

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/23/2014
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NAME OF PROVIDER OR SUPPLIER  SCOTT'S HOME HEALTHCARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902
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G000000	<p>This visit was a federal Home Health complaint survey.</p> <p>Complaint IN00142042 - Substantiated: Federal deficiencies related to the allegations were cited. Unrelated deficiencies were also cited.</p> <p>Survey Date: January 15, 16, 21, 22, and 23, 2014</p> <p>Facility #: 012928</p> <p>Medicaid vendor #: 201091400</p> <p>Surveyor: Bridget Boston, RN , PHNS</p> <p>Total Census: 96</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 31, 2014</p>	G000000	No correction needed. Initial comments only.	

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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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 policy review, and interview, the agency failed to ensure the ordered number of hours were provided by the home health aide for 2 (# 1 and 4) of 12 records reviewed of patients that receive aide services with the potential to affect all of the agency's current patients that received aide services.</p> <p>The findings include:</p> <p>1. Clinical record 1, start of care 12/21/13, included a physician ordered plan of care for the certification period 12/21/13 through 2/18/14 with orders for aide services 4 hours a day, seven days a week.</p> <p>A. The record evidenced aide services were provided only three days during the second week of the certification period, 12/22/13 through 12/28/13. Aide services were provided on December 22, 27, and 28th.</p> <p>B. On 1/15/14 at 5:30 PM,</p>	G000158	<p>TO CORRECT THIS DEFICIENCY PHYSICIAN ORDER NUMBER OF HOURS WILL BE ENTERED INTO A NEW COMPUTER SYSTEM WHICH WILL GO LIVE ON 2/17/14. AN OFFICE NURSE HAS BEEN HIRED TO ENTER ORDERS INTO THE SYSTEM AND TO SUERVISE THE SCHEDULERS TO ENSURE HOURS THAT ARE ORDERED ARE PROVIDED BY HOME HEALTH AIDES. THE DESIGNATED OFFICE NURSE WILL BE RESPONSIBLE TO ENSURE THAT PHYSICIANS ORDERS MATCH HOURS PROVIDED IN THE SCHEDULING SYSTEM. THE DON WILL ENSURE THAT THIS IS COMPLETED BY THE OFFICE NURSE. WE WILL ENSUE THAT THIS CORRECTION CONTINUES TO BE UPHELD BY THE ADON OR OTHER DESIGNATED NURSE ENTERING ORDERS INTO THE COMPUTER PROGRAM AS NEW ORDERS ARE RECEIVED AT THAT TIME SHE WILL AUDIT AT LEAST 10% OF ALL PATIENT SCHEDULES TO ENSURE ORDERS MATCH PROVIDED CARE.</p>	02/17/2014			

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	<p>employee B indicated services were not provided as ordered on the plan of care.</p> <p>2. Clinical record 4, start of care 1/16/13, included a physician ordered plan of care for the certification period 11/12/13 through 1/10/14 with orders for aide services 6 hours a day, five - seven days a week. The plan of care was signed by employee B, a registered nurse and dated 11/11/13.</p> <p>A. The record evidenced a physician order dated 11/11/13 written by employee D which stated, "Begin home health aide 4 hours / day X 7 days / week through 12/24/13 per Medicaid PA. On 12/25/13 begin home health services 6 hours / day X 7 days / week per Medicaid PA."</p> <p>B. The patient remained on services until 12/19/13 at which time the patient requested to be transferred to another home health agency. The record failed to evidence the agency provided a minimum of four hours of aide services daily. The record evidenced the patient received three hours of aide services daily.</p> <p>3. The policy titled "Home Care Program - Client Assessment" number 207.00 effective date 7/20/12 stated,</p>						

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G000159	<p>"Based on the evaluation, the professional team member: A. Develop goals with the client and client family for treatment and modalities that are reasonable and measurable. B. Develop and implements a client care plan based on the needs identified, client participation and discharge plans."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record and policy review and interview, the agency failed to ensure physician orders were written for all services provided and the plans of care included interventions to meet patient's goals for 2 of 12 records reviewed (8 and 11) with the potential to affect all the patients of the agency.  The findings include:  1. Clinical record 8 evidenced a plan of care for the certification period 11/21/13</p>	G000159	TO CORRECT THIS DEFICIENCY THE DON AND ALT DON WILL CONDUCT A TRAINING CLASS WITH ALL SKILLED NURSES TO ENSURE THAT WHEN WRITING PHYSICIANS ORDERS THESE WILL ALSO BE INCLUDED IN THE POC WITH INTERVENTIONS TO MEET PATIENT GOALS AN OFFICE LPN HAS BEEN HIRED TO SUPERVISE DATAENTRY CLERK AND TO ASSIST RN'S WITH BRINGING ORDERS FORWARD FROM PREVIOUS	02/17/2014			

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	<p>through 1/19/2014 with orders for skilled nursing once a week to preset the patient's medications and for aide services 6 hours a day, seven days a week through out the certification period. The record failed to evidence physician orders for services after 1/19/14. The plan of care included the patient's goals and stated, "Patient will live safely in home, ... Patient will have no reported falls by 11/20/13 [sic]." The plan of care, aide assignment, and record failed to evidence the interventions developed and implemented with the patient to attain the patient's goals to "live in the home safely" and "no reported falls."</p> <p>A. Skilled nurse visit note dated 12/23/13, written by employee C, indicated the aide of the day reported the patient had fallen on 12/23/13 and emergency medical services were called to assist the patient off the floor as the nurse and aide could not assist successfully.</p> <p>B. A supervisory visit note written by employee F and dated 1/13/14 included documentation the patient reported a fall from bed.</p> <p>C. The record evidenced employee C, a licensed practical nurse, conducted</p>		<p>POC TO RECERTIFICATION POC TO INCLUDE NEW PHYSICIANS ORDERS. ALSO TO INCLUDE WAIVER AND CHOICE SERVICES AND ANY OTHER COORDINATION OF CARE. THE DON WILL BE RESPONSIBLE FOR ENSURING THAT THIS DEFICIENCY IS CORRECTED. TO ENSURE THIS CORRECTION IS UPHELD IN THE FUTURE THE DON WILL CONDUCT A PATIENT RECORD AUJDIT OF PHYSICIAN ORDERS AND PLANS OF CARE IN THE AMOUNT OF 10% PER MONTH.</p>		

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	<p>a skilled nurse visit on 1/20/14 and preset the patient's medications and employee E, a home health aide, provided aide services for 6 hours on 1/20/14.</p> <p>D. The administrative documents reviewed included the schedule of aide visits to be made to the patient's home. The schedule evidenced, home health aide, employee E, was scheduled for 6 hours on 1/21/14 and employee G was scheduled for 6 hours on 1/22/14.</p> <p>E. On 1/23/14 at 1:30 PM, employee A indicated the plan of care for the certification period to begin 1/20/14 was printed just before 1:30 PM and was not yet reviewed by the registered nurse. She indicated there was no written physician order for any of the services provided after 1/19/14.</p> <p>2. Clinical record 11, start of care 12/30/13, evidenced a physician ordered plan of care for the certification period 12/30/13 through 2/27/14. The plan of care included the patient's insulin, Lantus, was administered at 76 units daily.</p> <p>During a home visit on 1/21/14 at 2 PM, the patient indicated the insulin Lantus was self administered 76 units</p>			

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G000171	<p>twice a day, once in the morning and once in the evening. The patient reported the dose was increased to twice a day months earlier and blood glucose results were improved with the dose.</p> <p>3. The agency policy titled "Verbal Orders Policy and Procedure" effective date 7/20/12 stated, "Verbal orders will be received from the primary physician by an RN. Procedure: The verbal orders will be written on an MD order form and signed by the RN."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed the initial patient assessment in 1 of 6 clinical records reviewed of patients admitted after 12/10/13, the date of the last survey, with the potential to affect all future patients. (1)</p> <p>The findings include:</p> <p>1. Clinical record 1 evidenced a physician ordered plan of care for the certification period 12/20/13 through 2/18/14 and a start of care date of 12/21/13. The record evidenced a skilled nurse noted dated 12/21/13, time</p>	G000171	<p>TO CORRECT THIS DEFICIENCY THE DON AND ALT DON WILL HAVE AN IN-SERVICE TO TRAIN ALL NURSES THAT THE RN COMPLETES THE INITIAL ASSESSMENT ALSO THE POLICY AND PROCEDURE FOR THE INITIAL ASSESSMENT WILL BE REVIEWED/REVISED TO INCLUDE THIS CORRECTION. THE DON IS RESPONSIBLE FOR MAKING SURE THIS CORRECTION IS UPHELD. DON AUDITS 10% OF ALL PATIENT RECORDS EACH MONTH AND PROVIDES CONTINUED TRAINING WITH RN'S AS NEEDED TO ENSURE THAT THE RN COMPLETES</p>	02/17/2014

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G000176	<p>of visit 2 PM to 3 PM and written by employee C, a licensed practical nurse (LPN), and a comprehensive assessment completed by employee B at 3:20 PM, after the LPN visit, and dated 12/21/13.</p> <p>2. On 1/15/14 at 5:30 PM, employee B indicated she requested the licensed practical nurse to make the initial visit to the patients home and begin the comprehensive assessment.</p> <p>3. The policy titled "Policy for Scope of Practice" effective date 7/20/12 stated "In the home health care setting the registered nurse shall do the following: 1. Make the initial evaluation visit." 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. Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse coordinated care with the licensed practical nurse and the home health aides effectively in 2 of 12 records reviewed (8 and 13) of patients who received home health aide services with the potential to affect all patients who receive home health aide services.</p>	G000176	<p>INITIAL ASSESSMENTS.</p> <p>TO CORRECT THIS DEFICIENCY THE DON AND ALT DON WILL TRAIN THE RN'S WHO COMPLETE ADMISSIONS AND RECERTIFICATIONS TO MAKE HOME HEALTH AIDE CARE PLANS MORE SPECIFIC TO EACH PATIENTS NEEDS BY ADDING SPECIFIC COMMENTS TO THE HHA CARE PLAN ALL NURSE MEETING WILL BE CONDUCTED WEEKLY TO</p>	02/17/2014			

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	<p>Findings</p> <p>1. Clinical record 8 evidenced a plan of care for the certification period 11/21/13 through 1/19/2014 with orders for skilled nursing once a week to preset the patient's medications and for aide services 6 hours a day, seven days a week through out the certification period. The record evidenced the patient was blind, had a history of falls, right arm paralysis, ambulated with assistive devices, and diagnoses included hypertension and hepatitis C. The clinical record failed to evidence any communication between the registered nurse and the licensed practical nurse and the home health aide concerning the patient's status and condition.</p> <p>A. Skilled nurse visit note dated 12/23/13, written by employee C , indicated the aide of the day reported the patient had fallen on 12/23/13 and emergency medical services were called to assist the patient off the floor as the nurse and aide was unsuccessful in their attempt to assist the patient.</p> <p>B. A supervisory visit note written by employee F and dated 1/13/14 included documentation the patient reported a fall from bed.</p>		<p>DISCUSS PATIENT CARE COORDINATION BETWEEN RN'S AND LPN'S. ALL NURSES WILL BE TRAINED TO REVIEW THE PATIENTS RECORD INCLUDING THE POC BEFORE VISITING THAT PATIENT AND PROVIDING SERVICES ALL NURSES WILL BE TRAINED TO MAKE A CLINICAL NOTE IN THE PATIENTS CHART REGARDING PATIENTS STATUS AND CONDITION L[N]'S WILL BE TRAINED TO CONTACT THE RN CASE MANAGER WITH STATUS AND CONDITION CHANGES FOUND DURING THEIR VISITS AND TO WRITE A CLINICALD NOTE TO BE PLACED IN PATIENTS CHART. RN CASE MANAGER WITH STATUS AND CONDITION CHANGES FOUND DURING THEIR VISITS AND TO WRITE A CLINICAL NOTE TO BE PLACED IN PATIENTS CHART. RN CASE MANAGER WILL NOTIFY LPN OF CHANGES TO POC. DON AND ALT DON WILL TRAIN RN'S WHO DO ADMISSIONS TO CARRY FORWARD RISK ASSESSMENTS FROM THE COMPREHENSIVE ASSESSMENT TO THE POC SPECIFICALLY TO THE PATIENTS NEEDS. AN OFFICE NURSE HAS BEEN HIRED TO SUPERVISE THE SCHEDULERS. THIS NURSE AND THE SCHEDULERS WILL BE TRAINED TO</p>		

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	<p>C. The record evidenced employee C, a licensed practical nurse, provided the weekly skilled nurse visits with medication preset and assessments throughout the certification period and home health aides services were provided daily.</p> <p>2. Clinical record 13, start of care 10/22/13, evidenced a comprehensive assessment dated 10/22/13 and a physician ordered plan of care for the certification period 10/22/13 through 12/20/13 with orders for home health aide services 3 hours a day, seven days a week throughout the certification period. The comprehensive assessment dated 10/22/13, evidenced the following:</p> <p>A. A functional risk assessment that identified the patient had pain of the back, left knee, and right shoulder. The patient described the pain as "constant." The patient's risk of fall was a score of 8. A score of greater or equal to 4 was categorized as a High Risk of Falls.</p> <p>B. The patient's skin was described. The assessment stated, "BLE [Bilateral lower extremity] Brick red and have healed blisters. ... Right posterior calf ... above ankle 2 cm [centimeter] scab, left anterior calf - near ankle bone - 1 cm</p>		<p>COMMUNICATE ALL PATIENT CHANGES, CONCERNS, COMPLAINTS ETC... TO THE DON TO BE REVIEWED IMMEDIATELY AND ACTIONS IMPLEMENTED. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD. THE DON WILL CONDUCT AN AUDIT OF 10% OF PATIENT RECORDS EACH MONTH TO ENSURE COORDINATION OF CARE WITH LPN'S AND HHA'S ARE DOCUMENTED PROPERLY AND WILL CONTINUE TRAINING IN-SERVICES TO ENSURE ALL NURSING STAFF UNDERSTANDS THEIR ROLL IN COORDINATION OF CARE AS NEEDED.</p>		

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	<p>scab."</p> <p>C. The patient was identified with chewing and / or swallowing problems and the assessment stated, "HHA [home health aide] will assist with meal preparation and prepare healthy, easy to eat foods."</p> <p>D. The assessment identified the patient had limited range of motion of the right side of the body related to a previous stroke and stated, "Can only raise right arm 6 inches from side" and resided with family members which were not physically capable to assist the patient with any activities of daily living.</p> <p>E. The clinical record failed to evidence any communication occurred between the registered nurse and the home health aide with preventative measures for the problems and risks identified.</p> <p>F. On 1/21/14 at 2 PM, during a home visit, the patient and other household members identified the aide typically provided care in the evening from 7 - 10 PM and assisted the patient with hygiene and bathing and completed housekeeping tasks.</p>						

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G000229	<p>3. The agency policy titled "Scope of Services" number 229.00 effective date 7/20/12 stated, "The services are coordinated by the designated Case Manager."</p> <p>484.36(d)(2) SUPERVISION 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. Based on clinical record and policy review, the agency failed to ensure the registered nurse completed supervisory visits at least every fourteen days in 1 of 3 records (8) reviewed of patients that received home health aide and skilled services creating the potential to affect all patients receiving home health aide services.</p> <p>The findings include</p> <p>1. Clinical record # 8, start of care 11/26/12, evidenced home health aide services were provided daily for 6 hours, seven days a week, during the certification period 11/21/13 through 1/19/14 and until 1/23/14. The record evidenced a licensed practical nurse conducted the skilled nurse visits weekly through out the certification period. The record evidenced supervisory visits were</p>	G000229	TO CORRECT THIS DEFICIENCY WE ARE IMPLEMENTING A NEW COMPUTER PROGRAM FOR SCHEDULING ALL VISITS INCLUDING SUPERVISORY VISITS, HHA VISITS ALL NURSING VISITS. THIS WILL ENSURE THAT SUPERVISORY VISITS WILL BE TRACKED AND COMPLETED WITHIN COMPLIANCE OF FEDERAL AND STATE REGULATIONS. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD. THE DON WILL ENSURE THAT THE RN'S ARE TRAINED TO COMPLETE SUPERVISORY VISITS WITHIN FEDERAL AND STATE COMPLIANCE AND WILL CONDUCT AN AUDIT OF 10% OF ALL PATIENT RECORDS INCLUDING SUPERVISORY VISITS EACH MONTH TO CONFIRM COMPLIANCE.	02/17/2014	

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G000230	<p>conducted by a registered nurse on 11/25/13, 12/13/13, 12/28/13, and 1/13/14.</p> <p>2. The agency policy titled "Supervision of Staff" number 4.59 stated, "Home Health Aide: ... When clients are receiving skilled care in addition to personal care the registered nurse will make a supervisory visit to the clients residence at least every two weeks."</p> <p>484.36(d)(3) SUPERVISION If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse made a home health aide supervisory visit while the aide was present and providing care to ensure the aide is properly caring for the patient in 1 of 1 active clinical records reviewed of patient receiving home health aide only services for more than 60 days creating the potential to affect all patients that</p>	G000230	TO CORRECT THIS DEFICIENCY WE ARE IMPLEMENTING A NEW COMPUTER PROGRAM FOR SCHEDULING ALL VISITS, INCLUDING SUPERVISORY VISITS, HHA VISITS, ALL NURSING VISITS. THIS WILL ENSURE TAHT SUPERVISORY VISITS WILL BE TRACKED AND COMPLETED WITHIN COMPLIENCE OF FEDERAL	02/17/2014

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NAME OF PROVIDER OR SUPPLIER  SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1817 DOGWOOD CT KOKOMO, IN 46902		
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	<p>receive only home health aide services. (# 3)</p> <p>Findings include:</p> <p>1. Clinical record 3, start of care 5/24/13, evidenced a plan of care dated 11/20/13 through 1/18/14 with orders for home health aide services only. The record failed to evidence a registered nurse conducted a supervisory while the aide was providing care.</p> <p>The record evidenced one supervisory visits were made on 9/15/13, 11/15/13, and 12/15/13. The documentation failed to evidence the aide was present in the home and providing care during the supervisory visit.</p> <p>2. On 1/16/14 at 2 PM, employee D, a registered nurse, indicated she conducted the last two supervisory visits to the patients home, dated 11/15/13 and 12/15/13, and that the aide was not present at the time of these supervisory visits.</p>		<p>AND STATE REGULATIONS. THE COMPUTER SYSTEM WILL ALSO ALLOW THE NURSE SCHEDULER TO ENSURE THAT SUPERVISORY VISIT ON NON-SKILLED PATIENTS WILL BE COMPLETED WHEN AIDE IS PRESENT AT LEAST 1 TIME EVERY 60 DAYS. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD. THE DON WILL ENSURE THAT THE RN'S ARE TRAINED TO COMPLETE SUPERVISORY VISITS WITHIN FEDERAL AND STATE COMPLIANCE AND WILL CONDUCT AN AUDIT OF 10% OF ALL PATIENT RECORDS INCLUDING SUPERVISORY VISITS EACH MONTH TO CONFIRM COMPLIANCE.</p>		

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G000331	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed the initial patient assessment in 1 of 6 clinical records reviewed of patients admitted after 12/10/13, the date of the last survey, with the potential to affect all future patients. (1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 1 evidenced a physician ordered plan of care for the certification period 12/20/13 through 2/18/14 and a start of care date of 12/21/13. The record evidenced a skilled nurse noted dated 12/21/13, time of visit 2 PM to 3 PM and written by employee C, a licensed practical nurse (LPN), and a comprehensive assessment completed by employee B at 3:20 PM, after the LPN visit, and dated 12/21/13.</li> <li>2. On 1/15/14 at 5:30 PM, employee B indicated she requested the licensed practical nurse to make the initial visit to</li> </ol>	G000331	<p>TO CORRECT THIS DEFICIENCY THE RN'S WILL BE TRAINED BY THE DON AND ALT DON THAT ONLY THE RN COMPLETES ASSESSMENT TO DETERMINE IMMEDIATE CARE AND SUPPORT NEEDS OF PATIENT. THE ADMISSION POLICY AND PROCEDURE WILL ALSO BE REVIEWED AND REVISE TO INCLUDE THIS CORRECTION. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD BY AUDITING 10% OF ALL PATIENT RECORDS EACH MONTH TO ENSURE THE RN'S COMPLETES THE ADMISSION ASSESSMENT PROPERLY AND TRAINS RN'S AS NEEDED PER AUDIT.</p>	02/17/2014			

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G000341	<p>the patients home and begin the comprehensive assessment.</p> <p>3. The policy titled "Policy for Scope of Practice" effective date 7/20/12 stated "In the home health care setting the registered nurse shall do the following: 1. Make the initial evaluation visit."</p> <p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record review and interview, the agency failed to ensure a discharge assessment with OASIS items was conducted after the last service was provided and was accurate reflection of the patient for 1 of 1 clinical record reviewed that required a discharge assessment with OASIS items. (patient 4)</p> <p>The findings include:</p> <p>1. Clinical record 4, start of care 1/16/13, included a physician ordered plan of care for the certification period 11/12/13 through 1/10/14 with orders for skilled nurse and aide services.</p>	G000341	<p>TO CORRECT THIS DEFICIENCY WE HAVE ASSIGNED AN OFFICE CLERK TO NOTIFY EACH NURSE OF HOLDS, DISCHARGES AND ADMISSIONS SO THAT NO SERVICES WE BE PROVIDED AFTER A DISCHARGE OR ATTEMPTED WHEN A PATIENT IS ON HOLD. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD BY AUDITING 10% OF ALL PATIENT RECORDS, COORDINATING WEEKLY NURSING MEETINGS AND ENSURING PATIENT STATUS AND CONDITION CHANGES ARE DISCUSSED AT THESE MEETINGS. WILL ALSO</p>	02/17/2014

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	<p>A. The record evidenced an aide visit note dated 11/24/13 which indicated the patient went to the emergency room on 11/24/13.</p> <p>B. The record evidenced employee C, a licensed practical nurse, provided two skilled nurse visits on 12/19/13. The first visit note indicated the nurse collected a blood sample, documented the patient's laboratory value of international normalized ratio (INR) was 2.5, and the patient's medications were preset. (INR is a blood test which measures how long it would take the patient's blood to clot.) The second home visit note documented the patient's preset medication was adjusted to reflect the physician's response to the INR value.</p> <p>C. The record evidenced the patient notified the agency of the decision to be transferred to another agency and employee D, a registered nurse, completed a discharge assessment with OASIS items off site at 1 PM on 12/19/13, before employee C completed the two nurse visits of the same date. The discharge assessment failed to reflect the patient's emergent care on 11/24/13 at OASIS item M 2300.</p>		DIRECT REGULAR CLINICAL OFFICE PERSONAL METINGS TO ENSURE OFFICE STAFF ARE AWARE OF PATIENT CHANGES AND COMMUNICATING CHANGES TO FIELD STAFF.		

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N000000	<p>2. On 1/23/14 at 1 PM, employee A indicated employee D needs more training.</p> <p>This visit was a state Home Health complaint survey.</p> <p>Complaint IN00142042 - Substantiated: State deficiencies related to the allegations were cited. Unrelated deficiencies were also cited.</p> <p>Survey Date: January 15, 16, 21, 22, and 23, 2014</p> <p>Facility #: 012928</p> <p>Medicaid vendor #: 201091400</p> <p>Surveyor: Bridget Boston, RN , PHNS</p> <p>Total Census: 96</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 31, 2014</p>	N000000	No correction needed. Initial comments only.	

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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and policy review, and interview, the agency failed to ensure the ordered number of hours were provided by the home health aide for 2 (# 1 and 4) of 12 records reviewed of patients that receive aide services with the potential to affect all of the agency's current patients that received aide services.</p> <p>The findings include:</p> <p>1. Clinical record 1, start of care 12/21/13, included a physician ordered plan of care for the certification period 12/21/13 through 2/18/14 with orders for aide services 4 hours a day, seven days a week.</p> <p>A. The record evidenced aide services were provided only three days during the second week of the certification period, 12/22/13 through 12/28/13. Aide services were provided on December 22, 27, and 28th.</p> <p>B. On 1/15/14 at 5:30 PM,</p>	N000522	<p>TO CORRECT THIS DEFICIENCY PHYSICIAN ORDER NUMBER OF HOURS WILL BE ENTERED INTO A NEW COMPUTER SYSTEM WHICH WILL GO LIVE ON 2/17/14. AN OFFICE NURSE HAS BEEN HIRED TO ENTER ORDERS INTO THE SYSTEM AND TO SUERVISE THE SCHEDULERS TO ENSURE HOURS THAT ARE ORDERED ARE PROVIDED BY HOME HEALTH AIDES. THE DESIGNATED OFFICE NURSE WILL BE RESPONSIBLE TO ENSURE THAT PHYSICIANS ORDERS MATCH HOURS PROVIDED IN THE SCHEDULING SYSTEM. THE DON WILL ENSURE THAT THIS IS COMPLETED BY THE OFFICE NURSE. WE WILL ENSUE THAT THIS CORRECTION CONTINUES TO BE UPHELD BY THE ADON OR OTHER DESIGNATED NURSE ENTERING ORDERS INTO THE COMPUTER PROGRAM AS NEW ORDERS ARE RECEIVED AT THAT TIME SHE WILL AUDIT AT LEAST 10% OF ALL PATIENT SCHEDULES TO ENSURE ORDERS MATCH PROVIDED CARE.</p>	02/17/2014			

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	<p>employee B indicated services were not provided as ordered on the plan of care.</p> <p>2. Clinical record 4, start of care 1/16/13, included a physician ordered plan of care for the certification period 11/12/13 through 1/10/14 with orders for aide services 6 hours a day, five - seven days a week. The plan of care was signed by employee B, a registered nurse and dated 11/11/13.</p> <p>A. The record evidenced a physician order dated 11/11/13 written by employee D which stated, "Begin home health aide 4 hours / day X 7 days / week through 12/24/13 per Medicaid PA. On 12/25/13 begin home health services 6 hours / day X 7 days / week per Medicaid PA."</p> <p>B. The patient remained on services until 12/19/13 at which time the patient requested to be transferred to another home health agency. The record failed to evidence the agency provided a minimum of four hours of aide services daily. The record evidenced the patient received three hours of aide services daily.</p> <p>3. The policy titled "Home Care Program - Client Assessment" number 207.00 effective date 7/20/12 stated,</p>			

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N000524	<p>"Based on the evaluation, the professional team member: A. Develop goals with the client and client family for treatment and modalities that are reasonable and measurable. B. Develop and implements a client care plan based on the needs identified, client participation and discharge plans." 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 policy review and interview, the agency failed to ensure physician orders were written for all services provided and the plans of</p>	N000524	TO CORRECT THIS DEFICIENCY THE DON AND ALT DON WILL CONDUCT A TRAINING CLASS WITH ALL SKILLED NURSES TO ENSURE	02/17/2014			

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	<p>care included interventions to meet patient's goals for 2 of 12 records reviewed (8 and 11) with the potential to affect all the patients of the agency.</p> <p>The findings include:</p> <p>1. Clinical record 8 evidenced a plan of care for the certification period 11/21/13 through 1/19/2014 with orders for skilled nursing once a week to preset the patient's medications and for aide services 6 hours a day, seven days a week through out the certification period. The record failed to evidence physician orders for services after 1/19/14. The plan of care included the patient's goals and stated, "Patient will live safely in home, ... Patient will have no reported falls by 11/20/13 [sic]." The plan of care, aide assignment, and record failed to evidence the interventions developed and implemented with the patient to attain the patient's goals to "live in the home safely" and "no reported falls."</p> <p>A. Skilled nurse visit note dated 12/23/13, written by employee C, indicated the aide of the day reported the patient had fallen on 12/23/13 and emergency medical services were called to assist the patient off the floor as the nurse and aide could not assist</p>		<p>THAT WHEN WRITING PHYSICIANS ORDERS THESE WILL ALSO BE INCLUDED IN THE POC WITH INTERVENTIONS TO MEET PATIENT GOALS AN OFFICE LPN HAS BEEN HIRED TO SUPERVISE DATAENTRY CLERK AND TO ASSIST RN'S WITH BRINGING ORDERS FORWARD FROM PREVIOUS POC TO RECERTIFICATION POC TO INCLUDE NEW PHYSICIANS ORDERS. ALSO TO INCLUDE WAIVER AND CHOICE SERVICES AND ANY OTHER COODRDINATION OF CARE. THE DON WILL BE RESPONSIBLE FOR ENSURING THAT THIS DEFICIENCY IS CORRECTED. TO ENSURE THIS CORRECTION IS UPHELD IN THE FUTURE THE DON WILL CONDUCT A PATIENT RECORD AUJDIT OF PHYSICIAN ORDERS AND PLANS OF CARE IN THE AMOUNT OF 10% PER MONTH.</p>				

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	<p>successfully.</p> <p>B. A supervisory visit note written by employee F and dated 1/13/14 included documentation the patient reported a fall from bed.</p> <p>C. The record evidenced employee C, a licensed practical nurse, conducted a skilled nurse visit on 1/20/14 and preset the patient's medications and employee E, a home health aide, provided aide services for 6 hours on 1/20/14.</p> <p>D. The administrative documents reviewed included the schedule of aide visits to be made to the patient's home. The schedule evidenced, home health aide, employee E, was scheduled for 6 hours on 1/21/14 and employee G was scheduled for 6 hours on 1/22/14.</p> <p>E. On 1/23/14 at 1:30 PM, employee A indicated the plan of care for the certification period to begin 1/20/14 was printed just before 1:30 PM and was not yet reviewed by the registered nurse. She indicated there was no written physician order for any of the services provided after 1/19/14.</p> <p>2. Clinical record 11, start of care 12/30/13, evidenced a physician ordered</p>				

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N000540	<p>plan of care for the certification period 12/30/13 through 2/27/14. The plan of care included the patient's insulin, Lantus, was administered at 76 units daily.</p> <p>During a home visit on 1/21/14 at 2 PM, the patient indicated the insulin Lantus was self administered 76 units twice a day, once in the morning and once in the evening. The patient reported the dose was increased to twice a day months earlier and blood glucose results were improved with the dose.</p> <p>3. The agency policy titled "Verbal Orders Policy and Procedure" effective date 7/20/12 stated, "Verbal orders will be received from the primary physician by an RN. Procedure: The verbal orders will be written on an MD order form and signed by the RN." 410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse completed the initial patient assessment in 1 of 6 clinical records reviewed of patients</p>	N000540	TO CORRECT THIS DEFICIENCY THE DON AND ALT DON WILL HAVE AN IN-SERVICE TO TRAIN ALL NURSES THAT THE RN COMPLETES THE INITIAL ASSESSMENT ALSO THE	02/17/2014

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	<p>admitted after 12/10/13, the date of the last survey, with the potential to affect all future patients. (1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 1 evidenced a physician ordered plan of care for the certification period 12/20/13 through 2/18/14 and a start of care date of 12/21/13. The record evidenced a skilled nurse noted dated 12/21/13, time of visit 2 PM to 3 PM and written by employee C, a licensed practical nurse (LPN), and a comprehensive assessment completed by employee B at 3:20 PM, after the LPN visit, and dated 12/21/13.</li> <li>2. On 1/15/14 at 5:30 PM, employee B indicated she requested the licensed practical nurse to make the initial visit to the patients home and begin the comprehensive assessment.</li> <li>3. The policy titled "Policy for Scope of Practice" effective date 7/20/12 stated "In the home health care setting the registered nurse shall do the following: <ol style="list-style-type: none"> <li>1. Make the initial evaluation visit."</li> </ol> </li> </ol>		<p>POLICY AND PROCEDURE FOR THE INITIAL ASSESSMENT WILL BE REVIEWED/REVISED TO INCLUDE THIS CORRECTION. THE DON IS RESPONSIBLE FOR MAKING SURE THIS CORRECTION IS UPHELD. DON AUDITS 10% OF ALL PATIENT RECORDS EACH MONTH AND PROVIDES CONTINUED TRAINING WITH RN'S AS NEEDED TO ENSURE THAT THE RN COMPLETES INITIAL ASSESSMENTS.</p>		

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N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse coordinated care with the licensed practical nurse and the home health aides effectively in 2 of 12 records reviewed (8 and 13) of patients who received home health aide services with the potential to affect all patients who receive home health aide services.</p> <p>Findings</p> <p>1. Clinical record 8 evidenced a plan of care for the certification period 11/21/13 through 1/19/2014 with orders for skilled nursing once a week to preset the patient's medications and for aide services 6 hours a day, seven days a week through out the certification period. The record evidenced the patient was blind, had a history of falls, right arm paralysis, ambulated with assistive devices, and diagnoses included hypertension and hepatitis C. The clinical record failed to evidence any communication between the registered</p>	N000545	<p>TO CORRECT THIS DEFICIENCY THE DON AND ALT DON WILL TRAIN THE RN'S WHO COMPLETE ADMISSIONS AND RECERTIFICATIONS TO MAKE HOME HEALTH AIDE CARE PLANS MORE SPECIFIC TO EACH PATIENTS NEEDS BY ADDING SPECIFIC COMMENTS TO THE HHA CARE PLAN ALL NURSE MEETING WILL BE CONDUCTED WEEKLY TO DISCUSS PATIENT CARE COORDINATION BETWEEN RN'S AND LPN'S. ALL NURSES WILL BE TRAINED TO REVIEW THE PATIENTS RECORD INCLUDING THE POC BEFORE VISITING THAT PATIENT AND PROVIDING SERVICES ALL NURSES WILL BE TRAINED TO MAKE A CLINICAL NOTE IN THE PATIENTS CHART REGARDING PATIENTS STATUS AND CONDITION L[N'S WILL BE TRAINED TO CONTACT THE RN CASE MANAGER WITH STATUS AND CONDITION CHANGES FOUND DURING THEIR VISITS AND TO WRITE A CLINICALD NOTE TO BE PLACED IN PATIENTS CHART. RN CASE MANAGER</p>	02/17/2014	

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	<p>nurse and the licensed practical nurse and the home health aide concerning the patient's status and condition.</p> <p>A. Skilled nurse visit note dated 12/23/13, written by employee C , indicated the aide of the day reported the patient had fallen on 12/23/13 and emergency medical services were called to assist the patient off the floor as the nurse and aide was unsuccessful in their attempt to assist the patient.</p> <p>B. A supervisory visit note written by employee F and dated 1/13/14 included documentation the patient reported a fall from bed.</p> <p>C. The record evidenced employee C, a licensed practical nurse, provided the weekly skilled nurse visits with medication preset and assessments throughout the certification period and home health aides services were provided daily.</p> <p>2. Clinical record 13, start of care 10/22/13, evidenced a comprehensive assessment dated 10/22/13 and a physician ordered plan of care for the certification period 10/22/13 through 12/20/13 with orders for home health aide services 3 hours a day, seven days a week throughout the certification period.</p>		<p>WITH STATUS AND CONDITION CHAN GES FOUND DURING THEIR VISITS AND TO WRITE A CLINICAL NOTE TO BE PLACED IN PATIENTS CHART. RN CASE MANAGER WILL NOTIFY LPN OF CHAN GES TO POC. DON AND ALT DON WILL TRAIN RN'S WHO DO ADMISSIONS TO CARRY FORWARD RISK ASSESSMENTS FROM THE COMPREJHENSIVE ASSESSMENT TO THE POC SPECIFICALLY TO THE PATIENTS NEEDS. AN OFFICE NURSE HAS BEEN HIRED TO SUPERVISE THE SCHEDULERS. THIS NURSE AND THE SCHEDULERS WILL BE TRAINED TO COMMUNICATE ALL PATIENT CHANGES, CONCERNS, COMPLAINTS ETC... TO THE DON TO BE REVIEWED IMMEDIATELY AND ACTIONS IMPLEMENTED. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD. THE DON WILL CONDUCT AN AUDIT OF 10% OF PATIENT RECORDS EACH MONTH TO ENSURE COORDINATION OF CARE WITH LPN'S AND HHA'S ARE DOCUMENTED PROPERLY AND WILL CONTINUE TRAINING IN-SERVICES TO ENSURE ALL NURSING STAFF UNDERSTANDS THEIR ROLL IN COORDINATION OF CARE AS NEEDED.</p>				

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	<p>The comprehensive assessment dated 10/22/13, evidenced the following:</p> <p>A. A functional risk assessment that identified the patient had pain of the back, left knee, and right shoulder. The patient described the pain as "constant." The patient's risk of fall was a score of 8. A score of greater or equal to 4 was categorized as a High Risk of Falls.</p> <p>B. The patient's skin was described. The assessment stated, "BLE [Bilateral lower extremity] Brick red and have healed blisters. ... Right posterior calf ... above ankle 2 cm [centimeter] scab, left anterior calf - near ankle bone - 1 cm scab."</p> <p>C. The patient was identified with chewing and / or swallowing problems and the assessment stated, "HHA [home health aide] will assist with meal preparation and prepare healthy, easy to eat foods."</p> <p>D. The assessment identified the patient had limited range of motion of the right side of the body related to a previous stroke and stated, "Can only raise right arm 6 inches from side" and resided with family members which were not physically capable to assist the patient with any activities of daily</p>						

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N000606	<p>living.</p> <p>E. The clinical record failed to evidence any communication occurred between the registered nurse and the home health aide with preventative measures for the problems and risks identified.</p> <p>F. On 1/21/14 at 2 PM, during a home visit, the patient and other household members identified the aide typically provided care in the evening from 7 - 10 PM and assisted the patient with hygiene and bathing and completed housekeeping tasks.</p> <p>3. The agency policy titled "Scope of Services" number 229.00 effective date 7/20/12 stated, "The services are coordinated by the designated Case Manager."</p> <p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p>			

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	<p>Based on clinical record and policy review, the agency failed to ensure the registered nurse completed supervisory visits at least every fourteen days as required by agency policy in 1 of 3 records (8) reviewed of patients that received home health aide and skilled services creating the potential to affect all patients receiving home health aide services.</p> <p>The findings include</p> <ol style="list-style-type: none"> <li>1. Clinical record # 8, start of care 11/26/12, evidenced home health aide services were provided daily for 6 hours, seven days a week, during the certification period 11/21/13 through 1/19/14 and until 1/23/14. The record evidenced a licensed practical nurse conducted the skilled nurse visits weekly through out the certification period. The record evidenced supervisory visits were conducted by a registered nurse on 11/25/13, 12/13/13, 12/28/13, and 1/13/14.</li> <li>2. The agency policy titled "Supervision of Staff" number 4.59 stated, "Home Health Aide: ... When clients are receiving skilled care in addition to personal care the registered nurse will make a supervisory visit to the clients residence at least every two weeks."</li> </ol>	N000606	<p>TO CORRECT THIS DEFICIENCY WE ARE IMPLEMENTING A NEW COMPUTER PROGRAM FOR SCHEDULING ALL VISITS INCLUDING SUPERVISORY VISITS, HHA VISITS ALL NURSING VISITS. THIS WILL ENSURE THAT SUPERVISORY VISITS WILL BE TRACKED AND COMPLETED WITHIN COMPLIANCE OF FEDERAL AND STATE REGULATIONS. THE DON WILL ENSURE THAT THIS CORRECTION IS UPHELD. THE DON WILL ENSURE THAT THE RN'S ARE TRAINED TO COMPLETE SUPERVISORY VISITS WITHIN FEDERAL AND STATE COMPLIANCE AND WILL CONDUCT AN AUDIT OF 10% OF ALL PATIENT RECORDS INCLUDING SUPERVISORY VISITS EACH MONTH TO CONFIRM COMPLIANCE.</p>	02/17/2014			

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