 and B12, Neurotin, and Centrum Silver.</p> <p>a. The medication profile failed to evidence classifications / side effects for klor Con, Nystatin Cream, Mag Ox, Vitamin D, Neurotin, Zanaflex, Ritalin, and Diflunisal. The medication profile failed to evidence the patient was allergic to cortisone and and Benedryl.</p> <p>b. A nursing visit note dated 04/23/14 stated the patient was seen in the emergency room on 04/19/14. The patient was sent home with Cipro 500 mg three times a day and fluconazole 200 mg daily. The clinical record failed to evidence that the medication profile had been updated to include the new</p>						

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N000000	<p>medications.</p> <p>6. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14. The medication profile dated 02/03/14 failed to evidence start dates for Zanaflex, Toprol XL, Lovaza, Axid, Tripilex, Plavix, Aspirin, Celexa, Simvastatin, Lantus, and Nitroglycerin.</p> <p>7. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14. The medication profile dated 09/27/13, 04/22/14, and 05/29/14 failed to evidence start dates for Aspirin, Carbidopa / levodopa, Carvedilol, Detrol, Divalpropex, Fosinapril, Hydrocodone, Furosemide, and Coumadin.</p> <p>8. The Alternate Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>This was a home health State re-licensure survey.</p>	N000000					

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N000458	<p>Survey Dates: June 16 - 19, 2014.</p> <p>Facility #: 012338</p> <p>Medicaid Vendor #: 201018830</p> <p>Surveyor: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 16</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 1, 2014</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.</p>			

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	<p>Based on personnel record and policy review and interview, the agency failed to ensure home health aides had completed a competency evaluation and were on the state aide registry for 2 of 5 home health aide records reviewed with the potential to affect all patents receiving aide services from employees A and E. (Employee A and E)</p> <p>Findings include:</p> <p>1. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "Guardian Home Health will only utilize Home Health Aides [HHA] who have satisfactorily demonstrated the ability to perform the duties and the responsibilities required for their position. All HHA employed by the Agency will meet the requirements of the State of Indiana (410 IAC 17 - 4 - 1) and centers for Medicare and Medicaid Services [CMS] Condition of Participation ... After hire and prior to providing direct client care services, a HHA will have successfully completed an evaluation program conducted by the agency. Evaluation will consist of two elements, observation of the HHA's performance or the required skills / tasks conducted with a patient / client and written examination ... Upon a HHA's successful completion of the competency</p>	N000458	<p>Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 10% of all employee records will be audited quarterly for evidence that deficiencies don't recur. All training and education required prior to a home health aide providing care to a client, to include classroom/theory education, practical/hands on training and competency review through demonstration of skills/tasks/duties and written competency exam will be provided through contract by an educational facility or Registered Nurse not employed by the agency. Upon successful completion of this training and competency review, the agency</p>	07/16/2014	

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N000464	<p>evaluation, the Agency will submit the Indiana Home Health Aide Registry Application ... to the state ... "</p> <p>2. Personnel record A, a home health aide, date of hire 11/06/13 and first patient contact 11/06/13, failed to evidence a written competency test and that the aide was on the state aide registry.</p> <p>3. Personnel record E, a home health aide, date of hire 10/29/13 and first patient contact 10/31/13, failed to evidence a written competency test and that the aide was on the state aide registry.</p> <p>4. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM that she thought employees A and E were registered home health aides and was not able to locate the written examination.</p>		<p>will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services. The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p>		

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	<p>Home health agency administration/management</p> <p>Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with:</p> <p>(A) a documented:</p> <p>(i) history of tuberculosis;</p> <p>(ii) previously positive test result for tuberculosis; or</p> <p>(iii) completion of treatment for tuberculosis;</p> <p>or</p> <p>(B) newly positive results to the tuberculin skin test;</p> <p>must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must:</p> <p>(A) be completed annually; and</p> <p>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p>			
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	<p>(A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel record and policy review and interview, the agency failed to ensure employees providing care on behalf of the agency were evaluated for tuberculosis yearly for 1 of 5 home health aide records reviewed (F).</p> <p>Findings include:</p> <p>1. A policy titled "Employee Initial and Annual TB Testing" dated 03/07/12 stated, "The Agency will ensure that all employees, persons providing care on behalf of the agency, and contractors having direct patient care are evaluated for tuberculosis and will ensure that appropriate documentation is maintained ... TB screening by the Mantoux method will be repeated annually for employees with a negative history of tuberculosis and a negative history of tuberculin testing."</p> <p>2. Personnel record F, a home health aide, date of hire 11/08/11, failed to</p>	N000464	<p>The Executive Director has in-serviced the administrative assistant on the following: The current policy titled "Employee Initial and Annual TB Testing" dated 03/07/12 will stand as written. However, changes will be made to the current tracking system. The administrative assistant who is responsible for sending reminders to employees for many issues which includes the pending expiration of their current TB screening, will continue to provide 2 notices in the 60 days immediately preceding the expiration of the last TB screening. The change will occur when at the first notice of pending expiration, the Administrative Assistant will place a hold on the employees ability to be placed on the schedule the day of expiration of current TB screening through the computer software program the agency uses for scheduling. Notices of pending expiration are given at 60 & 30 days prior to the expiration date. This will ensure the aide will not be</p>	07/16/2014

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N000500	<p>evidence a negative skin test within 1 year of when the last PPD had been administered.</p> <p>3. The Administrator / Director of Nursing indicated on 06/19/14 at 3:00 PM that she had spoken with Employee F and the employee was aware that a yearly PPD was needed but she had yet to get it done.</p> <p>410 IAC 17-12-3(b)(2)(B) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so. Based on clinical record and policy review and interview, the agency failed to investigate a complaint made by a patient regarding treatment and care furnished by a home health aide for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services by the</p>	N000500	<p>scheduled when not in compliance with policy which will result in the agency remaining in compliance.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. 10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: In the case of discharge, the agency will provide the Physician, who signs the Plan of Care for the Client, with the reason(s) for the requested</p>	07/16/2014

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	<p>home health agency. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, start of care 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry, and errands. The patient was discharged on 04/28/14.</p> <p>a. A skilled nursing note written by the ADON (Alternate Director of Nursing) dated 04/23/14 stated the ADON had spoken with the DON (Director of Nursing) and discussed continued issues of non-compliance with medications, visits, and constant changes in schedules. The ADON explained to the DON that the patient had stated one of their employees was fired from another home health agency for stealing and apparently was accusing one of the staff members of being on drugs. The note stated the DON instructed the ADON to send a 5 - day notice of discharge and the ADON sent the letter via mail that day.</p>		<p>discharge and obtain, at the minimum, a verbal order for discharge, prior to providing the Client with a 5 day notice of intent to discharge from the agencies services.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: All grievances will be investigated according to current policy. The agency will in-service all employees on possible grievances and include this list in the "Patient Rights" portion of the agencies orientation of all employees. The list will include but not be limited to the possible grievances of complaints regarding staff. The agency will in-service all employees on the current grievance policy & procedure which will outline required time frame constraints for responding and documenting of the grievance procedure.</p> <p>The Administrator will be required to note every grievance filed in the agencies Grievance log.</p>				

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	<p>b. An undated discharge letter was evidenced in the clinical record with an effective date of discharge on 04/28/14.</p> <p>c. A skilled nursing note written by the ADON dated 04/28/14 stated a discharge order was sent to the medical doctor on that day.</p> <p>d. A physician order for discharge was written and faxed on 04/28/14. The order was faxed back to the agency signed on 04/29/14.</p> <p>2. The clinical record and the agency grievance and complaint book failed to indicate if the complaint was investigated. The clinical record and the agency grievance / complaint book failed to evidence earlier / previous complaints and investigations that the patient had since admission.</p> <p>3. The Alternate Director of Nursing indicated on 06/18/14 at 3:05 PM that she felt the complaint "held credence due to the patient's personality" and the aide was pregnant. The Administrator indicated the patient was a difficult patient and they had problems staffing for the patient and felt they could not meet her needs.</p> <p>4. A policy titled "Clients Rights and Responsibilities" dated 01/01/10 stated,</p>		<p>The Grievance log will be audited quarterly.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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N000504	<p>"The Agency will investigate complaints made by the Client and / or his / her family or legal representative. Every effort will be made to resolve issues or concerns.</p> <p>5. A policy titled "Client Complaints and Grievances" dated 12/22/10 stated, "All complaints will be investigated within in then (10) days of receipt; the entire process from receipt of complaint through resolution will not exceed thirty (30) days. Resolution action (s) will be documented and the client will be informed to ensure his / her agreement. The Administrator, Director of Nursing, or Assistant Director of Nursing will investigate all complaints and all information related to the complaint will be recorded on the complaint form and logged within 24 hours of receipt. The Administrator, Director of Nursing, or designee will initiate investigation within the same time period ... Clients will be allowed to voice grievances without fear of reprisal ... "</p> <p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be</p>				

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	<p>furnished, and of any changes in the care to be furnished as follows:</p> <p>(i) The home health agency shall advise the patient in advance of the:</p> <p>(AA) disciplines that will furnish care; and</p> <p>(BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record and document review and interview, the agency failed to ensure a patient representatives was informed in advance about the care to be furnished in regard to medication administration orally and in writing for 2 of 10 records reviewed creating the potential to affect all patients who was receiving medication administration by a home health aide.</p> <p>Findings include:</p> <p>1. 410 IAC 17-9-20 "Medication Assistance" defined Sec. 20. "Medication Assistance means the provision of assistance: (1) through providing reminders or cues to take medications, the opening of pre-set medication containers, and providing assistance in the handling or ingesting of noncontrolled substances medication, including eye drops, herbs, supplements, and over-the-counter medication; and (2) to an individual who is unable to accomplish the task due to an impairment and who is: (A) competent and has directed the services; or (B) incompetent</p>	N000504	<p>The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A)</p>	07/16/2014

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NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1521 S 3RD ST TERRE HAUTE, IN 47802			
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	<p>and has the services directed by a competent individual who may consent to health care for the impaired individual."</p> <p>2. Clinical record number 2, SOC (start of care) 01/09/12, included a plan of care established by the physician for 04/28/14 to 06/26/14 for home health aide services 8 hours a day, 3 to 5 days a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision.</p> <p>a. The clinical record evidenced a medication administration schedule for the months of January, February, March, April, and May, 2014. The dates and times are initialed by employee A, home health aide.</p> <p>b. The clinical record failed to evidence the patient representative was informed in advance about the administration of medication by a home health aide.</p> <p>3. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician dated 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up and home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks for bathing, grooming, meal prep, meal prep,</p>		<p>competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: The Client shall be informed at every admission what services will be covered by their particular pay source and what will not be covered by their particular pay source via a new form created by the agency which will state these items and require Client signature for documentation of notification of this information. The Director</p>				

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N000505	<p>medication assistance, and supervision.</p> <p>a. The clinical record evidenced a medication administration schedule for the months of March, April, and May, 2014. The dates and times were initialed by employees A and D, home health aides.</p> <p>b. The clinical record failed to evidence the patient representative was informed in advance about the administration of medication to be provided by a home health aide.</p> <p>4. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following:</p>		of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.				

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	<p>(AA) The care or treatment. (BB) Changes in the care or treatment.</p> <p>Based on clinical record and document review and interview, the agency failed to ensure a patient representatives was informed in advance about the care to be furnished in regard to medication administration orally and in writing for 2 of 10 records reviewed creating the potential to affect all patients who was receiving medication administration by a home health aide. (#2 and 4)</p> <p>Findings include:</p> <p>1. 410 IAC 17-9-20 "Medication Assistance" defined Sec. 20. "Medication Assistance means the provision of assistance: (1) through providing reminders or cues to take medications, the opening of pre-set medication containers, and providing assistance in the handling or ingesting of noncontrolled substances medication, including eye drops, herbs, supplements, and over-the-counter medication; and (2) to an individual who is unable to accomplish the task due to an impairment and who is: (A) competent and has directed the services; or (B) incompetent and has the services directed by a competent individual who may consent to health care for the impaired individual."</p>	N000505	<p>The Executive Director has in-serviced staff on the following corrective action: The Client shall be informed at every admission what services will be covered by their particular pay source and what will not be covered by their particular pay source via a new form created by the agency which will state these items and require Client signature for documentation of notification of this information.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of</p>	07/16/2014

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	<p>2. Clinical record number 2, SOC (start of care) 01/09/12, included a plan of care established by the physician for 04/28/14 to 06/26/14 for home health aide services 8 hours a day, 3 to 5 days a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision.</p> <p>a. The clinical record evidenced a medication administration schedule for the months of January, February, March, April, and May, 2014. The dates and times are initialed by employee A, home health aide.</p> <p>b. The clinical record failed to evidence the patient representative was informed in advance about the administration of medication by a home health aide.</p> <p>3. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician dated 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up and home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks for bathing, grooming, meal prep, meal prep, medication assistance, and supervision.</p> <p>a. The clinical record evidenced a medication administration schedule for</p>		<p>non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual. The Director of Home Health Services will be responsible for</p>				

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N000514	<p>the months of March, April, and May, 2014. The dates and times were initialed by employees A and D, home health aides.</p> <p>b. The clinical record failed to evidence the patient representative was informed in advance about the administration of medication to be provided by a home health aide.</p> <p>4. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on clinical record and policy review and interview, the agency failed</p>	N000514	<p>monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has</p>	07/16/2014			

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	<p>to investigate a complaint made by a patient regarding treatment and care furnished by a home health aide for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services by the home health agency. (# 6)</p> <p>Findings include:</p> <p>1. Clinical record number 6, start of care 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry, and errands.</p> <p>A skilled nursing note written by the ADON (Alternate Director of Nursing) dated 04/23/14 stated the ADON had spoken with the DON (Director of Nursing) an discussed continued issues of non-compliance with medications, visits, and constant changes in schedules. The ADON explained to the DON that the patient had stated one of their employees was fired from another home health agency for stealing and apparently was accusing one of the staff members being on drugs.</p>		<p>in-serviced staff on the following corrective action: All grievances will be investigated according to current policy. The agency will in-service all employees on possible grievances and include this list in the "Patient Rights" portion of the agencies orientation of all employees. The list will include but not be limited to the possible grievances of complaints regarding staff. The agency will in-service all employees on the current grievance policy & procedure which will outline required time frame constraints for responding and documenting of the grievance procedure.</p> <p>The Administrator will be required to note every grievance filed in the agencies Grievance log.</p> <p>The Grievance log will be audited quarterly.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless</p>	

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	<p>2. The clinical record and the agency grievance and complaint book failed to indicate if the complaint was investigated. The clinical record and the agency grievance / complaint book failed to evidence earlier / previous complaints and investigations that the patient had since admission.</p> <p>3. The Alternate Director of Nursing indicated on 06/18/14 at 3:05 PM that she felt the complaint "held credence due to the patient's personality" and the aide was pregnant.</p> <p>4. A policy titled "Clients Rights and Responsibilities" dated 01/01/10 stated, "The Agency will investigate complaints made by the Client and / or his / her family or legal representative. Every effort will be made to resolve issues or concerns.</p> <p>5. A policy titled "Client Complaints and Grievances" dated 12/22/10 stated, "All complaints will be investigated within in then (10) days of receipt; the entire process from receipt of complaint through resolution will not exceed thirty (30) days. Resolution action (s) will be documented and the client will be informed to ensure his / her agreement. The Administrator, Director of Nursing, or Assistant Director of Nursing will</p>		<p>the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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N000518	<p>investigate all complaints and all information related to the complaint will be recorded on the complaint form and logged within 24 hours of receipt. The Administrator, Director of Nursing, or designee will initiate investigation within the same time period ... "</p> <p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record, policy, and document review and interview, the agency failed to ensure patients were provided the current Indiana Advance Directives, including a description of applicable State law, and agency policy of Advance Directives in 10 of 10 records reviewed creating the potential to affect all 16 patients receiving home health services (# 1 - 10).</p> <p>Findings include</p>			N000518	<p>The Executive Director has in-serviced staff on the following corrective action: All Clients will receive the effective May 2004 and revised July 1, 2013 State of Indiana Advanced Directives document & the agencies policies regarding advanced directives. All admission folders will have the outdated version removed and the current, July 1, 2013, version in place with the agencies policies on advanced directives.</p> <p>The Director of Home Health</p>		07/16/2014

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	<p>1. The admission package given to the patients failed to include the effective May 2004 and revised July 1, 2013, state of Indiana Advanced Directives and agency policy in the admission folder that was distributed to the patients at the start of care (SOC).</p> <p>2. Clinical record number 1, SOC 04/09/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>3. Clinical record number 2, SOC 01/09/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>4. Clinical record number 3, SOC 03/15/12, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>5. Clinical record number 4, SOC 03/05/14, failed to contain an updated</p>		<p>Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>6. Clinical record number 5, SOC 04/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>7. Clinical record number 6, SOC 02/10/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>8. Clinical record number 7, SOC 04/23/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>9. Clinical record number 8, SOC 02/03/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the</p>				

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	<p>agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record number 9, SOC 12/12/11, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>11. Clinical record number 10, SOC 05/13/13, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document and the agency policies regarding advance directives. The patient signed that the document was received on the SOC date.</p> <p>12. The Administrator and the Director of Nursing indicated on 06/19/14 at 04:00 PM they were not aware of the updated version of the advance directors nor were they aware of the need to include the agency policies regarding advance directives in the admission packet.</p> <p>13. A policy titled "Advance Directives" dated 05/2010 stated "The Admitting RN [Registered Nurse] will present the Indiana State Department of Health Advance Directive brochure to all adult</p>						

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N000522	<p>Clients at the time of admission. The RN will inform the Client about the Agency's policies regarding Advance Directives ...</p> <p>"</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 clinical record and agency policy review and interview, the agency failed to ensure care and services had been provided in accordance with physician orders in 2 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency. (# 4 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 4, SOC (start of care) 03/05/14, included a plan of care established by the physician 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up and home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks.</p> <p>a. The clinical record evidenced extra skilled nursing visits during the</p>	N000522	The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care. The Director of Home Health Services will be responsible for monitoring the	07/16/2014

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	<p>weeks of 03/09/14 and 03/23/14 and two extra visits the weeks of 04/06/14, 04/13/14, 04/20/14, and 06/04/14. The clinical record failed to evidence orders for the extra nursing visits.</p> <p>b. The clinical record failed to evidence a minimum of 5 home health aide visits during the week of 03/05/14 (1 visit made) and the week of 03/16/14 (2 visits made). The clinical record failed to evidence orders for a change in the number of home health aide visits.</p> <p>2. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician for 02/10/14 to 04/10/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry, and errands.</p> <p>a. The clinical record failed to evidence a skilled nurse visit the weeks of 02/16/14, 03/02/14, 03/16/14, 03/30/14, and 03/13/14. Two skilled nursing visits were made the week of 03/23/14.</p> <p>b. The clinical record failed to evidence at least 3 home health aide</p>		<p>corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: all skilled nursing and staff who are responsible for scheduling that no visit outside the frequency & duration specifically outlined in the Plan of Care for each Client will be made without a minimum of a verbal order from the physician signing the Plan of Care to provide such visit. This will include extra visits being requested as PRN at the time of the initial Plan of Care and Prior Authorization request. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: on what constitutes a "change in condition". This in-service will include the current policy on "change in condition". Instruction will be that all employees are responsible for reporting any change of condition to a Registered Nurse. The Registered Nurse receiving the report of a change in condition or observing a</p>		

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	<p>visits the week of 02/16/14.</p> <p>3. The Alternate Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>4. A policy titled "Physician Communication and Orders" dated 08/18/10 stated, "All communication with a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care."</p> <p>5. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The</p>		<p>change in condition will assess the change and notify the Physician signing the Plan of Care within 24 hours of the report or observed change in condition.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>		

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N000524	<p>home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</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: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all medications, treatments, and services in 8 of 10 records reviewed creating the</p>	N000524	The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use.	07/19/2014

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	<p>potential to affect all 16 patients receiving services within the agency. (# 1, 2, 3, 5, 6, 8, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/09/14, included a plan of care established by the physician for 04/09/14 to 06/07/14 for home health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry and errands.</p> <p>a. An OASIS Assessment dated 06/03/14 stated the patient's had a 14 French foley catheter inserted to the urostomy stoma and that a family member irrigates the catheter twice a day. The plan of care failed to evidence the type and size of the foley catheter; the type, amount, and frequency of irrigation; and the maintenance of the catheter.</p> <p>b. A physician's progress note dated 04/15/14 stated the patient takes Docusate Sodium 100 mg (milligrams) capsules three times a day. An OASIS Assessment dated 06/03/14 stated "takes 3 softeners" for bowel movement and constipation. The plan of care failed to evidence the Docusate Sodium 100 mg capsules in the medication section of the</p>		<p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is</p>	

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	<p>plan of care.</p> <p>c. A physician's progress note dated 04/15/14 stated the patient had allergies of Cipro, Iodine, Metformin, Ampicillin, and Vitamin B. The plan of care failed to evidence Cipro, Iodine, Metformin, and Ampicillin in the allergy section of the plan of care.</p> <p>d. An OASIS Assessment dated 06/03/14 stated "no raw veggies" under the diet section of the assessment. The plan of care failed to evidence the no raw vegetables under the diet section of the plan of care and care plan.</p> <p>2. Clinical record number 2, SOC 01/09/12, included a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinent care, medication assistance and supervision due to MR (mentally retardation) status. An OASIS Assessment dated 05/13/14 stated the patient was receiving services with an outside agency. The plan of care failed to evidence the agency and type of services being provided to the patient.</p> <p>3. Clinical record number 3, SOC</p>		<p>corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: Agency policy will change requiring an Initial Assessment being performed prior to the Start of Care Date rather than</p>				

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	<p>03/15/12, included a plan of care established by a physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 for home health aide 2 to 4 hours per day 4 to 6 days a week for 9 weeks. The plan of care failed to include specific home health aide duties and services.</p> <p>A physician's order dated 10/13/12 stated vital sign parameters of systolic blood pressure less than 90 or greater than 140, diastolic blood pressure less than 60 or greater than 90, heart rate less than 60 or greater than 110, oral temperature greater than 101, respirations less than 11 or greater than 26, and pain greater than 8 on a 10 point scale. The plan of care failed to evidence the vital sign parameters.</p> <p>4. Clinical record number 5, SOC 04/28/14, included a plan of care established by a physician for 04/28/14 to 06/26/14 for home health aide services 2 hours a day, 3 days a week for 9 weeks assisting the patient with "bathing only."</p> <p>a. A physician order dated 04/01/14 stated Area 7 requested the home health agency to assist the patient with bathing, meal prep, and errands. Review of the home health aide care plan stated that the home health aide was to assist with application of TED hose, assist with</p>		<p>a Comprehensive Assessment. The Start of Care date will be the initiation of staffing for services provided by the agency after a pay source such as Medicaid PA is obtained, unless the Physician has ordered/indicated a specific Start of Care date which will be used and staffing will begin on the indicated date.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of</p>	

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	<p>hygiene and grooming, and vital sign parameters to be used to notify the case manager. The plan of care failed to include the application of TED hose, specific bathing, assistance with hygiene and grooming, meal prep, errands, and vital sign parameters.</p> <p>b. A start of care assessment was obtained on 04/08/14. A nursing note dated 04/28/14 stated that the plan of care was received signed by the physician on 04/28/14 and the prior authorization was sent to Medicaid on 04/28/14. A reassessment was obtained on 05/15/14. Home Health Aide services started on 05/26/14 per patient request. The plan of care failed to evidence the correct start of care and certification dates based on the 05/15/14 reassessment.</p> <p>5. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician 02/10/14 to 04/10/14 for skilled nursing 1 hour every other week for 7 weeks for medication set up and home health aide 2 - 4 hours a day, 3 - 5 days a week for 9 weeks for bathing, grooming, meal prep, light housekeeping, laundry, and errands. The home health aide care plan evidenced vital sign parameters to notify the registered nurse. The plan of care failed to include the vital sign parameters.</p>		<p>Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>		

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	<p>a. The OASIS Comprehensive Admission Assessment dated 02/07/14 stated the patient was receiving homemaker services from another agency. A nursing note dated 04/29/14 indicated the patient was receiving homemaker services from another agency. The plan of care failed to evidence the patient was receiving services from an outside agency.</p> <p>b. A follow up Comprehensive assessment for recertification was completed by an RN (Registered Nurse) on 04/09/14. The clinical record failed to evidence a revised plan of care for the certification period of 04/11/14 to 06/09/14.</p> <p>6. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 06/03/14 to 08/01/14 for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medication and home health aide services 204 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry and errands. The clinical record evidenced homemaker visits were provided on 06/01/14, 06/03/14, and 06/05/14. The plan of care failed to include homemaker services.</p>						

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	<p>7. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week, for 9 weeks.</p> <p>a. An FSSA assessment dated 09/26/13 stated the patient's family member monitored the patient's coumadin levels each week and adjusted dosages as needed. The registered nurse failed to monitor / follow the patient's coumadin levels and adjust dosages on the medication profile as needed. The assessment also indicated that the physician had reduced the frequency of the patient's aspirin from twice a day to once a day. The plan of care continued to evidence the patient was receiving aspirin twice a day.</p> <p>b. The 10/02/13 to 11/30/14, 12/01/13 to 01/29/14, 01/30/14 to 03/30/14, 03/31/13 to 05/28/14, and 05/30/14 to 07/28/14 plans of care failed to evidence the patient was having routine protime levels performed. A faxed medication list dated 01/28/14 stated the patient's current dosage of coumadin was 1 mg (milligrams). The coumadin dosage on the plan of care</p>						

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	<p>remained at 2.5 mg.</p> <p>c. The clinical record evidenced visit notes that the patient was receiving home health aide and attendant care services. The plan of care failed to evidence that the patient was receiving attendant care services.</p> <p>d. A physician's order dated 10/3/12 stated vital sign parameters of systolic blood pressure less than 90 and greater than 140, diastolic blood pressure less than 60 and greater than 90, pulse less than 60 and greater than 110, temperature greater than 101, and respirations less than 11 and greater than 26. The 03/31/14 to 05/28/14 and 05/29/14 to 07/27/14 plans of care failed to evidence vital sign parameters.</p> <p>8. A clinical record number 10, SOC 05/13/13, included a plan of care established by a physician for 03/09/14 to 05/07/14. A faxed medication list dated 01/10/14 stated the patient was receiving Detrol 5 mg three times a day. The plan of care failed to evidence the updated / current frequency of the medication.</p> <p>9. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at</p>				

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N000527	<p>3:00 PM.</p> <p>10. A policy titled "Client Plan of Care" dated 05/23/11 stated "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</p> <p>11. A policy titled "Physician Communication and Orders" dated 08/18/10 stated "Physician order must include the following information: Name of Client, specific orders for treatments, frequency, and special instructions if applicable; the discipline, e.g. skilled nurse, home health aide, therapist, required to carry out the orders; If a medication order, the name of the medication, dosage, route, frequency, and start and stop date if applicable ... "</p> <p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care</p>						

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	<p>professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the physician was notified of a changes in condition related to falls, fractures, wounds, and pain for 4 of 10 records reviewed creating the potential to affect all 16 patients currently receiving care from the home health agency. (# 2, 3, 8, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 02/27/14 to 04/27/14 and 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included, but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p> <p>A hospital discharge summary dated 05/23/14 stated the patient was discharged home with Fluconazole 150</p>	N000527	<p>The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will</p>	07/19/2014

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NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1521 S 3RD ST TERRE HAUTE, IN 47802
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	<p>mg (milligrams) weekly. Below the discharged medications, the summary stated the patient was had a "critical" reaction to Fluconazole. A skilled nursing notes dated 05/20/14, 06/03/14, and 06/11/14 stated the patient had a rash to the buttock / peri area with a raised area on the right buttock. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>2. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 with orders for home health aide services.</p> <p>a. A nursing note dated 02/03/14 stated a staff member had informed the Alternate Director of Nursing that she had to lower the patient to the floor because as she was in another room, she had heard the patient yelling for help and found the patient "hanging" out of his chair. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>b. A nursing note dated 02/28/14 stated that the patient was assessed and had an open wound on the scrotum measuring 0.5 inches in diameter and 0.3 cm (centimeters) deep draining small amount of bloody drainage. The clinical</p>		<p>include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician</p>	

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	<p>record failed to evidence the physician was notified of the findings.</p> <p>c. A nursing note dated 05/02/14 stated the patient was assessed and had purple feet that was cool to touch, no pedal pulses, and an open area on the right great toe that was draining serous drainage. The clinical record failed to evidence the physician was notified of the findings.</p> <p>d. A faxed "Physician Update" dated 05/27/14 stated during a home health aide supervisory visit on 05/23/14, the case manager observed the patient to have had a blister measuring 3 inches in diameter with a 1/2 inch open area in the center of the blister located on the patient's left thigh. The patient had told the case manager that he had spilled hot food in his lap. The Case Manager, a Registered Nurse, failed to notify the physician in a timely manner.</p> <p>3. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14 with orders for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medications and home health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light</p>		<p>signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Director of Home Health services will provide in-service to all administrative and skilled nursing staff outlining the requirement that after any fall or decline in physical ability, a request will be made for a physical therapy evaluation through the physician signing the Plan of Care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following</p>	

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	<p>housekeeping, laundry and errands. The patient's diagnoses included, but were not limited to, cerebral artery occlusion, right hemiparesis, and aphasia.</p> <p>A skilled nursing visit note dated 03/31/14 stated the patient had a blood pressure of 166 / 100. The clinical record failed to evidence the physician had been notified.</p> <p>6. Clinical record number 10, SOC 05/13/13 evidenced a plan of care dated 03/09/14 to 05/07/14 with orders for home health aide services.</p> <p>a. A skilled nursing note dated 08/09/13 stated that a staff employee had notified the agency of the patient fall that resulted in a trip to the emergency room on 08/08/13 which resulted in a dislocated elbow. The clinical record failed to evidence the physician was notified of the patient's fall and injury.</p> <p>b. A comprehensive recertification assessment dated 11/15/13 stated that the patient was complaining of an unsteady gait and frequent falls. The clinical record failed to notify the physician of the patient's falls.</p> <p>c. A comprehensive recertification assessment dated 03/05/14 stated that the</p>		<p>corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>				

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	<p>patient had fallen a couple of times in the house and had increased shortness of breath with minimal exertion. The patient had complained of sternum pain around the scar tissue area. The registered nurse instructed the patient to notify the physician. The clinical record failed to evidence the physician had been notified of the patient's falls and symptoms.</p> <p>d. The Alternate Director of Nursing indicated on 06/19/14 at 3:00 PM the physician had not been notified.</p> <p>8. A policy titled "Physician Communication and Orders" dated 08/18/10 stated, "All communication with a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care.</p> <p>9. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised</p>				

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N000541	<p>whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</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 clinical record and policy review and interview, the agency failed to ensure the Registered Nurse reassess a patient's vital signs during each skilled nursing visit for 1 of 10 records reviewed (# 8) and failed to reassess patient wounds for 3 of 3 records reviewed of patients with wounds (# 6, 9, and 10) creating the potential to affect all 16 patients receiving services within the agency.</p> <p>Findings include:</p> <p>1. Clinical record number 6, start of care</p>	N000541	The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every	07/19/2014

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	<p>(SOC) 11/25/13, included a plan of care established by the physician for the certification period 03/25/14 to 05/23/14 with orders for skilled nursing services. A 30 day Comprehensive assessment dated 05/14/14 provided a wound measurement to the right heel. The clinical record failed to evidence any further measurements after 05/14/14.</p> <p>2. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14 for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medication. The patient's diagnoses included, but were not limited to, cerebral artery occlusion, right hemiparesis, and aphasia.</p> <p>a. A skilled nursing visit note dated 02/10/14 failed to evidence that a blood pressure had been obtained.</p> <p>b. Four (4) skilled nursing visit notes dated 02/03/14, 02/05/14, 02/06/14, and 02/11/14 failed to evidence that a blood pressure, pulse, respirations, and temperature had been obtained.</p> <p>c. A skilled nursing visit note dated 02/13/14 failed to evidence blood pressure had been obtained and that the cardio, respiratory, neuro, and</p>		<p>Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: Wound monitoring. The Physician signing the Plan of Care and the Physician directing wound care services, if the Client should be receiving care through another Physician, will be notified within 24 hours if the Registered Nurse finds a decline in wound healing. Otherwise, the Physician signing the Plan of Care and the Physician directing wound care services will be notified of wound status no less than every 60 days via the Physicians 60 day summary or by a Physicians</p>				

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	<p>genitourinary had been assessed.</p> <p>d. A skilled nursing visit note dated 04/14/14 failed to evidence blood pressure, pulse, respirations, and temperature had been obtained and that the digestive / nutrition had been assessed.</p> <p>3. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week, for 9 weeks.</p> <p>a. A comprehensive recertification assessment dated 01/24/14 had stated that the patient's caregiver had indicated the patient had an area on the buttocks that was open but no drainage. The registered nurse did not assess the patient's wound.</p> <p>b. A comprehensive recertification assessment dated 03/25/14 stated that the patient's bilateral heels were broken down with eschar approximately 2.5 cm (centimeters) in diameter, the coccyx wound was healing and there were no open areas, and the right inner thigh was broken down with a small amount of bloody drainage. The clinical record failed to evidence the registered nursing</p>		<p>update. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: to obtain a complete set of vital signs at any visit to the home of a Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Director of Home Health services will provide in-service to all administrative and skilled nursing staff outlining the requirement that after any fall or decline in physical ability, a request will be made for a physical therapy evaluation through the physician signing the Plan of Care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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	<p>routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration.</p> <p>c. A nursing supervisory visit note dated 04/22/14 stated that the patient's heels were assessed and the left heel had a large black scab approximately 1 1/2 inches in diameter, the right heel had a smaller black scab approximately 3/4 inch in diameter, and back of the right leg above the heel had an open area approximately 1/2 inch in diameter draining a small amount of serous drainage. The clinical record failed to evidence that the registered nurse routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration.</p> <p>d. A comprehensive recertification assessment dated 05/29/14 stated the doctor was contacted by a family member due to the foul smelling drainage from the left heel wound. The "black scab was loosening around the edges." The note stated the right heel could possibly be infected as well as 2 pressure areas. The right heel was approximately 1 inch, tan and classified as a stage III. The right ankle was approximately 2 inches and classified as a stage III. The family member was asked to notify the agency if the doctor calls back with instructions /</p>						

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	<p>prescriptions. The left heel was approximately 2 inches, scant purulent drainage with slough, foul odor, and classified as a stage III; the left ankle was not measured and classified as a stage II; and the back of the right ankle / heel was not measured and classified as a stage II. The clinical record failed to evidence the registered nursing routinely assessed and measured the pressure area wounds to prevent further breakdown and deterioration.</p> <p>4. Clinical record number 10, SOC 12/13/13, included a plan of care established by the physician for the certification period 12/13/13 to 01/16/14 with orders for skilled nursing 7 days a week for 2 months for daily dressing changes. An Admission Assessment dated 12/13/13 provided a wound measurement to an ulcer of the lower extremity. The clinical record failed to evidence any further measurement after 12/13/13.</p> <p>5. The Director of Nursing indicated on 06/06/14 at 11:00 AM that wound measurements should had been done weekly and she had already identified this was a problem within the agency.</p> <p>6. An undated policy titled "Wound Care Management" stated</p>						

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N000542	<p>"Documentation of wounds must include type of wound, measurements, including length, depth, and width, description of the wound bed, surrounding area, undermining, staging, color, odor, and estimated amount of drainage ... wound status or measurements will be documented by the RN and / or LPN ..."</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> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the Registered Nurse updated the plan of care to include all medications, treatments, and services in 8 of 10 records reviewed creating the potential to affect all 16 patients receiving services within the agency. (# 1, 3, 5, 6, 9, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/09/14, included a plan of care established by the physician for 04/09/14</p>	N000542	The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and	07/19/2014

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	<p>to 06/07/14 for home health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry and errands.</p> <p>a. An OASIS Assessment dated 06/03/14 stated the patient's had a 14 French foley catheter inserted to the urostomy stoma and that a family member irrigates the catheter twice a day. The plan of care failed to evidence the type and size of the foley catheter; the type, amount, and frequency of irrigation; and the maintenance of the catheter.</p> <p>b. A physician's progress note dated 04/15/14 stated the patient takes Docusate Sodium 100 mg (milligrams) capsules three times a day. An OASIS Assessment dated 06/03/14 stated "takes 3 softeners" for bowel movement and constipation. The plan of care failed to evidence the Docusate Sodium 100 mg capsules in the medication section of the plan of care.</p> <p>c. A physician's progress note dated 04/15/14 stated the patient had allergies of Cipro, Iodine, Metformin, Ampicillin, and Vitamin B. The plan of care failed to evidence Cipro, Iodine, Metformin, and Ampicillin in the allergy section of the plan of care.</p>		<p>implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client. If the Physician chooses not to include vital sign parameters on the Plan of Care,</p>	

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	<p>d. An OASIS Assessment dated 06/03/14 stated "no raw veggies" under the diet section of the assessment. The plan of care failed to evidence the no raw vegetables under the diet section of the plan of care and care plan.</p> <p>2. Clinical record number 2, SOC 01/09/12, included a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinent care, medication assistance and supervision due to MR (mentally retardation) status. An OASIS Assessment dated 05/13/14 stated the patient was receiving services with an outside agency. The plan of care failed to evidence the agency and type of services being provided to the patient.</p> <p>3. Clinical record number 3, SOC 03/15/12, included a plan of care established by a physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 for home health aide 2 to 4 hours per day 4 to 6 days a week for 9 weeks. The plan of care failed to include specific home health aide duties and services.</p> <p>A physician's order dated 10/13/12</p>		<p>the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: current policy on the time frames for completing Initial Assessments, Admission Assessments, Recertification Assessments, Resumption of Care Assessments and Supervisory visits. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the</p>				

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	<p>stated vital sign parameters of systolic blood pressure less than 90 or greater than 140, diastolic blood pressure less than 60 or greater than 90, heart rate less than 60 or greater than 110, oral temperature greater than 101, respirations less than 11 or greater than 26, and pain greater than 8 on a 10 point scale. The plan of care failed to evidence the vital sign parameters.</p> <p>4. Clinical record number 5, SOC 04/28/14, included a plan of care established by a physician for 04/28/14 to 06/26/14 for home health aide services 2 hours a day, 3 days a week for 9 weeks assisting the patient with "bathing only."</p> <p>a. A physician order dated 04/01/14 stated Area 7 requested the home health agency to assist the patient with bathing, meal prep, and errands. Review of the home health aide care plan stated that the home health aide was to assist with application of TED hose, assist with hygiene and grooming, and vital sign parameters to be used to notify the case manager. The plan of care failed to include the application of TED hose, specific bathing, assistance with hygiene and grooming, meal prep, errands, and vital sign parameters.</p> <p>b. A start of care assessment was</p>		<p>Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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	<p>obtained on 04/08/14. A nursing note dated 04/28/14 stated that the plan of care was received signed by the physician on 04/28/14 and the prior authorization was sent to Medicaid on 04/28/14. A reassessment was obtained on 05/15/14. Home Health Aide services started on 05/26/14 per patient request. The plan of care failed to evidence the correct start of care and certification dates based on the 05/15/14 reassessment.</p> <p>5. Clinical record number 6, SOC 02/10/14, included a plan of care established by the physician 02/10/14 to 04/10/14 for skilled nursing 1 hour every other week for 7 weeks for medication set up and home health aide 2 - 4 hours a day, 3 - 5 days a week for 9 weeks for bathing, grooming, meal prep, light housekeeping, laundry, and errands. The home health aide care plan evidenced vital sign parameters to notify the registered nurse. The plan of care failed to include the vital sign parameters.</p> <p>a. The OASIS Comprehensive Admission Assessment dated 02/07/14 stated the patient was receiving homemaker services from another agency. A nursing note dated 04/29/14 indicated the patient was receiving homemaker services from another agency. The plan of care failed to</p>						

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	<p>evidence the patient was receiving services from an outside agency.</p> <p>b. A follow up Comprehensive assessment for recertification was completed by an RN (Registered Nurse) on 04/09/14. The clinical record failed to evidence a revised plan of care for the certification period of 04/11/14 to 06/09/14.</p> <p>6. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 06/03/14 to 08/01/14 for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medication and home health aide services 204 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry and errands. The clinical record evidenced homemaker visits were provided on 06/01/14, 06/03/14, and 06/05/14. The plan of care failed to include homemaker services.</p> <p>7. Clinical record number 9, SOC 12/12/11, included a plan of care established by the physician for the certification periods of 03/31/14 to 05/29/14 and 05/30/14 to 07/28/14 for home health aide services 4 to 8 hours a day, 5 to 7 days a week, for 9 weeks.</p>						

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	<p>a. An FSSA assessment dated 09/26/13 stated the patient's family member monitored the patient's coumadin levels each week and adjusted dosages as needed. The registered nurse failed to monitor / follow the patient's coumadin levels and adjust dosages on the medication profile as needed. The assessment also indicated that the physician had reduced the frequency of the patient's aspirin from twice a day to once a day. The plan of care continued to evidence the patient was receiving aspirin twice a day.</p> <p>b. The 10/02/13 to 11/30/14, 12/01/13 to 01/29/14, 01/30/14 to 03/30/14, 03/31/13 to 05/28/14, and 05/30/14 to 07/28/14 plans of care failed to evidence the patient was having routine protime levels performed. A faxed medication list dated 01/28/14 stated the patient's current dosage of coumadin was 1 mg (milligrams). The coumadin dosage on the plan of care remained at 2.5 mg.</p> <p>c. The clinical record evidenced visit notes that the patient was receiving home health aide and attendant care services. The plan of care failed to evidence that the patient was receiving attendant care services.</p>						

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	<p>d. A physician's order dated 10/3/12 stated vital sign parameters of systolic blood pressure less than 90 and greater than 140, diastolic blood pressure less than 60 and greater than 90, pulse less than 60 and greater than 110, temperature greater than 101, and respirations less than 11 and greater than 26. The 03/31/14 to 05/28/14 and 05/29/14 to 07/27/14 plans of care failed to evidence vital sign parameters.</p> <p>8. A clinical record number 10, SOC 05/13/13, included a plan of care established by a physician for 03/09/14 to 05/07/14. A faxed medication list dated 01/10/14 stated the patient was receiving Detrol 5 mg three times a day. The plan of care failed to evidence the updated / current frequency of the medication.</p> <p>9. The Alternate Director of Nursing and the Administrator were unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>10. A policy titled "Client Plan of Care" dated 05/23/11 stated "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or</p>						

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N000543	<p>environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</p> <p>11. A policy titled "Physician Communication and Orders" dated 08/18/10 stated "Physician order must include the following information: Name of Client, specific orders for treatments, frequency, and special instructions if applicable; the discipline, e.g. skilled nurse, home health aide, therapist, required to carry out the orders; If a medication order, the name of the medication, dosage, route, frequency, and start and stop date if applicable ... "</p> <p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record and policy</p>	N000543		07/19/2014			

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	<p>review and interview, the Registered Nurse failed to ensure a patient be referred for therapy services due to falls and shortness of breath with minimal exertions for 1 of 10 records reviewed creating the potential to affect all 16 patients receiving services with the agency. (# 10)</p> <p>Findings include:</p> <p>1. Clinical record number 10, start of care 05/13/13 evidenced a plan of care dated 03/09/14 to 05/07/14 with orders for home health aide services.</p> <p>a. A skilled nursing note dated 08/09/13 stated that a staff employee had notified the agency of the patient's fall that resulted in a trip to the emergency room on 08/08/13 which resulted in a dislocated elbow. The registered nurse failed to obtain a referral for physical therapy assessment.</p> <p>b. A comprehensive recertification assessment dated 11/15/13 stated that the patient was complaining of an unsteady gait and frequent falls. The registered nurse failed to obtain a referral for physical therapy assessment.</p> <p>c. A comprehensive recertification assessment dated 03/05/14 stated that the</p>		<p>The Director of Home Health services will provide in-service to all administrative and skilled nursing staff outlining the requirement that after any fall or decline in physical ability, a request will be made for a physical therapy evaluation through the physician signing the Plan of Care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen</p>	

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N000546	<p>patient had fallen a couple of times in the house and increased shortness of breath with minimal exertion. The registered nurse failed to obtain a referral for physical therapy assessment.</p> <p>2. The Alternate Director of Nursing indicated on 06/19/14 at 3:00 PM that the physician had not been notified to obtain a referral for physical therapy assessment.</p> <p>3. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</p> <p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the</p>		<p>as prescribed and authorized by the Physician signing the Plan of Care.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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	<p>following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse notified the physician of a changes in condition related to falls, fractures, wounds, and pain for 5 of 10 records reviewed creating the potential to affect all 16 patients currently receiving care from the home health agency. (# 2, 3, 6, 8, and 10)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 02/27/14 to 04/27/14 and 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included, but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p>	N000546	<p>The Executive Director has in-serviced nursing staff on the following corrective action: Wound monitoring. The Physician signing the Plan of Care and the Physician directing wound care services, if the Client should be receiving care through another Physician, will be notified within 24 hours if the Registered Nurse finds a decline in wound healing. Otherwise, the Physician signing the Plan of Care and the Physician directing wound care services will be notified of wound status no less than every 60 days via the Physicians 60 day summary or by a Physicians update. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use. The Director of Home Health Services will be responsible for</p>	07/16/2014	

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	<p>A hospital discharge summary dated 05/23/14 stated the patient was discharged home with Fluconazole 150 mg (milligrams) weekly. Below the discharged medications, the summary stated the patient was had a "critical" reaction to Fluconazole. A skilled nursing notes dated 05/20/14, 06/03/14, and 06/11/14 stated the patient had a rash to the buttock / peri area with a raised area on the right buttock. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>2. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 with orders for home health aide services.</p> <p>a. A nursing note dated 02/03/14 stated a staff member had informed the Alternate Director of Nursing that she had to lower the patient to the floor because as she was in another room, she had heard the patient yelling for help and found the patient "hanging" out of his chair. The clinical record failed to evidence that the physician was notified of the findings.</p> <p>b. A nursing note dated 02/28/14 stated that the patient was assessed and had an open wound on the scrotum</p>		<p>monitoring the corrective actions to ensure this deficiency is corrected and will not recur. The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that</p>	

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	<p>measuring 0.5 inches in diameter and 0.3 cm (centimeters) deep draining small amount of bloody drainage. The clinical record failed to evidence the physician was notified of the findings.</p> <p>c. A nursing note dated 05/02/14 stated the patient was assessed and had purple feet that was cool to touch, no pedal pulses, and an open area on the right great toe that was draining serous drainage. The clinical record failed to evidence the physician was notified of the findings.</p> <p>d. A faxed "Physician Update" dated 05/27/14 stated during a home health aide supervisory visit on 05/23/14, the case manager observed the patient to have had a blister measuring 3 inches in diameter with a 1/2 inch open area in the center of the blister located on the patient's left thigh. The patient had told the case manager that he had spilled hot food in his lap. The Case Manager, a Registered Nurse, failed to notify the physician in a timely manner.</p> <p>3. Clinical record 8, SOC 02/03/14, included a plan of care established by the physician for 04/04/14 to 06/02/14 with orders for skilled nursing nursing services 1 hour every other week for 9 weeks to set up medications and home</p>		<p>deficiencies don't recur. The Director of Home Health services will provide in-service to all administrative and skilled nursing staff outlining the requirement that after any fall or decline in physical ability, a request will be made for a physical therapy evaluation through the physician signing the Plan of Care for the Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>health aide services 2 to 4 hours per day, 5 to 7 times a week for 9 weeks to assist with bathing, grooming, meal prep, light housekeeping, laundry and errands. The patient's diagnoses included, but were not limited to, cerebral artery occlusion, right hemiparesis, and aphasia.</p> <p>A skilled nursing visit note dated 03/31/14 stated the patient had a blood pressure of 166 / 100. The clinical record failed to evidence the physician had been notified.</p> <p>6. Clinical record number 10, SOC 05/13/13 evidenced a plan of care dated 03/09/14 to 05/07/14 with orders for home health aide services.</p> <p>a. A skilled nursing note dated 08/09/13 stated that a staff employee had notified the agency of the patient fall that resulted in a trip to the emergency room on 08/08/13 which resulted in a dislocated elbow. The clinical record failed to evidence the physician was notified of the patient's fall and injury.</p> <p>b. A comprehensive recertification assessment dated 11/15/13 stated that the patient was complaining of an unsteady gait and frequent falls. The clinical record failed to notify the physician of the patient's falls.</p>				

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	<p>c. A comprehensive recertification assessment dated 03/05/14 stated that the patient had fallen a couple of times in the house and had increased shortness of breath with minimal exertion. The patient had complained of sternum pain around the scar tissue area. The registered nurse instructed the patient to notify the physician. The clinical record failed to evidence the physician had been notified of the patient's falls and symptoms.</p> <p>d. The Alternate Director of Nursing indicated on 06/19/14 at 3:00 PM the physician had not been notified.</p> <p>8. A policy titled "Physician Communication and Orders" dated 08/18/10 stated, "All communication with a physician shall be documented in the medical record. Communication with a Client's physician is required in the following situations ... upon admission, recert or discharge ... a change in the client's condition occurs ... when there has been a change in the frequency of services ... and when the Client is non-compliant with the established Plan of Care.</p> <p>9. A policy titled "Client Plan of Care" dated 05/23/11 stated, "The initial Plan of</p>			

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N000550	<p>Care is developed within [5] working days of the initiation of home care services ... The Plan of Care is revised whenever necessary to accommodate changes in a Client's health status or environment and no less frequently than every sixty [60] days ... The Plan of Care will include ... Type of home health care services required i.e., skilled nursing, home health aide, homemaker ... The home health care staff will promptly inform the physician of any changes that suggest a need to alter the Client's Plan of Care ... "</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 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 and policy review and interview, the agency failed to ensure the registered nurse delegated services to the home health aide that were within the aide's scope of practice for 3 of 10 records reviewed creating the potential to affect all patients receiving home health aide services.</p>	N000550	The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication	07/16/2014

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	<p>Findings include:</p> <p>1. A policy titled "Home Health Aide Medication Assistance with Medications" dated 01/01/10 stated "An HHA [home health aide] cannot provide assistance with medication to a Client with an alteration in mental status which includes confusion or lack of orientation, unless the services to be provided are directed by a competent individual who may consent to health care for the impaired individual [IC 6-18-2-28.5] ... Assistance with medications is defined to include ... providing assistance in the handling or ingesting of non - controlled substance medications; including eye drops, herbs, supplements and over - the - counter medications ... a HHA may apply topical medications to intact, unbroken skin surfaces ... "</p> <p>2. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "Eight [8] of the 12 required hours of in-service education will be in any eight of the following subject areas ... Medication assistance, any other tasks that the home health agency may choose to have the home health aide perform ... "</p> <p>3. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of</p>		<p>administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent</p>	

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	<p>care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p> <p>a. One of two home health aide care plans stated, "hydrocolloid dressing to right buttock - change when soiled." The second care plan stated, "Notify Dr. [doctor] if pain not controlled with meds [medications]." The dressing change and notification of the MD are out of the scope of practice for a home health aide.</p> <p>b. The home health aide care plan stated to notify the registered nurse and hold blood pressure medications for blood pressures less than 90/60 and greater than 160/100. A home health a visit note dated 12/17/14 stated that the patient had a blood pressure of 88/58 and stated, "med held at 11:00 PM." A home health aide visit note dated 12/31/13 stated the patient had a blood pressure of 80/53 and stated a blood pressure medication of clonidine was held by the</p>		<p>individual who may consent to health care for the impaired individual.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the</p>	

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	<p>home health aide. Administration and holding of medications is not within the scope of practice of a home health aide.</p> <p>c. A home health aide visit note dated 06/05/14 stated the home health aide notified the Alternate Director of Nursing of pain the patient was having. The Alternate Director of Nursing instructed the home health aide to give the patient a narcotic pain medication of Hydrocodone. Administration of medications is not within the scope of practice of a home health aide.</p> <p>d. The clinical record evidenced a medication administration schedule for the months of January, February, March, April, and May, 2014. Medications that was being administered routinely was Reglan (stomach medication), Inderal (blood pressure medication), Docusate Sodium (stool softener), Gas X, and Clonidine (blood pressure medication). In December 2013 and January 2014, medications included Hydrocodone as needed (narcotic pain medication), Tramadol as needed (non-narcotic pain medication), Levaquin (an antibiotic that the patient had a history of an allergy to medication), and Levothyroxine (thyroid medication). The dates and times of administration are initialed by employee A, a home health aide. The clinical and</p>		<p>Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>	

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	<p>employee record failed to evidence the employee was educated and trained on administering medications and the signs and symptoms of adverse / allergic reactions to medications. Administration of medications is not within the scope of practice of a home health aide.</p> <p>4. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 for home health aide services. A home health aide care plan with a revision date of 05/02/14 stated "MACE tx [treatment] every morning [manual ante grade colonic enema]." This treatment is not within the scope of practice of a home health aide.</p> <p>5. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician for 03/05/14 to 05/03/14 home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks. The clinical record evidenced a medication administration schedule for the months of March, April, and May, 2014. Medications that were being administered routinely was Loratidine, Synthroid, Valporic Acid, Cogentin, Zyprexa, and Hiblicens. The dates and times are initialed by employees A and E, home health aides. The clinical and</p>			

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N000596	<p>employee record failed to evidence that the employee was educated and trained on administering medications and the signs and symptoms of adverse / allergic reactions to medications. Administration of medications is not within the scope of practice of a home health aide.</p> <p>6. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM there was no written directives to administer medications and the home health aides were being told to perform this task without consent from the family or proper training.</p> <p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel record and policy review, and interview, the agency failed to ensure that prior to patient contact, employees who furnish home health aide services completed a competency evaluation for 2 of 5 home health aide files reviewed. (A and E)</p>	N000596	Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency	07/16/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "Guardian Home Health will only utilize Home Health Aides [HHA] who have satisfactorily demonstrated the ability to perform the duties and the responsibilities required for their position. All HHA employed by the Agency will meet the requirements of the State of Indiana (410 IAC 17 - 4 - 1) and centers for Medicare and Medicaid Services [CMS] Condition of Participation ... After hire and prior to providing direct client care services, a HHA will have successfully completed evaluation program conducted by the agency. Evaluation will consist of two elements, observation of the HHA's performance or the required skills / tasks conducted with a patient / client and written examination ... Upon a HHA's successful completion of the competency evaluation, the Agency will submit the Indiana Home Health Aide Registry Application ... to the state ... " 2. Personnel record A, a home health aide, date of hire 11/06/13 and first patient contact 11/06/13, failed to evidence a written competency test. 3. Personnel record E, a home health 		<p>will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>All training and education required prior to a home health aide providing care to a client, to include classroom/theory education, practical/hands on training and competency review through demonstration of skills/tasks/duties and written competency exam will be provided through contract by an educational facility or Registered Nurse not employed by the agency . Upon successful completion of this training and competency review, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing</p>	

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N000597	<p>aide, date of hire 10/29/13 and first patient contact 10/31/13, failed to evidence a written competency test.</p> <p>4. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM that she was not able to locate the written examination.</p> <p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on personnel record and policy review and interview, the agency failed to ensure that prior to patient contact, employees who furnish home health aide services be registered on the state aide registry for 2 of 5 home health aide files reviewed. (A and E)</p> <p>Findings include:</p> <p>1. A policy titled "Home Health Aide Training, Evaluation, and Supervision"</p>	N000597	<p>home health care services.</p> <p>All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health</p>	07/16/2014

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	<p>dated 08/26/10 stated, "Guardian Home Health will only utilize Home Health Aides [HHA] who have satisfactorily demonstrated the ability to perform the duties and the responsibilities required for their position. All HHA employed by the Agency will meet the requirements of the State of Indiana (410 IAC 17 - 4 - 1) and centers for Medicare and Medicaid Services [CMS] Condition of Participation ... After hire and prior to providing direct client care services, a HHA will have successfully completed evaluation program conducted by the agency. Evaluation will consist of two elements, observation of the HHA's performance or the required skills / tasks conducted with a patient / client and written examination ... Upon a HHA's successful completion of the competency evaluation, the Agency will submit the Indiana Home Health Aide Registry Application ... to the state ... "</p> <p>2. Personnel record A, a home health aide, date of hire 11/06/13 and first patient contact 11/06/13, failed to evidence the aide was registered on the state aide registry.</p> <p>3. Personnel record E, a home health aide, date of hire 10/29/13 and first patient contact 10/31/13, failed to evidence the aide was registered on the</p>		<p>care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>2) All training and education required prior to a home health aide providing care to a client, to include classroom/theory education, practical/hands on training and competency review through demonstration of skills/tasks/duties and written competency exam will be provided through contract by an educational facility or Registered Nurse not employed by the agency . Upon successful completion of this training and competency review, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services.</p> <p>All new employees will have this verified by the administrative assistant and the Director of Home</p>	

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N000598	<p>state aide registry.</p> <p>4. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM that she thought employees A and E were registered on the state aide registry.</p> <p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on personnel record and policy review, and interview, the agency failed to provide documentation that employees completed the home health aide competency evaluation and were registered on the state aide registry for 2 of 5 home health aide files reviewed. (A and E)</p> <p>Findings include:</p> <p>1. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "Guardian Home Health will only utilize Home Health Aides [HHA] who have satisfactorily</p>	N000598	<p>Health Services.</p> <p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>Currently all home health aides are on the State Registry. All potential employees hired for the purpose of providing home health aide services will be required to complete a written home health aide competency test. Upon successful completion of the test, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services. All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p>	07/16/2014

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	<p>demonstrated the ability to perform the duties and the responsibilities required for their position. All HHA employed by the Agency will meet the requirements of the State of Indiana (410 IAC 17 - 4 -1) and centers for Medicare and Medicaid Services [CMS] Condition of Participation ... After hire and prior to providing direct client care services, a HHA will have successfully completed evaluation program conducted by the agency. Evaluation will consist of two elements, observation of the HHA's performance or the required skills / tasks conducted with a patient / client and written examination ... Upon a HHA's successful completion of the competency evaluation, the Agency will submit the Indiana Home Health Aide Registry Application ... to the state ... "</p> <p>2. Personnel record A, a home health aide, date of hire 11/06/13 and first patient contact 11/06/13, failed to evidence a written competency test and that the aide was registered on the state aide registry.</p> <p>3. Personnel record E, a home health aide, date of hire 10/29/13 and first patient contact 10/31/13, failed to evidence a written competency test and that the aide was registered on the state aide registry.</p>		<p>The Director of Home Health Services will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>All training and education required prior to a home health aide providing care to a client, to include classroom/theory education, practical/hands on training and competency review through demonstration of skills/tasks/duties and written competency exam will be provided through contract by an educational facility or Registered Nurse not employed by the agency . Upon successful completion of this training and competency review, the agency will ensure the home health aide has submitted the Indiana Home Health Aide Registry application and is on the Registry for the prior to the employee providing home health care services.</p> <p>All new employees will have this verified by the administrative assistant and the Director of Home Health Services.</p> <p>The Director of Home Health Services will be responsible for</p>	

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NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME HEALTH LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1521 S 3RD ST TERRE HAUTE, IN 47802			
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N000603	<p>4. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM that she thought employees A and E were registered home health aides and was not able to locate the written examination.</p> <p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide may not be assigned to perform additional tasks not included in the original competency evaluation until he or she has successfully been evaluated as competent in that task.</p> <p>Based on clinical record and policy review and interview, the Registered Nurse failed to ensure competency training included medication and enema administration and proper consent was obtained from the patient's representative for the home health aide to administer medications and provide treatments that were not within the aide's scope of practice for 3 of 10 records reviewed creating the potential to affect all 16 patient's receiving services with the agency. (# 2, 3, and 4)</p> <p>Findings include:</p> <p>1. A policy titled "Home Health Aide</p>	N000603	<p>monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all employee records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the</p>	07/16/2014			

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	<p>Medication Assistance with Medications" dated 01/01/10 stated "An HHA [home health aide] cannot provide assistance with medication to a Client with an alteration in mental status which includes confusion or lack of orientation, unless the services to be provided are directed by a competent individual who may consent to health care for the impaired individual [IC 6-18-2-28.5] ... Assistance with medications is defined to include ... providing assistance in the handling or ingesting of non - controlled substance medications; including eye drops, herbs, supplements and over - the - counter medications ... a HHA may apply topical medications to intact, unbroken skin surfaces ... "</p> <p>2. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "Eight [8] of the 12 required hours of in-service education will be in any eight of the following subject areas ... Medication assistance, any other tasks that the home health agency may choose to have the home health aide perform ... "</p> <p>3. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication</p>		<p>counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical</p>		

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	<p>set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p> <p>a. One of two home health aide care plans stated, "hydrocolloid dressing to right buttock - change when soiled." The second care plan stated, "Notify Dr. [doctor] if pain not controlled with meds [medications]." The agency's competency evaluation program did not include dressing change. The record failed to evidence the patient or the patient's representative had given consent for the aide to change the dressing.</p> <p>b. The home health aide care plan stated to notify the registered nurse and hold blood pressure medications for blood pressures less than 90/60 and greater than 160/100. A home health a visit note dated 12/17/14 stated that the patient had a blood pressure of 88/58 and stated, "med held at 11:00 PM." A home health aide visit note dated 12/31/13 stated the patient had a blood pressure of 80/53 and stated a blood pressure medication of clonidine was held by the</p>		<p>records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced staff on the following corrective action: the scope of practice of a home health aide. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care</p>	

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	<p>home health aide. The agency's competency evaluation program did not include administration and holding of medications. The record failed to evidence the patient or the patient's representative had given consent for the aide to administer medications.</p> <p>c. A home health aide visit note dated 06/05/14 stated the home health aide notified the Alternate Director of Nursing of pain the patient was having. The Alternate Director of Nursing instructed the home health aide to give the patient a narcotic pain medication of Hydrocodone. The agency's competency evaluation program did not include administration of medications. The record failed to evidence the patient or the patient's representative had given consent for the aide to administer medications.</p> <p>d. The clinical record evidenced a medication administration schedule for the months of January, February, March, April, and May, 2014. Medications that was being administered routinely was Reglan (stomach medication), Inderal (blood pressure medication), Docusate Sodium (stool softener), Gas X, and Clonidine (blood pressure medication). In December 2013 and January 2014,</p>		<p>for the Client. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>medications included Hydrocodone as needed (narcotic pain medication), Tramadol as needed (non-narcotic pain medication), Levaquin (an antibiotic that the patient had a history of an allergy to medication), and Levothyroxine (thyroid medication). The dates and times of administration are initialed by employee A, a home health aide. The clinical and employee record failed to evidence the employee was educated and trained on administering medications and the signs and symptoms of adverse / allergic reactions to medications. The record failed to evidence the patient or the patient's representative had given consent for the aide to administer medications.</p> <p>4. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14 for home health aide services. A home health aide care plan with a revision date of 05/02/14 stated "MACE tx [treatment] every morning [manual ante grade colonic enema]." The agency's competency evaluation program did not include administration of enemas. The record failed to evidence the patient or the patient's representative had given consent for the aide to administer enemas.</p>						

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	<p>5. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician for 03/05/14 to 05/03/14 home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks. The clinical record evidenced a medication administration schedule for the months of March, April, and May, 2014. Medications that were being administered routinely was Loratidine, Synthroid, Valporic Acid, Cogentin, Zyprexa, and Hiblicens. The dates and times are initialed by employees A and E, home health aides. The clinical and employee records failed to evidence that the employee was educated and trained on administering medications and the signs and symptoms of adverse / allergic reactions to medications. The record failed to evidence the patient or the patient's representative had given consent for the aide to administer medications.</p> <p>6. The Alternate Director of Nursing indicated on 06/19/14 at 1:00 PM there was no written directives to administer medications and the home health aides were being told to perform this task without consent from the family or proper training.</p>						

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N000604	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on clinical record review, the agency failed to ensure the home health aide informed the nurse of abnormal blood pressure and pulse readings for 1 of 10 records reviewed with the potential to affect all patients receiving home health aide services. (#2)</p> <p>Findings include:</p> <p>Clinical record number 2, start of care 01/09/12, evidenced a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient. The patient's diagnoses included but were not limited to, cerebral palsy, tibial / fibula repair, hip fracture, and profound intellect disability.</p> <p>The home health aide care plan stated to notify the registered nurse and hold blood pressure medications for blood pressures</p>	N000604	<p>The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A)</p>	07/16/2014

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	<p>less than 90/60 and greater than 160/100. A home health a visit note dated 12/17/14 stated that the patient had a blood pressure of 88/58 and stated, "med held at 11:00 PM." A home health aide visit note dated 12/31/13 stated the patient had a blood pressure of 80/53 and stated a blood pressure medication of clonidine was held by the home health aide. A home health aide visit note dated 01/02/14 stated the patient had a blood pressure of 82/53. A home health aide visit note dated 02/02/14 stated the patient had a blood pressure of 150/88. A home health aide visit note dated 02/04/14 stated the patient had a blood pressure of 149/101. A home health aide visit note dated 02/14/14 stated the patient had a blood pressure of 129/103. A home health aide visit note dated 02/25/14 stated the patient had a blood pressure of 155/125 and a pulse of 120. A home health aide visit note dated 04/29/14 stated the patient had a blood pressure of 76/60. A home health aide visit note dated 05/01/14 stated the patient had a blood pressure of 144/100. The clinical record failed to evidence the registered nurse was notified for these abnormal blood pressure readings and elevated pulse rate.</p>		<p>competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: incidents requiring reporting and the incident reporting procedure, including the correct forms to use.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p>	

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			<p>The Incident log and 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME , orders on the Plan of Care, medication/allergy reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>		

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	<p>Based on clinical record and policy review and interview, the agency failed to ensure the Registered Nurse made an on-site visit to the patient's home no less frequently than every 2 weeks as required by agency policy for 2 of 10 records reviewed creating the potential to affect all patients receiving skilled and home health aide services. (# 2 and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 2, SOC (start of care) 01/09/12, evidenced a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient.</p> <p>The clinical record evidenced supervisory visits on 04/22/14, 05/20/14, and 06/03/14.</p> <p>2. Clinical record number 6, SOC 02/07/14, evidenced a plan of care established by the physician for 02/07/14 to 04/07/14 for skilled nursing services 1 hour every other week for 7 weeks to set up medications and home health aide services 2 to 4 hours per day, 3 to 5 times</p>	N000606	<p>The Executive Director has in-serviced nursing staff on the following corrective action: current policy on the time frames for completing Initial Assessments, Admission Assessments, Recertification Assessments, Resumption of Care Assessments and Supervisory visits. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director will in-service skilled nursing on the procedure for filling out all forms contained in the admission packet including the Consent & Agreement of Services form which contains the pay source for services. Included in the admission packet is the OASIS and Aide Care Plan form which identify the services to be provided to the Client. In-service education will include the instruction the Client must be informed and agree to the services that will be provided. Informed consent and agreement to services will be validated by the Client or their appointed designee signing the OASIS assessment and the Consent & Agreement of Services form.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to</p>	07/16/2014			

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N000608	<p>a week for 9 weeks to assist with bathing, grooming, meal preparation, light housekeeping, laundry, and errands.</p> <p>The clinical record evidenced supervisory visits on 03/05/14 and 03/26/14.</p> <p>3. The Alternate Director of Nursing and the Administrator was unable to provide any additional documentation and/or information when asked on 06/16/14 at 3:00 PM.</p> <p>4. A policy titled "Home Health Aide Training, Evaluation, and Supervision" dated 08/26/10 stated, "If a Client is receiving skilled services as well as aide services, the HHA [home health aide] will be supervised by a qualified Registered Nurse at least every 2 weeks, whether on site while the HHA is present or when the HHA is not present."</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information.</p>		<p>ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p>				

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	<p>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure clinical records contained accurate information and signed and dated verbal orders for 4 of 10 records reviewed creating the potential to affect all 16 current patients receiving services. (# 1, 2, 3, and 4)</p> <p>Findings include:</p> <p>1. Clinical record number 1, SOC (start of care) 04/09/14, included plans of care established by the physician dated 04/09/14 to 06/07/14 and 06/08/14 to 08/16/14. The plans of care failed to evidence a nurse's signature and date of the verbal start of care</p> <p>2. Clinical record number 2, SOC 01/09/12, evidenced a plan of care established by the physician for 04/28/14 to 06/26/14 for skilled nursing 1 hour a</p>	N000608	<p>The Executive Director has in-serviced nursing staff on the following corrective action: Effective 06.16.14, the agency changed and immediately implemented the policy related to medication assistance with medication administration by the home health aide. Home health aides definition of medication administration assistance includes but does not go beyond: 1) providing reminders or cues to take medications, the opening of pre-set medication containers and providing assistance in the handling or ingestion of non-controlled substances medication, including eye drops, herbs, supplements and over the counter medication, 2) to an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the</p>	07/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2014
NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME HEALTH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1521 S 3RD ST TERRE HAUTE, IN 47802		
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	<p>day, 1 time a week for medication set up and home health aide 8 hours a day, 3 to 5 times a week for feeding, grooming, personal hygiene, incontinence care, medication assistance, and supervision of the patient.</p> <p>a. A physician order dated 01/31/14 stated to hold blood pressure medications for blood pressure of less than 90/60 and to notify the office for blood pressures greater than 160 /100.</p> <p>b. A home health aide care plan dated 05/16/14 stated the call parameters for the patient's vital signs was for Temperature greater than 100, blood pressure greater than 140/90 and less than 90/60, pulse greater than 120 and less than 60, and respirations less than 11 and greater than 29. In a box next to the checking of vital signs, the parameters state blood pressure less than 100/60 and greater than 160/ 90 and greater than 101 for Temperature.</p> <p>3. Clinical record number 3, SOC 03/15/12, included plans of care established by the physician for 03/05/14 to 05/03/14 and 05/04/14 to 07/02/14. The plans of care stated that the patient was taking 150 mg (milligrams) of Wellbutrin daily. The medication profile stated the patient was taking 100 mg of</p>		<p>impaired individual. Should any aide be selected to provide medication assistance to include an individual who is unable to accomplish the task due to an impairment and who is A) competent and has directed the services; or B) incompetent and has the services directed by a competent individual who may consent to the health care for the impaired individual, the agency will in-service the home health aide on desired action(s) of medication(s) and potential side effects to be reported immediately to the supervisory Registered Nurse. The agency will, prior to assigning this task, obtain consent from the competent individual unable to accomplish the task due to an impairment or in the case of an incompetent individual, obtain consent from a competent individual who may consent to health care for the impaired individual. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced nursing staff on the following corrective action: The agency will request, from every Physician who signs the Plan of Care, vital sign parameters for each Client.</p>		

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	<p>Welbutrin.</p> <p>a. A physician's order dated 10/13/12 stated vital sign parameters of systolic blood pressure less than 90 or greater than 140, diastolic blood pressure less than 60 or greater than 90, heart rate less than 60 or greater than 110, oral temperature greater than 101, respirations less than 11 or greater than 26.</p> <p>b. A home health aide care plan states vital sign parameters for blood pressure was greater than 160 / 90 or less than 100 / 60, heart rate greater than 126, and respirations greater than 26.</p> <p>4. Clinical record number 4, SOC 03/05/14, included a plan of care established by the physician dated 03/05/14 to 05/03/14 for skilled nursing 1 hour every other week for medication set up and home health aide 6 to 8 hours a day, 5 to 7 days a week for 9 weeks.</p> <p>a. The medication profile stated the patient was receiving 250 mg of Valporic Acid three times a day and Zyprexa 10 mg three times a day.</p> <p>b. The medication administration record for March stated Valporic Acid 250 mg three times a day and Zyprexa 10 mg three times a day was given on March</p>		<p>If the Physician chooses not to include vital sign parameters on the Plan of Care, the agency will request that vital signs be taken weekly and at every skilled nursing visit with result logged on a vital sign flow sheet and sent to the Physician signing the Plan of Care no less than every 60 days. If the Physician signing the Plan of Care chooses to set parameters, values outside the parameters will be provided to the Physician within 24 hours. The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. 10% of all clinic records will be audited quarterly for evidence that deficiencies don't recur. The Executive Director has in-serviced nursing staff on the following corrective action: A new policy will be developed and implemented requiring all OASIS assessments to be verified by a Registered Nurse other than the Registered Nurse who completed the assessment. In addition, all plans of care at the time of admission, re-admission, recertification, resumption of care, or discharge will be compared & verified by a Registered Nurse other than the Registered Nurse who completed the assessment. This verification will include orders received since the last OASIS assessment, DME, orders on the Plan of Care, medication/allergy</p>	

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	11 and 12th. A new medication record for March 13 to 31st, April, and May 2014 stated Valporic Acid was 500 mg three times a day and Zyprexa 5 mg three times a day. The clinical record failed to evidence orders in regards to the change of dosages in both medications.		<p>reconciliation, plans of care for the home health aide, attendant care, and homemaker services. Ancillary services or services provided through another agency, Physician or specialists practice and any other provider providing services or care for the Client.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> <p>10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.</p> <p>The Executive Director has in-serviced staff on the following corrective action: A Physician update and medication reconciliation will be sent to the Physician signing the Plan of Care within 24 hours of the Registered Nurse being made aware of any change in medication by any source unless the Registered Nurse can verify via a medication label the change was made by the Physician signing the Plan of Care. The Plan of Care will be updated to reflect the change at this time or upon clarification from the Physician signing the Plan of Care. This will include non-compliance of the Client in following the medication regimen as prescribed and authorized by the Physician signing the Plan of Care.</p> <p>The Director of Home Health Services will be responsible for monitoring the corrective actions to ensure this deficiency is corrected</p>	

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			and will not recur. 10% of all clinical records will be audited quarterly for evidence that deficiencies don't recur.		