STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157581	A. BUILDING 00 B. WING	01/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED HOME HEALTHCARE INC	1947 HARDER CT STE B SCHERERVILLE, IN 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000		G0000		

This visit was for a home health federal recertification survey. This was a partial extended survey.

Survey date: January 9 - 12, 2012

Facility #: 011121

Medicaid vendor #: 200839240

Surveyor: Ingrid Miller, PHNS, RN

Skilled unduplicated census: 153

Quality Review: Joyce Elder, MSN, BSN, RN

January 17, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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G0121	The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on personnel file review, interview, and policy review, the agency failed to ensure that 1 of 1 administrator had an annual evaluation as required by agency policy. (file A) Findings 1. Personnel file A, date of hire 6/12/06, failed to evidence an annual performance evaluation. 2. On 1/12/12 at 3 PM, the administrator indicated the annual evaluation had not been completed per agency policy. 3. The agency policy titled "Performance Evaluation" with no effective date states, "A competency-based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."	G0121	Performance evaluation was immediately done on employee of personnel file A by member of the board of directors January 13, 2012. See Attachment A. Administrator in-serviced human resources in updating employee files and keeping employee records current. 100% of employee files will be audited yearly for evidence that a performance evaluation is completed. Administrator is responsible for monitoring compliance in the conduction of annual performance evaluations and ensure that this deficiency is corrected and will not recur.	01/13/2012

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G0158	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and policy review, and interview, the agency failed to ensure skilled nurse services were provided as ordered on the plan of care for 3 of 12 records (Clinical record #2, 3, and 11) with the potential to effect all of the patients of the agency. Findings 1. Clinical record #2, start of care (SOC) 12/20/11, included a plan of care with a certification period of 12/20/11 - 2/17/12. Care failed to follow the written plan of care (POC) as evidenced by the following: a. The clinical record document titled "Skilled Nursing Assessment" signed by Employee D, a registered nurse (RN), on 1/4/12, stated under vital signs, "BP [Blood Pressure] sitting 172/82." On page 2 of this skilled nursing assessment under cardiovascular -- SN [Skilled Nurse] instructed pt/cg [patient/caregiver] on: BP rechecked: 156/80. b. The POC states, "SN to inform the physician if the SBP [systolic blood pressure] is greater than 160 mmHg [millimeters of mercury]."	G0158	The administrator will in-service nursing staff that all provided services follows a written order signed by a physician. Reinforcement will be given to the staff that all skilled nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Administrator informed staff that any changes in the POC need to be reviewed and signed by the physician. Complete date 2/6/12. Clinical record #2, administrator discussed with employee D regarding visit on 1/4/12 about the BP over the ordered parameter as written in the POC. Employee D reports that they did inform the physician but failed to document communication. Narrative addendum for that visit was added to clinical record. See Attachment B. Clinical record #3, administrator reviewed with Employee I the importance of measuring wounds and accurately documenting the assessment of length, width, and depth. Clinical record #11, administrator provided education to nursing staff regarding all skilled nursing services must follow the written POC as ordered by the physician. Administrator also reviewed policy and procedures with Employee H and	02/06/2012

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	c. On 1/11/12 at 3:20 PM, the administrator indicated the systolic blood pressure reading was over the parameter of 160 mmHg and was to be called in to the physician as ordered on the POC. 2. Clinical record #3, SOC 10/14/11, included a plan of care for certification periods of 10/14/11 - 12/12/11 and 12/14/11 - 2/10/12. The recertification assessment completed by Employee I, Registered Nurse, on 12/8/11 identified the patient had 2 wounds. The area on the left buttocks indicated two pressure wounds at sites A and B. The wound description lacked measurements of the length, width and depth of these wounds. a. The plan of care dated and signed by Employees A and C, Registered Nurses on 10/14/11 for the certification period of 10/14/11 - 12/12/11 stated the following: "Orders for Discipline and Treatments (Specify amount/frequency/duration): Skilled nursing is to assess pt.'s [patient's] physical and mental status ..." b. On 1/11/12 at 3:40 PM, the administrator indicated skilled nursing did not assess the patient's physical status by measuring the wounds as indicated on the POC.		staff that any changes in the POC must be reviewed and signed by the physician prior to carrying out any nursing interventions. In addition, emphasized that all medications need to be included in the POC and all wound care should correspond with a physician order or POC. 10% of clinical records will be audited quarterly to ensure services provided follows physician written order and the established POC. Administrator and Director of Nursing will be responsible for educating the staff regarding the patient POC and be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	3. Clinical record #11, SOC 9/20/11, included a plan of care for the certification period of 9/30/11 - 11/28/11, failed to evidence an accurate POC as evidenced by the following documents and interview: The POC failed to evidence an order for wound care or medicated powder. This POC was signed on 9/30/11 and dated by Employees C and H, RNs. a. The initial and assessment document titled "Outcome and Assessment Information Set (Oasis-C) Start of Care Version" with a date of 9/30/11 and signed by Employee H stated, "Integumentary Status: Surgical Wounds at post pacemaker implementation. This wound was described to be in the trunk area, a surgical wound, length 5 cm, no odor after cleansing, attached edges, normal surrounding tissue, dressing type duoderm, and new evaluation." At the end of the assessment, a narrative stated, "Teaching regarding ... limitations to left shoulder and wound care dressings." b. A clinical document dated 10/4/11 titled "Skilled Nursing Assessment - Notes" was signed by patient #11 and Employee H, RN, under patient caregiver comments, stated, "Wound care done." Under the wound section of this assessment, the nurse stated, "Site left			

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	chest, Cleansed with normal saline, covered with non-adherent dressing, and secured with tape." D. A clinical document titled "Resumption of Care following Inpatient Stay" dated 10/13/11 and signed by Employee H stated, "Teachings regarding medication with small excoriated area under right breast note of apply medicated powder after bathing." D. On 1/11/11 at 3:50 PM, the administrator indicated no wound care or application of medicated powder were included on the POC. 4. The agency policy titled Patient Plan of Care with no effective date stated, "The plan of care should be developed, implemented, and revised in coordination with the patient, the physician, and the interdisciplinary team members involved in the patient's care, in accordance with accepted standards of practice."			

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G0159	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 current medications and treatments were listed on the plan of care for 2 of 12 clinical records reviewed (Clinical record #1 and #11) with the potential to effect all the patients of the agency. Findings include 1. Clinical record #1, start of care (SOC) 6/13/11 and certification period 12/10/11 - 2/7/12, failed to evidence an accurate plan of care (POC) as noted by the following documents and interview: A. A physician's order signed by Employee C, Registered Nurse (RN) and dated 12/7/11 stated, "Order: PLS [please] confirm: recertification dates from 12/10/11 - 2/7/12. Continue SN [skilled nurse] and HHA [Home health aide] visit diet medication and treatment ... New meds [medications]: Colchicine 0.6 mg	G0159	The administrator will in-service nursing staff that all provided services follows the written medical POC. Reinforcement will be given to the staff that all skilled nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Administrator informed staff that any new orders, especially all patient medications, need to be updated in the written POC and signed by the physician. Complete date 2/6/12. Clinical record #1, on 1/13/12 an addendum order for correction on the POC was written to include the new medications on the plan of care as ordered. See attachment C. Clinical record #11, administrator provided education to nursing staff regarding all skilled nursing services must follow the written POC as ordered by the physician. Administrator also reviewed policy and procedures with Employee H and staff that any changes in the POC must be reviewed and signed by the	02/06/2012

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	[milligram] tab [tablet] every 2 hrs [hours] po [by mouth] prn [as needed] for pain, hydrocodone/apap [acetaminophen] 100/650 mg tab every 6 hrs po prn for pain." B. A clinical record document titled "Home Health Certification and Plan of Treatment with a certification period of 12/10/11 - 2/7/12 and signed by Employees C and E, RNs, on 12/10/11, failed to evidence colchicine or hydrocodone/apap. C. On 1/11/12 at 3:15 PM the administrator indicated the colchicine and hydrocodone/APAP were not included on the plan of care. 2. Clinical record #11, SOC 9/20/11 with a certification period of 9/30/11 - 11/28/11, failed to evidence an accurate POC as evidenced by the following documents and interview: A. The POC with a certification period of 9/30/11 - 11/28/11 failed to evidence an order for medicated powder. This POC was signed on 9/30/11 and dated by Employees C and H, RNs. B. On 1/11/11 at 3:50 PM, the administrator indicated no medicated powder was included on the POC.		physician prior to carrying out any nursing interventions. In addition,emphasized that all medications need to be included in the POC. 10% of all clinical records will be audited quarterly for evidence that the medical plan of care include all pertinent patient information especially all current medications. Administrator and Director of nursing is responsible for monitoring and educating the staff in updating the POC and maintaining adherence to policies regarding the patient POC to ensure this deficiency is corrected and will nor reoccur.	

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	3. The agency document titled "Job Description: Skilled Nurse" with no effective or revision date stated, "Duties and Responsibilities ... Makes home visits, performs physical assessments, evaluates patient's needs and consults with physicians if necessary to develop plan of care and documents appropriately and in a timely manner."			

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G0170	The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and policy review, and interview, the agency failed to ensure skilled services were provided as ordered on the plan of care for 3 of 12 records (Clinical record #2, 3, and 11) with the potential to effect all of the patients of the agency. Findings 1. Clinical record #2, start of care (SOC) 12/20/11, included a plan of care with a certification period of 12/20/11 - 2/17/12. Care failed to follow the written plan of care (POC) as evidenced by the following: a. The clinical record document titled "Skilled Nursing Assessment" signed by Employee D, a registered nurse (RN), on 1/4/12, stated under vital signs, "BP [Blood Pressure] sitting 172/82." On page 2 of this skilled nursing assessment under cardiovascular -- SN [Skilled Nurse] instructed pt/cg [patient/caregiver] on: BP rechecked: 156/80. b. The POC states, "SN to inform the physician if the SBP [systolic blood pressure] is greater than 160 mmHg [millimeters of mercury]."	G0170	The administrator will in-service nursing staff that all provided services follows a written order signed by a physician. Reinforcement will be given to the staff that all skilled nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Administrator informed staff that any changes in the POC need to be reviewed and signed by the physician. Complete date 2/6/12. Clinical record #2, administrator discussed with employee D regarding visit on 1/4/12 about the BP over the ordered parameter as written in the POC. Employee D reports that they did inform the physician but failed to document communication. Narrative addendum for that visit was added to clinical record. See Attachment B. Clinical record #3, administrator reviewed with Employee I the importance of measuring wounds and accurately documenting the assessment of length, width, and depth. Clinical record #11, administrator provided education to nursing staff regarding all skilled nursing services must follow the written POC as ordered by the physician. Administrator also reviewed policy and procedures with Employee H and staff that any changes in the POC	02/06/2012

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	c. On 1/11/12 at 3:20 PM, the administrator indicated the systolic blood pressure reading was over the parameter of 160 mmHg and was to be called in to the physician as ordered on the POC. 2. Clinical record #3, SOC 10/14/11, included a plan of care for certification periods of 10/14/11 - 12/12/11 and 12/14/11 - 2/10/12. The recertification assessment completed by Employee I, Registered Nurse, on 12/8/11 identified the patient had 2 wounds. The area on the left buttocks indicated two pressure wounds at sites A and B. The wound description lacked measurements of the length, width and depth of these wounds. a. The plan of care dated and signed by Employees A and C, Registered Nurses on 10/14/11 for the certification period of 10/14/11 - 12/12/11 stated the following: "Orders for Discipline and Treatments (Specify amount/frequency/duration): Skilled nursing is to assess pt.'s [patient's] physical and mental status ..." b. On 1/11/12 at 3:40 PM, the administrator indicated skilled nursing did not assess the patient's physical status by measuring the wounds as indicated on the POC. 3. Clinical record #11, SOC 9/20/11,		must be reviewed and signed by the physician prior to carrying out any nursing interventions. In addition, emphasized that all medications need to be included in the POC and all wound care should correspond with a physician order or POC. 10% of clinical records will be audited quarterly to ensure services provided follows physician written order and the established POC. Administrator and Director of Nursing will be responsible for educating the staff regarding the patient POC and monitor compliance to policy and procedures to ensure this deficiency is corrected and will not reoccur.	

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	included a plan of care for the certification period of 9/30/11 - 11/28/11, failed to evidence an accurate POC as evidenced by the following documents and interview: The POC failed to evidence an order for wound care or medicated powder. This POC was signed on 9/30/11 and dated by Employees C and H, RNs. a. The initial and assessment document titled "Outcome and Assessment Information Set (Oasis-C) Start of Care Version" with a date of 9/30/11 and signed by Employee H stated, "Integumentary Status: Surgical Wounds at post pacemaker implementation. This wound was described to be in the trunk area, a surgical wound, length 5 cm, no odor after cleansing, attached edges, normal surrounding tissue, dressing type duoderm, and new evaluation." At the end of the assessment, a narrative stated, "Teaching regarding ... limitations to left shoulder and wound care dressings." b. A clinical document dated 10/4/11 titled "Skilled Nursing Assessment - Notes" was signed by patient #11 and Employee H, RN, under patient caregiver comments, stated, "Wound care done." Under the wound section of this assessment, the nurse stated, "Site left chest, Cleansed with normal saline,			

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	covered with non-adherent dressing, and secured with tape." D. A clinical document titled "Resumption of Care following Inpatient Stay" dated 10/13/11 and signed by Employee H stated, "Teachings regarding medication with small excoriated area under right breast note of apply medicated powder after bathing." D. On 1/11/11 at 3:50 PM, the administrator indicated no wound care or application of medicated powder were included on the POC. 4. The agency policy titled Patient Plan of Care with no effective date stated, "The plan of care should be developed, implemented, and revised in coordination with the patient, the physician, and the interdisciplinary team members involved in the patient's care, in accordance with accepted standards of practice."			

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G0229	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 review and policy review and interview, the agency failed to ensure the registered nurse made on-site visits to the patient's home no less frequently than every 2 weeks for 3 of 8 clinical records reviewed of patients with skilled and home health aide services. (Clinical records #1, #2, and #11). Findings 1. Clinical record #1 included a plan of care (POC) for the certification period 10/11/11 - 12/9/11 with orders for home health aide services two times a week for 8 weeks and 1 times a week for 1 week. The record failed to evidence any supervisory visits from 10/11/11 - 12/9/11 despite aide visits which occurred as ordered on the POC. 2. Clinical record #2 included a POC for the certification period 12/20/11 - 2/17/12 with orders for home health aide services three times a week for two weeks and two times a week for seven weeks. The record failed to evidence any supervisory visits from 12/20/11 through 1/12/12 despite aide visits which occurred as ordered on the POC.	G0229	The alternate administrator in-serviced all skilled nurses and home health aides that a supervisory visit must be done every 2 weeks and an on-site visit with the HHA be done every 30 days. Home health aide supervision policy was reinforced. The field nursing supervisor will monitor frequency of HHA visits for accuracy and completeness. 10% of clinical records will be audited quarterly to ensure home health aide supervision visits were performed according to policy. Administrator will be responsible for monitoring compliance to ensure this deficiency is corrected and will not reoccur.	01/27/2012

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	3. Clinical record #11 included a POC for the certification period 9/30/11 - 11/28/11 with orders for home health aide services two times a week times 8 weeks. The record failed to evidence any supervisory visits made during this time despite aide visits which occurred as ordered on the POC. 4. On 1/11/12 at 3:15 PM, the administrator indicated no supervisory visits were evidenced in these clinical records. 5. The agency policy titled "Home Health Aide Supervision" with no effective date stated, "Supervisor visits are made to clients by registered nurses and the nurse supervisor to assure that home health aide services are being provided in accordance with the plan of care and Agency policy ... The registered nurse makes a home health aide supervisory visit to the patient at least every two weeks, either when the aide is present to observe and assist, or when the aide absent, to assess the relationship and determine whether goals are being met."			

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G0236	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. Based on clinical record and policy review and interview, the agency failed to ensure clinical records were maintained per agency policy for 1 of 12 records reviewed (Clinical record #8). Findings 1. Clinical record #8, start of care 9/26/11, evidenced documents with dates altered on the following clinical documents: a. The clinical document titled "HCFA [Health Care Financing Administration] Medical Information Release Authorization" signed by the patient with a date of 9/26/11 and signed by Employee F with a date of 9/26/11. Both dates had been altered with the "6" written over another number. The other number written below this superimposed number could no longer be read.	G0236	The alternate administrator in-serviced all staff regarding documenting corrections in the clinical records. Clinical data collection policy was reinforced. 10% of clinical records will be audited quarterly to ensure clinical records with errors are corrected per policy. Administrator will be responsible for monitoring compliance to ensure this deficiency is corrected and will not reoccur.	01/27/2012

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	b. The clinical document titled "Admission Checklist" with patient #8's name and dated of 9/26/11. This date had been altered with the "6" written over with another number now illegible. The document also evidenced referral form date completed: 9/26/11 and date received 9/26/11, Physician telephone and other verbal orders date completed: 9/26/11 and date received 9/26/11, patient's rights and responsibilities date completed 9/26/11, advance directives date completed 9/26/11, initial discharge plan date completed 9/26/11. Each "6" had been written over with another number now illegible. c. The clinical document titled "Medicare Questionnaire" with the patient #8's signature with written date of 9/26/11 and Employee F's signature with the written date of 9/26/11. Each "6" in the written dates by the signature of the patient and the signature of the employee had been written over another number now illegible. d. The clinical document titled "Patient Rights and Responsibilities" with the patient #8's name and date of 9/26/11 at the beginning of the listed patient rights and responsibilities. The rights follow. At the end of the document, the patient			

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	signature and the date of 9/26/11 and Employee F's signature with date of 9/26/11. Each "6" in the written dates by the signature of the patient and the signature of the employee had been written over with another number now illegible. e. The clinical document titled "Drug Regimen Review" with the patient name and a list of all the patient's medications with the start date of 9/26/11. The "6" in this date has been written over with another number now illegible. Employee F's signature is written in the signature box. f. The clinical document titled "Start of Care version" with the start of care date of 9/26/11 and date assessment completed of 9/28/11. The "6" and "8" have been written over with other numbers now illegible. This document ends with the signature of the patient on 9/28/11 and Employee F's signature also signed on 9/28/11. Each "6" in the written dates by the signature of the patient and the signature of the employee had been written over with another number now illegible. 2. On 1/12/12 at 1:15 PM, the administrator indicated the numbers had been altered and not corrected per agency			

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	policy. 3. The agency policy titled "Clinical/service data collection" with a policy number of C:2-033.1 with a revision date of May 2010 stated, "Errors in documentation will be corrected as follows: Draw a line through the entry, date and initial. Do not erase, use correction fluid or deface a document."			

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G0334	The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on clinical record and policy review and interview, the agency failed to ensure the wound assessment completed by the registered nurse as part of the comprehensive assessment was complete for 1 of 12 records reviewed (clinical record #3). Findings include 1. Clinical record #3, start of care 10/14/11, evidenced a recertification assessment completed by Employee I, Registered Nurse, on 12/8/11 with a wound assessment. The area on the left buttocks indicated two pressure wounds at sites A and B. The wound description lacked measurements of the length, width and depth. 2. On 1/11/12 at 3:40 PM , the administrator indicated that the wound assessment on the comprehensive assessment was not complete. 3. The agency policy titled "Initial and Comprehensive Assessment" stated, "Purpose: To provide guidelines for the initial assessment of patients admitted to service and for completing the plan of	G0334	The administrator in-services nursing staff regarding completion of the comprehensive assessment per policy. Reinforcement will be given to the nurses that all pertinent physical findings must be documented in their assessment. Clinical record #3, administrator reviewed with Employee I the importance of measuring wounds and accurately documenting the assessment of length, width, and depth. 10% of all clinical records will be audited quarterly for evidence that the comprehensive assessment documentation is complete and that all pertinent physical findings are reported in a timely manner. Administrator and director of nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will no recur.	02/06/2012

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	care. Policy An initial patient assessment will be performed and documented in the patient's clinical record by a registered nurse ... A comprehensive patient assessment will be completed within 5 calendar days of the patient's start of care. The assessment will be patient- specific and comprehensive to include the patient's need for home care, rehabilitative care, social, and discharge planning needs. The assessment will also include the exact use of the current versions of the Outcomes and Assessment information set (Oasis) ... the comprehensive assessment for each patient much be completed in its entirety by a single clinician. During the initial and comprehensive patient assessment, all baseline data to be used in measuring the patient's progress towards goals and other relevant information will be documented in the patient's clinical records ... A physical assessment, including blood pressure, temperature, height/weight, nutritional status and other relevant data related to pertinent physical findings."			

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G0337	The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record review, policy review, and interview, the agency failed to ensure current medications were accurately listed according to professional standards on the medication profile for 2 of 12 clinical records reviewed (Clinical record #1 and # 11). Findings 1. Clinical record #1, start of care (SOC) 6/13/11 and certification period 12/10/11 - 2/7/12, failed to evidence an updated medication profile as noted by the following documents and interview: A. A physician's order signed by Employee C, Registered Nurse (RN) and dated 12/7/11 stated, "Order: PLS [please] confirm: recertification dates from 12/10/11 - 2/7/12. Continue SN [skilled nurse] and HHA [Home health aide] visit diet medication and treatment ... New meds [medications]: Colchicine 0.6 mg [milligram] tab [tablet] every 2 hrs [hours] po [by mouth] prn [as needed] for	G0337	The administrator in-services nursing staff on maintaining the drug regimen review and the policy of updating the medications. Reinforcement will be given to the staff regarding the policy of reviewing all patient medications. Clinical record #1, on 1/13/12 an addendum order for correction on the POC was written to include the new medications on the plan of care as ordered. See attachment C. Clinical record #11, administrator provided education to nursing staff regarding all skilled nursing services must follow the written POC as ordered by the physician. It was also emphasized that all medications need to be included in the POC. 10% of all clinical records will be audited quarterly for evidence that the comprehensive assessment includes a review of all medications the patient is currently taking and that the drug regimen review is is kept up to date. Administrator and Director of nursing are responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	02/06/2012

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	pain, hydrocodone/apap [acetaminophen] 100/650 mg tab every 6 hrs po prn for pain." B. A clinical record document titled "Drug Regimen Review" with review dates of 6/13/11, 8/10/11, 10/16/11 and 12/7/11 and signed by Employee C RN failed to list Colchicine or hydrocodone/apap. C. On 1/11/12 at 3:15 PM, the administrator indicated the colchicine and hydrocodone/APAP were not included on the medication profile. 2. Clinical record #11, SOC 9/20/11 with a certification period of 9/30/11 - 11/28/11, failed to evidence an updated medication profile initiated by the RN as evidenced by the following documents and interview: A. The plan of care with a certification period of 9/30/11 - 11/28/11 failed to evidence an order for medicated powder. This POC was signed on 9/30/11 and dated by Employee C and H, both RNs. B. A clinical document titled "Resumption of Care following Inpatient Stay" dated 10/13/11 and signed by Employee H stated, "Teachings regarding			

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	medication with small excoriated area under right breast note apply medicated powder after bathing." C. On 1/11/11 at 3:50 PM, the administrator indicated the application of medicated powder was not included on the medication profile. 3. The agency policy titled "Medication Profile" with a policy number HH:2-028.1 and a revision date of May 2010 stated, "A drug regimen review will be performed at the time of admission, when updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of a new medication."			

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N0446	Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on personnel file review, interview, and policy review, the agency failed to ensure that 1 of 1 administrator had an annual evaluation as required by agency policy. (file A) Findings 1. Personnel file A, date of hire 6/12/06, failed to evidence an annual performance evaluation. 2. On 1/12/12 at 3 PM, the administrator indicated the annual evaluation had not been completed per agency policy. 3. The agency policy titled "Performance Evaluation" with no effective date states, "A competency-based performance evaluation will be conducted for all employees after 1 year of employment and at least annually thereafter."	N0446	Performance evaluation was immediately done on employee of personnel file A by member of the board of directors January 13, 2012. See Attachment A. Administrator in-serviced human resources in updating employee files and keeping employee records current. 100% of employee files will be audited yearly for evidence that a performance evaluation is completed. Administrator is responsible for monitoring compliance in the conduction of annual performance evaluations and ensure that this deficiency is corrected and will not recur.	01/13/2012

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N0456	Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on document review and interview, the administrator failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency with the potential to affect all the agency's patients. Findings include 1. On 1/12/12 at 1:45 PM, the administrator and alternate administrator indicated the quality assurance program failed to evidence a quality assurance program that objectively and systematically monitored and evaluated the quality and appropriateness of patient care and identified problem resolution and patient care improvement. 2. The agency document titled "Clinical record review Target Outcome: Improvement in Ambulation/Locomotion" with a signature from Employee C Registered Nurse (RN) and no date states,	N0456	Quality assurance program was reviewed and discussed with the Performance Improvement Committee January 13, 2012. The program was restructured to reflect the immediate needs of the agency and begin clinical record reviews on a quarterly basis. It was further established that educational in-services to the staff be done on those identified deficiencies, and follow-up of those deficiencies be randomly reviewed in the clinical records. Documentation of progress will be measured objectively and quantitatively to demonstrate compliance or resolution. Director of Nursing and Performance Improvement Coordinator is responsible for monitoring compliance to policy and procedures regarding the quality assurance program and will educate responsible staff the importance of maintaining program. Board of directors will review this bi-yearly for evidences of an established quality assurance program. First clinical record review will be done by February 1, 2012 and deficiencies will be identified the same day. In-service topic for February	01/13/2012

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	"Best Practice Care Behaviors" with clinical record numbers for 5 records. 13 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 3. The agency document titled "Clinical record review Target Outcome: Improvement in Transferring' with a signature from Employee C RN and no date states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 13 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 4. The agency document titled "Clinical record review Target Outcome: Improvement with pain during activity" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 14 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 5. The agency document titled "Clinical record review Target Outcome:		month will be related to problems identified from clinical record review. Six month time frame will be allowed for improvement and by August 1,2012 a follow-up audit of the charts will be done for evaluation.	

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	Improvement in Urinary incontinence/Bladder control" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 11 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 6. The agency document titled "Clinical record review Target Outcome: Improvement in Bathing" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 13 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 7. The agency document titled "Clinical record review Target Outcome: Improvement in Management of Oral Meds" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 17 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found.			

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	8. The agency document titled "Clinical record review Target Outcome: Improvement in Dyspnea" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 12 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED HOME HEALTHCARE INC	1947 HARDER CT STE B SCHERERVILLE, IN 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0458	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. Based on personnel file review, interview, and policy review, the agency failed to ensure that 1 of 1 administrator had an annual evaluation as required by agency policy. (file A) Findings 1. Personnel file A, date of hire 6/12/06, failed to evidence an annual performance evaluation. 2. On 1/12/12 at 3 PM, the administrator indicated the annual evaluation had not been completed per agency policy. 3. The agency policy titled "Performance Evaluation" with no effective date states, "A competency-based performance evaluation will be conducted for all	N0458	Performance evaluation was immediately done on employee of personnel file A by member of the board of directors January 13, 2012. See Attachment A. Administrator in-serviced human resources in updating employee files and keeping employee records current. 100% of employee files will be audited yearly for evidence that a performance evaluation is completed. Administrator is responsible for monitoring compliance in the conduction of annual performance evaluations and ensure that this deficiency is corrected and will not recur.	01/13/2012

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	employees after 1 year of employment and at least annually thereafter."			

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N0472	Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on document review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems and improve patient care for 1 of 1 agency. Findings include 1. On 1/12/12 at 1:45 PM, the administrator and alternate administrator indicated the quality assurance program failed to evidence a quality assurance program that objectively and systematically monitored and evaluated the quality and appropriateness of patient care and identified problem resolution and patient care improvement. 2. The agency document titled "Clinical record review Target Outcome: Improvement in Ambulation/Locomotion"	N0472	Quality assurance program was reviewed and discussed with the Performance Improvement Committee January 13, 2012. The program was restructured to reflect the immediate needs of the agency and begin clinical record reviews on a quarterly basis. It was further established that educational in-services to the staff be done on those identified deficiencies, and follow-up of those deficiencies be randomly reviewed in the clinical records. Documentation of progress will be measured objectively and quantitatively to demonstrate compliance or resolution. Director of Nursing and Performance Improvement Coordinator is responsible for monitoring compliance to policy and procedures regarding the quality assurance program and will educate responsible staff the importance of maintaining program. Board of directors will review this bi-yearly for evidences	01/13/2012

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	with a signature from Employee C Registered Nurse (RN) and no date states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 13 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 3. The agency document titled "Clinical record review Target Outcome: Improvement in Transferring' with a signature from Employee C RN and no date states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 13 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 4. The agency document titled "Clinical record review Target Outcome: Improvement with pain during activity" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 14 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found.		of an established quality assurance program. First clinical record review will be done by February 1, 2012 and deficiencies will be identified the same day. In-service topic for February month will be related to problems identified from clinical record review. Six month time frame will be allowed for improvement and by August 1,2012 a follow-up audit of the charts will be done for evaluation.	

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	5. The agency document titled "Clinical record review Target Outcome: Improvement in Urinary incontinence/Bladder control" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 11 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 6. The agency document titled "Clinical record review Target Outcome: Improvement in Bathing" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 13 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found. 7. The agency document titled "Clinical record review Target Outcome: Improvement in Management of Oral Meds" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 17 best practice care behaviors were selected and checked off in each of the 5 records audited. No			

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	deficient practices were noted on this audit and no follow-up was found. 8. The agency document titled "Clinical record review Target Outcome: Improvement in Dyspnea" with a signature from Employee C and no date noted states, "Best Practice Care Behaviors" with clinical record numbers for 5 records. 12 best practice care behaviors were selected and checked off in each of the 5 records audited. No deficient practices were noted on this audit and no follow-up was found.			

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N0522	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 skilled nurse services were provided as ordered on the plan of care for 3 of 12 records (Clinical record #2, 3, and 11) with the potential to effect all of the patients of the agency. Findings 1. Clinical record #2, start of care (SOC) 12/20/11, included a plan of care with a certification period of 12/20/11 - 2/17/12. Care failed to follow the written plan of care (POC) as evidenced by the following: a. The clinical record document titled "Skilled Nursing Assessment" signed by Employee D, a registered nurse (RN), on 1/4/12, stated under vital signs, "BP [Blood Pressure] sitting 172/82." On page 2 of this skilled nursing assessment under cardiovascular -- SN [Skilled Nurse] instructed pt/cg [patient/caregiver] on: BP rechecked: 156/80. b. The POC states, "SN to inform the physician if the SBP [systolic blood pressure] is greater than 160 mmHg [millimeters of mercury]."	N0522	The administrator will in-service nursing staff that all provided services follows a written order signed by a physician. Reinforcement will be given to the staff that all skilled nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Administrator will inform staff that any changes in the POC need to be reviewed and signed by the physician. Clinical record #2, administrator discussed with employee D regarding visit on 1/4/12 about the BP over the ordered parameter as written in the POC. Employee D reports that they did inform the physician but failed to document communication. Narrative addendum for that visit was added to clinical record. See Attachment B. Clinical record #3, administrator reviewed with Employee I the importance of measuring wounds and accurately documenting the assessment of length, width, and depth. Clinical record #11, administrator provided education to nursing staff regarding all skilled nursing services must follow the written POC as ordered by the physician. Administrator also reviewed policy and procedures with Employee H and	02/06/2012

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	c. On 1/11/12 at 3:20 PM, the administrator indicated the systolic blood pressure reading was over the parameter of 160 mmHg and was to be called in to the physician as ordered on the POC. 2. Clinical record #3, SOC 10/14/11, included a plan of care for certification periods of 10/14/11 - 12/12/11 and 12/14/11 - 2/10/12. The recertification assessment completed by Employee I, Registered Nurse, on 12/8/11 identified the patient had 2 wounds. The area on the left buttocks indicated two pressure wounds at sites A and B. The wound description lacked measurements of the length, width and depth of these wounds. a. The plan of care dated and signed by Employees A and C, Registered Nurses on 10/14/11 for the certification period of 10/14/11 - 12/12/11 stated the following: "Orders for Discipline and Treatments (Specify amount/frequency/duration): Skilled nursing is to assess pt.'s [patient's] physical and mental status ..." b. On 1/11/12 at 3:40 PM, the administrator indicated skilled nursing did not assess the patient's physical status by measuring the wounds as indicated on the POC.		staff that any changes in the POC must be reviewed and signed by the physician prior to carrying out any nursing interventions. In addition, emphasized that all medications need to be included in the POC and all wound care should correspond with a physician order or POC. Administrator and Director of Nursing will be responsible for educating the staff regarding the patient POC and monitor compliance to policy and procedures. 10% of clinical records will be audited quarterly to ensure services provided follows physician written order and the established POC.	

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	3. Clinical record #11, SOC 9/20/11, included a plan of care for the certification period of 9/30/11 - 11/28/11, failed to evidence an accurate POC as evidenced by the following documents and interview: The POC failed to evidence an order for wound care or medicated powder. This POC was signed on 9/30/11 and dated by Employees C and H, RNs. a. The initial and assessment document titled "Outcome and Assessment Information Set (Oasis-C) Start of Care Version" with a date of 9/30/11 and signed by Employee H stated, "Integumentary Status: Surgical Wounds at post pacemaker implementation. This wound was described to be in the trunk area, a surgical wound, length 5 cm, no odor after cleansing, attached edges, normal surrounding tissue, dressing type duoderm, and new evaluation." At the end of the assessment, a narrative stated, "Teaching regarding ... limitations to left shoulder and wound care dressings." b. A clinical document dated 10/4/11 titled "Skilled Nursing Assessment - Notes" was signed by patient #11 and Employee H, RN, under patient caregiver comments, stated, "Wound care done." Under the wound section of this assessment, the nurse stated, "Site left			

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	chest, Cleansed with normal saline, covered with non-adherent dressing, and secured with tape." D. A clinical document titled "Resumption of Care following Inpatient Stay" dated 10/13/11 and signed by Employee H stated, "Teachings regarding medication with small excoriated area under right breast note of apply medicated powder after bathing." D. On 1/11/11 at 3:50 PM, the administrator indicated no wound care or application of medicated powder were included on the POC. 4. The agency policy titled Patient Plan of Care with no effective date stated, "The plan of care should be developed, implemented, and revised in coordination with the patient, the physician, and the interdisciplinary team members involved in the patient's care, in accordance with accepted standards of practice."			

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N0524	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.	N0524		
	Based on clinical record and policy review and interview, the agency failed to ensure current medications and treatments were listed on the plan of care for 2 of 12 clinical records reviewed (Clinical record #1 and #11) with the potential to effect all the patients of the agency. Findings include 1. Clinical record #1, start of care (SOC) 6/13/11 and certification period 12/10/11 - 2/7/12, failed to evidence an accurate plan of care (POC) as noted by the		The administrator will in-service nursing staff that all provided services follows the written medical POC. Reinforcement will be given to the staff that all skilled nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Administrator informed staff that any new orders, especially all patient medications, need to be updated in the written POC and signed by the physician. Clinical record #1, on 1/13/12 an addendum order for correction on the POC was written to include	02/06/2012

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	following documents and interview: A. A physician's order signed by Employee C, Registered Nurse (RN) and dated 12/7/11 stated, "Order: PLS [please] confirm: recertification dates from 12/10/11 - 2/7/12. Continue SN [skilled nurse] and HHA [Home health aide] visit diet medication and treatment ... New meds [medications]: Colchicine 0.6 mg [milligram] tab [tablet] every 2 hrs [hours] po [by mouth] prn [as needed] for pain, hydrocodone/apap [acetaminophen] 100/650 mg tab every 6 hrs po prn for pain." B. A clinical record document titled "Home Health Certification and Plan of Treatment with a certification period of 12/10/11 - 2/7/12 and signed by Employees C and E, RNs, on 12/10/11, failed to evidence colchicine or hydrocodone/apap. C. On 1/11/12 at 3:15 PM the administrator indicated the colchicine and hydrocodone/APAP were not included on the plan of care. 2. Clinical record #11, SOC 9/20/11 with a certification period of 9/30/11 - 11/28/11, failed to evidence an accurate POC as evidenced by the following documents and interview:		the new medications on the plan of care as ordered. See Attachment C. Clinical record #11, administrator provided education to nursing staff regarding all skilled nursing services must follow the written POC as ordered by the physician. Administrator also reviewed policy and procedures with Employee H and staff that any changes in the POC must be reviewed and signed by the physician prior to carrying out any nursing interventions. In addition, emphasized that all medications need to be included in the POC. 10% of all clinical records will be audited quarterly for evidence that the medical plan of care include all patient medications. Administrator and Director of nursing is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	A. The POC with a certification period of 9/30/11 - 11/28/11 failed to evidence an order for medicated powder. This POC was signed on 9/30/11 and dated by Employees C and H, RNs. B. On 1/11/11 at 3:50 PM, the administrator indicated no medicated powder was included on the POC. 3. The agency document titled "Job Description: Skilled Nurse" with no effective or revision date stated, "Duties and Responsibilities ... Makes home visits, performs physical assessments, evaluates patient's needs and consults with physicians if necessary to develop plan of care and documents appropriately and in a timely manner."			

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N0537	Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and policy review, and interview, the agency failed to ensure skilled services were provided as ordered on the plan of care for 3 of 12 records (Clinical record #2, 3, and 11) with the potential to effect all of the patients of the agency. Findings 1. Clinical record #2, start of care (SOC) 12/20/11, included a plan of care with a certification period of 12/20/11 - 2/17/12. Care failed to follow the written plan of care (POC) as evidenced by the following: a. The clinical record document titled "Skilled Nursing Assessment" signed by Employee D, a registered nurse (RN), on 1/4/12, stated under vital signs, "BP [Blood Pressure] sitting 172/82." On page 2 of this skilled nursing assessment under cardiovascular -- SN [Skilled Nurse] instructed pt/cg [patient/caregiver] on: BP rechecked: 156/80. b. The POC states, "SN to inform the physician if the SBP [systolic blood pressure] is greater than 160 mmHg [millimeters of mercury]."	N0537	The administrator will in-service nursing staff that all provided services follows a written order signed by a physician. Reinforcement will be given to the staff that all skilled nursing services should be provided in accordance to the written plan of care (POC) or written physician order. Administrator informed staff that any changes in the POC need to be reviewed and signed by the physician. Clinical record #2, administrator discussed with employee D regarding visit on 1/4/12 about the BP over the ordered parameter as written in the POC. Employee D reports that they did inform the physician but failed to document communication. Narrative addendum for that visit was added to clinical record. See Attachment B. Clinical record #3, administrator reviewed with Employee I theimportance of measuring wounds and accurately documenting the assessment oflength, width, and depth. Clinical record #11, administrator provided education to nursing staff regarding all skilled nursing services must follow the written POC as ordered by the physician. Administrator also reviewed policy and procedures with Employee H and	02/06/2012

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	c. On 1/11/12 at 3:20 PM, the administrator indicated the systolic blood pressure reading was over the parameter of 160 mmHg and was to be called in to the physician as ordered on the POC. 2. Clinical record #3, SOC 10/14/11, included a plan of care for certification periods of 10/14/11 - 12/12/11 and 12/14/11 - 2/10/12. The recertification assessment completed by Employee I, Registered Nurse, on 12/8/11 identified the patient had 2 wounds. The area on the left buttocks indicated two pressure wounds at sites A and B. The wound description lacked measurements of the length, width and depth of these wounds. a. The plan of care dated and signed by Employees A and C, Registered Nurses on 10/14/11 for the certification period of 10/14/11 - 12/12/11 stated the following: "Orders for Discipline and Treatments (Specify amount/frequency/duration): Skilled nursing is to assess pt.'s [patient's] physical and mental status ..." b. On 1/11/12 at 3:40 PM, the administrator indicated skilled nursing did not assess the patient's physical status by measuring the wounds as indicated on the POC.		staff that any changes in the POC must be reviewed and signed by the physician prior to carrying out any nursing interventions. In addition, emphasized that all medications need to be included in the POC and all wound care should correspond with a physician order or POC. Administrator and Director of Nursing will be responsible for educating the staff regarding the patient POC and monitor compliance to policy and procedures. 10% of clinical records will be audited quarterly to ensure services provided follows physician written order and the established POC.	

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	157581	A. BUILDING 00 B. WING	01/12/2012

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	3. Clinical record #11, SOC 9/20/11, included a plan of care for the certification period of 9/30/11 - 11/28/11, failed to evidence an accurate POC as evidenced by the following documents and interview: The POC failed to evidence an order for wound care or medicated powder. This POC was signed on 9/30/11 and dated by Employees C and H, RNs. a. The initial and assessment document titled "Outcome and Assessment Information Set (Oasis-C) Start of Care Version" with a date of 9/30/11 and signed by Employee H stated, "Integumentary Status: Surgical Wounds at post pacemaker implementation. This wound was described to be in the trunk area, a surgical wound, length 5 cm, no odor after cleansing, attached edges, normal surrounding tissue, dressing type duoderm, and new evaluation." At the end of the assessment, a narrative stated, "Teaching regarding ... limitations to left shoulder and wound care dressings." b. A clinical document dated 10/4/11 titled "Skilled Nursing Assessment - Notes" was signed by patient #11 and Employee H, RN, under patient caregiver comments, stated, "Wound care done." Under the wound section of this assessment, the nurse stated, "Site left			

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	chest, Cleansed with normal saline, covered with non-adherent dressing, and secured with tape." D. A clinical document titled "Resumption of Care following Inpatient Stay" dated 10/13/11 and signed by Employee H stated, "Teachings regarding medication with small excoriated area under right breast note of apply medicated powder after bathing." D. On 1/11/11 at 3:50 PM, the administrator indicated no wound care or application of medicated powder were included on the POC. 4. The agency policy titled Patient Plan of Care with no effective date stated, "The plan of care should be developed, implemented, and revised in coordination with the patient, the physician, and the interdisciplinary team members involved in the patient's care, in accordance with accepted standards of practice."			

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N0606	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. Based on clinical record review and policy review and interview, the agency failed to ensure the registered nurse made on-site visits to the patient's home no less frequently than every 2 weeks for 3 of 8 clinical records reviewed of patients with skilled and home health aide services. (Clinical records #1, #2, and #11). Findings 1. Clinical record #1 included a plan of care (POC) for the certification period 10/11/11 - 12/9/11 with orders for home health aide services two times a week for 8 weeks and 1 times a week for 1 week. The record failed to evidence any supervisory visits from 10/11/11 - 12/9/11 despite aide visits which occurred as ordered on the POC. 2. Clinical record #2 included a POC for the certification period 12/20/11 - 2/17/12 with orders for home health aide services three times a week for two weeks and two times a week for seven weeks. The record failed to evidence any supervisory visits	N0606	The alternate administrator in-serviced all skilled nurses and home health aides that a supervisory visit must be done every 2 weeks and an on-site visit with the HHA be done every 30 days. Home health aide supervision policy was reinforced. The field nursing supervisor will monitor frequency of HHA visits for accuracy and completeness. 10% of clinical records will be audited quarterly to ensure home health aide supervision visits were performed according to policy. Administrator will be responsible for monitoring compliance to ensure this deficiency is corrected and will not reoccur.	01/27/2012

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	from 12/20/11 through 1/12/12 despite aide visits which occurred as ordered on the POC. 3. Clinical record #11 included a POC for the certification period 9/30/11 - 11/28/11 with orders for home health aide services two times a week times 8 weeks. The record failed to evidence any supervisory visits made during this time despite aide visits which occurred as ordered on the POC. 4. On 1/11/12 at 3:15 PM, the administrator indicated no supervisory visits were evidenced in these clinical records. 5. The agency policy titled "Home Health Aide Supervision" with no effective date stated, "Supervisor visits are made to clients by registered nurses and the nurse supervisor to assure that home health aide services are being provided in accordance with the plan of care and Agency policy ... The registered nurse makes a home health aide supervisory visit to the patient at least every two weeks, either when the aide is present to observe and assist, or when the aide absent, to assess the relationship and determine whether goals are being met."			

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N0608	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. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (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. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.	N0608		
	Based on clinical record and policy review and interview, the agency failed to ensure clinical records were maintained per agency policy for 1 of 12 records reviewed (Clinical record #8). Findings 1. Clinical record #8, start of care 9/26/11, evidenced documents with dates altered on the following clinical documents: a. The clinical document titled "HCFA [Health Care Financing Administration] Medical Information Release Authorization" signed by the patient with a date of 9/26/11 and signed by Employee		The alternate administrator in-serviced all staff regarding documenting corrections in the clinical records. Clinical data collection policy was reinforced. 10% of clinical records will be audited to ensure clinical records with errors are corrected per policy. Administrator will be responsible for monitoring compliance to ensure this deficiency will not reoccur.	01/27/2012

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	F with a date of 9/26/11. Both dates had been altered with the "6" written over another number. The other number written below this superimposed number could no longer be read. b. The clinical document titled "Admission Checklist" with patient #8's name and dated of 9/26/11. This date had been altered with the "6" written over with another number now illegible. The document also evidenced referral form date completed: 9/26/11 and date received 9/26/11, Physician telephone and other verbal orders date completed: 9/26/11 and date received 9/26/11, patient's rights and responsibilities date completed 9/26/11, advance directives date completed 9/26/11, initial discharge plan date completed 9/26/11. Each "6" had been written over with another number now illegible. c. The clinical document titled "Medicare Questionnaire" with the patient #8's signature with written date of 9/26/11 and Employee F's signature with the written date of 9/26/11. Each "6" in the written dates by the signature of the patient and the signature of the employee had been written over another number now illegible. d. The clinical document titled "Patient			

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	Rights and Responsibilities" with the patient #8's name and date of 9/26/11 at the beginning of the listed patient rights and responsibilities. The rights follow. At the end of the document, the patient signature and the date of 9/26/11 and Employee F's signature with date of 9/26/11. Each "6" in the written dates by the signature of the patient and the signature of the employee had been written over with another number now illegible. e. The clinical document titled "Drug Regimen Review" with the patient name and a list of all the patient's medications with the start date of 9/26/11. The "6" in this date has been written over with another number now illegible. Employee F's signature is written in the signature box. f. The clinical document titled "Start of Care version" with the start of care date of 9/26/11 and date assessment completed of 9/28/11. The "6" and "8" have been written over with other numbers now illegible. This document ends with the signature of the patient on 9/28/11 and Employee F's signature also signed on 9/28/11. Each "6" in the written dates by the signature of the patient and the signature of the employee had been written over with another number now			

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	illegible. 2. On 1/12/12 at 1:15 PM, the administrator indicated the numbers had been altered and not corrected per agency policy. 3. The agency policy titled "Clinical/service data collection" with a policy number of C:2-033.1 with a revision date of May 2010 stated, "Errors in documentation will be corrected as follows: Draw a line through the entry, date and initial. Do not erase, use correction fluid or deface a document."			