

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER OMNI HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 N WEINBACK AVE STE 610 EVANSVILLE, IN 47711
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G000000	<p>This was a federal home health recertification survey. This survey was partial extended on 5-20-14 and fully extended on 5-21-14</p> <p>Survey dates: 5-20-14 to 5-23-14</p> <p>Facility #: 004583</p> <p>Medicaid #: 200512710B</p> <p>Surveyors: Vickie, Harmon RN, PHNS Nina Koch, RN, PHNS</p> <p>Census: 353 Skilled unduplicated skilled nursing admissions in the past year</p> <p>Omni Home Care is precluded from providing its own home health training and competency evaluation program for a period of two years beginning 5/23/2014 - 5/23/16 due to being found out of compliance with the Conditions of Participation Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Skilled Nursing Services; and 484.55 Comprehensive Assessment of Patients.</p> <p>The administrator and clinical manager</p>	G000000	See Plan of Correction.	

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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G000110	<p>we notified of this preclusion at an exit conference on 5-23-2014 at 3:30 PM.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 2, 2014</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, agency policy review, and interview, the agency failed to ensure documentation identified if the patient had an Advanced Directive in 2 of 12 records reviewed (# 5, 6) with the potential to affect all the agency's active patients.</p>	G000110	<p>Re-education with all clinicians – nursing and therapy staffs of the requirement to inform; distribute written information to the patient, in advance, concerning the HHA's policies on advance directives, including a description of applicable State law; and to document evidence if the patient has executed an advance directive. Education was completed on 6/3/14 by the</p>	06/15/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, start of care 3-21-14, included an "Admission Consent & Service Agreement", signed by the patient on 3-21-14 and a start of care comprehensive assessment dated 2-28-14. Both documents failed to evidence if the patient had executed an advance directive. 2. An agency policy titled "2.9 Advanced Directives" dated 12-91, revised 4-03 and 5-03 states, "The existence or non-existence of an advance directive will be documented on the Start of Care OASIS and on the conditions of admission form." 3. Employee A, the administrator, on 5-20-2014 at 445 PM, indicated the receipt of information about advanced directives is to be documented on the Admission Consent and Service Agreement at the start of care. 4. Clinical record number 5, start of care 2-28-14, included an "Admission Consent & Service Agreement", signed by the patient on 2-28-14 and a start of care comprehensive assessment dated 2-28-14. Both documents failed to evidence if the patient had executed an advance directive. 		<p>Director of Professional Services (DPS). The two patients #5 and #6 were contacted via phone by the DPS to determine if the patient had executed an advance directive. This communication was documented on the Communication Note on 6/6/14. Documentation of an executed advance directive will be located on the Admission Consent and Service Agreement and/or the SOC Comprehensive Assessment beginning 6/3/14. Documentation of an executed advance directive will be located on the Conditions of Admission form and within the EMR (HCHB) on the Client Information Report beginning with all admissions beginning with the implementation of HCHB on 6/15/14. To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure that the admitting clinician has documented if the patient has executed an advance directive. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing</p>	

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G000156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to ensure treatments and services had been provided in accordance with physician's orders in 4 of 12 records reviewed creating the potential to affect all of the agency's 353 active patients (see G 158), failed to ensure the plan of care included all equipment required for 1 of 12 records reviewed creating the potential</p>	G000156	<p>compliance. Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to acceptance of patients, plan of care (G159), medical supervision and notification of patient changes (G164), provision of care in accordance with physician orders (G158) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p>	06/10/2014

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	<p>to affect all 353 of the agency's patients (See G 159), and failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed with the potential to affect all of the agency's active patients (See G 164),</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p>		<p>See CAP for G158, G159 and G164 for complete plan.</p> <p>Continued re-education of all agency staff on policies & requirements as they relate to: plan of care (G159), medical supervision and notification of patient changes (G164), provision of care in accordance with physician orders (G158). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders <p>On 6/15/14 the agency will begin transitioning to an electronic medical record – HomeCare HomeBase (HCHB). HCHB:</p> <ul style="list-style-type: none"> · Allows clinicians to complete all documentation onsite using mobile point-of-care devices (tablets). · Empowers field clinicians from the moment of login, 	

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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. Based on clinical record and agency policy review, home visit observation, and interview, the agency failed to ensure care and services had been provided in accordance with physician orders in 4 (#s 4, 5, 6, and 7) of 12 records reviewed creating the potential to affect all of the agency's 353 current patients.</p> <p>Findings include:</p> <p>1. The record for patient number 4</p>	G000158	<p>accessing the Electronic Medical Record for each patient, as well as any critical alerts pertaining to the day's visits.</p> <ul style="list-style-type: none"> Allows the clinician to synchronize visit data in about two minutes. Ensures data is encrypted and meets all HIPAA security standards. <p>Re-education with all agency staff regarding professional expectations as they relate to provision of care in accordance with physician orders (G158) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all agency staff the policies & the</p>	06/10/2014

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	<p>included a plan of care established by the patient's physician for the certification period 3-25-2014 to 5-23-2014 that included orders for skilled nurse to monitor for adherence to diabetic regimen, signs and symptoms of exacerbation, lesions of lower extremities, worsening of diabetic condition, notify physician if condition not improving and for physical therapy (PT) two times weekly for five weeks, and occupational therapy (OT) two times weekly for two weeks and one time weekly for two weeks beginning 3-31-2014.</p> <p>A. An initial comprehensive assessment completed at the start of care failed to include assessment of recommended blood glucose ranges or frequency to check the blood glucose. Skilled nursing notes for the certification period failed to evidence teaching or assessment for adherence to a diabetic regimen or safe blood glucose parameters.</p> <p>B. The clinical record evidenced a physician order to apply antibiotic ointment topically to any open area at each dressing change weekly and as needed to prevent infection. Skilled nursing notes dated 4-17-2014 to 5-8-2014 identified open areas but failed to</p>		<p>requirements as they relate to provision of care in accordance with physician orders (G158). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the provision of care in accordance with physician orders. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and</p>	

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	<p>evidence that antibiotic ointment was applied.</p> <p>C. The clinical record failed to evidence that the patient was seen by the occupational therapist for the week of 4-6-2014 to 4-12-2014.</p> <p>D. The clinical record evidenced only one visit from the physical therapist for the weeks of 4-6-2014 to 4-12-2014 and 4-13-2014 to 4-19-2014</p> <p>E. The administrator indicated on 5-22-2014 at 330 PM the skilled nursing notes did not indicate interventions for diabetes care and antibiotic ointment as ordered and the record did not contain PT and OT notes for the dates specified.</p> <p>2. The record for patient number 6 included a plan of care (POC) for the certification period 3-21-2014 to 5-19-2014 with orders for regular diet, complete metabolic panel (CMP), complete blood count (CBC), and trileptal level to be collected by 4-14-2014.</p> <p>A. The clinical record failed to evidence that the trileptal level was collected as ordered. A lab report for blood specimens collected 4-11-2014 included only results for a CBC and</p>		<p>analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

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	<p>CMP.</p> <p>B. A skilled nursing visit note dated 4-11-2014 evidenced low sodium diet teaching to decrease edema in the patient's bilateral lower extremities. The POC includes a regular diet and failed to evidence physician orders for low sodium diet teaching.</p> <p>C. A skilled nursing visit note dated 4-11-2014 indicated that a urine specimen was collected per order in the patient's home. The clinical record failed to evidence a physician order to collect a urine specimen.</p> <p>D. The comprehensive nursing assessment completed by the registered nurse, evidenced +2 edema in bilateral lower extremities. Skilled nursing visit notes dated 4-11-2014 and 4-14-2014 evidenced teaching to wear elastic stockings and to keep feet elevated to reduce edema. The clinical record failed to evidence a physician order for elastic stockings or management of edema to the lower extremities.</p> <p>3. The record for patient number 7 included a plan of care for the certification period 4-9-2014 to 6-7-2014 with orders for skilled nursing one time weekly for three weeks and every other week for six weeks to assess right neck incision, monitor adherence to diabetic</p>			

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	<p>regimen, instruct diabetic management to include 1800 calorie diabetic diet, foot care education and signs and symptoms of hypo/hyperglycemia, assess and instruct use of glucometer and sliding scale (SS) insulin, notify physician with blood glucose results less than 60 and greater than 300, notify physician of blood pressure (BP) greater than 180/100 ... pulse less than 60 and assess effects of pain medication.</p> <p>A. Skilled nursing visit notes dated 4-18-2014, 4-24-2014, and 5-14-2014 failed to evidence the nurse assessed the right neck incision, evaluated the patient's use of a glucometer, or performed diabetic teaching. Visit notes dated 4-24-2014 and 5-14-2014 failed to evidence the skilled nurse evaluated the patient blood sugar and use of SS insulin.</p> <p>B. A nursing note dated 4-18-2014 states, "The patient had an elevated blood pressure yesterday AM 154/106. The clinical record failed to evidence the physician was notified of the elevated BP.</p> <p>C. On 5-21-2014 at 3 PM, employee D, a registered nurse (RN), was observed to provide care to the patient. The RN failed to assess the patient's use of a glucometer, did not provide instruction</p>			

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	<p>about diabetes care or 1800 calorie diet and did not evaluate the incision site to the right neck. The patient complained of pain in her throat and the skilled nurse stated, "This was due to her fibromyalgia" but did not assess the patient's pain for character, onset, duration, or intensity. The patient stated, "When she had a heart attack in 2004, the pain was mostly in her neck."</p> <p>D. The clinical record failed to evidence a nursing visit was made during the week of 5-4/2014 to 5-10-2014.</p> <p>E. A nursing note dated 4-12-2014 indicated the patient called to report a pulse of 47 and she was unsure whether to take her pain medication. The clinical record failed to evidence that the physician was notified.</p> <p>4. An agency policy titled "Plan of care-CMS # 485 and Physician Orders," undated, states, "Care and services provided will be provided according to the physician orders."</p> <p>5. Clinical record number 5 failed to evidence therapy evaluations were completed as ordered and that laboratory specimens were obtained as ordered. The record included a plan of care for the certification period 2-28-14 to 4-28-14</p>						

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	<p>that states, "Obtain therapy evaluation: PT [physical therapy] & OT [occupational therapy]." The record also included a "Physician's Verbal/Communication Note" dated 3-27-14 that states, "Repeat PT/INR [blood test] 4/2/14."</p> <p>A. The record failed to evidence the physical and occupational therapy evaluations had been completed.</p> <p>B. The administrator stated, on 5-21-14 at 10:15 AM, "The evaluations were not done."</p> <p>C. The record failed to evidence the skilled nurse had obtained the ordered laboratory test on 4-2-14.</p> <p>D. The record included a skilled nurse visit note dated 4-11-14 that states, "PT/INR per microcoag [type of machine] 39.7/4.0." The record failed to evidence an order for the skilled nurse to obtain the blood specimen on 4-11-14.</p> <p>E. The administrator indicated, on 5-21-14 at 10:15 AM, the record did not evidence the skilled nurse had obtained the ordered blood specimen on 4-2-14 and that the record did not include an order for the skilled nurse to obtain a blood specimen on 4-11-14.</p>			

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G000159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review and observation agency failed to ensure the plan of care include equipment required for 1 (# 9) of 12 records re-creating the potential to affect all 353 of the ag patients.</p> <p>Findings Include:</p> <p>A home visit was made to patient number 9 on at 1230 PM with employee F, a physical therap (PTA). The PTA was observed to ambulate the using a gait belt. The plan of care for the certif period 4-1-2014 to 5-30-2014 failed to evidenc belt.</p>	G000159	<p>Re-education with all agency staff regarding professional expectations as they relate to the development of the POC, including the type of services and equipment required (G159) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14. Continued re-education of all agency staff on the requirements as they relate to the development of the POC, including the type of services and equipment required (G159). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies: · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal</p>	06/10/2014

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			<p>Orders After HCHB implementation on 6/15/14 the DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC, including the type of services and equipment required. To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure that the POC developed, includes the type of services and equipment required. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER OMNI HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 N WEINBACK AVE STE 610 EVANSVILLE, IN 47711
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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. Based on clinical record review and agency policy review, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed (6, 7) with the potential to affect all of the agency's active patients.</p> <p>Findings Include:</p> <p>1. Clinical record number 6 included a resumption of care assessment on 4-24-2014 where the skilled nurse documented the patient's pain level was a "9" on a scale of 1 - 10. The record failed to evidence that the physician had been notified of the patient's pain level.</p>	G000164	<p>review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to physician notification of any changes that suggest the need to alter the plan of care (G164) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14. Continued re-education of all agency staff on the requirements as they relate to physician notification of any changes that suggest the need to alter the plan of care (G164). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies: · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders After HCHB</p>	06/10/2014

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	<p>2. Clinical record number 7 included a plan of care for the certification period 4-9-2-14 to 6-7-2014 with an order to notify the physician for pulse less than 60 and greater than 100. The record evidenced a skilled nursing note dated 4-12-2014 stating that the patient called to report a pulse of 47 and the patient was unsure whether to take pain medication. The clinical record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 4-98 titled "2.17 Plan of Care" states, "The RN(registered nurse) ... will contact the patient's physician or his/her agent to report assessment findings. ... Documentation of the clinician's communication with the physician must be maintained in the medical record."</p>		<p>implementation on 6/15/14: · DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. · Missed Visits - any ordered visit that is missed will generate a Missed Visit Note to be reviewed by the CLM and sent to the physician by the CLM. · Reporting of Clinical Changes that may require the alteration of the POC -Vitals Signs outside of MD ordered parameters alert the clinician at the time of occurrence. After the visit is transmitted the CLM is alerted to any vital signs outside of MD ordered parameters, including pain. · Reporting of Clinical Changes that may require the alteration of the POC Physician notification will be documented in a Physician Notification Coordination Note. To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the occurrence of physician notification of any changes that suggest the need to alter the plan of care. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and</p>		

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G000168	484.30 SKILLED NURSING SERVICES Based on clinical record and agency policy review, observation, and interview, it was determined the agency failed to ensure nursing services had been provided in accordance with physician orders in 4 of 12 records reviewed creating the potential to affect all of the agency's 353 current patients (See G 170), failed to ensure the registered nurse completely and accurately evaluated the	G000168	analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance. Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance. Re-education with all registered nurse staff regarding professional expectations as they relate to the provision of nursing services in accordance with physician orders (G170), the registered nurse must completely and accurately evaluate the patient's needs at the time of recertification or resumption of care after hospitalization (G172), the registered nurse must update and	06/10/2014

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	<p>patient's needs at the time of recertification or resumption of care after hospitalization in 4 of 12 records reviewed of patients who had a recertification or resumption of care assessment creating the potential to affect all of the agency's patients receiving services longer than 60 days (See G 172), failed to ensure the registered nurse (RN) had updated and revised the plan of care (POC) in 3 of 12 records reviewed creating the potential to affect all of the agency's 353 current patients that receive skilled nursing services (see G 173), and failed to ensure the registered nurse promptly alerted the physician to changes in the patient's condition for 2 of 12 records reviewed with the potential to affect all of the agency's active patients (see G 176).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.30 Skilled Nursing Services.</p>		<p>revise the plan of care (G173) and the registered nurse must inform the physician of changes in the patient's condition and needs (G176) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>See CAP for G170, G172, G173, and G176 for complete plan.</p> <p>Continued re-education of all registered nurse staff on policies & requirements as they relate to: the provision of nursing services in accordance with physician orders (G170), the registered nurse must completely and accurately evaluate the patient's needs at the time of recertification or resumption of care after hospitalization (G172), the registered nurse must update and revise the plan of care (G173) and the registered nurse must inform the physician of changes in the patient's condition and needs (G176). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment 	

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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record and agency policy review, home visit observation, and interview, the agency failed to ensure nursing services had been provided in accordance with physician orders in 4 (#s 4, 5, 6, and 7) of 12 records reviewed</p>	G000170	<ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>On 6/15/14 the agency will begin transitioning to an electronic medical record – HomeCare HomeBase (HCHB). HCHB:</p> <ul style="list-style-type: none"> · Allows clinicians to complete all documentation onsite using mobile point-of-care devices (tablets). · Empowers field clinicians from the moment of login, accessing the Electronic Medical Record for each patient, as well as any critical alerts pertaining to the day's visits. · Allows the clinician to synchronize visit data in about two minutes. <p>Ensures data is encrypted and meets all HIPAA security standards.</p> <p>Re-education with all registered nurse staff regarding professional expectations as they relate to provision of care in accordance with physician orders (G170) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p>	06/10/2014

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	<p>creating the potential to affect all of the agency's 353 current patients.</p> <p>Findings include:</p> <p>1. The record for patient number 4 included a plan of care established by the patient's physician for the certification period 3-25-2014 to 5-23-2014 that included orders for skilled nurse to monitor for adherence to diabetic regimen, signs and symptoms of exacerbation, lesions of lower extremities, worsening of diabetic condition, notify physician if condition not improving.</p> <p>A. An initial comprehensive assessment completed at the start of care failed to include assessment of recommended blood glucose ranges or frequency to check the blood glucose. Skilled nursing notes for the certification period failed to evidence teaching or assessment for adherence to a diabetic regimen or safe blood glucose parameters.</p> <p>B. The clinical record evidenced a physician order to apply antibiotic ointment topically to any open area at each dressing change weekly and as needed to prevent infection. Skilled nursing notes dated 4-17-2014 to 5-8-</p>		<p>Continued re-education of all registered nurse staff on the policies & the requirements as they relate to provision of care in accordance with physician orders (G170). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure that the provision of care occurs in accordance with physician orders. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and</p>	

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	<p>2014 identified open areas but failed to evidence that antibiotic ointment was applied.</p> <p>C. The administrator indicated on 5-22-2014 at 330 PM the skilled nursing notes did not indicate interventions for diabetes care and antibiotic ointment as ordered.</p> <p>2. The record for patient number 6 included a plan of care (POC) for the certification period 3-21-2014 to 5-19-2014 with orders for regular diet, complete metabolic panel (CMP), complete blood count (CBC), and trileptal level to be collected by 4-14-2014.</p> <p>A. The clinical record failed to evidence that the trileptal level was collected as ordered. A lab report for blood specimens collected 4-11-2014 included only results for a CBC and CMP.</p> <p>B. A skilled nursing visit note dated 4-11-2-14 evidenced low sodium diet teaching to decrease edema in the patient's bilateral lower extremities. The POC includes a regular diet and failed to evidence physician orders for low sodium diet teaching.</p>		<p>is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>				

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	<p>C. A skilled nursing visit note dated 4- indicated that a urine specimen was collected p order in the patient's home. The clinical record evidence a physician order to collect a urine sp</p> <p>D. The comprehensive nursing assessment completed by the registered nurse, evidenced +2 edema in bilateral extremities. Skilled nursing visit notes dated 4-11-2014 and 4-14-2014 evidence teaching to wear elastic stockings and to keep feet elevated to reduce edema. The clinical record failed to evidence a physician order for elastic stockings or management of edema to the lower extremities.</p> <p>3. The record for patient number 7 included a plan of care for the certification period 4-9-2-14 to 6-7-2014 with orders for skilled nursing one time weekly for three weeks and every other week for six weeks to assess right neck incision, monitor adherence to diabetic regimen, instruct diabetic management to include 1800 calorie diabetic diet, foot care education and signs and symptoms of hypo/hyperglycemia, assess and instruct use of glucometer and sliding scale (SS) insulin, notify physician with blood glucose results less than 60 and greater than 300, notify physician of blood pressure (BP) greater than 180/100 ... pulse less than 60 and assess effects of</p>			

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	<p>pain medication.</p> <p>A. Skilled nursing visit notes dated 4-18-2014, 4-24-2014, and 5-14-2014 failed to evidence the nurse assessed the right neck incision, evaluated the patient's use of a glucometer, or performed diabetic teaching. Visit notes dated 4-24-2014 and 5-14-2014 failed to evidence the skilled nurse evaluated the patient blood sugar and use of SS insulin.</p> <p>B. A nursing note dated 4-18-2014 states, "The patient had an elevated blood pressure yesterday AM 154/106. The clinical record failed to evidence the physician was notified of the elevated BP.</p> <p>C. On 5-21-2014 at 3 PM, employee D, a registered nurse (RN), was observed to provide care to the patient. The RN failed to assess the patient's use of a glucometer, did not provide instruction about diabetes care or 1800 calorie diet and did not evaluate the incision site to the right neck. The patient complained of pain in her throat and the skilled nurse stated, "This was due to her fibromyalgia" but did not assess the patient's pain for character, onset, duration, or intensity. The patient stated, "When she had a heart attack in 2004, the pain was mostly in her neck."</p>			

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	<p>D. A nursing note dated 4-12-2014 indicated the patient called to report a pulse of 47 and she was unsure whether to take her pain medication. The clinical record failed to evidence that the physician was notified.</p> <p>4. An agency policy titled "Plan of care-CMS # 485 and Physician Orders," undated, states, "Care and services provided will be provided according to the physician orders."</p> <p>5. Clinical record number 5 failed to evidence laboratory specimens were obtained as ordered. The record included a "Physician's Verbal/Communication Note" dated 3-27-14 that states, "Repeat PT/INR [blood test] 4/2/14."</p> <p>A. The record failed to evidence the skilled nurse had obtained the ordered laboratory test on 4-2-14.</p> <p>B. The record included a skilled nurse visit note dated 4-11-14 that states, "PT/INR per microcoag [type of machine] 39.7/4.0." The record failed to evidence an order for the skilled nurse to obtain the blood specimen on 4-11-14.</p> <p>C. The administrator indicated, on 5-21-14 at 10:15 AM, the record did not</p>			

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G000172	<p>evidence the skilled nurse had obtained the ordered blood specimen on 4-2-14 and that the record did not include an order for the skilled nurse to obtain a blood specimen on 4-11-14.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs.</p> <p>Based on clinical record review, the agency failed to ensure the registered nurse completely and accurately evaluated the patient's needs at the time of recertification or resumption of care after hospitalization in 4 (#s 1, 5, 6, and 10) of 12 records reviewed of patients who had a recertification or resumption of care assessment creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p> <p>Findings Include :</p> <p>1. Clinical record number 6 included a resumption of care comprehensive assessment completed on 4-24-2014.</p>	G000172	<p>Re-education with all registered nurse staff regarding professional expectations as they relate to the development of the POC, including recertification or resumption of care after hospitalization (G172) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to the development of the POC, including recertification or resumption of care after hospitalization (G172). Re-education to be completed by</p>	06/10/2014	

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	<p>The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A) The assessment identified the patient's current pain level was a "9". The sections labeled, "interferes with" and "patient experiencing pain" of the assessment had been left blank.</p> <p>B) The assessment section labeled "home environment/safety" had been left blank.</p> <p>C) The assessment section labeled "advanced directives" had been left blank.</p> <p>D) The mobility assessment section titled "Timed Up and Go" was left blank.</p> <p>2. Clinical record number 10 included a recertification comprehensive assessment completed on 4-8-2014. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The portion of the assessment that identified the condition of the patient's pupils and if there were any vision problems had been left blank.</p> <p>B. The urine color, clarity, odor present, and catheter present portions of the urinary assessment had been left</p>		<p>DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC, including the type of services and equipment required.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the development of the POC, including recertification or resumption of care after hospitalization. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office</p>				

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	<p>blank</p> <p>3. Clinical record number 1 included a resumption of care comprehensive assessment dated 3-22-14. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The pain assessment indicated the patient had pain in the right hip and knee and the left knee. The assessment failed to indicate how the pain interfered with or impacted the patient's functional/activity level. This portion of the assessment had been left blank.</p> <p>B. The assessment identified the patient used nebulizer treatments. The assessment failed to include how many times per day, under what circumstances, if the treatments were effective, and the type of machine used.</p> <p>4. Clinical record number 5 included a recertification comprehensive assessment. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The portion of the assessment that identified the condition of the patient's pupils and if there were any vision problems had been left blank.</p>		<p>for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>		

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G000173	<p>B. The assessment indicated the patient had intermittent pain but failed to identify the location of the pain, if the pain interfered with the patient's functional/activity level, if there was a pattern to the pain, and if breakthrough medication was needed.</p> <p>C. The skin turgor portion of the assessment had been left blank.</p> <p>D. The assessment identified the patient used nebulizer treatments. The assessment failed to include how many times per day, under what circumstances, if the treatments were effective, and the type of machine used.</p> <p>E. The "rhythm" and "character" portion of the cardiovascular assessment had been left blank. The "other symptoms" and "other abnormalities" portion of the cardiovascular assessment had been left blank.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review and observation, the agency failed to ensure the registered nurse (RN) had updated and revised the plan of care (POC) in 3</p>	G000173	Re-education with all registered nurse staff regarding professional expectations as they relate to the responsibility to update and revise	06/10/2014

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	<p>(#s 4, 6, 7) of 12 records reviewed creating the potential to affect all of the agency's 353 current patients that receive skilled nursing services.</p> <p>Findings Include:</p> <p>1. Clinical record number 6 includes a plan of care established by the patient's physician for the certification period 3-21-2014 to 5-19-2014. A skilled nursing note dated 4-16-2014 by employee C, a RN, states a urine specimen was collected per written order at the patient's home. The clinical record failed to evidence the RN obtained a physician order to collect a urine specimen.</p> <p>2. Clinical record number 4 failed to evidence the RN had updated the plan of care to reflect the patient's current needs and status. The clinical record contained a resumption of care comprehensive nursing assessment completed 4-11-2014. The section titled "endocrine assessment" evidenced that the patient used a glucometer (blood sugar monitoring device). The record failed to evidence the RN updated the POC to include frequency of testing or parameters for results of blood sugar.</p> <p>3. The clinical record for patient number 7 included a plan of care established by the patient's physician for the certification period 4-9-2014 to 5-7-2014. A nursing comprehensive assessment completed 4-9-2014 evidenced the patient has fibromyalgia. During a home visit</p>		<p>the plan of care (G173) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to the responsibility to update and revise the plan of care (G173). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC, including the type of services and equipment required.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted</p>		

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	5-21-2014 at 3 PM, employee D, a RN, was ob instructing the patient about fibromyalgia. The record failed to evidence the RN updated the pl to include nursing care and teaching for fibrom		<p>weekly for a maximum of 20 charts per month x 3 months to ensure the registered nurse updates and/or revises the plan of care as needed. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible</p>	

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G000176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and agency policy review, the registered nurse (RN) failed to inform the physician of changes in the patient's condition and needs for 2 of 12 (#s 6,7) records reviewed creating the potential to affect all of the agency's patients receiving skilled nursing services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6 included a resumption of care assessment on 4-24-2014 where the skilled nurse documented the patient's pain level was a "9" on a scale of 1 - 10. The record failed to evidence that the physician had been notified of the patient's pain level. 2. Clinical record number 7 included a plan of care for the certification period 4-9-2-14 to 6-7-2014 with an order to 	G000176	<p>for ongoing compliance.</p> <p>Re-education with all registered nurse staff regarding professional expectations as they relate to physician notification of any changes that suggest the need to alter the plan of care (G176) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to physician notification of any changes that suggest the need to alter the plan of care (G176). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment 	06/10/2014

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	<p>notify the physician for pulse less than 60 and greater than 100. The record evidenced a skilled nursing note dated 4-12-2014 stating that the patient called to report a pulse of 47 and the patient was unsure whether to take pain medication. The clinical record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 4-98 titled "2.17 Plan of Care" states, "The RN(registered nurse) ... will contact the patient's physician or his/her agent to report assessment findings. ... Documentation of the clinician's communication with the physician must be maintained in the medical record."</p>		<ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>After HCHB implementation on 6/15/14:</p> <ul style="list-style-type: none"> · DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. · Missed Visits - any ordered visit that is missed will generate a Missed Visit Note to be reviewed by the CLM and sent to the physician by the CLM. · Reporting of Clinical Changes that may require the alteration of the POC -Vitals Signs outside of MD ordered parameters alert the clinician at the time of occurrence. After the visit is transmitted the CLM is alerted to any vital signs outside of MD ordered parameters, including pain. · Reporting of Clinical Changes that may require the alteration of the POC Physician notification will be documented in a Physician Notification Coordination Note. 	

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			<p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure provision of care in accordance with physician orders. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p>	

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G000185	<p>484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure therapy services had been provided in accordance with the plan of care in 1 (# 5) of 8 records reviewed of patients that received therapy services from the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 5 included a plan of care for the certification period 2-28-14 to 4-28-14 that states, "Obtain therapy evaluation: PT [physical therapy] & OT [occupational therapy]." The record failed to evidence the physical and occupational therapy evaluations had been completed. The administrator stated, on 5-21-14 at 10:15 AM, "The evaluations were not done." 	G000185	<p>The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to provision of therapy services in accordance with the POC (G185) will be done at the mandatory staff meeting. This education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of staff on policies & requirements as they relate to: provision of therapy services in accordance with the POC (G185). Education to be completed by DPS by 6/20/14. All staff will be re-educated in and principles of the following policies:</p> <p>2.6 Assessment/Reassessment</p> <p>2.17 Plan of Care</p>	06/10/2014	

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			<p>.After HCHB implementation on 6/15/14 the:</p> <ul style="list-style-type: none"> DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. Missed Visits - any ordered visit that is missed will generate a Missed Visit Note to be reviewed by the CLM and sent to the physician by the CLM. <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the provision of therapy services in accordance with the POC. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of</p>		

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G000321	<p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.</p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completion in 4 (#s 2, 3, 5 and 9) of 12 records reviewed of patients whose OASIS should have been transmitted within 30 days creating the potential to affect all of the agency's patients who require OASIS to be transmitted.</p>	G000321	<p>this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to OASIS data must be transmitted within 30 days of completion (G321) will be done at the mandatory staff meeting. This education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of staff on policies & requirements as</p>	06/10/2014

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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. An ISDH document dated 5-15-2014 evidenced a discharge assessment had been completed on 1-16-2014 for patient number 2. The document evidenced the OASIS data had not been transmitted until 4-9-2014. 2. An ISDH document dated 5-15-2014 evidenced a recertification assessment had been completed on 12-2-2013 for patient number 3. The document evidenced the OASIS data had not been transmitted until 1-3-2-14. 3. An ISDH document dated 5-15-2014 evidenced a discharge assessment had been completed on 2-19-2014 for patient number 5. The document evidenced the OASIS data had not been transmitted until 4-9-2014. 4. An ISDH document dated 5-14-2014 evidenced a start of care assessment had been completed on 11-29-2013 for patient number 9. The document evidenced the OASIS data had not been transmitted until 1-3-2014. 5. The Administrator was unable to provide any additional documentation and/or information when asked on 5-21-14 at 8:30 AM. She stated that she 		<p>they relate to: OASIS data must be transmitted within 30 days of completion (G321). Education to be completed by DPS by 6/20/14. All staff will be re-educated in and principles of the following policies:</p> <p>2.6 Assessment/Reassessment</p> <p>2.17 Plan of Care</p> <p>5.2 Information Management</p> <p>.After HCHB implementation on 6/15/14 the:</p> <ul style="list-style-type: none"> · DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. · The Initial OASIS Comprehensive Assessment will be transmitted within no greater than 14 days following completion. · Missed Visits - any ordered visit that is missed will generate a Missed Visit Note to be reviewed by the CLM and sent to the physician by the CLM. <p>To ensure ongoing compliance, 5</p>				

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	was aware that there were instances of late OASIS data submission by the agency.		<p>chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the provision of therapy services in accordance with the POC. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible</p>		

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G000330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS</p> <p>Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure start of care comprehensive assessments were complete and accurately reflected the patients' status in</p>	G000330	<p>for ongoing compliance.</p> <p>Re-education with all registered nurse staff regarding professional expectations as they relate to the completion and accuracy of the start of care (G335), recertification, including drug regimen review (G337 & G339), resumption of care (G340) and</p>	06/10/2014

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	<p>3 of 12 records reviewed with start of care comprehensive assessments completed by the registered nurse creating the potential to affect all of the agency's future patients (See G 335); by failing to ensure the medication profile was completed as part of the comprehensive assessment for 3 of 7 patients that received services for more than 60 days and with the recertification assessment (See G 337); by failing to ensure the recertification assessment was complete and accurately reflected the patients' status in 2 of 7 records reviewed of patients who had a recertification assessment creating the potential to affect all of the agency's patients receiving services longer than 60 days (See G 339); by failing to ensure the resumption of care assessment was complete and accurately reflected the patients' status in 2 of 12 records reviewed creating the potential to affect all of the agency's patients who are hospitalized (See G 340), and by failing to ensure the comprehensive assessment had been updated at the time of discharge from skilled services in 1 of 2 discharged records reviewed (See G 341).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this Condition, 42 CFR 484.55</p>		<p>discharge (G341) comprehensive assessments was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>See CAP for G170, G172, G173, and G176 for complete plan.</p> <p>Continued re-education of all registered nurse staff on policies & requirements as they relate to: the completion and accuracy of the start of care (G335), recertification, including drug regimen review (G337 & G339), resumption of care (G340) and discharge (G341) comprehensive assessments Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.7 Patient Transfer/Discharge · 2.26 Medication Administration and Management <p>On 6/15/14 the agency will begin</p>	

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NAME OF PROVIDER OR SUPPLIER OMNI HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 N WEINBACK AVE STE 610 EVANSVILLE, IN 47711
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G000335	<p>Comprehensive Assessment of Patients.</p> <p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and agency policy review and interview, the agency failed to ensure start of care comprehensive assessments were complete and accurately reflected the patients' status in 3 (#s 2, 5, 11) of 12 records reviewed creating the potential to affect all of the agency's patients.</p>	G000335	<p>transitioning to an electronic medical record – HomeCare HomeBase (HCHB). HCHB:</p> <ul style="list-style-type: none"> Allows clinicians to complete all documentation onsite using mobile point-of-care devices (tablets). Empowers field clinicians from the moment of login, accessing the Electronic Medical Record for each patient, as well as any critical alerts pertaining to the day's visits. Allows the clinician to synchronize visit data in about two minutes. <p>Ensures data is encrypted and meets all HIPAA security standards</p> <p>Re-education with all registered nurse staff regarding professional expectations as they relate to the completion and accuracy of the start of care comprehensive assessments (G335) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p>	06/10/2014

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	<p>Findings include:</p> <p>1. Clinical record number 2 included a comprehensive nursing assessment for start of care completed by employee G, a Registered Nurse (RN), dated 10/15/13.</p> <p>A) The pain assessment section of the document failed to identify how the patient's pain interfered with functional activity level and safety and failed to identify if there was a pattern to the pain. These assessment items were left blank.</p> <p>B) The neuro / psychosocial assessment section of the document were left blank for assessment of the patient's bilateral hand grip strength and leg strength and pupillary response.</p> <p>C) The cardiovascular assessment section of the document were left blank for capillary refill and peripheral pulses.</p> <p>D) The respiratory assessment section of the document were left blank for short of breath at rest or with exertion.</p> <p>2. Clinical record number 11 included a comprehensive nursing assessment for start of care completed by employee G, a RN, dated 4-18-2014.</p> <p>A) The immunization history section</p>		<p>Continued re-education of all registered nurse staff on the policies & the requirements as they relate to the completion and accuracy of the start of care comprehensive assessments (G335). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the completion and accuracy of the start of care comprehensive assessments (G335).</p>		

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	<p>of the assessment, including flu and pneumonia vaccines, was left blank.</p> <p>B) The referral date was left blank</p> <p>C) The capillary refill and peripheral pulses section of the cardiovascular assessment were left blank.</p> <p>3. Clinical record number 5 included a start of care comprehensive assessment dated 2-28-14. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The "Eyes" portion of the assessment to include pupils, eyes, and vision portion of the assessment had been left blank.</p> <p>B. A portion of the pain assessment had been left blank. The assessment evidenced the patient has occasional pain in the back. The assessment failed to indicate how or if the pain interfered or impacted the patient's function and activity level.</p> <p>C. The assessment identified the patient was "disoriented" and the patient was "oriented to: person, place."</p> <p>D. The "leg strength" portion of the assessment had been left blank.</p>		<p>Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

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G000337	<p>E. The "religious preference" portion of the assessment had been left blank.</p> <p>F. The "advance directive" portion of the assessment indicated the patient had a "Power of Attorney" but failed to specify if the patient had executed an advance directive.</p> <p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the recertification comprehensive assessment included a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy for #3 of 7 patients with a recertification assessment. (# 9, 10, 12)</p>	G000337	<p>Re-education with all registered nurse staff regarding professional expectations as they relate to the completion and accuracy of the recertification comprehensive assessment, including the drug regimen review (G337) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all</p>	06/10/2014

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 9 failed to evidence a review of all medications was completed at the time of recertification comprehensive assessments on 3-28-2014. 2. Clinical record number 10 failed to evidence a review of all medications was completed at the time of recertification comprehensive assessments on 4-8-2014. 3. Clinical record number 12 failed to evidence a review of all medications was completed at the time of recertification comprehensive assessments on 1-7-2014, 3-6-2014, and 5-5-2014. 4. An undated agency policy titled Medication Reconciliation states, "Medications ordered while the patient is receiving care will be compared to the medication list/profile. The medication list/profile will be updated with each new or changed medication. 5. Employee A, the administrator and a registered nurse (RN), on 5-22-2014 at 1005 AM, indicated the agency's process for medication review was for the RN to review the medication profile at the time of the visit for start of care, resumption of 		<p>registered nurse staff on the policies & the requirements as they relate to the completion and accuracy of the recertification comprehensive assessment, including the drug regimen review (G337) Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.26 Medication Administration and Management <p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the completion and accuracy of the recertification comprehensive assessment, including the drug regimen review</p>		

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	care, and recertification and place the date the review was completed at the bottom of the medication profile form.		<p>(G337). Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

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G000339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.</p> <p>Based on clinical record review, the agency failed to ensure the recertification assessment was complete and accurately reflected the patients' status in 2 (#s 5 and 10) of 7 records reviewed of patients who had a recertification assessment creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p> <p>Findings Include :</p> <p>1. Clinical record number 10 included a recertification comprehensive assessment completed on 4-8-2014. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The portion of the assessment that identified the condition of the patient's pupils and if there were any vision problems had been left blank.</p>	G000339	<p>Re-education with all registered nurse staff regarding professional expectations as they relate to the completion and accuracy of the recertification assessment (G339) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to the completion and accuracy of the recertification assessment (G339). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care 	06/10/2014			

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	<p>B. The urine color, clarity, odor present, and catheter present portions of the urinary assessment had been left blank</p> <p>2. Clinical record number 5 included a recertification comprehensive assessment. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The portion of the assessment that identified the condition of the patient's pupils and if there were any vision problems had been left blank.</p> <p>B. The assessment indicated the patient had intermittent pain but failed to identify the location of the pain, if the pain interfered with the patient's functional/activity level, if there was a pattern to the pain, and if breakthrough medication was needed.</p> <p>C. The skin turgor portion of the assessment had been left blank.</p> <p>D. The assessment identified the patient used nebulizer treatments. The assessment failed to include how many times per day, under what circumstances, if the treatments were effective, and the type of machine used.</p>		<p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC, including the type of services and equipment required.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the registered nurse accurately completes the recertification assessment. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure</p>	

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G000340	<p>E. The "rhythm" and "character" portion of the cardiovascular assessment had been left blank. The "other symptoms" and "other abnormalities" portion of the cardiovascular assessment had been left blank.</p> <p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.</p> <p>Based on clinical record review, the agency failed to ensure the resumption of care assessment was complete and accurately reflected the patients' status in 2 (#s 1 and 6) of 12 records reviewed creating the potential to affect all of the</p>	G000340	<p>compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all registered nurse staff regarding professional expectations as they relate to the completion and accuracy of the resumption assessment (G340) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by</p>	06/10/2014

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	<p>agency's patients who are hospitalized.</p> <p>Findings include:</p> <p>1. Clinical record number 6 included a resumption of care comprehensive assessment completed on 4-24-2014. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A) The assessment identified the patient's current pain level was a "9". The sections labeled, "interferes with" and "patient experiencing pain" of the assessment had been left blank.</p> <p>B) The assessment section labeled "home environment/safety" had been left blank.</p> <p>C) The assessment section labeled "advanced directives" had been left blank.</p> <p>D) The mobility assessment section titled "Timed Up and Go" was left blank.</p>		<p>the Executive Director on 6/10/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to the completion and accuracy of the resumption assessment (G340). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>After HCHB implementation on 6/15/14:</p> <ul style="list-style-type: none"> · DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to the completion and accuracy of the resumption assessment. Successful compliance will be 100%. All results are included in</p>		

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			<p>the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>		

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G000341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record and agency policy review and interview, the agency failed to ensure the comprehensive assessment had been updated at the time of discharge from the agency in 1 (# 1) of 2 discharged records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An agency policy dated 2-91 and revised 4-3, 5-3 and 8-4 titled 2.7 Patient Transfer/Discharge states, " A Transfer/Discharge OASIS is completed within 48 hours of transfer to an inpatient facility, discharge or notification of such." 2. Clinical record number 1 evidenced the patient had been transferred to the hospital on 3-22-14. The record evidenced the transfer comprehensive assessment had not been completed until 4-29-14. <p>The administrator stated, on 5-20-14 at 11:05 AM, "The nurse learned of the patient's transfer to the hospital on</p>	G000341	<p>Re-education with all registered nurse staff regarding professional expectations as they relate to the completion and accuracy of the discharge assessment (G341) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to the completion and accuracy of the discharge assessment (G341). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.7 Patient Transfer/Discharge 	06/10/2014

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	4-5-14. The patient resides in an assisted living facility. They are usually pretty good about notifying us when a patient goes to the hospital but didn't this time."		<p>After HCHB implementation on 6/15/14:</p> <ul style="list-style-type: none"> DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to the completion and accuracy of the discharge assessment. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is</p>		

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N000000	<p>This was a state home health relicensure survey.</p> <p>Survey dates: 5-20-14 to 5-23-14</p> <p>Facility #: 004583</p> <p>Medicaid #: 200512710B</p> <p>Surveyors: Vickie, Harmon RN, PHNS Nina Koch, RN, PHNS</p> <p>Census: 353 Skilled unduplicated skilled nursing admissions in the past year</p>	N000000	<p>unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>See Plan of Correction.</p>	

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N000458	<p>Quality Review: Joyce Elder, MSN, BSN, RN June 2, 2014</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.</p> <p>Based on interview and review of personnel files, the agency failed to ensure that agency personnel files included an annual performance evaluation for 1 of 11 employee files reviewed.</p> <p>Findings Include:</p> <p>1. The personnel file for employee A, the agency's administrator, date of hire 11/23/12, failed to include an annual</p>	N000458	<p>Employee file – Employee A has been reviewed and an annual performance evaluation was completed and given to the employee on 6/10/14.</p> <p>To ensure ongoing compliance, 10 personnel files will be audited quarterly to ensure that annual performance evaluations are completed according Indiana licensure certification requirements. Successful compliance will be 100%. All</p>	06/10/2014

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	<p>performance evaluation of the employee.</p> <p>2. The employee stated that she had a copy of her ninety day performance evaluation but that documentation of a annual evaluation was not available.</p>		<p>results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>		

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N000518	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record review, agency policy review, and interview, the agency failed to ensure documentation identified if the patient had an Advanced Directive in 2 of 12 records reviewed (# 5, 6) with the potential to affect all the agency's active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 6, start of care 3-21-14, included an "Admission Consent & Service Agreement", signed by the patient on 3-21-14 and a start of care comprehensive assessment dated 2-28-14. Both documents failed to evidence if the patient had executed an advance directive. 2. An agency policy titled "2.9 Advanced Directives" dated 12-91, revised 4-03 and 5-03 states, "The existence or non-existence of an advance directive 	N000518	<p>Re-education with all clinicians – nursing and therapy staffs of the requirement to inform; distribute written information to the patient, in advance, concerning the HHA's policies on advance directives, including a description of applicable State law; and to document evidence if the patient has executed an advance directive. Education was completed on 6/3/14 by the Director of Professional Services (DPS).</p> <p>The two patients #5 and #6 were contacted via phone by the DPS to determine if the patient had executed an advance directive. This communication was documented on the Communication Note on 6/6/14.</p>	06/15/2014
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	<p>will be documented on the Start of Care OASIS and on the conditions of admission form."</p> <p>3. Employee A, the administrator, on 5-20-2014 at 445 PM, indicated the receipt of information about advanced directives is to be documented on the Admission Consent and Service Agreement at the start of care.</p> <p>4. Clinical record number 5, start of care 2-28-14, included an "Admission Consent & Service Agreement", signed by the patient on 2-28-14 and a start of care comprehensive assessment dated 2-28-14. Both documents failed to evidence if the patient had executed an advance directive.</p>		<p>Documentation of an executed advance directive will be located on the Admission Consent and Service Agreement and/or the SOC Comprehensive Assessment beginning 6/3/14.</p> <p>Documentation of an executed advance directive will be located on the Conditions of Admission form and within the EMR (HCHB) on the Client Information Report beginning with all admissions beginning with the implementation of HCHB on 6/15/14.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure that the admitting clinician has documented if the patient has executed an advance directive. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</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: Based on clinical record and agency policy review, home visit observation, and interview, the agency failed to ensure care and services had been provided in accordance with physician orders in 4 (#s 4, 5, 6, and 7) of 12 records reviewed creating the potential to affect all of the agency's 353 current patients.</p>	N000522	<p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to provision of care in accordance with physician orders (N522) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14. Continued re-education of all agency staff the policies & the requirements as</p>	06/10/2014

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	<p>Findings include:</p> <p>1. The record for patient number 4 included a plan of care established by the patient's physician for the certification period 3-25-2014 to 5-23-2014 that included orders for skilled nurse to monitor for adherence to diabetic regimen, signs and symptoms of exacerbation, lesions of lower extremities, worsening of diabetic condition, notify physician if condition not improving and for physical therapy (PT) two times weekly for five weeks, and occupational therapy (OT) two times weekly for two weeks and one time weekly for two weeks beginning 3-31-2014.</p> <p>A. An initial comprehensive assessment completed at the start of care failed to include assessment of recommended blood glucose ranges or frequency to check the blood glucose. Skilled nursing notes for the certification period failed to evidence teaching or assessment for adherence to a diabetic regimen or safe blood glucose parameters.</p> <p>B. The clinical record evidenced a physician order to apply antibiotic ointment topically to any open area at each dressing change weekly and as</p>		<p>they relate to provision of care in accordance with physician orders (N522). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>After HCHB implementation on 6/15/14 the DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the provision of care in accordance with physician orders. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance. Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home</p>	

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	<p>needed to prevent infection. Skilled nursing notes dated 4-17-2014 to 5-8-2014 identified open areas but failed to evidence that antibiotic ointment was applied.</p> <p>C. The clinical record failed to evidence that the patient was seen by the occupational therapist for the week of 4-6-2014 to 4-12-2014.</p> <p>D. The clinical record evidenced only one visit from the physical therapist for the weeks of 4-6-2014 to 4-12-2014 and 4-13-2014 to 4-19-2014</p> <p>E. The administrator indicated on 5-22-2014 at 330 PM the skilled nursing notes did not indicate interventions for diabetes care and antibiotic ointment as ordered and the record did not contain PT and OT notes for the dates specified.</p> <p>2. The record for patient number 6 included a plan of care (POC) for the certification period 3-21-2014 to 5-19-2014 with orders for regular diet, complete metabolic panel (CMP), complete blood count (CBC), and trileptal level to be collected by 4-14-2014.</p> <p>A. The clinical record failed to evidence that the trileptal level was</p>		<p>visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>	

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	<p>collected as ordered. A lab report for blood specimens collected 4-11-2014 included only results for a CBC and CMP.</p> <p>B. A skilled nursing visit note dated 4-11-2-14 evidenced low sodium diet teaching to decrease edema in the patient's bilateral lower extremities. The POC includes a regular diet and failed to evidence physician orders for low sodium diet teaching.</p> <p>C. A skilled nursing visit note dated 4-1 indicated that a urine specimen was collected p order in the patient's home. The clinical record evidence a physician order to collect a urine sp</p> <p>D. The comprehensive nursing assessment completed by the registered nurse, evidenced +2 edema in bilateral extremities. Skilled nursing visit notes dated 4-11-2014 and 4-14-2014 evidence teaching to wear elastic stockings and to keep feet elevated to reduce edema. The clinical record failed to evidence a physican order for elastic stockings or managment of edema to the lower extremties.</p> <p>3. The record for patient number 7 included a plan of care for the certification period 4-9-2-14 to 6-7-2014 with orders for skilled nursing one time</p>			

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	<p>weekly for three weeks and every other week for six weeks to assess right neck incision, monitor adherence to diabetic regimen, instruct diabetic management to include 1800 calorie diabetic diet, foot care education and signs and symptoms of hypo/hyperglycemia, assess and instruct use of glucometer and sliding scale (SS) insulin, notify physician with blood glucose results less than 60 and greater than 300, notify physician of blood pressure (BP) greater than 180/100 ... pulse less than 60 and assess effects of pain medication.</p> <p>A. Skilled nursing visit notes dated 4-18-2014, 4-24-2014, and 5-14-2014 failed to evidence the nurse assessed the right neck incision, evaluated the patient"s use of a glucometer, or performed diabetic teaching. Visit notes dated 4-24-2014 and 5-14-2014 failed to evidence the skilled nurse evaluated the patient blood sugar and use of SS insulin.</p> <p>B. A nursing note dated 4-18-2014 states, "The patient had an elevated blood pressure yesterday AM 154/106. The clinical record failed to evidence the physician was notified of the elevated BP.</p> <p>C. On 5-21-2014 at 3 PM, employee D, a registered nurse (RN), was observed</p>			

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	<p>to provide care to the patient. The RN failed to assess the patient's use of a glucometer, did not provide instruction about diabetes care or 1800 calorie diet and did not evaluate the incision site to the right neck. The patient complained of pain in her throat and the skilled nurse stated, "This was due to her fibromyalgia" but did not assess the patient's pain for character, onset, duration, or intensity. The patient stated, "When she had a heart attack in 2004, the pain was mostly in her neck."</p> <p>D. The clinical record failed to evidence a nursing visit was made during the week of 5-4/2014 to 5-10-2014.</p> <p>E. A nursing note dated 4-12-2014 indicated the patient called to report a pulse of 47 and she was unsure whether to take her pain medication. The clinical record failed to evidence that the physician was notified.</p> <p>4. An agency policy titled "Plan of care-CMS # 485 and Physician Orders," undated, states, "Care and services provided will be provided according to the physician orders."</p> <p>5. Clinical record number 5 failed to evidence therapy evaluations were completed as ordered and that laboratory specimens were obtained as ordered. The</p>			

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	<p>record included a plan of care for the certification period 2-28-14 to 4-28-14 that states, "Obtain therapy evaluation: PT [physical therapy] & OT [occupational therapy]." The record also included a "Physician's Verbal/Communication Note" dated 3-27-14 that states, "Repeat PT/INR [blood test] 4/2/14."</p> <p>A. The record failed to evidence the physical and occupational therapy evaluations had been completed.</p> <p>B. The administrator stated, on 5-21-14 at 10:15 AM, "The evaluations were not done."</p> <p>C. The record failed to evidence the skilled nurse had obtained the ordered laboratory test on 4-2-14.</p> <p>D. The record included a skilled nurse visit note dated 4-11-14 that states, "PT/INR per microcoag [type of machine] 39.7/4.0." The record failed to evidence an order for the skilled nurse to obtain the blood specimen on 4-11-14.</p> <p>E. The administrator indicated, on 5-21-14 at 10:15 AM, the record did not evidence the skilled nurse had obtained the ordered blood specimen on 4-2-14 and that the record did not include an</p>			

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N000524	<p>order for the skilled nurse to obtain a blood specimen on 4-11-14.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record review and observation agency failed to ensure the plan of care include equipment required for 1 (# 9) of 12 records re-creating the potential to affect all 353 of the ag patients. Findings Include:</p>	N000524	Re-education with all agency staff regarding professional expectations as they relate to the development of the POC, including the type of services and equipment required (N524) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14. Continued	06/10/2014

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NAME OF PROVIDER OR SUPPLIER OMNI HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 N WEINBACK AVE STE 610 EVANSVILLE, IN 47711
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	A home visit was made to patient number 9 on at 1230 PM with employee F, a physical therapist (PTA). The PTA was observed to ambulate the patient using a gait belt. The plan of care for the certification period 4-1-2014 to 5-30-2014 failed to evidence a gait belt.		re-education of all agency staff on the requirements as they relate to the development of the POC, including the type of services and equipment required (N524). Re-education to be completed by DPS by 6/20/14 . All staff will be re-educated in the principles of the following policies: <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders After HCHB implementation on 6/15/14 the DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC, including the type of services and equipment required. To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure that the POC developed, includes the type of services and equipment required. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance. Additionally every agency receives at least one corporate audit annually. The	

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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 clinical record review and agency policy review, the agency failed to ensure the agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care for 2 of 12 records reviewed (6, 7) with the potential to affect all of the agency's active patients.</p> <p>Findings Include:</p>	N000527	<p>purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to physician notification of any changes that suggest the need to alter the plan of care (N527) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14. Continued re-education of all agency staff on the requirements as they relate to physician notification of any</p>	06/10/2014

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	<p>1. Clinical record number 6 included a resumption of care assessment on 4-24-2014 where the skilled nurse documented the patient's pain level was a "9" on a scale of 1 - 10. The record failed to evidence that the physician had been notified of the patient's pain level.</p> <p>2. Clinical record number 7 included a plan of care for the certification period 4-9-2-14 to 6-7-2014 with an order to notify the physician for pulse less than 60 and greater than 100. The record evidenced a skilled nursing note dated 4-12-2014 stating that the patient called to report a pulse of 47 and the patient was unsure whether to take pain medication. The clinical record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 4-98 titled "2.17 Plan of Care" states, "The RN(registered nurse) ... will contact the patient's physician or his/her agent to report assessment findings. ... Documentation of the clinician's communication with the physician must be maintained in the medical record."</p>		<p>changes that suggest the need to alter the plan of care (N527). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies: · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders After HCHB implementation on 6/15/14: · DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. · Missed Visits - any ordered visit that is missed will generate a Missed Visit Note to be reviewed by the CLM and sent to the physician by the CLM. · Reporting of Clinical Changes that may require the alteration of the POC -Vitals Signs outside of MD ordered parameters alert the clinician at the time of occurrence. After the visit is transmitted the CLM is alerted to any vital signs outside of MD ordered parameters, including pain. · Reporting of Clinical Changes that may require the alteration of the POC Physician notification will be documented in a Physician Notification Coordination Note. To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the occurrence of physician notification of any changes that</p>		

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N000537	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		suggest the need to alter the plan of care. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance. Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance		

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	<p>nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review, home visit observation, and interview, the agency failed to ensure nursing services had been provided in accordance with physician orders in 4 (#s 4, 5, 6, and 7) of 12 records reviewed creating the potential to affect all of the agency's 353 current patients.</p> <p>Findings include:</p> <p>1. The record for patient number 4 included a plan of care established by the patient's physician for the certification period 3-25-2014 to 5-23-2014 that included orders for skilled nurse to monitor for adherence to diabetic regimen, signs and symptoms of exacerbation, lesions of lower extremities, worsening of diabetic condition, notify physician if condition not improving.</p> <p>A. An initial comprehensive assessment completed at the start of care failed to include assessment of recommended blood glucose ranges or frequency to check the blood glucose. Skilled nursing notes for the certification period failed to evidence teaching or assessment for adherence to a diabetic regimen or safe blood glucose</p>	N000537	<p>Re-education with all agency staff regarding professional expectations as they relate to provision of care in accordance with physician orders (N537) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14. Continued re-education of all agency staff the policies & the requirements as they relate to provision of care in accordance with physician orders (N537). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policy: · 2.17 Plan of Care · 2.18 Verbal Orders After HCHB implementation on 6/15/14 the DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the provision of care in accordance with physician orders. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and</p>	06/10/2014			

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	<p>parameters.</p> <p>B. The clinical record evidenced a physician order to apply antibiotic ointment topically to any open area at each dressing change weekly and as needed to prevent infection. Skilled nursing notes dated 4-17-2014 to 5-8-2014 identified open areas but failed to evidence that antibiotic ointment was applied.</p> <p>C. The administrator indicated on 5-22-2014 at 330 PM the skilled nursing notes did not indicate interventions for diabetes care and antibiotic ointment as ordered.</p> <p>2. The record for patient number 6 included a plan of care (POC) for the certification period 3-21-2014 to 5-19-2014 with orders for regular diet, complete metabolic panel (CMP), complete blood count (CBC), and trileptal level to be collected by 4-14-2014.</p> <p>A. The clinical record failed to evidence that the trileptal level was collected as ordered. A lab report for blood specimens collected 4-11-2014 included only results for a CBC and CMP.</p>		<p>analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance. Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>				

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	<p>B. A skilled nursing visit note dated 4-11-2014 evidenced low sodium diet teaching to decrease edema in the patient's bilateral lower extremities. The POC includes a regular diet and failed to evidence physician orders for low sodium diet teaching.</p> <p>C. A skilled nursing visit note dated 4-11-2014 indicated that a urine specimen was collected per order in the patient's home. The clinical record failed to evidence a physician order to collect a urine specimen.</p> <p>D. The comprehensive nursing assessment completed by the registered nurse, evidenced +2 edema in bilateral extremities. Skilled nursing visit notes dated 4-11-2014 and 4-14-2014 evidenced teaching to wear elastic stockings and to keep feet elevated to reduce edema. The clinical record failed to evidence a physician order for elastic stockings or management of edema to the lower extremities.</p> <p>3. The record for patient number 7 included a plan of care for the certification period 4-9-2014 to 6-7-2014 with orders for skilled nursing one time weekly for three weeks and every other week for six weeks to assess right neck incision, monitor adherence to diabetic regimen, instruct diabetic management to include 1800 calorie diabetic diet, foot</p>			

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	<p>care education and signs and symptoms of hypo/hyperglycemia, assess and instruct use of glucometer and sliding scale (SS) insulin, notify physician with blood glucose results less than 60 and greater than 300, notify physician of blood pressure (BP) greater than 180/100 ... pulse less than 60 and assess effects of pain medication.</p> <p>A. Skilled nursing visit notes dated 4-18-2014, 4-24-2014, and 5-14-2014 failed to evidence the nurse assessed the right neck incision, evaluated the patient's use of a glucometer, or performed diabetic teaching. Visit notes dated 4-24-2014 and 5-14-2014 failed to evidence the skilled nurse evaluated the patient blood sugar and use of SS insulin.</p> <p>B. A nursing note dated 4-18-2014 states, "The patient had an elevated blood pressure yesterday AM 154/106. The clinical record failed to evidence the physician was notified of the elevated BP.</p> <p>C. On 5-21-2014 at 3 PM, employee D, a registered nurse (RN), was observed to provide care to the patient. The RN failed to assess the patient's use of a glucometer, did not provide instruction about diabetes care or 1800 calorie diet and did not evaluate the incision site to</p>			

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	<p>the right neck. The patient complained of pain in her throat and the skilled nurse stated, "This was due to her fibromyalgia" but did not assess the patient's pain for character, onset, duration, or intensity. The patient stated, "When she had a heart attack in 2004, the pain was mostly in her neck."</p> <p>D. A nursing note dated 4-12-2014 indicated the patient called to report a pulse of 47 and she was unsure whether to take her pain medication. The clinical record failed to evidence that the physician was notified.</p> <p>4. An agency policy titled "Plan of care-CMS # 485 and Physician Orders," undated, states, "Care and services provided will be provided according to the physician orders."</p> <p>5. Clinical record number 5 failed to evidence laboratory specimens were obtained as ordered. The record included a "Physician's Verbal/Communication Note" dated 3-27-14 that states, "Repeat PT/INR [blood test] 4/2/14."</p> <p>A. The record failed to evidence the skilled nurse had obtained the ordered laboratory test on 4-2-14.</p>			

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N000541	<p>B. The record included a skilled nurse visit note dated 4-11-14 that states, "PT/INR per microcoag [type of machine] 39.7/4.0." The record failed to evidence an order for the skilled nurse to obtain the blood specimen on 4-11-14.</p> <p>C. The administrator indicated, on 5-21-14 at 10:15 AM, the record did not evidence the skilled nurse had obtained the ordered blood specimen on 4-2-14 and that the record did not include an order for the skilled nurse to obtain a blood specimen on 4-11-14.</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review, the agency failed to ensure the registered nurse completely and accurately evaluated the patient's needs at the time of recertification or resumption of care after hospitalization in 4 (#s 1, 5, 6, and 10) of 12 records reviewed of patients who had a recertification or resumption of care assessment creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p>	N000541	Re-education with all registered nurse staff regarding professional expectations as they relate to the completion and accuracy of the start of care comprehensive assessments (N541) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.	06/10/2014			

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	<p>Findings Include :</p> <p>1. Clinical record number 6 included a resumption of care comprehensive assessment completed on 4-24-2014. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A) The assessment identified the patient's current pain level was a "9". The sections labeled, "interferes with" and "patient experiencing pain" of the assessment had been left blank.</p> <p>B) The assessment section labeled "home environment/safety" had been left blank.</p> <p>C) The assessment section labeled "advanced directives" had been left blank.</p> <p>D) The mobility assessment section titled "Timed Up and Go" was left blank.</p> <p>2. Clinical record number 10 included a recertification comprehensive assessment completed on 4-8-2014. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The portion of the assessment that identified the condition of the patient's</p>		<p>Continued re-education of all registered nurse staff on the policies & the requirements as they relate to the completion and accuracy of the start of care comprehensive assessments (N541). Education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>After HCHB implementation on 6/15/14 the</p> <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the completion and accuracy of the start of care comprehensive assessments (G335).</p> <p>Successful compliance will be 100%. All results are included in</p>		

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	<p>pupils and if there were any vision problems had been left blank.</p> <p>B. The urine color, clarity, odor present, and catheter present portions of the urinary assessment had been left blank</p> <p>3. Clinical record number 1 included a resumption of care comprehensive assessment dated 3-22-14. The assessment failed to be complete and accurately reflect the patient's status.</p> <p>A. The pain assessment indicated the patient had pain in the right hip and knee and the left knee. The assessment failed to indicate how the pain interfered with or impacted the patient's functional/activity level. This portion of the assessment had been left blank.</p> <p>B. The assessment identified the patient used nebulizer treatments. The assessment failed to include how many times per day, under what circumstances, if the treatments were effective, and the type of machine used.</p> <p>4. Clinical record number 5 included a recertification comprehensive assessment. The assessment failed to be complete and accurately reflect the patient's status.</p>		<p>the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p>		

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N000542	<p>A. The portion of the assessment that identified the condition of the patient's pupils and if there were any vision problems had been left blank.</p> <p>B. The assessment indicated the patient had intermittent pain but failed to identify the location of the pain, if the pain interfered with the patient's functional/activity level, if there was a pattern to the pain, and if breakthrough medication was needed.</p> <p>C. The skin turgor portion of the assessment had been left blank.</p> <p>D. The assessment identified the patient used nebulizer treatments. The assessment failed to include how many times per day, under what circumstances, if the treatments were effective, and the type of machine used.</p> <p>E. The "rhythm" and "character" portion of the cardiovascular assessment had been left blank. The "other symptoms" and "other abnormalities" portion of the cardiovascular assessment had been left blank.</p>			
	410 IAC 17-14-1(a)(1)(C)			

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	<p>Scope of Services</p> <p>Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record review and observation, the agency failed to ensure the registered nurse (RN) had updated and revised the plan of care (POC) in 3 (#s 4, 6, 7) of 12 records reviewed creating the potential to affect all of the agency's 353 current patients that receive skilled nursing services.</p> <p>Findings Include:</p> <p>1. Clinical record number 6 includes a plan of care established by the patient's physician for the period 3-21-2014 to 5-19-2014. A skilled nurse note dated 4-16-2014 by employee C, a RN, state urine specimen was collected per written order patient's home. The clinical record failed to evidence RN obtained a physician order to collect a urine</p> <p>2. Clinical record number 4 failed to evidence the RN had updated the plan of care to reflect the patient's current needs and status. The clinical record contained a resumption of care comprehensive nursing assessment completed 4-11-2014. The section titled "endocrine assessment" evidenced that the patient used a</p>	N000542	<p>Re-education with all registered nurse staff regarding professional expectations as they relate to the responsibility to update and revise the plan of care (N542) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive Director on 6/10/14.</p> <p>Continued re-education of all registered nurse staff on the requirements as they relate to the responsibility to update and revise the plan of care (N542). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.6 Assessment/Reassessment · 2.17 Plan of Care <p>After HCHB implementation on 6/15/14 the</p>	06/10/2014			

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	<p>glucometer (blood sugar monitoring device). The record failed to evidence the RN updated the POC to include frequency of testing or parameters for results of blood sugar.</p> <p>3. The clinical record for patient number 7 incl of care established by the patient's physician fo certification period 4-9-2014 to 5-7-2014. A m comprehensive assessment completed 4-9-2014 the patient has fibromyalgia. During a home vi 5-21-2014 at 3 PM, employee D, a RN, was ob instructing the patient about fibromyalgia. The record failed to evidence the RN updated the pl to include nursing care and teaching for fibrom</p>		<p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC, including the type of services and equipment required.</p> <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the registered nurse updates and/or revises the plan of care as needed. Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses</p>		

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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 clinical record and agency policy review, the registered nurse (RN) failed to inform the physician of changes in the patient's condition and needs for 2 of 12 (#s 6,7) records reviewed creating the potential to affect all of the agency's patients receiving skilled nursing</p>	N000546	<p>medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to physician notification of any changes that suggest the need to alter the plan of care (N546) was done at the 6/10/14 mandatory staff meeting. This re-education was completed by the Executive</p>	06/10/2014

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	<p>services.</p> <p>Findings include:</p> <p>1. Clinical record number 6 included a resumption of care assessment on 4-24-2014 where the skilled nurse documented the patient's pain level was a "9" on a scale of 1 - 10. The record failed to evidence that the physician had been notified of the patient's pain level.</p> <p>2. Clinical record number 7 included a plan of care for the certification period 4-9-2-14 to 6-7-2014 with an order to notify the physician for pulse less than 60 and greater than 100. The record evidenced a skilled nursing note dated 4-12-2014 stating that the patient called to report a pulse of 47 and the patient was unsure whether to take pain medication. The clinical record failed to evidence the physician was notified.</p> <p>3. An agency policy dated 4-98 titled "2.17 Plan of Care" states, "The RN(registered nurse) ... will contact the patient's physician or his/her agent to report assessment findings. ... Documentation of the clinician's communication with the physician must be maintained in the medical record."</p>		<p>Director on 6/10/14.</p> <p>Continued re-education of all agency staff on the requirements as they relate to physician notification of any changes that suggest the need to alter the plan of care (N546). Re-education to be completed by DPS by 6/20/14. All staff will be re-educated in the principles of the following policies:</p> <ul style="list-style-type: none"> · 2.3 Physician Responsibility · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders <p>After HCHB implementation on 6/15/14:</p> <ul style="list-style-type: none"> · DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. · Missed Visits - any ordered visit that is missed will generate a Missed Visit Note to be reviewed by the CLM and sent to the physician by the CLM. 		

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			<ul style="list-style-type: none"> Reporting of Clinical Changes that may require the alteration of the POC -Vitals Signs outside of MD ordered parameters alert the clinician at the time of occurrence. After the visit is transmitted the CLM is alerted to any vital signs outside of MD ordered parameters, including pain. Reporting of Clinical Changes that may require the alteration of the POC Physician notification will be documented in a Physician Notification Coordination Note. <p>To ensure ongoing compliance, 5 chart audits will be conducted weekly for a maximum of 20 charts per month x 3 months to ensure the occurrence of physician notification of any changes that suggest the need to alter the plan of care.</p> <p>Successful compliance will be 100%. All results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. The DPS is ultimately responsible for ongoing compliance.</p>	

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			<p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance <i>with</i> all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated. The DPS is ultimately responsible for ongoing compliance</p>		