

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157560	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2013
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NAME OF PROVIDER OR SUPPLIER  BEST CHOICE HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 5701 ELMWOOD AVE STE N INDIANAPOLIS, IN 46203
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G000000	<p>This visit was a Home Health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: May 29-June 6, 2013 Partial Extended Survey Dates: June 4-6, 2013</p> <p>Facility Number: 004282</p> <p>Provider Number: 157560</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor - Team Leader Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 1134 Home Health Aide Only: 0 Personal Care Only: 0 Total: 1134</p> <p>Sample: RR w/HV: 7 RR w/o HV: 10 Total: 17</p> <p>Quality Review: Joyce Elder, MSN, BSN,</p>	G000000		

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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	RN  June 17, 2013			

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G000143	<p><b>484.14(g)</b> <b>COORDINATION OF PATIENT SERVICES</b> All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure coordination of care occurred with the physician for 2 of 17 clinical records reviewed with the potential to affect all patients of the agency. (#11 and #17)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Plan of Care" policy number 206 dated 10/2004 states, "9. Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care."</li> <li>The policy titled "Care Coordination" policy number 207 dated 10/2004 states, "7. If changes are recommended, the physician is contacted for new treatment or frequency orders."</li> <li>The policy titled "Staff Communication Process" policy number 232 dated 10/2004 states, "3. The Agency's home care staff notifies any</li> </ol>	G000143	The Clinical Director will in-service all professional staff on notifying the physician of any changes in patient condition, care coordination and staff communication. 10% of all clinical records will be audited quarterly for evidence of communication between staff members regarding changes in patient condition, as well as notifying the physician of any changes in patient condition. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	07/03/2013

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	<p>changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care."</p> <p>4. Clinical record #11, start of care 4/8/13, contained a Skilled Nursing (SN) Note dated 5/10/13 that identified the blood pressure was 210/105. The visit note had "See back note." The record failed to evidence the physician was notified of the increased blood pressure.</p> <p>During an interview on 6/6/13 at 4:30 PM, employee G, Alternate Administrator, indicated the chart did not contain a "back note," and there wasn't any documentation to support the physician was notified of the elevated blood pressure.</p> <p>5. Clinical record #17, start of care 12/16/12, contained a plan of care for the certification period 12/16/12 to 2/13/13 with orders for skilled nursing (SN) to instruct patient on diabetic care, diet, and blood glucose monitoring. The SN was also to assess general systems status every visit. Review of the record evidenced the following:</p> <p>A. A document titled "Face-to-Face Encounter" dated 12/6/12 states,</p>						

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	<p>"Patient needs better monitoring &amp; dietary assistance to better control DMI [Diabetes Mellitus Type I], but he is unable to perform these duties himself."</p> <p>The record failed to evidence the physician was notified of the patient's inabilities.</p> <p>B. The Nursing Comprehensive Assessment was preformed on 12/6/12. The SN documented the blood glucose was 259, and the blood pressure was 140/72. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>C. On 12/28/12, the SN Note identified the patient had a blood pressure of 174/103 and a blood glucose ranging from 250 to 300. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>D. On 12/29/12, a Physical Therapy Note evidenced the patient had a blood pressure of 170/99. The record failed to evidence the MD was notified of the elevated blood pressure.</p> <p>E. On 1/3/13, a SN Note identified the patient had a blood pressure of 178/93. The document further mentions that the</p>			

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	<p>patient hadn't started taking their blood pressure medication and was not taking the prescribed Metformin. The record failed to evidence the MD was notified of the elevated blood pressure and medication non-compliance.</p> <p>F. On 1/9/13, a SN Note contained a blood pressure of 172/83 and blood glucose of 341. The document further notes that the "patient continue[s] to threaten self," "states cannot afford meals on wheels," "patient non-compliant with meds and diet." The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose, patient threatening self, lack of money for meals on wheels, and non-compliance with medications and diet.</p> <p>G. During an interview on 6/6/13 at 1:33 PM, employee G, Alternate Administrator, indicated the MD should have been notified about abnormal vital signs, blood glucose, and patient status changes.</p>			

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure Skilled Nursing (SN) was measuring wounds on a weekly basis in 2 of 17 clinical records reviewed with the potential to affect all patients of the agency receiving wound care. (#1 and #3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Assessment/Staging of Pressure Ulcers" policy number G-150 dated 8/2002 states, "Measure wound weekly and prn [as necessary] for significant changes (include length, width, and depth)."</li> <li>Clinical record #1, start of care 12/8/12, contained a home health certification and plan of care dated 4/7/13 to 6/5/13 which states for SN to perform wound care to RLE (right lower extremity). Review of the record evidenced the following:</li> </ol>	G000158	The Clinical Director will in-service all nursing staff on measuring wounds weekly and as necessary for significant changes to include length, width and depth. 10% of all clinical records will be audited quarterly for evidence of documentation of wound measurements weekly and as necessary for significant changes, including length, width and depth. The Clinical Director will be responsible for monitoring these corrections to ensure that this deficeincy is corrected and will not recur.	07/03/2013			

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	<p>A. On 4/5/13, the "Recertification/Follow-Up Assessment" document described a RLE wound. The record failed to evidence the wound measurement under the "Wound/Lesion" section of this document.</p> <p>B. SN nursing visited the patient on 4/7/13, 4/8/13, 4/9/13, 4/10/13, 4/12/13, 4/13/13, 4/14/13, 4/15/13, 4/16/13, 4/17/13, 4/20/13, 4/22/13, 4/24/13, 4/29/13, 5/1/13, 5/4/13, 5/6/13, 5/10/13, 5/12/13, 5/14/13, 5/17/13, 5/21/13, and 5/24/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>3. Clinical record #3, start of care 3/21/13, contained a home health certification and plan of care dated 5/20/13 to 7/18/13 which states for SN to monitor foot ulcer. Review of the record evidenced the following:</p> <p>A. On 4/18/13, the "Skilled Nursing Note" contained wound measurements.</p> <p>B. On 5/17/13, the "Recertification/Follow-Up Assessment" contained wound measurements under the "Wound/Lesion" section of this document.</p>			

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	<p>C. SN visited the patient on 4/11/13, 4/25/13, 4/30/13, 5/2/13, 5/7/13, 5/9/13, 5/14/13, 5/16/13, 5/21/13, and 5/23/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>4. During an interview on 6/5/13 at 10:31 AM, employee G, Alternate Administrator, indicated the SN would need to measure the wound weekly unless the patient had a wound clinic appointment. Employee G further indicated that they were unable to locate wound measurements in any wound clinic documentation.</p>			

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G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 2 of 17 clinical records reviewed with the potential to affect all patients of the agency. (#11 and #17)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The policy titled "Plan of Care" policy number 206 dated 10/2004 states, "9. Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care."</li> <li>2. The policy titled "Care Coordination" policy number 207 dated 10/2004 states, "7. If changes are recommended, the physician is contacted for new treatment or frequency orders."</li> <li>3. The policy titled "Staff Communication Process" policy number 232 dated 10/2004 states, "3. The Agency's home care staff notifies any</li> </ol>	G000164	The Clinical Director will in-service all professional staff on notifying the physician of any changes in patient condition, care coordination and staff communication. 10% of all clinical records will be audited quarterly for evidence of communication between staff members regarding changes in patients condition, as well as documentation of notifying the physician of any changes in condition. The Clinical Director will be responsible for monitoring these corrective acts to ensure that this deficiency is corrected and will not recur.	07/03/2013

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	<p>changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care."</p> <p>4. Clinical record #11, start of care 4/8/13, contained a Skilled Nursing (SN) Note dated 5/10/13 that identified the blood pressure was 210/105. The visit note had "See back note." The record failed to evidence the physician was notified of the increased blood pressure.</p> <p>During an interview on 6/6/13 at 4:30 PM, employee G, Alternate Administrator, indicated the chart did not contain a "back note," and there wasn't any documentation to support the physician was notified of the elevated blood pressure.</p> <p>5. Clinical record #17, start of care 12/16/12, contained a plan of care for the certification period 12/16/12 to 2/13/13 with orders for skilled nursing (SN) to instruct patient on diabetic care, diet, and blood glucose monitoring. The SN was also to assess general systems status every visit. Review of the record evidenced the following:</p> <p>A. A document titled "Face-to-Face Encounter" dated 12/6/12 states,</p>			

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	<p>"Patient needs better monitoring &amp; dietary assistance to better control DMI [Diabetes Mellitus Type I], but he is unable to perform these duties himself."</p> <p>The record failed to evidence the physician was notified of the patient's inabilities.</p> <p>B. The Nursing Comprehensive Assessment was preformed on 12/6/12. The SN documented the blood glucose was 259, and the blood pressure was 140/72. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>C. On 12/28/12, the SN Note identified the patient had a blood pressure of 174/103 and a blood glucose ranging from 250 to 300. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>D. On 12/29/12, a Physical Therapy Note evidenced the patient had a blood pressure of 170/99. The record failed to evidence the MD was notified of the elevated blood pressure.</p> <p>E. On 1/3/13, a SN Note identified the patient had a blood pressure of 178/93. The document further mentions that the</p>				

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	<p>patient hadn't started taking their blood pressure medication and was not taking the prescribed Metformin. The record failed to evidence the MD was notified of the elevated blood pressure and medication non-compliance.</p> <p>F. On 1/9/13, a SN Note contained a blood pressure of 172/83 and blood glucose of 341. The document further notes that the "patient continue[s] to threaten self," "states cannot afford meals on wheels," "patient non-compliant with meds and diet." The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose, patient threatening self, lack of money for meals on wheels, and non-compliance with medications and diet.</p> <p>G. During an interview on 6/6/13 at 1:33 PM, employee G, Alternate Administrator, indicated the MD should have been notified about abnormal vital signs, blood glucose, and patient status changes.</p>				

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G000170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure Skilled Nursing (SN) was measuring wounds on a weekly basis in 2 of 17 clinical records reviewed with the potential to affect all patients of the agency receiving wound care. (#1 and #3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Assessment/Staging of Pressure Ulcers" policy number G-150 dated 8/2002 states, "Measure wound weekly and prn [as necessary] for significant changes (include length, width, and depth)."</li> <li>Clinical record #1, start of care 12/8/12, contained a home health certification and plan of care dated 4/7/13 to 6/5/13 which states for SN to perform wound care to RLE (right lower extremity). Review of the record evidenced the following: <ul style="list-style-type: none"> <li>A. On 4/5/13, the "Recertification/Follow-Up Assessment" document described a RLE wound. The</li> </ul> </li> </ol>	G000170	The Clinical Director will in-service all nursing staff on documentation of measuring wounds weekly and as necessary for significant changes to include, length, width and depth. 10% of all clinical records will be audited quarterly for evidence of documentation of wound measurements weekly and as necessary for significant changes, including length, width and depth. The Clinical Director will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.	07/03/2013	

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	<p>record failed to evidence the wound measurement under the "Wound/Lesion" section of this document.</p> <p>B. SN nursing visited the patient on 4/7/13, 4/8/13, 4/9/13, 4/10/13, 4/12/13, 4/13/13, 4/14/13, 4/15/13, 4/16/13, 4/17/13, 4/20/13, 4/22/13, 4/24/13, 4/29/13, 5/1/13, 5/4/13, 5/6/13, 5/10/13, 5/12/13, 5/14/13, 5/17/13, 5/21/13, and 5/24/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>3. Clinical record #3, start of care 3/21/13, contained a home health certification and plan of care dated 5/20/13 to 7/18/13 which states for SN to monitor foot ulcer. Review of the record evidenced the following:</p> <p>A. On 4/18/13, the "Skilled Nursing Note" contained wound measurements.</p> <p>B. On 5/17/13, the "Recertification/Follow-Up Assessment" contained wound measurements under the "Wound/Lesion" section of this document.</p> <p>C. SN visited the patient on 4/11/13, 4/25/13, 4/30/13, 5/2/13, 5/7/13,</p>			

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	<p>5/9/13, 5/14/13, 5/16/13, 5/21/13, and 5/23/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>4. During an interview on 6/5/13 at 10:31 AM, employee G, Alternate Administrator, indicated the SN would need to measure the wound weekly unless the patient had a wound clinic appointment. Employee G further indicated that they were unable to locate wound measurements in any wound clinic documentation.</p>			

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G000176	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the registered nurse coordinated services with the physician for 2 of 17 clinical records reviewed with the potential to affect all patients of the agency. (#11 and #17)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Plan of Care" policy number 206 dated 10/2004 states, "9. Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care."</li> <li>The policy titled "Care Coordination" policy number 207 dated 10/2004 states, "7. If changes are recommended, the physician is contacted for new treatment or frequency orders."</li> <li>The policy titled "Staff Communication Process" policy number 232 dated 10/2004 states, "3. The</li> </ol>	G000176	The Clinical Director will in-service all professional staff on notifying the physician of any changes in patient condition, care coordination and staff communication. 10% of all clinical records will be audited quarterly for evidence of communication between staff members regarding changes in patients condition as well as documentation notifying the physician of any changes in condition. The Clinical Director will be responsible for monitoring these correcticve actions to ensure that this deficiency is corrected and will not recur.	07/03/2013

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	<p>Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care."</p> <p>4. Clinical record #11, start of care 4/8/13, contained a Skilled Nursing (SN) Note dated 5/10/13 that identified the blood pressure was 210/105. The visit note had "See back note." The record failed to evidence the physician was notified of the increased blood pressure.</p> <p>During an interview on 6/6/13 at 4:30 PM, employee G, Alternate Administrator, indicated the chart did not contain a "back note," and there wasn't any documentation to support the physician was notified of the elevated blood pressure.</p> <p>5. Clinical record #17, start of care 12/16/12, contained a plan of care for the certification period 12/16/12 to 2/13/13 with orders for skilled nursing (SN) to instruct patient on diabetic care, diet, and blood glucose monitoring. The SN was also to assess general systems status every visit. Review of the record evidenced the following:</p> <p>A. A document titled "Face-to-Face</p>			

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	<p>Encounter" dated 12/6/12 states, "Patient needs better monitoring &amp; dietary assistance to better control DMI [Diabetes Mellitus Type I], but he is unable to perform these duties himself." The record failed to evidence the physician was notified of the patient's inabilities.</p> <p>B. The Nursing Comprehensive Assessment was preformed on 12/6/12. The SN documented the blood glucose was 259, and the blood pressure was 140/72. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>C. On 12/28/12, the SN Note identified the patient had a blood pressure of 174/103 and a blood glucose ranging from 250 to 300. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>D. On 12/29/12, a Physical Therapy Note evidenced the patient had a blood pressure of 170/99. The record failed to evidence the MD was notified of the elevated blood pressure.</p> <p>E. On 1/3/13, a SN Note identified the patient had a blood pressure of 178/93.</p>			

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	<p>The document further mentions that the patient hadn't started taking their blood pressure medication and was not taking the prescribed Metformin. The record failed to evidence the MD was notified of the elevated blood pressure and medication non-compliance.</p> <p>F. On 1/9/13, a SN Note contained a blood pressure of 172/83 and blood glucose of 341. The document further notes that the "patient continue[s] to threaten self," "states cannot afford meals on wheels," "patient non-compliant with meds and diet." The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose, patient threatening self, lack of money for meals on wheels, and non-compliance with medications and diet.</p> <p>G. During an interview on 6/6/13 at 1:33 PM, employee G, Alternate Administrator, indicated the MD should have been notified about abnormal vital signs, blood glucose, and patient status changes.</p>				

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G000225	<p><b>484.36(c)(2)</b> <b>ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE</b> The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on policy review, clinical record review, and interview, the home health agency failed to ensure the home health aide followed the written plan of care as ordered in 1 of 17 records reviewed that were receiving home health aid (HHA) services. (#2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The policy titled "Home Health Aide Plan of Care" policy number 230 dated 10/2004 states, "3. All care provide[d] to patients follows the established HHA plan of care."</li> <li>2. Clinical record #2, start of care 4/15/13, included a Home Health Aide Assignment / Care Plan as of 5/6/13 which indicated the HHA was to change bed linens. Review of the documents titled "Home Health Aide Visit Note" failed to evidence bed linens were changed on 5/6/13 and 5/16/13.</li> <li>3. During an interview on 6/6/13 at 5:27</li> </ol>	G000225	The Clinical Director will in-service all home health aides on following the written home health aide plan of care.10% of all clinical records will be audited quarterly for evidence that all care provided to patients, follows the established home health aide plan of care.The Clinical Director will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.	07/03/2013

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	PM, employee G, Alternate Administrator, indicated the HHA should been following the HHA Care Plan.			

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G000337	<p><b>484.55(c) DRUG REGIMEN REVIEW</b> The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the medication profile was updated and accurate when there were medication changes in 3 of 17 clinical records reviewed with the potential to affect all patients at this agency. (#4, #16, #17)</p> <p>Findings include:</p> <p>1. The policy titled "Medication Management" policy number 233 dated 10/2004 states,"5. All current medications are listed in the clinical record on the <i>Medication List</i> form including OTC drugs, herbal remedies, vitamins and minerals ... 6. The <i>Medication List</i> includes the following information: ... (d) Date ordered ... (h) Date discontinued ... (i) Signature of reviewer ... (j) Date of review ... 7. The <i>Medication List</i> is updated for each change to reflect current medications,</p>	G000337	The Clinical Director will in-service all nursing staff on medication management and drug regimen review.10% of all clinical records will be audited quarterly for evidence that the medication profile is updated and accurate when there are medication changes.The Clinical Director will be responsible for monitoring the corrective actions to ensure that this deficiency is corrected and will not recur.	07/03/2013	

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	<p>new and/or discontinued medications or at least every sixty (60) days."</p> <p>2. Clinical record #4 included a start of care of 4/18/13. Review of the clinical record evidenced the Medication Profile included an order for Lasix 20 mg by mouth daily and as needed on 4/25/13. On 5/13/13, the order was changed to Lasix 40 milligram (mg) by mouth daily and as needed. The record failed to evidence a RN reviewed the medications and signed off when Lasix was added on 4/25/13 or changed on 5/13/13.</p> <p>During an interview on 6/5/13 at 1:00 PM, employee G, Alternate Administrator, indicated the Medication Profile should have been reviewed and signed off by a RN on 4/25/13 and 5/13/13.</p> <p>3. Clinical record #16 included a start of care of 4/7/13. Review of the clinical record evidenced the Medication Profile did not include a "Start Date" or a "Stop Date" for all ordered medications.</p> <p>During an interview on 6/6/13 at 4:12 PM, employee G, Alternate Administrator, indicated the Medication Profile needed a "Start Date" and or a "Stop Date" for all ordered medications.</p>				

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	<p>4. Clinical record #17 included a start of care of 12/16/12. The clinical record evidenced a Skilled Nursing Note on 1/3/13 that stated "Norvasc daily" added next to "New Medications." On 1/8/13, orders for Norvasc 5 mg by mouth daily was added to the Medication Profile. The record failed to evidence an order for Norvasc on the Medication Profile for 1/3/13.</p> <p>A. A Skilled Nursing Note on 1/16/13 rates the patient's neck pain relief as a "2" and was relieved by Oxycontin 20 mg. On 1/8/13, orders for Oxycontin 40 mg by mouth every eight hours and as needed was added to the Medication Profile. The record failed to evidence an order for Oxycontin 20 mg on the Medication Profile for 1/16/13.</p> <p>B. On 1/21/13, the "Patient Update/MD Order" document contained "Updated Information" that another physician prescribed insulin "per phone conversation with pt [patient]." The record failed to evidence insulin orders on the Medication Profile.</p> <p>C. During an interview on 6/6/13 at 4:19 PM, employee G, Alternate Administrator, indicated the Medication</p>			

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	Profile needed to be updated accurately each day a new medication was ordered.			

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N000000	<p>This visit was a Home Health state relicensure survey.</p> <p>Survey Dates: May 29-June 6, 2013</p> <p>Facility Number: 004282</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor - Team Leader Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 1134 Home Health Aide Only: 0 Personal Care Only: 0 Total: 1134</p> <p>Sample: RR w/HV: 7 RR w/o HV: 10 Total: 17</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 17, 2013</p>	N000000			

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N000484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure coordination of care occurred with the physician for 2 of 17 clinical records reviewed with the potential to affect all patients of the agency. (#11 and #17)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Plan of Care" policy number 206 dated 10/2004 states, "9. Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care."</li> <li>The policy titled "Care Coordination" policy number 207 dated 10/2004 states, "7. If changes are recommended, the physician is contacted for new treatment or frequency orders."</li> <li>The policy titled "Staff</li> </ol>	N000484	The Clinical Director will in-service all professional staff on notifying the physician of any changes in patient condition, care coordination and staff communication. 10% of all clinical records will be audited quarterly for evidence of communication between staff members regarding changes in patient condition, as well as notifying the physician of any changes in patient condition. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	07/03/2013

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	<p>Communication Process" policy number 232 dated 10/2004 states, "3. The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care."</p> <p>4. Clinical record #11, start of care 4/8/13, contained a Skilled Nursing (SN) Note dated 5/10/13 that identified the blood pressure was 210/105. The visit note had "See back note." The record failed to evidence the physician was notified of the increased blood pressure.</p> <p>During an interview on 6/6/13 at 4:30 PM, employee G, Alternate Administrator, indicated the chart did not contain a "back note," and there wasn't any documentation to support the physician was notified of the elevated blood pressure.</p> <p>5. Clinical record #17, start of care 12/16/12, contained a plan of care for the certification period 12/16/12 to 2/13/13 with orders for skilled nursing (SN) to instruct patient on diabetic care, diet, and blood glucose monitoring. The SN was also to assess general systems status every visit. Review of the record evidenced the following:</p>			

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	<p>A. A document titled "Face-to-Face Encounter" dated 12/6/12 states, "Patient needs better monitoring &amp; dietary assistance to better control DMI [Diabetes Mellitus Type I], but he is unable to perform these duties himself." The record failed to evidence the physician was notified of the patient's inabilities.</p> <p>B. The Nursing Comprehensive Assessment was preformed on 12/6/12. The SN documented the blood glucose was 259, and the blood pressure was 140/72. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>C. On 12/28/12, the SN Note identified the patient had a blood pressure of 174/103 and a blood glucose ranging from 250 to 300. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>D. On 12/29/12, a Physical Therapy Note evidenced the patient had a blood pressure of 170/99. The record failed to evidence the MD was notified of the elevated blood pressure.</p>			

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	<p>E. On 1/3/13, a SN Note identified the patient had a blood pressure of 178/93. The document further mentions that the patient hadn't started taking their blood pressure medication and was not taking the prescribed Metformin. The record failed to evidence the MD was notified of the elevated blood pressure and medication non-compliance.</p> <p>F. On 1/9/13, a SN Note contained a blood pressure of 172/83 and blood glucose of 341. The document further notes that the "patient continue[s] to threaten self," "states cannot afford meals on wheels," "patient non-compliant with meds and diet." The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose, patient threatening self, lack of money for meals on wheels, and non-compliance with medications and diet.</p> <p>G. During an interview on 6/6/13 at 1:33 PM, employee G, Alternate Administrator, indicated the MD should have been notified about abnormal vital signs, blood glucose, and patient status changes.</p>						

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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:</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure Skilled Nursing (SN) was measuring wounds on a weekly basis in 2 of 17 clinical records reviewed with the potential to affect all patients of the agency receiving wound care. (#1 and #3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Assessment/Staging of Pressure Ulcers" policy number G-150 dated 8/2002 states, "Measure wound weekly and prn [as necessary] for significant changes (include length, width, and depth)."</li> <li>Clinical record #1, start of care 12/8/12, contained a home health certification and plan of care dated 4/7/13 to 6/5/13 which states for SN to perform wound care to RLE (right lower extremity). Review of the record evidenced the following:</li> </ol>	N000522	<p>The Clinical Director will in-service all nursing staff on documentation of measuring wounds weekly and as necessary for significant changes to include length, width and depth. 10% of all clinical records will be audited quarterly for evidence of documentation of wound measurement weekly and as necessary for significant changes, including length, width and depth. The Clinical Director will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.</p>	07/03/2013	

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	<p>A. On 4/5/13, the "Recertification/Follow-Up Assessment" document described a RLE wound. The record failed to evidence the wound measurement under the "Wound/Lesion" section of this document.</p> <p>B. SN nursing visited the patient on 4/7/13, 4/8/13, 4/9/13, 4/10/13, 4/12/13, 4/13/13, 4/14/13, 4/15/13, 4/16/13, 4/17/13, 4/20/13, 4/22/13, 4/24/13, 4/29/13, 5/1/13, 5/4/13, 5/6/13, 5/10/13, 5/12/13, 5/14/13, 5/17/13, 5/21/13, and 5/24/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>3. Clinical record #3, start of care 3/21/13, contained a home health certification and plan of care dated 5/20/13 to 7/18/13 which states for SN to monitor foot ulcer. Review of the record evidenced the following:</p> <p>A. On 4/18/13, the "Skilled Nursing Note" contained wound measurements.</p> <p>B. On 5/17/13, the "Recertification/Follow-Up Assessment" contained wound measurements under the "Wound/Lesion" section of this document.</p>			

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	<p>C. SN visited the patient on 4/11/13, 4/25/13, 4/30/13, 5/2/13, 5/7/13, 5/9/13, 5/14/13, 5/16/13, 5/21/13, and 5/23/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>4. During an interview on 6/5/13 at 10:31 AM, employee G, Alternate Administrator, indicated the SN would need to measure the wound weekly unless the patient had a wound clinic appointment. Employee G further indicated that they were unable to locate wound measurements in any wound clinic documentation.</p>			

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 2 of 17 clinical records reviewed with the potential to affect all patients of the agency. (#11 and #17)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The policy titled "Plan of Care" policy number 206 dated 10/2004 states, "9. Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care."</li> <li>2. The policy titled "Care Coordination" policy number 207 dated 10/2004 states, "7. If changes are recommended, the physician is contacted for new treatment or frequency orders."</li> <li>3. The policy titled "Staff Communication Process" policy number</li> </ol>	N000527	The Clinical Director will in-service all professional staff on notifying the physician of any changes in patient condition, care coordination and staff communication. 10% of all clinical records will be audited quarterly for evidence of communication between staff members regarding changes in patient condition, as well as notifying the physician of any changes in patient condition. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	07/03/2013			

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	<p>232 dated 10/2004 states, "3. The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care."</p> <p>4. Clinical record #11, start of care 4/8/13, contained a Skilled Nursing (SN) Note dated 5/10/13 that identified the blood pressure was 210/105. The visit note had "See back note." The record failed to evidence the physician was notified of the increased blood pressure.</p> <p>During an interview on 6/6/13 at 4:30 PM, employee G, Alternate Administrator, indicated the chart did not contain a "back note," and there wasn't any documentation to support the physician was notified of the elevated blood pressure.</p> <p>5. Clinical record #17, start of care 12/16/12, contained a plan of care for the certification period 12/16/12 to 2/13/13 with orders for skilled nursing (SN) to instruct patient on diabetic care, diet, and blood glucose monitoring. The SN was also to assess general systems status every visit. Review of the record evidenced the following:</p> <p>A. A document titled "Face-to-Face</p>			

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	<p>Encounter" dated 12/6/12 states, "Patient needs better monitoring &amp; dietary assistance to better control DMI [Diabetes Mellitus Type I], but he is unable to perform these duties himself." The record failed to evidence the physician was notified of the patient's inabilities.</p> <p>B. The Nursing Comprehensive Assessment was preformed on 12/6/12. The SN documented the blood glucose was 259, and the blood pressure was 140/72. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>C. On 12/28/12, the SN Note identified the patient had a blood pressure of 174/103 and a blood glucose ranging from 250 to 300. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>D. On 12/29/12, a Physical Therapy Note evidenced the patient had a blood pressure of 170/99. The record failed to evidence the MD was notified of the elevated blood pressure.</p> <p>E. On 1/3/13, a SN Note identified the patient had a blood pressure of 178/93.</p>			

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	<p>The document further mentions that the patient hadn't started taking their blood pressure medication and was not taking the prescribed Metformin. The record failed to evidence the MD was notified of the elevated blood pressure and medication non-compliance.</p> <p>F. On 1/9/13, a SN Note contained a blood pressure of 172/83 and blood glucose of 341. The document further notes that the "patient continue[s] to threaten self," "states cannot afford meals on wheels," "patient non-compliant with meds and diet." The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose, patient threatening self, lack of money for meals on wheels, and non-compliance with medications and diet.</p> <p>G. During an interview on 6/6/13 at 1:33 PM, employee G, Alternate Administrator, indicated the MD should have been notified about abnormal vital signs, blood glucose, and patient status changes.</p>			

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N000532	<p>410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 2 of 17 clinical records reviewed with the potential to affect all patients of the agency. (#11 and #17)</p> <p>Findings include:</p> <p>1. The policy titled "Plan of Care" policy number 206 dated 10/2004 states, "9. Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care."</p> <p>2. The policy titled "Care Coordination" policy number 207 dated 10/2004 states, "7. If changes are recommended, the physician is contacted for new treatment</p>	N000532	The Clinical Director will in-service all professional staff on notifying the physician of any changes in patient condition, care coordination and staff communication. 10% of all clinical records will be audited quarterly for evidence of communication between staff members regarding changes in patient condition, as well as notifying the physician of any changes in patient condition. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	07/03/2013	

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	<p>or frequency orders."</p> <p>3. The policy titled "Staff Communication Process" policy number 232 dated 10/2004 states, "3. The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care."</p> <p>4. Clinical record #11, start of care 4/8/13, contained a Skilled Nursing (SN) Note dated 5/10/13 that identified the blood pressure was 210/105. The visit note had "See back note." The record failed to evidence the physician was notified of the increased blood pressure.</p> <p>During an interview on 6/6/13 at 4:30 PM, employee G, Alternate Administrator, indicated the chart did not contain a "back note," and there wasn't any documentation to support the physician was notified of the elevated blood pressure.</p> <p>5. Clinical record #17, start of care 12/16/12, contained a plan of care for the certification period 12/16/12 to 2/13/13 with orders for skilled nursing (SN) to instruct patient on diabetic care, diet, and blood glucose monitoring. The SN was also to assess general systems</p>						

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	<p>status every visit. Review of the record evidenced the following:</p> <p>A. A document titled "Face-to-Face Encounter" dated 12/6/12 states, "Patient needs better monitoring &amp; dietary assistance to better control DMI [Diabetes Mellitus Type I], but he is unable to perform these duties himself." The record failed to evidence the physician was notified of the patient's inabilities.</p> <p>B. The Nursing Comprehensive Assessment was preformed on 12/6/12. The SN documented the blood glucose was 259, and the blood pressure was 140/72. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>C. On 12/28/12, the SN Note identified the patient had a blood pressure of 174/103 and a blood glucose ranging from 250 to 300. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>D. On 12/29/12, a Physical Therapy Note evidenced the patient had a blood pressure of 170/99. The record failed to</p>			

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	<p>evidence the MD was notified of the elevated blood pressure.</p> <p>E. On 1/3/13, a SN Note identified the patient had a blood pressure of 178/93. The document further mentions that the patient hadn't started taking their blood pressure medication and was not taking the prescribed Metformin. The record failed to evidence the MD was notified of the elevated blood pressure and medication non-compliance.</p> <p>F. On 1/9/13, a SN Note contained a blood pressure of 172/83 and blood glucose of 341. The document further notes that the "patient continue[s] to threaten self," "states cannot afford meals on wheels," "patient non-compliant with meds and diet." The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose, patient threatening self, lack of money for meals on wheels, and non-compliance with medications and diet.</p> <p>G. During an interview on 6/6/13 at 1:33 PM, employee G, Alternate Administrator, indicated the MD should have been notified about abnormal vital signs, blood glucose, and patient status</p>						

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N000537	<p>410 IAC 17-14-1(a) Scope of Services 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:</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure Skilled Nursing (SN) was measuring wounds on a weekly basis in 2 of 17 clinical records reviewed with the potential to affect all patients of the agency receiving wound care. (#1 and #3)</p> <p>Findings include:</p> <p>1. The policy titled "Assessment/Staging of Pressure Ulcers" policy number G-150 dated 8/2002 states, "Measure wound weekly and prn [as necessary] for significant changes (include length, width, and depth)."</p> <p>2. Clinical record #1, start of care 12/8/12, contained a home health certification and plan of care dated 4/7/13 to 6/5/13 which states for SN to perform wound care to RLE (right lower extremity). Review of the record evidenced the following:</p>	N000537	The Clinical Director will in-service all nursing staff on documentation of measuring wounds weekly and as necessary for significant changes to include length, width and depth. 10% of all clinical records will be audited quarterly for evidence of documentation of wound measurement weekly and as necessary for significant changes, including length, width and depth. The Clinical Director will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.	07/03/2013			

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	<p>A. On 4/5/13, the "Recertification/Follow-Up Assessment" document described a RLE wound. The record failed to evidence the wound measurement under the "Wound/Lesion" section of this document.</p> <p>B. SN nursing visited the patient on 4/7/13, 4/8/13, 4/9/13, 4/10/13, 4/12/13, 4/13/13, 4/14/13, 4/15/13, 4/16/13, 4/17/13, 4/20/13, 4/22/13, 4/24/13, 4/29/13, 5/1/13, 5/4/13, 5/6/13, 5/10/13, 5/12/13, 5/14/13, 5/17/13, 5/21/13, and 5/24/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>3. Clinical record #3, start of care 3/21/13, contained a home health certification and plan of care dated 5/20/13 to 7/18/13 which states for SN to monitor foot ulcer. Review of the record evidenced the following:</p> <p>A. On 4/18/13, the "Skilled Nursing Note" contained wound measurements.</p> <p>B. On 5/17/13, the "Recertification/Follow-Up Assessment" contained wound measurements under the "Wound/Lesion" section of this document.</p>			

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	<p>C. SN visited the patient on 4/11/13, 4/25/13, 4/30/13, 5/2/13, 5/7/13, 5/9/13, 5/14/13, 5/16/13, 5/21/13, and 5/23/13. The record failed to evidence that SN measured the wound during these visits.</p> <p>4. During an interview on 6/5/13 at 10:31 AM, employee G, Alternate Administrator, indicated the SN would need to measure the wound weekly unless the patient had a wound clinic appointment. Employee G further indicated that they were unable to locate wound measurements in any wound clinic documentation.</p>			

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NAME OF PROVIDER OR SUPPLIER  BEST CHOICE HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 5701 ELMWOOD AVE STE N INDIANAPOLIS, IN 46203			
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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on policy review, record review, and interview, the home health agency failed to ensure the registered nurse coordinated services with the physician for 2 of 17 clinical records reviewed with the potential to affect all patients of the agency. (#11 and #17)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The policy titled "Plan of Care" policy number 206 dated 10/2004 states, "9. Agency professional staff promptly alerts the physician of any changes in patient condition that suggest a need to alter the plan of care."</li> <li>The policy titled "Care Coordination" policy number 207 dated 10/2004 states, "7. If changes are recommended, the physician is contacted for new treatment</li> </ol>	N000546	The Clinical Director will in-service all professional staff on notifying the physician of any changes in patient condition, care coordination and staff communication. 10% of all clinical records will be audited quarterly for evidence of communication between staff members regarding changes in patient condition, as well as notifying the physician of any changes in patient condition. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	07/03/2013			

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	<p>or frequency orders."</p> <p>3. The policy titled "Staff Communication Process" policy number 232 dated 10/2004 states, "3. The Agency's home care staff notifies any changes in patient condition, complaints, or problems promptly to all persons involved in the patient's care."</p> <p>4. Clinical record #11, start of care 4/8/13, contained a Skilled Nursing (SN) Note dated 5/10/13 that identified the blood pressure was 210/105. The visit note had "See back note." The record failed to evidence the physician was notified of the increased blood pressure.</p> <p>During an interview on 6/6/13 at 4:30 PM, employee G, Alternate Administrator, indicated the chart did not contain a "back note," and there wasn't any documentation to support the physician was notified of the elevated blood pressure.</p> <p>5. Clinical record #17, start of care 12/16/12, contained a plan of care for the certification period 12/16/12 to 2/13/13 with orders for skilled nursing (SN) to instruct patient on diabetic care, diet, and blood glucose monitoring. The SN was also to assess general systems</p>						

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	<p>status every visit. Review of the record evidenced the following:</p> <p>A. A document titled "Face-to-Face Encounter" dated 12/6/12 states, "Patient needs better monitoring &amp; dietary assistance to better control DMI [Diabetes Mellitus Type I], but he is unable to perform these duties himself." The record failed to evidence the physician was notified of the patient's inabilities.</p> <p>B. The Nursing Comprehensive Assessment was preformed on 12/6/12. The SN documented the blood glucose was 259, and the blood pressure was 140/72. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>C. On 12/28/12, the SN Note identified the patient had a blood pressure of 174/103 and a blood glucose ranging from 250 to 300. The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose.</p> <p>D. On 12/29/12, a Physical Therapy Note evidenced the patient had a blood pressure of 170/99. The record failed to</p>			

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	<p>evidence the MD was notified of the elevated blood pressure.</p> <p>E. On 1/3/13, a SN Note identified the patient had a blood pressure of 178/93. The document further mentions that the patient hadn't started taking their blood pressure medication and was not taking the prescribed Metformin. The record failed to evidence the MD was notified of the elevated blood pressure and medication non-compliance.</p> <p>F. On 1/9/13, a SN Note contained a blood pressure of 172/83 and blood glucose of 341. The document further notes that the "patient continue[s] to threaten self," "states cannot afford meals on wheels," "patient non-compliant with meds and diet." The record failed to evidence the MD was notified of the elevated blood pressure and blood glucose, patient threatening self, lack of money for meals on wheels, and non-compliance with medications and diet.</p> <p>G. During an interview on 6/6/13 at 1:33 PM, employee G, Alternate Administrator, indicated the MD should have been notified about abnormal vital signs, blood glucose, and patient status</p>				

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N000597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on personnel file review and interview, the agency failed to ensure home health aides (HHA) were entered on and in good standing on the state aide registry for 4 of 6 HHA files reviewed of HHAs employed by the agency with the potential to affect all patients receiving HHA services. (A, B, C, E)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file A, date of hire 3/2/2010, failed to the aide was entered on and in good standing on the state aide registry.</li> <li>2. Personnel file B, date of hire 6/27/08, failed to the aide was entered on and in good standing on the state aide registry.</li> <li>3. Personnel file C, date of hire 8/22/12, failed to the aide was entered on and in good standing on the state aide registry.</li> <li>4. Personnel file E, date of hire 3/4/13, failed to the aide was entered on and in</li> </ol>	N000597	The Clinical Director will submit all required information to the state aide registry, to ensure all aides are entered on the registry and are in good standing. All home health aide employment files will be reviewed at the time of hire and at least annually for evidence that the aide is listed on the state registry and is in good standing. The Clinical Director will be responsible for monitoring these corrections to ensure that this deficiency is corrected and will not recur.	07/03/2013	

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	<p>good standing on the state aide registry.</p> <p>5. During an interview on 6/5/13 at 3:00 PM, employee G, Alternate Administrator, indicated employees A, B, C, and E were not officially registered as HHAs.</p>			