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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15K066 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/14/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448 |
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| G000000 | <p>This was a Federal home health recertification survey. This was an extended survey.</p> <p>Survey Dates: March 11, 12, 13, 14, and 17, 2014</p> <p>Facility #: 012412</p> <p>Medicaid Vendor #: 201013320</p> <p>Surveyors: Shannon Pietraszewski, RN, PHNS</p> <p>Census: 102</p> <p>Lifecare Home Health is precluded from providing its own home health aide training and/or competency evaluation program for two years beginning 3/25/14 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30 Skilled Nursing Services.</p> <p>The Administrator and the Director of Clinical Services were informed of the above-stated preclusion at the exit conference held at this agency on 3/17/14</p> | G000000 |  |  |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|  | <p>at 4:00 PM.</p> <p>Quality Review: Joyce Elder, MSN,<br/>BSN, RN</p> <p>March 25, 2014</p> |  |  |  |
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| G000121 | <p>484.12(c)<br/>COMPLIANCE W/ ACCEPTED PROFESSIONAL STD<br/>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.<br/>Based on observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 2 of 3 home visit observations completed creating the potential to affect all of the agency's 44 current patients. (#3 and 5)</p> <p>The findings include:</p> <p>1. The agency's policy titled "Standard Precautions" dated 08/22/11 stated, "Organization personnel will adhere to the following precautions and will instruct patients and family / caregivers in infection control precautions, as appropriate to the patient's care needs ... Under standard precautions, blood and certain body fluids of all patients are considered potentially infectious for blood borne pathogens, such as human immunodeficiency virus (HIV), and hepatitis B virus (HBV). Standard precautions apply to blood and other body fluids potentially containing blood or bloodborne pathogens. These body fluids</p> | G000121 | <p>The DON has conducted in-services to all direct care staff on the following: Universal Precautions, hand washing technique, cleaning of equipment, bag technique, glove use and clean work surfaces. Education on aspects of infection control will be conducted on hire, annually and as needed. Competency with hand washing, glove use and nursing bag techniques will be conducted as part of the orientation process. The DON will be responsible for monitoring the corrective actions to ensure that this deficiency does not recur.</p> | 04/11/2014 |
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|                    | <p>include: emesis, sputum, feces, urine ... "</p> <p>2. The agency's policy titled "Universal Precautions" dated 11/30/12 stated, "In order to protect employees, patients, families and caregivers from exposure to blood or body fluids, the staff will use Universal Precautions at all times ... Hand washing procedure will be used at all times, and will not be negated due to use of gloves ... Standard or Universal Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which care is delivered ... Wear gloves whenever handling client body fluids or linens soiled with body fluids ... "</p> <p>3. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> |               |   |                      |

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|  | <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves.</p> <p>IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>4. A home visit was made to patient number 3 on 03/12/14 at 1:00 PM with employee B, a Licensed Practical Nurse. During the home visit, Employee B was observed to preset medication planners and prefilled insulin syringes for the patient who was visually impaired. She washed her hands and donned clean</p> |  |  |  |
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|                    | <p>gloves and placed the pill planner boxes on the patient's kitchen table without preparing a clean work area. She then filled the pill planners with medications, removing the pill from foil packaging touching the pills with her gloved hands as she placed them in the pill planner. During the medication set up she was touching the tabletop and pushing back her sleeves with her gloved hands. Employee B then used her gloved hands to sweep the trash and debris from the tabletop and placed it in the trash. She then began to prefill insulin syringes for patient # 3 without changing her gloves or washing her hands and again without cleaning the work area on the tabletop. Employee B then removed her stethoscope from around her neck and auscultated the patients heart and lung sounds without first cleaning her stethoscope. She then assessed the patient's feet and pedal pulses and, without changing her gloves or washing her hands, returned the stethoscope around her neck without cleaning it.</p> <p>5. A home visit was made to patient # 5 home on 03/14/14 at 9:30 AM with employee D, a home health aide. During the home visit, the aide was observed to remove the patients brief and clothing prior to washing hands and donning gloves. Employee D picked up</p> |               |   |                      |

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|  | <p>the brief and placed the brief in the trash without wearing gloves. Employee D began to assist the patient with bathing, washing the areas of the patients the body that the patient was unable to reach, and drying the patient's back all without wearing gloves. Employee D assisted the patient with her clothes and deodorant without wearing gloves or washing her hands. She then picked up soiled clothing and towels from the floor without gloves and placed them on the chair. She assisted the patient to the living room and returned to the bathroom, picked up the clothes with bare hands, and placed the dirty clothes in the utility room to be washed.</p> <p>6. The Director of Nursing indicated on 03/14/14 at 11:00 AM the employees did not follow the agency's own infection control procedures and policy.</p> |  |  |  |
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| G000143   | <p>484.14(g)<br/>COORDINATION OF PATIENT SERVICES<br/>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and policy review, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 3 of 10 clinical records reviewed creating the potential to affect all patients receiving more than one service. (#1, 2, and 6 )</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 1 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 that evidenced the patient was receiving services from another agency. The clinical record failed to evidence communication and / or coordination of care with the other agency.</li> <li>Clinical record number 2, start of care (SOC) 07/07/11, failed to evidence the home health aide communicated with the case manager. <ol style="list-style-type: none"> <li>A home health aide (HHA) visit note dated 12/09/13 at 07:40 AM stated,</li> </ol> </li> </ol> | G000143   | The Administrator and DON have conducted in-services with all home health aides for the need to report any changes in patient condition the the RN case manager and the required documentation. A new communication for change of condition form has been developed to document the change and the follow up measures. The DON has in-serviced all nursing case managers on the need to coordinate all care needs with all entities involved in patient care and the reporting process for changes in patient condition. The clinical records have been audited for compliance with care coordination needs. The DON will review each new start of care to identify those patients who have care coordination needs and follow up with the RN case manager for compliance. 10% of the clinical records will be audited quarterly to ensure compliance with reporting change of condition and care coordination. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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|   | <p>"Area of broken skin on (L) buttock 1/4" [inch] diameter ... " The clinical record failed to evidence the case manager was notified.</p> <p>b. A HHA note dated 12/31/13 at 8:50 PM and 01/28/14 at 8:56 PM indicated the patient's buttocks was free of any sores. A HHA visit note dated 01/30/14 at 10:00 PM stated, "She has a little rash on her right thigh ... " The clinical record failed to evidence the case manager was notified.</p> <p>c. A HHA visit note dated 01/31/14 at 4:45 (no AM or PM indicated) stated, "Her left shoulder hurts today ... " A visit note dated 02/01/14 at 4:42 (no AM or PM indicated) stated, "[Name of Patient] shoulder still hurts. She decided not to shower today to avoid any strain on her shoulder ..." The clinical record failed to evidence the case manager was notified.</p> <p>d. A HHA visit note dated 02/06/14 at 9:51 PM stated, "She turned over in bed and twisted her left knee. She yelled, but there was nothing observable." A HHA visit note dated 02/07/14 at 4:35 PM stated "[Name of Patient] left knee is sore today ... " The clinical record failed to evidence the case manager was notified.</p> |   |   |   |  |   |  |

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|  | <p>e. An attendant care note dated 02/11/14 at 2:50 AM stated, "Desitin applied to 1/4" [inch] diameter skin breakdown on (L) buttock ... " The clinical record failed to evidence the case manager was notified.</p> <p>f. A HHA visit note dated 02/15/14 at 8:20 AM stated, "Desitin applied to area on (L) buttock with skin breakdown [a little more than 1/4"] ... " The clinical record failed to evidence the case manager was notified.</p> <p>h. A HHA visit note dated 02/18/14 at 8:57 AM indicated the patient's bottom was healed. A HHA visit note dated 02/25/14 at 9:49 PM stated "(Name of Patient) has 2 sores on her bottom - one on each cheek ... " The clinical record failed to evidence the case manager was notified.</p> <p>i. A HHA visit note dated 02/27/14 at 9:43 PM stated, "She had patches on the sores on her bottom ... " The clinical record failed to evidence the case manager was notified.</p> <p>j. A HHA visit note dated 03/01/14 at 4:23 PM stated, "There is one sore on [Name of Patient] bottom that is of concern [size of sore drawn] that size ... " The clinical record failed to evidence the</p> |  |  |  |
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|  | <p>case manager was notified.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 for HHA up to 4 hours daily up to 7 days per week. The plan of care stated the patient was receiving attendant care services with an outside provider. The HHA, employee C, worked for both the agency and the outside provider as an attendant.</p> <p>a. During a home visit on 03/12/14 at 2:00 PM, a binder with the HHA paperwork was on the counter of the patient's kitchen. Upon reviewing the visit notes, it was observed that the home health aide was mixing / combining her duties under the surveying agency and under the outside agency. Employee C, a home health aide, documented that employee C gave the patient a bath at 8:30 AM for the outside provider and gave a bath at 9:30 AM for the agency.</p> <p>b. Employee C indicated during the visit that she was told by her agency that she must document that she provided the services on their form, same as she would document for the agency. The employee indicated she was hired by both agencies and she was in the patient's home all day until 3:00 PM.</p> |  |  |  |
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|  | <p>c. The Director of Nursing indicated the Alternate Administrator for the agency was also the Administrator for the outside provider. The outside agency was in the same building and utilized the same aides for both services. The Director of Nursing indicated she didn't think about checking and comparing the duties of the agency home health aides to the outside agency's attendant care services.</p> <p>3. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated, "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Coordinate patient services between other care providers as necessary."</p> |  |  |  |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15K066 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                    |  | X3) DATE SURVEY COMPLETED<br><br>03/14/2014 |  |
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| G000144   | <p>484.14(g)<br/>COORDINATION OF PATIENT SERVICES<br/>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p> <p>Based on clinical record and policy review, the agency failed to ensure all personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 3 of 10 clinical records reviewed creating the potential to affect all patients receiving more than one service. (#1, 2, and 6 )</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record 1 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 that evidenced the patient was receiving services from another agency. The clinical record failed to evidence communication and / or coordination of care with the other agency.</li> <li>Clinical record number 2, start of care (SOC) 07/07/11, failed to evidence the home health aide communicated with the case manager.</li> </ol> | G000144   | The Administrator and DON have conducted in-services with all home health aides for the need to report any changes in patient condition the the RN case manager and the required documentation. A new communication for change of condition form has been developed to document the change and the follow up measures. The DON has in-serviced all nursing case managers on the need to coordinate all care needs with all entities involved in patient care and the reporting process for changes in patient condition. The clinical records have been audited for compliance with care coordination needs. The DON will review each new start of care to identify those patients who have care coordination needs and follow up with the RN case manager for compliance. 10% of the clinical records will be audited quarterly to ensure compliance with reporting change of condition and care coordination. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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|  | <p>a. A home health aide (HHA) visit note dated 12/09/13 at 07:40 AM stated, "Area of broken skin on (L) buttock 1/4" [inch] diameter ... " The clinical record failed to evidence the case manager was notified.</p> <p>b. A HHA note dated 12/31/13 at 8:50 PM and 01/28/14 at 8:56 PM indicated the patient's buttocks was free of any sores. A HHA visit note dated 01/30/14 at 10:00 PM stated, "She has a little rash on her right thigh ... " The clinical record failed to evidence the case manager was notified.</p> <p>c. A HHA visit note dated 01/31/14 at 4:45 (no AM or PM indicated) stated, "Her left shoulder hurts today ... " A visit note dated 02/01/14 at 4:42 (no AM or PM indicated) stated, "[Name of Patient] shoulder still hurts. She decided not to shower today to avoid any strain on her shoulder ..." The clinical record failed to evidence the case manager was notified.</p> <p>d. A HHA visit note dated 02/06/14 at 9:51 PM stated, "She turned over in bed and twisted her left knee. She yelled, but there was nothing observable." A HHA visit note dated 02/07/14 at 4:35 PM stated "[Name of Patient] left knee is sore today ... " The clinical record failed to evidence the case manager was</p> |  |  |  |
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|   | <p>notified.</p> <p>e. An attendant care note dated 02/11/14 at 2:50 AM stated, "Desitin applied to 1/4" [inch] diameter skin breakdown on (L) buttock ... " The clinical record failed to evidence the case manager was notified.</p> <p>f. A HHA visit note dated 02/15/14 at 8:20 AM stated, "Desitin applied to area on (L) buttock with skin breakdown [a little more than 1/4"] ... " The clinical record failed to evidence the case manager was notified.</p> <p>h. A HHA visit note dated 02/18/14 at 8:57 AM indicated the patient's bottom was healed. A HHA visit note dated 02/25/14 at 9:49 PM stated "(Name of Patient) has 2 sores on her bottom - one on each cheek ... " The clinical record failed to evidence the case manager was notified.</p> <p>i. A HHA visit note dated 02/27/14 at 9:43 PM stated, "She had patches on the sores on her bottom ... " The clinical record failed to evidence the case manager was notified.</p> <p>j. A HHA visit note dated 03/01/14 at 4:23 PM stated, "There is one sore on [Name of Patient] bottom that is of</p> |   |   |   |  |   |  |

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|  | <p>concern [size of sore drawn) that size ... "</p> <p>The clinical record failed to evidence the case manager was notified.</p> <p>2. Clinical record number 6 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 for HHA up to 4 hours daily up to 7 days per week. The plan of care stated the patient was receiving attendant care services with an outside provider. The HHA, employee C, worked for both the agency and the outside provider as an attendant.</p> <p>a. During a home visit on 03/12/14 at 2:00 PM, a binder with the HHA paperwork was on the counter of the patient's kitchen. Upon reviewing the visit notes, it was observed that the home health aide was mixing / combining her duties under the surveying agency and under the outside agency. Employee C, a home health aide, documented that employee C gave the patient a bath at 8:30 AM for the outside provider and gave a bath at 9:30 AM for the agency.</p> <p>b. Employee C indicated during the visit that she was told by her agency that she must document that she provided the services on their form, same as she would document for the agency. The employee indicated she was hired by both agencies</p> |  |  |  |
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|                    | <p>and she was in the patient's home all day until 3:00 PM.</p> <p>c. The Director of Nursing indicated the Alternate Administrator for the agency was also the Administrator for the outside provider. The outside agency was in the same building and utilized the same aides for both services. The Director of Nursing indicated she didn't think about checking and comparing the duties of the agency home health aides to the outside agency's attendant care services.</p> <p>3. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated, "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Coordinate patient services between other care providers as necessary."</p> |               |   |                      |

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| G000156   | <p>484.18<br/>ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and policy review, observation, and interview, it was determined the agency failed to ensure the visits were provided as ordered on the plan of care in 3 of 10 records reviewed creating the potential to affect all current 102 patients (See G 158); failed to ensure the plan of care had been updated and included all types of services and equipment required, frequency of visits, nutritional requirements, medications, and treatments for 5 of 10 records reviewed creating the potential to affect all 102 patients receiving services (See G 159); and failed to ensure a qualified professional notified the physician of changes in patients condition for 3 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients (See G 164).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to meet the requirements of the Condition of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p> | G000156   | The DON and RN homecare consultant have in-serviced the RN case managers on the development and completion of the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and followed. Education provided on documenting on the POC the frequency and duration of services, missed visit reporting and documentation and the need to report all changes in patient condition to the physician. The clinical records have been audited for the above deficiencies and have been addressed with the appropriate RN case manager. A process of communication form for condition changes has been implemented. The clinical documentation will be reviewed by the DON for compliance the POC and proper notification of change in condition. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC, notification of patient change in condition and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014           |   |

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| G000158   | <p>484.18<br/>ACCEPTANCE OF PATIENTS, POC, MED SUPER<br/>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.<br/>Based on clinical record and policy review and interview, the agency failed to ensure the visits were provided as ordered on the plan of care in 3 of 10 records reviewed (# 4, 5, and 10) creating the potential to affect all current 102 patients.<br/><br/>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14 with orders for skilled nursing to visit the patient daily 7 days a week for wound care. <ul style="list-style-type: none"> <li>a. A physician order dated 01/21/14 indicated to change nursing visits from 1 time a day to two times a day for wound care.</li> <li>b. A physician order dated 01/28/14 stated to change nursing visits from 2 times a day to 1 time a week for medication set up in the home.</li> <li>c. The clinical record failed to evidence skilled nursing visits were made</li> </ul> </li> </ol> | G000158   | The DON, Administrator & homecare consultant has in-serviced the clinical staff on following the POC, ensuring that all frequency of disciplines are documented on the POC and changes are noted with physician interim orders when necessary and those interim orders are followed. Education provided on documenting on the POC the frequency and duration of services, missed visit reporting, documentation of continued attempts to comply with frequency of visit as outlined on the POC and documentation and reporting of changes in patient condition to the physician. The clinical records have been audited for the above deficiencies and have been addressed with the appropriate professional. An RN consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will | 04/11/2014  |  |   |  |

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|                    | <p>on 1/19/14, 01/27/14, 01/28/14, and the week of 02/09/14. The clinical record included two visits made by a skilled nurse on 01/20/14.</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 12/27/13 to 02/24/14 with orders for skilled nursing visits weekly for medication set-up.</p> <p>a. The clinical record failed to evidence that a skilled nurse visited the patient during weeks 3, 4, 5, 6, 8, and 9.</p> <p>b. A progress note dated 02/11/14 stated the weather prevented the SN from visiting. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>c. A progress note dated 02/18/14 stated the weather prevented the SN from getting up the patient's driveway. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> <p>3. Clinical record 10 included a plan of</p> |               | not recur.  |                      |

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|  | <p>care established by the physician for the certification period of 12/11/13 to 02/08/14 with orders for a home health aide (HHA) up to 12 hours a day 7 days a week. The clinical record failed to evidence that a HHA visit was made between 12/11/13 to 12/17/13, between 12/20/13 to 12/22/13, and between 12/25/13 to 12/31/13.</p> <p>The Administrator and Director of Nursing indicated on 03/17/14 at 2:50 PM that the patient was combative and difficult to staff. The patient was discharged / transferred to another agency on 12/31/13.</p> <p>4. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Shall accept and carry out physician ... orders (oral and written) ... "</p> |  |  |  |
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| G000159   | <p>484.18(a)<br/>PLAN OF CARE</p> <p>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 observation, clinical record and policy review, and interview, the agency failed to ensure the plan of care had been updated and included all types of services and equipment required, frequency of visits, nutritional requirements, medications, and treatments for 5 of 10 records reviewed creating the potential to affect all 102 patients receiving services. (# 1, 2, 4, 5, and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 that stated, "RN [registered nurse] for supervision of home health aide [HHA] per State and Federal Regulations." Addendum 21 on the plan of care stated, "SN [skilled nurse] up to 2 hours a day, up to 3 days a week." The clinical record failed to evidence a home</p> | G000159   | The DON and RN homecare consultant have in-serviced the RN case managers on following the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and followed. Education provided on documenting on the POC the frequency and duration of services, missed visiting reporting and documentation of changes in patient condition the physician. A new communication of change in condition form has been implemented. The clinical records have been audited for the above deficiencies and have been addressed with the appropriate professional. An RN homecare consultant has been hired to assist with education and oversight. The clinical documentation will be reviewed by the DON for compliance with the POC and proper notification of changes in condition. 10% of the clinical records will be audited quarterly for compliance with the | 04/11/2014  |  |   |  |

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|   | <p>health aide was in the home.</p> <p>During a home visit on 03/12/14 at 10:00 AM, the patient was observed to have a lymphedema sleeve on her right leg. The patient indicated she had been receiving lymphedema treatments for 2 hours 3 times a week for several months. The patient indicated that the nurse obtains leg measurements and vital signs before and after treatments. The patient also provided a jar of medicated ointment called Triamcinolone that was to be applied to affected areas on her legs on an as needed basis. Employee B, a licensed practical nurse (LPN), indicated she provided these services 3 times a week and applied the ointment on an as needed basis. The plan of care failed to evidence the lymphedema treatment, location of the bilateral lower extremity measurements, orders for vital signs to be done before and after treatments, and the medicated cream with directions for use.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plans of care included a clinical addendum that stated, "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]." The plan of</p> |   | <p>POC proper documentation and notification of patient condition changes. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> |   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15K066 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                    |  | X3) DATE SURVEY COMPLETED<br><br>03/14/2014 |  |
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|   | <p>care failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> <p>a. A home visit was made to the patient on 03/12/14 at 11:15 AM. The patient was observed lying in bed with a specialty inflatable mattress pad in place. The plan of care failed to evidence the inflatable mattress pad.</p> <p>b. The "Clinical Addendum" on the plan of care stated, "HHA [home health aide] up to 10 hours a day, up to 7 days a week ... aide interventions ... ATTC (attendant care) interventions ... " The Comprehensive Assessment dated 02/17/14 stated, "up to 112 hrs [hours] per mo [month] x 2 months." The plan of care failed to evidence a specific frequency of visits for the HHA and attendant care services. The plan of care failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> <p>3. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14. The clinical record evidenced the patient received bolus enteral feedings per gastric tube. The plan of care failed to evidence the type, volume, and frequency of the enteral feeding;</p> |   |   |   |  |   |  |

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|   | <p>instructions for nursing interventions; and management of the enteral feeding tube.</p> <p>4. Clinical record number 5 included a plan of care established by the physician for the certification periods 12/27/13 to 02/24/14 and 02/25/14 to 04/25/14 with orders for HHA up to 8 hours a day, up to 7 days a week. The clinical record evidenced an attendant was in the home. The clinical record failed to evidence the plan of care had specific frequency of visits for the HHA and failed to include the frequency and duties of the attendant care services.</p> <p>5. Clinical record number 6 included a plan of care established by the physician for the certification period of 01/02/14 to 03/02/14 with orders for skilled nursing to see patient every other week for medication set up. Clinical record evidenced the patient self catheterizes with a 14 French caude catheter and that the patient receives attendant care services from an outside agency. The plan of care failed to evidence the patient self catheterizes with a 14 French Claude catheter and the patient was receiving attendant care services from an outside agency.</p> <p>6. The Director of Nursing (DoN) and the Administrator was not able to provide</p> |   |   |                      |   |

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|                    | <p>any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>7. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Regularly re-evaluate the patient's nursing needs ... Coordinate patient services between other care providers as necessary ... Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs ... Shall accept and carry out physician ... orders (oral and written) ... Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems.</p> <p>8. A policy titled "Administration and Patient Care: Plan of Care [485]" dated 11/29/12 stated "The patient's plan of care is developed by a physician, in consultation with the home health professional staff, and with patient's</p> |               |   |                      |

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|                    | <p>participation ... Type of home health care services and equipment required ... nursing services needed, frequency of nursing services, medications, diet, home health aide services with frequency, medical supplies / appliances necessary , any other appropriate items ... changes in the plan of care are documented through written and signed plans of modification or, if changes are requested orally, are reduced to writing ... Staff members promptly inform the physician of any changes that suggest a need to alter the patient's plan of care."</p> |               |   |                      |

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| G000164   | <p>484.18(b)<br/>PERIODIC REVIEW OF PLAN OF CARE<br/>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.<br/>Based on clinical record and policy review and interview, the agency failed to ensure a qualified professional notified the physician of changes in patients condition for 3 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients. (# 2, 7, 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 12/23/13 to 02/20/14.</p> <p>a. A home health aide visit note dated 01/07/14 at 8:50 AM stated "Patient was vomiting all evening, notified the nurse at the office ... "</p> <p>b. A home health aide visit note dated 01/07/14 at 9:45 AM stated "Patient was vomiting ... packed things up to go to hospital. Notified office."</p> <p>c. A home health aide visit note dated 01/07/14 at 4:45 PM stated "Patient vomited 3 times; notified the office ... "</p> | G000164   | The DON, Administrator and homecare consultant has conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on going needs and notifying the physician in any change in patient condition and/or needs;the process of reporting changes and needs to the physician. Travel charts have been established to include all necessary documents including the POC. The clinical records have been audited with education provided to the nursing staff on noted deficiencies. An RN homecare consultant has been hired to assist with education and oversight. Documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of change in condition. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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|   | <p>d. The clinical record failed to evidence that the office / case manager / skilled nurse notified the physician of the change in patient's condition.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period of 01/30/14 to 03/30/14.</p> <p>a. A skilled nursing note dated 02/12/14 stated that a consulting specialty physician for the patient changed the psychotropic medication from Zoloft to Abilify due to diarrhea. The clinical record failed to evidence that the patients attending physician was notified of the medication change or of the symptoms that resulted in the change being made by the specialty physician.</p> <p>b. A skilled nursing note dated 02/19/14 stated that the patient had a fever greater than 100 F. The nurse documented that she advised the patients caregiver to notify the doctor. The clinical record failed to evidence that the skilled nurse had notified the attending physician.</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 02/06/14 to 04/06/14. The plan of care included a</p> |   |   |   |  |   |  |

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|  | <p>diagnosis of a seizure disorder.</p> <p>a. The plan of care included medications of Kepra, Topamax, and Phenobarbital, to control seizure activity and skilled nursing to assess the patient for changes in neurological status at each visit.</p> <p>b. Skilled nursing notes dated 02/10, 02/12, 02/13, and 03/03 to 03/09/14 identified the patient had separate episodes of seizure activity. The clinical record failed to evidence the skilled nurse notified the patient's attending physician of the number of episodes of seizure activity.</p> <p>4. The Director of Nursing and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>5. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs ... Shall accept and carry out</p> |  |  |  |
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|                    | <p>physician ... orders (oral and written)<br/>...Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems."</p> |               |   |                      |

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| G000168 | <p>484.30<br/>SKILLED NURSING SERVICES</p> <p>Based on clinical record review, agency policy review, observation, and interview, it was determined the agency failed to ensure skilled nursing visits were provided in accordance to the plan of care for 2 of 10 records reviewed with the potential to affect all of the agency's current 102 patients receiving services (See G 170); failed to ensure the Registered Nurse tracked and evaluated an identified skin tear regularly in 1 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients (G 172); failed to ensure the registered nurse revised the plan of care failed to include all types of services and equipment required, frequency of visits, nutritional requirements, medications and treatments for 5 of 10 records reviewed creating the potential to affect all 102 patients receiving services (See G 173); and failed to ensure the Registered Nurse informed the physician of changes in the patient's condition for 3 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 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:</p> | G000168 | <p>The DON and Administrator have conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, the need for all treatments, equipment, nutritional needs and medications, disciplines and frequency/duration be accurately documented on the POC, disciplines will comply with frequency and duration of visits and outlined on POC, evaluating and re-evaluating the patient's on-going needs including wound care best practices and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly; the frequency of all disciplines need to be followed including changes in frequency documented by interim physician orders. The process of coordination of care with other entities providing services to the patient. Travel charts have been established to include all necessary documents including the POC. The records have been audited with education provided to the nursing staff on deficiencies noted. An RN homecare consultant has been hired to assist with education and oversight. Skilled care documentation will be reviewed by the DON for compliance with</p> | 04/11/2014 |
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|                    | Skilled Nursing Services.  |               | the POC regulations concerning notification of changes in patient condition, coordination of care and use of best nursing practices. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. |                      |

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| G000170   | <p>484.30<br/>SKILLED NURSING SERVICES<br/>The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and policy review and interview, the agency failed to ensure the skilled nurse visits were provided as ordered on the plan of care in 2 of 10 records reviewed (# 4 and 5) creating the potential to affect all current 102 patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14 with orders for skilled nursing to visit the patient daily 7 days a week for wound care. <ul style="list-style-type: none"> <li>a. A physician order dated 01/21/14 indicated to change nursing visits from 1 time a day to two times a day for wound care.</li> <li>b. A physician order dated 01/28/14 stated to change nursing visits from 2 times a day to 1 time a week for medication set up in the home.</li> <li>c. The clinical record failed to evidence skilled nursing visits were made on 1/19/14, 01/27/14, 01/28/14, and the week of 02/09/14. The clinical record</li> </ul> </li> </ol> | G000170   | <p>The DON, Administrator and homecare consultant has conducted in-services with all nursing staff addressing the compliance with the POC and the established frequency of visits of each discipline and also any change in the frequency by interim orders; the process of documentation of missed visits and rescheduling of ordered visits. Travel charts have been established to include the POC. The clinical records have been audited with education provided to the nursing staff on deficiencies noted. A tracking procedure has been established to ensure compliance with discipline frequencies as outlined on the POC and interim orders. An RN homecare consultant has been hired to assist with the education and oversight. Documentation will be reviewed by the DON for compliance with the POC and frequency of visits. 10% of the clinical records will be audited quarterly to ensure compliance with the above correction plan. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> | 04/11/2014           |   |

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|  | <p>included two visits made by a skilled nurse on 01/20/14.</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 12/27/13 to 02/24/14 with orders for skilled nursing visits weekly for medication set-up.</p> <p>a. The clinical record failed to evidence that a skilled nurse visited the patient during weeks 3, 4, 5, 6, 8, and 9.</p> <p>b. A progress note dated 02/11/14 stated the weather prevented the SN from visiting. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>c. A progress note dated 02/18/14 stated the weather prevented the SN from getting up the patient's driveway. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> <p>3. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated</p> |  |  |  |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448 |
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|  | "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Shall accept and carry out physician ... orders (oral and written) ... " |  |  |  |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15K066 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                    |  | X3) DATE SURVEY COMPLETED<br>03/14/2014 |  |
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| G000172   | <p>484.30(a)<br/>DUTIES OF THE REGISTERED NURSE<br/>The registered nurse regularly re-evaluates the patients nursing needs.<br/>Based on clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse tracked and evaluated an identified skin tear regularly in 1 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plans of care included a clinical addendum that stated "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]."</p> <p>a. A "Comprehensive Adult Assessment Update" dated 02/17/14 stated "pink coccyx-sm [small] skin tear healing ... sm [small] skin tear on (L) coccyx that is healing. foam boarder dressing and cream applied to area by HHA."</p> <p>b. A home health aide (HHA) visit note dated 12/09/13 at 07:40 AM. The note stated "Area of broken skin on (L)</p> | G000172   | <p>The DON and Administrator has in-serviced all home health aides on the need to report to the RN case manager any change in condition of the patient and the process to report changes in patient condition. The DON has in-serviced the nursing care staff on the process of re-evaluation of patient needs, the documentation of on going evaluations and best practice concerning the evaluation of patient needs and changes to the POC to address new patient needs as they occur. The clinical records have been audited and education provided to individual personnel for any deficiencies noted. An RN homecare consultant has been hired to assist with the education and oversight. Documentation will be reviewed by the DON for compliance with reporting of changes in patient condition and skilled follow up needs for those changes. 10% of the clinical records will be audited quarterly to ensure compliance with the above correction plan. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> | 04/11/2014  |  |   |  |

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|   | <p>buttock 1/4" [inch] diameter ... " The clinical record failed to evidence the case manager was notified.</p> <p>c. A HHA visit note dated 01/30/14 at 10:00 PM stated "She has a little rash on her right thigh ... " The clinical record failed to evidence the case manager was notified.</p> <p>d. An attendant care note dated 02/11/14 at 2:50 AM stated "Desitin applied to 1/4" [inch] diameter skin breakdown on (L) buttock ... "</p> <p>e. A HHA visit note dated 03/01/14 at 4:23 PM stated "There is one sore on [Name of Patient] bottom that is of concern [size of sore drawn) that size ... "</p> <p>3. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> <p>4. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Regularly re-evaluate the patient's nursing needs."</p> |   |   |   |  |   |  |

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| G000173   | <p>484.30(a)<br/>DUTIES OF THE REGISTERED NURSE<br/>The registered nurse initiates the plan of care and necessary revisions.<br/>Based on observation, clinical record and policy review, and interview, the Registered Nurse failed to ensure the plan of care had been updated and included all types of services and equipment required, frequency of visits, nutritional requirements, medications and treatments for 5 of 10 records reviewed creating the potential to affect all 102 patients receiving services. (# 1, 2, 4, 5, and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 that stated, "RN [registered nurse] for supervision of home health aide [HHA] per State and Federal Regulations." Addendum 21 on the plan of care stated, "SN [skilled nurse] up to 2 hours a day, up to 3 days a week." The clinical record failed to evidence a home health aide was in the home.</p> <p>During a home visit on 03/12/14 at 10:00 AM, the patient was observed to have a lymphedema sleeve on her right leg. The patient indicated she had been receiving lymphedema treatments for 2 hours 3 times a week for several months.</p> | G000173   | <p>The DON and Administrator has in-serviced the professional staff on following the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and followed. Education provided on documenting on the POC the frequency and duration of services, missed visit reporting and documentation and the need to report all changes in patient condition to the physician. The clinical records have audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by the DON for compliance with the POC and proper notification of changes in condition. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> | 04/11/2014  |  |   |  |

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|                    | <p>The patient indicated that the nurse obtains leg measurements and vital signs before and after treatments. The patient also provided a jar of medicated ointment called Triamcinolone that was to be applied to affected areas on her legs on an as needed basis. Employee B, a licensed practical nurse (LPN), indicated she provided these services 3 times a week and applied the ointment on an as needed basis. The plan of care failed to evidence the lymphedema treatment, location of the bilateral lower extremity measurements, orders for vital signs to be done before and after treatments, and the medicated cream with directions for use.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plans of care included a clinical addendum that stated, "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]." The plan of care failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> <p>a. A home visit was made to the patient on 03/12/14 at 11:15 AM. The patient was observed lying in bed with a specialty inflatable mattress pad in place.</p> |               |   |                      |

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|   | <p>The plan of care failed to evidence the inflatable mattress pad.</p> <p>b. The "Clinical Addendum" on the plan of care stated, "HHA [home health aide] up to 10 hours a day, up to 7 days a week ... aide interventions ... ATTC (attendant care) interventions ... " The Comprehensive Assessment dated 02/17/14 stated, "up to 112 hrs [hours] per mo [month] x 2 months." The plan of care failed to evidence a specific frequency of visits for the HHA and attendant care services. The plan of care failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> <p>3. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14. The clinical record evidenced the patient received bolus enteral feedings per gastric tube. The plan of care failed to evidence the type, volume, and frequency of the enteral feeding; instructions for nursing interventions; and management of the enteral feeding tube.</p> <p>4. Clinical record number 5 included a plan of care established by the physician for the certification periods 12/27/13 to 02/24/14 and 02/25/14 to 04/25/14 with orders for HHA up to 8 hours a day, up to</p> |   |   |   |  |   |  |

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|   | <p>7 days a week. The clinical record evidenced an attendant was in the home. The clinical record failed to evidence the plan of care had specific frequency of visits for the HHA and failed to include the frequency and duties of the attendant care services.</p> <p>5. Clinical record number 6 included a plan of care established by the physician for the certification period of 01/02/14 to 03/02/14 with orders for skilled nursing to see patient every other week for medication set up. Clinical record evidenced the patient self catheterizes with a 14 French caude catheter and that the patient receives attendant care services from an outside agency. The plan of care failed to evidence the patient self catheterizes with a 14 French Claude catheter and the patient was receiving attendant care services from an outside agency.</p> <p>6. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>7. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team</p> |   |   |                      |   |

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|  | <p>of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Regularly re-evaluate the patient's nursing needs ... Coordinate patient services between other care providers as necessary ... Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs ... Shall accept and carry out physician ... orders (oral and written) ... Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems.</p> <p>8. A policy titled "Administration and Patient Care: Plan of Care [485]" dated 11/29/12 stated "The patient's plan of care is developed by a physician, in consultation with the home health professional staff, and with patient's participation ... Type of home health care services and equipment required ... nursing services needed, frequency of nursing services, medications, diet, home health aide services with frequency, medical supplies / appliances necessary , any other appropriate items ... changes in the plan of care are documented through</p> |  |  |  |
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|                    | written and signed plans of modification or, if changes are requested orally, are reduced to writing ... Staff members promptly inform the physician of any changes that suggest a need to alter the patient's plan of care."<br>7. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM. |               |   |                      |

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| G000176   | <p>484.30(a)<br/>DUTIES OF THE REGISTERED NURSE<br/>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse informed the physician of changes in the patient's condition for 3 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients. (# 2, 7, 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 12/23/13 to 02/20/14.</p> <p>a. A home health aide visit note dated 01/07/14 at 8:50 AM stated "Patient was vomiting all evening, notified the nurse at the office ... "</p> <p>b. A home health aide visit note dated 01/07/14 at 9:45 AM stated "Patient was vomiting ... packed things up to go to hospital. Notified office."</p> <p>c. A home health aide visit note dated 01/07/14 at 4:45 PM stated "Patient</p> | G000176   | The DON and Administrator have conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on-going needs and notifying the physician in any change in patient condition and needs; the process of reporting changes and needs to the physician promptly. Travel charts have been established to include all necessary documents including the POC. The clinical records have been audited with education provided to the nursing staff on deficiencies noted. An RN homecare consultant has been hired to assist with education and oversight. Documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of changes in patient condition. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014           |   |

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|   | <p>vomited 3 times; notified the office ... "</p> <p>d. The clinical record failed to evidence that the office / case manager / skilled nurse notified the physician of the change in patient's condition.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period of 01/30/14 to 03/30/14.</p> <p>a. A skilled nursing note dated 02/12/14 stated that a consulting specialty physician for the patient changed the psychotropic medication from Zoloft to Abilify due to diarrhea. The clinical record failed to evidence that the patients attending physician was notified of the medication change or of the symptoms that resulted in the change being made by the specialty physician.</p> <p>b. A skilled nursing note dated 02/19/14 stated that the patient had a fever greater than 100 F. The nurse documented that she advised the patients caregiver to notify the doctor. The clinical record failed to evidence that the skilled nurse had notified the attending physician.</p> <p>3. Clinical record number 9 included a plan of care established by the physician</p> |   |   |                      |   |

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|   | <p>for the certification period 02/06/14 to 04/06/14. The plan of care included a diagnosis of a seizure disorder.</p> <p>a. The plan of care included medications of Kepra, Topamax, and Phenobarbital, to control seizure activity and skilled nursing to assess the patient for changes in neurological status at each visit.</p> <p>b. Skilled nursing notes dated 02/10, 02/12, 02/13, and 03/03 to 03/09/14 identified the patient had separate episodes of seizure activity. The clinical record failed to evidence the skilled nurse notified the patient's attending physician of the number of episodes of seizure activity.</p> <p>4. The Director of Nursing and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>5. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Inform the physician and other appropriate medical personnel of</p> |   |   |   |  |   |  |

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|  | changes in the patient's condition and needs ... Shall accept and carry out physician ... orders (oral and written) ...Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems." |  |  |  |
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| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448 |  |   |  |
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| G000224   | <p>484.36(c)(1)<br/>ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE<br/>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.<br/>Based on clinical record and policy review and interview, the agency failed to ensure the home health aide and attendant care written care instructions did not duplicate services for each shift / visit provided in a 24 hour day, 7 days a week in 1 of 10 records reviewed creating the potential to affect all of the agency's current 102 patients. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 12/23/13 to 02/20/14 that identified the patient was receiving services from a home health aide (HHA) up to 10 hours a day, up to 7 days per week as well as attendant care interventions. The plan of care also included the patient was incontinent of bowel and bladder, hearing limitations, wheelchair and bedside commode, left foot contracture and may apply non medicated protective cream to skin daily PRN (if necessary), and the patient was an aspiration and choking risk that</p> | G000224   | The DON has in-serviced the RN case managers on coordination of the home health aide and attendant care services to provide coordinated care and defined duties for each with an established frequency and duration. In-service has been provided to the direct care staff on its use. The clinical documentation has been audited and personnel have been educated on deficiencies noted. Documentation will be reviewed by the DON for compliance with coordinated care plans for the home health aide and defined tasks, frequency and duration. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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|  | <p>required 1:1 at meals. The clinical record included home health aide visits that varied for 1 hour in the morning, 3 to 7 hours late morning to mid afternoon altering with attendant care services, 2 to 3 hours in the evening followed by attendant care services during sleeping hours.</p> <p>a. The plan of care included "Aide Interventions: assist with bathing [tub, shower, chair, bed bath, partial, complete). Assist with dressing. Assist with hair care. Assist with shampoo. Assist with skin care; may apply non medicated protective cream to skin daily PRN. Assist with foot care. Assist with nail care. Assist with oral care. Check skin for pressure areas. Assist with meal preparation. Assist with meal set up. Encourage fluids. Do laundry. Clean kitchen, bedroom, bathroom. Make bed, change bed linens. Maintain fall precautions. Maintain safe and clean environment."</p> <p>b. The plan of care included "ATTC [attendant care] Aide Interventions: assist with bathing [tub, shower, chair, bed bath, partial, complete). Assist with dressing. Assist with hair care. Assist with shampoo. Assist with skin care; may apply non medicated protective cream to skin daily PRN. Assist with</p> |  |  |  |
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|                    | <p>foot care. Assist with nail care. Assist with oral care. Check skin for pressure areas. Assist with meal preparation. Assist with meal set up. Encourage fluids. Do laundry. Clean kitchen, bedroom, bathroom. Make bed, change bed linens. Maintain fall precautions. Maintain safe and clean environment. Run errands as requested."</p> <p>c. A "Home Health Aide Care Plan" was revised on 12/18/13 and 02/17/14 to include the HHA was to provide bathing assistance per patient request, hygiene assistance such as assist with dressing, hair care, shampoo, foot care, and nail care per patient request. Personal care, skin care, check for ulcers, oral care, and toileting assistance "AM" and "PM." The HHA care plan failed to evidence specific duties to be performed by the HHA during each provided shift. The home health aide care plan failed to evidence specific frequency and duration of visits, the patient's hearing limitations, and requirement of 1:1 at meals.</p> <p>d. A "485 Non-skilled Plan of Care Worksheet" dated 02/17/14 stated the patient was receiving attendant care services up to 112 hours per month for 2 months.</p> <p>e. A "Patient Assessment Form"</p> |               |   |                      |

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|   | <p>included the preferred service days to be Monday through Sunday. Personal care assessment form included assistance with showers, bath chair, shampoo, brushing hair, fingernails, toenails, brushing teeth, floss, toileting, transferring, housekeeping, transportation, and meals. The personal care assessment form failed to evidence specific duties to be performed by the personal service attendant during each provided shift.</p> <p>6. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> <p>7. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients ... Coordinate patient services between other care providers as necessary ... assign staff to provide care to the patient ... home health aide and or other individuals ... delegate duties and tasks ... as appropriate ... "</p> |   |   |   |  |   |  |

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| G000225   | <p>484.36(c)(2)<br/>ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE</p> <p>The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.</p> <p>Based on clinical record review and interview, the agency failed to ensure the home health aide and attendant only provided services that were within the scope of practice for 1 of 10 records reviewed creating the potential to affect patients who are receiving home health aide and attendant care services within the agency. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plans of care included a clinical addendum that stated "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]." Application of a dressing and cream is not within the scope of practice of the HHA.</p> <p>a. A "Comprehensive Adult Assessment Update" dated 02/17/14 stated "pink coccyx-sm [small] skin tear healing ... sm [small] skin tear on (L)</p> | G000225   | <p>The DON have provided an in-service to the RN case managers on the regulations concerning the tasks that can be assigned to a home health aide to complete. The clinical records have been audited to ensure aides are only performing tasks that they are allowed to provide per the aide scope of practice. An RN home care consultant has been hired to assist with education and oversight. The DON to ensure compliance with aide scope of practice will review home health aide care plans. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.</p> | 04/11/2014  |  |   |  |

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|  | <p>coccyx that is healing. foam boarder dressing and cream applied to area by HHA." Application of a dressing and cream is not within the scope of practice of the HHA.</p> <p>b. An attendant care note dated 02/11/14 at 2:50 AM stated "Desitin applied to 1/4" [inch] diameter skin breakdown on (L) buttock ... " Application of medication is not within the scope of practice of the attendant.</p> <p>2. The Administrator and Director of Nursing were not able to provide any further documentation or information on 03/17/14 at 2:50 PM.</p> |  |  |  |
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| G000335   | <p>484.55(b)(2)<br/>COMPLETION OF THE COMPREHENSIVE ASSESSMENT<br/>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 policy review and interview, the agency failed to ensure the Registered Nurse thoroughly assessed the patient's skin breakdown for 1 of 10 records reviewed creating the potential to affect all of the agency's current 102 patients. (# 2)</p> <p>Finding include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plan of cares included a clinical addendum that stated, "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]." A "Comprehensive Adult Assessment Update" dated 02/17/14 stated, "pink coccyx-sm [small] skin tear healing ... sm [small] skin tear on (L) coccyx that is healing. foam boarder dressing and cream applied to area by HHA." The clinical record failed to evidence the Registered Nurse fully assessed the skin</p> | G000335   | The DON has provided in-service to the RN case managers on the comprehensive assessment and it's completion with all needed assessments, including measurement of any wound/skin breakdown. The clinical records have been audited for compliance with a completed comprehensive assessment and education has been provided as necessary to the individual clinicians. A RN homecare consultant has been hired to assist with education and oversight. The DON will review all comprehensive assessments to ensure compliance with a completed assessment with all elements addressed. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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|  | <p>breakdown by failing to describe the appearance and wound measurements.</p> <p>2. The DoN and the Administrator indicated on 03/14/14 at 3:00 PM that the registered nurse should have measured the wound and provided any treatment necessary.</p> <p>3. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated, "Registered Nurse shall provide direct care ... Regularly re-evaluate the patient's nursing needs."</p> |  |  |  |
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| G000337   | <p>484.55(c)<br/>DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on observation, clinical record review, and interview, the agency failed to ensure the medication profile included all medicated ointments for 1 of 10 record reviewed creating the potential to affect all 102 of the patients. (#1)</p> <p>Findings includes:</p> <p>During a home visit on 03/12/14 at 10:00 AM, patient #1 was observed to have a lymphedema sleeve on her right leg. The patient indicated she had been receiving lymphedema treatments for 2 hours 3 times a week for several months. The patient indicated that the nurse obtains leg measurements and vital signs before and after treatments. The patient also provided a jar of medicated ointment called Triamcinolone, that was to be applied to affected areas on her legs on an as needed basis. Employee B, a licensed practical nurse, indicated that she provided these services 3 times a week and applied the ointment on an as needed basis. The medication profile failed to</p> | G000337   | The DON has provided an in-servicing on the drug regimen review needs, including the requirement to keep the medication profile updated with all current medications including prescribed, and over the counter medications. This is done to identify and potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliance issues. The DON has ensured that each RN case manager has reviewed all drug regimen profiles for accuracy and correction of any additions or discontinued medications to include OTC, herbal and prescribed medications. 10% of the clinical records quarterly to ensure compliance and provide individual education to clinicians as necessary. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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| N000000                  | <p>include the cream.</p> <p>This was a State home health relicensure survey.</p> <p>Survey Dates: March 11, 12, 13, 14, and 17, 2014</p> <p>Facility #: 012412</p> <p>Medicaid Vendor #: 201013320</p> <p>Surveyors: Shannon Pietraszewski, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN<br/>March 25, 2014</p> | N000000             |  |                            |

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| N000470            | <p>410 IAC 17-12-1(m)<br/>Home health agency administration/management<br/>Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 2 of 3 home visit observations completed creating the potential to affect all of the agency's 44 current patients. (#3 and 5)</p> <p>The findings include:</p> <p>1. The agency's policy titled "Standard Precautions" dated 08/22/11 stated, "Organization personnel will adhere to the following precautions and will instruct patients and family / caregivers in infection control precautions, as appropriate to the patient's care needs ... Under standard precautions, blood and certain body fluids of all patients are considered potentially infectious for blood borne pathogens, such as human immunodeficiency virus (HIV), and hepatitis B virus (HBV). Standard precautions apply to blood and other body fluids potentially containing blood or</p> | N000470       | The DON has conducted in-services to all direct care staff on the following: Universal Precautions, hand washing technique, cleaning of equipment, bag technique, glove use and clean work surfaces. Education on aspects of infection control will be conducted on hire, annually and as needed. Competency with hand washing, glove use and nursing bag techniques will be conducted as part of the orientation process. The DON will be responsible for monitoring the corrective actions to ensure that this deficiency does not recur. | 04/11/2014           |

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|                    | <p>bloodborne pathogens. These body fluids include: emesis, sputum, feces, urine ... "</p> <p>2. The agency's policy titled "Universal Precautions" dated 11/30/12 stated, "In order to protect employees, patients, families and caregivers from exposure to blood or body fluids, the staff will use Universal Precautions at all times ... Hand washing procedure will be used at all times, and will not be negated due to use of gloves ... Standard or Universal Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which care is delivered ... Wear gloves whenever handling client body fluids or linens soiled with body fluids ... "</p> <p>3. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes,</p> |               |   |                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448 |
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|  | <p>nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves.</p> <p>IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>4. A home visit was made to patient number 3 on 03/12/14 at 1:00 PM with employee B, a Licensed Practical Nurse. During the home visit, Employee B was observed to preset medication planners and prefilled insulin syringes for the patient who was visually impaired. She</p> |  |  |  |
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|  | <p>washed her hands and donned clean gloves and placed the pill planner boxes on the patient's kitchen table without preparing a clean work area. She then filled the pill planners with medications, removing the pill from foil packaging touching the pills with her gloved hands as she placed them in the pill planner. During the medication set up she was touching the tabletop and pushing back her sleeves with her gloved hands. Employee B then used her gloved hands to sweep the trash and debris from the tabletop and placed it in the trash. She then began to prefill insulin syringes for patient # 3 without changing her gloves or washing her hands and again without cleaning the work area on the tabletop. Employee B then removed her stethoscope from around her neck and auscultated the patients heart and lung sounds without first cleaning her stethoscope. She then assessed the patient's feet and pedal pulses and, without changing her gloves or washing her hands, returned the stethoscope around her neck without cleaning it.</p> <p>5. A home visit was made to patient # 5 home on 03/14/14 at 9:30 AM with employee D, a home health aide. During the home visit, the aide was observed to remove the patients brief and clothing prior to washing hands and</p> |  |  |  |
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|                    | <p>donning gloves. Employee D picked up the brief and placed the brief in the trash without wearing gloves. Employee D began to assist the patient with bathing, washing the areas of the patients the body that the patient was unable to reach, and drying the patient's back all without wearing gloves. Employee D assisted the patient with her clothes and deodorant without wearing gloves or washing her hands. She then picked up soiled clothing and towels from the floor without gloves and placed them on the chair. She assisted the patient to the living room and returned to the bathroom, picked up the clothes with bare hands, and placed the dirty clothes in the utility room to be washed.</p> <p>6. The Director of Nursing indicated on 03/14/14 at 11:00 AM the employees did not follow the agency's own infection control procedures and policy.</p> |               |   |                      |

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| N000484   | <p>410 IAC 17-12-2(g)<br/>Q A and performance improvement<br/>Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.<br/>Based on clinical record and policy review, the agency failed to ensure all agency personnel furnishing services maintained liaison to ensure that their efforts were coordinated effectively and supported the objectives outlined in the plan of care in 1 of 10 clinical records reviewed creating the potential to affect all patients receiving more than one. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record number 2, start of care (SOC) 07/07/11, failed to evidence the home health aide communicated with the case manager.</p> <p>a. A home health aide (HHA) visit note dated 12/09/13 at 07:40 AM stated, "Area of broken skin on (L) buttock 1/4" [inch] diameter ... " The clinical record failed to evidence the case manager was notified.</p> <p>b. A HHA note dated 12/31/13 at</p> | N000484   | The Administrator and DON have conducted in-services with all home health aides for the need to report any changes in patient condition the the RN case manager and the required documentation. A new communication for change of condition form has been developed to document the change and the follow up measures. The DON has in-serviced all nursing case managers on the need to coordinate all care needs with all entities involved in patient care and the reporting process for changes in patient condition. The clinical records have been audited for compliance with care coordination needs. The DON will review each new start of care to identify those patients who have care coordination needs and follow up with the RN case manager for compliance. 10% of the clinical records will be audited quarterly to ensure compliance with reporting change of condition and care coordination. The DON will be responsible for monitoring these corrective actions to ensure | 04/11/2014  |  |   |  |

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|   | <p>8:50 PM and 01/28/14 at 8:56 PM indicated the patient's buttocks was free of any sores. A HHA visit note dated 01/30/14 at 10:00 PM stated, "She has a little rash on her right thigh ... " The clinical record failed to evidence the case manager was notified.</p> <p>c. A HHA visit note dated 01/31/14 at 4:45 (no AM or PM indicated) stated, "Her left shoulder hurts today ... " A visit note dated 02/01/14 at 4:42 (no AM or PM indicated) stated, "[Name of Patient] shoulder still hurts. She decided not to shower today to avoid any strain on her shoulder ..." The clinical record failed to evidence the case manager was notified.</p> <p>d. A HHA visit note dated 02/06/14 at 9:51 PM stated, "She turned over in bed and twisted her left knee. She yelled, but there was nothing observable." A HHA visit note dated 02/07/14 at 4:35 PM stated "[Name of Patient] left knee is sore today ... " The clinical record failed to evidence the case manager was notified.</p> <p>e. An attendant care note dated 02/11/14 at 2:50 AM stated, "Desitin applied to 1/4" [inch] diameter skin breakdown on (L) buttock ... " The clinical record failed to evidence the case manager was notified.</p> |   | this deficiency is corrected and will not recur.  |                      |   |

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|   | <p>f. A HHA visit note dated 02/15/14 at 8:20 AM stated, "Desitin applied to area on (L) buttock with skin breakdown [a little more than 1/4"] ... " The clinical record failed to evidence the case manager was notified.</p> <p>h. A HHA visit note dated 02/18/14 at 8:57 AM indicated the patient's bottom was healed. A HHA visit note dated 02/25/14 at 9:49 PM stated "(Name of Patient) has 2 sores on her bottom - one on each cheek ... " The clinical record failed to evidence the case manager was notified.</p> <p>i. A HHA visit note dated 02/27/14 at 9:43 PM stated, "She had patches on the sores on her bottom ... " The clinical record failed to evidence the case manager was notified.</p> <p>j. A HHA visit note dated 03/01/14 at 4:23 PM stated, "There is one sore on [Name of Patient] bottom that is of concern [size of sore drawn) that size ... " The clinical record failed to evidence the case manager was notified.</p> <p>2. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct</p> |   |   |   |  |   |  |

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|                    | care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Coordinate patient services between other care providers as necessary." |               |   |                      |

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| N000486   | <p>410 IAC 17-12-2(h)<br/>Q A and performance improvement<br/>Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record and policy review, the agency failed to ensure efforts were coordinated with other providers serving the patient in 2 of 10 clinical records reviewed creating the potential to affect all patients receiving more than one. (#1 and 6)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record 1 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 that evidenced the patient was receiving services from another agency. The clinical record failed to evidence communication and / or coordination of care with the other agency.</li> <li>2. Clinical record number 6 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 for HHA up to 4 hours daily up to 7 days per week. The plan of care stated the patient was receiving attendant care services with an outside provider. The HHA, employee C, worked for both the agency and the outside provider as an attendant.</li> </ol> | N000486   | The Administrator and DON have conducted in-services with all home health aides for the need to report any changes in patient condition the the RN case manager and the required documentation. A new communication for change of condition form has been developed to document the change and the follow up measures. The DON has in-serviced all nursing case managers on the need to coordinate all care needs with all entities involved in patient care and the reporting process for changes in patient condition. The clinical records have been audited for compliance with care coordination needs. The DON will review each new start of care to identify those patients who have care coordination needs and follow up with the RN case manager for compliance. 10% of the clinical records will be audited quarterly to ensure compliance with reporting change of condition and care coordination. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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|   | <p>a. During a home visit on 03/12/14 at 2:00 PM, a binder with the HHA paperwork was on the counter of the patient's kitchen. Upon reviewing the visit notes, it was observed that the home health aide was mixing / combining her duties under the surveying agency and under the outside agency. Employee C, a home health aide, documented that employee C gave the patient a bath at 8:30 AM for the outside provider and gave a bath at 9:30 AM for the agency.</p> <p>b. Employee C indicated during the visit that she was told by her agency that she must document that she provided the services on their form, same as she would document for the agency. The employee indicated she was hired by both agencies and she was in the patient's home all day until 3:00 PM.</p> <p>c. The Director of Nursing indicated the Alternate Administrator for the agency was also the Administrator for the outside provider. The outside agency was in the same building and utilized the same aides for both services. The Director of Nursing indicated she didn't think about checking and comparing the duties of the agency home health aides to the outside agency's attendant care services.</p> |   |   |   |  |   |  |

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|  | <p>3. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated, "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Coordinate patient services between other care providers as necessary."</p> |  |  |  |
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| N000522   | <p>410 IAC 17-13-1(a)<br/>Patient Care<br/>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:<br/>Based on clinical record and policy review and interview, the agency failed to ensure the visits were provided as ordered on the plan of care in 3 of 10 records reviewed (# 4, 5, and 10) creating the potential to affect all current 102 patients.</p> <p>The findings include:</p> <p>1. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14 with orders for skilled nursing to visit the patient daily 7 days a week for wound care.</p> <p>a. A physician order dated 01/21/14 indicated to change nursing visits from 1 time a day to two times a day for wound care.</p> <p>b. A physician order dated 01/28/14 stated to change nursing visits from 2 times a day to 1 time a week for medication set up in the home.</p> <p>c. The clinical record failed to evidence skilled nursing visits were made</p> | N000522   | <p>The DON has in-serviced the clinical staff on following the POC, ensuring that all frequency of disciplines are documented on the POC and changes are noted with physician interim orders when necessary and those interim orders are followed. Education provided on documenting on the POC the frequency and duration of services, missed visit reporting, documentation of continued attempts to comply with frequency of visit as outlined on the POC and documentation and reporting of changes in patient condition to the physician. The clinical records have been audited for the above deficiencies and have been addressed with the appropriate professional. An RN consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> | 04/11/2014  |  |   |  |

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|                    | <p>on 1/19/14, 01/27/14, 01/28/14, and the week of 02/09/14. The clinical record included two visits made by a skilled nurse on 01/20/14.</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 12/27/13 to 02/24/14 with orders for skilled nursing visits weekly for medication set-up.</p> <p>a. The clinical record failed to evidence that a skilled nurse visited the patient during weeks 3, 4, 5, 6, 8, and 9.</p> <p>b. A progress note dated 02/11/14 stated the weather prevented the SN from visiting. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>c. A progress note dated 02/18/14 stated the weather prevented the SN from getting up the patient's driveway. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> <p>3. Clinical record 10 included a plan of</p> |               |   |                      |

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| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448                                 |                      |   |
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|   | <p>care established by the physician for the certification period of 12/11/13 to 02/08/14 with orders for a home health aide (HHA) up to 12 hours a day 7 days a week. The clinical record failed to evidence that a HHA visit was made between 12/11/13 to 12/17/13, between 12/20/13 to 12/22/13, and between 12/25/13 to 12/31/13.</p> <p>The Administrator and Director of Nursing indicated on 03/17/14 at 2:50 PM that the patient was combative and difficult to staff. The patient was discharged / transferred to another agency on 12/31/13.</p> <p>4. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Shall accept and carry out physician ... orders (oral and written) ... "</p> |   |   |                      |   |

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| N000524   | <p>410 IAC 17-13-1(a)(1)<br/>Patient Care<br/>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on observation, clinical record and policy review, and interview, the agency failed to ensure the plan of care had been updated and included all types of services and equipment required, frequency of visits, nutritional requirements, medications, and treatments for 5 of 10 records reviewed creating the potential to affect all 102 patients receiving services. (# 1, 2, 4, 5, and 6)</p> <p>Findings include:</p> | N000524   | The DON, Administrator and RN homecare consultant have in-serviced the RN case managers on following the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and followed. Education provided on documenting on the POC the frequency and duration of services, missed visiting reporting and documentation of changes in patient condition the physician. A new communication of change in condition form has | 04/11/2014  |  |   |  |

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|   | <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 that stated, "RN [registered nurse] for supervision of home health aide [HHA] per State and Federal Regulations." Addendum 21 on the plan of care stated, "SN [skilled nurse] up to 2 hours a day, up to 3 days a week." The clinical record failed to evidence a home health aide was in the home and a duration for SN visits.</p> <p>During a home visit on 03/12/14 at 10:00 AM, the patient was observed to have a lymphedema sleeve on her right leg. The patient indicated she had been receiving lymphedema treatments for 2 hours 3 times a week for several months. The patient indicated that the nurse obtains leg measurements and vital signs before and after treatments. The patient also provided a jar of medicated ointment called Triamcinolone that was to be applied to affected areas on her legs on an as needed basis. Employee B, a licensed practical nurse (LPN), indicated she provided these services 3 times a week and applied the ointment on an as needed basis. The plan of care failed to evidence the lymphedema treatment, location of the bilateral lower extremity measurements, orders for vital signs to be</p> |   | <p>been implemented. The clinical records have been audited for the above deficiencies and have been addressed with the appropriate professional. An RN homecare consultant has been hired to assist with education and oversight. The clinical documentation will be reviewed by the DON for compliance with the POC and proper notification of changes in condition. 10% of the clinical records will be audited quarterly for compliance with the POC proper documentation and notification of patient condition changes. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> |   |  |   |  |

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|                    | <p>done before and after treatments, and the medicated cream with directions for use.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plans of care included a clinical addendum that stated, "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]." The plan of care failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> <p>a. A home visit was made to the patient on 03/12/14 at 11:15 AM. The patient was observed lying in bed with a specialty inflatable mattress pad in place. The plan of care failed to evidence the inflatable mattress pad.</p> <p>b. The "Clinical Addendum" on the plan of care stated, "HHA [home health aide] up to 10 hours a day, up to 7 days a week ... aide interventions ... ATTC (attendant care) interventions ... " The Comprehensive Assessment dated 02/17/14 stated, "up to 112 hrs [hours] per mo [month] x 2 months." The plan of care failed to evidence a specific frequency of visits for the HHA and attendant care services. The plan of care</p> |               |   |                      |

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|                    | <p>failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> <p>3. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14. The clinical record evidenced the patient received bolus enteral feedings per gastric tube. The plan of care failed to evidence the type, volume, and frequency of the enteral feeding; instructions for nursing interventions; and management of the enteral feeding tube.</p> <p>4. Clinical record number 5 included a plan of care established by the physician for the certification periods 12/27/13 to 02/24/14 and 02/25/14 to 04/25/14 with orders for HHA up to 8 hours a day, up to 7 days a week. The clinical record evidenced an attendant was in the home. The clinical record failed to evidence the plan of care had specific frequency of visits for the HHA and failed to include the frequency and duties of the attendant care services.</p> <p>5. Clinical record number 6 included a plan of care established by the physician for the certification period of 01/02/14 to 03/02/14 with orders for skilled nursing to see patient every other week for medication set up. Clinical record</p> |               |   |                      |

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|  | <p>evidenced the patient self catheterizes with a 14 French caude catheter and that the patient receives attendant care services from an outside agency. The plan of care failed to evidence the patient self catheterizes with a 14 French Claude catheter and the patient was receiving attendant care services from an outside agency.</p> <p>6. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>7. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Regularly re-evaluate the patient's nursing needs ... Coordinate patient services between other care providers as necessary ... Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs ... Shall accept and carry out physician ... orders (oral and written) ... Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical</p> |  |  |  |
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|   | <p>component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems.</p> <p>8. A policy titled "Administration and Patient Care: Plan of Care [485]" dated 11/29/12 stated "The patient's plan of care is developed by a physician, in consultation with the home health professional staff, and with patient's participation ... Type of home health care services and equipment required ... nursing services needed, frequency of nursing services, medications, diet, home health aide services with frequency, medical supplies / appliances necessary , any other appropriate items ... changes in the plan of care are documented through written and signed plans of modification or, if changes are requested orally, are reduced to writing ... Staff members promptly inform the physician of any changes that suggest a need to alter the patient's plan of care."</p> |   |   |                      |   |

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| N000527   | <p>410 IAC 17-13-1(a)(2)<br/>Patient Care<br/>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.<br/>Based on clinical record and policy review and interview, the agency failed to ensure a qualified professional notified the physician of changes in patients condition for 3 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients. (# 2, 7, 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 12/23/13 to 02/20/14.</p> <p>a. A home health aide visit note dated 01/07/14 at 8:50 AM stated "Patient was vomiting all evening, notified the nurse at the office ... "</p> <p>b. A home health aide visit note dated 01/07/14 at 9:45 AM stated "Patient was vomiting ... packed things up to go to hospital. Notified office."</p> <p>c. A home health aide visit note</p> | N000527   | The DON has conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on going needs and notifying the physician in any change in patient condition and/or needs;the process of reporting changes and needs to the physician. Travel charts have been established to include all necessary documents including the POC. The clinical records have been audited with education provided to the nursing staff on noted deficiencies. An RN homecare consultant has been hired to assist with education and oversight.Documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of change in condition. 10% of the clinical records will be audited quarterly for compliance.The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014  |  |   |  |

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|   | <p>dated 01/07/14 at 4:45 PM stated "Patient vomited 3 times; notified the office ... "</p> <p>d. The clinical record failed to evidence that the office / case manager / skilled nurse notified the physician of the change in patient's condition.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period of 01/30/14 to 03/30/14.</p> <p>a. A skilled nursing note dated 02/12/14 stated that a consulting specialty physician for the patient changed the psychotropic medication from Zoloft to Abilify due to diarrhea. The clinical record failed to evidence that the patients attending physician was notified of the medication change or of the symptoms that resulted in the change being made by the specialty physician.</p> <p>b. A skilled nursing note dated 02/19/14 stated that the patient had a fever greater than 100 F. The nurse documented that she advised the patients caregiver to notify the doctor. The clinical record failed to evidence that the skilled nurse had notified the attending physician.</p> <p>3. Clinical record number 9 included a</p> |   |   |                      |   |

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|   | <p>plan of care established by the physician for the certification period 02/06/14 to 04/06/14. The plan of care included a diagnosis of a seizure disorder.</p> <p>a. The plan of care included medications of Kepra, Topamax, and Phenobarbital, to control seizure activity and skilled nursing to assess the patient for changes in neurological status at each visit.</p> <p>b. Skilled nursing notes dated 02/10, 02/12, 02/13, and 03/03 to 03/09/14 identified the patient had separate episodes of seizure activity. The clinical record failed to evidence the skilled nurse notified the patient's attending physician of the number of episodes of seizure activity.</p> <p>4. The Director of Nursing and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>5. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Inform the physician and</p> |   |   |   |  |   |  |

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|                    | other appropriate medical personnel of changes in the patient's condition and needs ... Shall accept and carry out physician ... orders (oral and written) ...Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems." |               |   |                      |

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| N000537 | <p>410 IAC 17-14-1(a)<br/>Scope of Services<br/>Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:<br/>Based on clinical record and policy review and interview, the agency failed to ensure the skilled nurse visits were provided as ordered on the plan of care in 2 of 10 records reviewed (# 4 and 5) creating the potential to affect all current 102 patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14 with orders for skilled nursing to visit the patient daily 7 days a week for wound care.               <ol style="list-style-type: none"> <li>a. A physician order dated 01/21/14 indicated to change nursing visits from 1 time a day to two times a day for wound care.</li> <li>b. A physician order dated 01/28/14 stated to change nursing visits from 2 times a day to 1 time a week for medication set up in the home.</li> <li>c. The clinical record failed to</li> </ol> </li> </ol> | N000537 | <p>The DON has in-serviced the clinical staff on following the POC, ensuring that all frequency of disciplines are documented on the POC and changes are noted with physician interim orders when necessary and those interim orders are followed. Education provided on documenting on the POC the frequency and duration of services, missed visit reporting, documentation of continued attempts to comply with frequency of visit as outlined on the POC and documentation and reporting of changes in patient condition to the physician. The clinical records have been audited for the above deficiencies and have been addressed with the appropriate professional. An RN consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will not recur.</p> | 04/11/2014 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15K066 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                    |  | X3) DATE SURVEY COMPLETED<br><br>03/14/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448 |  |   |  |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE  |  |   |  |
|   | <p>evidence skilled nursing visits were made on 1/19/14, 01/27/14, 01/28/14, and the week of 02/09/14. The clinical record included two visits made by a skilled nurse on 01/20/14.</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 12/27/13 to 02/24/14 with orders for skilled nursing visits weekly for medication set-up.</p> <p>a. The clinical record failed to evidence that a skilled nurse visited the patient during weeks 3, 4, 5, 6, 8, and 9.</p> <p>b. A progress note dated 02/11/14 stated the weather prevented the SN from visiting. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>c. A progress note dated 02/18/14 stated the weather prevented the SN from getting up the patient's driveway. The clinical record failed to evidence that another visit was attempted later in the week.</p> <p>The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> |   |   |   |  |   |  |

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|  | 3. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Shall accept and carry out physician ... orders (oral and written) ... " |  |  |  |
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| N000541   | <p>410 IAC 17-14-1(a)(1)(B)<br/>Scope of Services<br/>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:<br/>(B) Regularly reevaluate the patient's nursing needs.<br/>Based on clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse tracked and evaluated an identified skin tear regularly in 1 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plans of care included a clinical addendum that stated "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]."</p> <p>a. A "Comprehensive Adult Assessment Update" dated 02/17/14 stated "pink coccyx-sm [small] skin tear healing ... sm [small] skin tear on (L) coccyx that is healing. foam boarder dressing and cream applied to area by HHA."</p> | N000541   | <p>The DON and Administrator has in-serviced all home health aides on the need to report to the RN case manager any change in condition of the patient and the process to report changes in patient condition. The DON has in-serviced the nursing care staff on the process of re-evaluation of patient needs, the documentation of on going evaluations and best practice concerning the evaluation of patient needs and changes to the POC to address new patient needs as they occur. The clinical records have been audited and education provided to individual personnel for any deficiencies noted. An RN homecare consultant has been hired to assist with the education and oversight. Documentation will be reviewed by the DON for compliance with reporting of changes in patient condition and skilled follow up needs for those changes. 10% of the clinical records will be audited quarterly to ensure compliance with the above correction plan. The DON will be responsible for monitoring these corrective actions to ensure this deficiency</p> | 04/11/2014           |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448 |  |   |  |
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|   | <p>b. A home health aide (HHA) visit note dated 12/09/13 at 07:40 AM. The note stated "Area of broken skin on (L) buttock 1/4" [inch] diameter ... " The clinical record failed to evidence the case manager was notified.</p> <p>c. A HHA visit note dated 01/30/14 at 10:00 PM stated "She has a little rash on her right thigh ... " The clinical record failed to evidence the case manager was notified.</p> <p>d. An attendant care note dated 02/11/14 at 2:50 AM stated "Desitin applied to 1/4" [inch] diameter skin breakdown on (L) buttock ... "</p> <p>e. A HHA visit note dated 03/01/14 at 4:23 PM stated "There is one sore on [Name of Patient] bottom that is of concern [size of sore drawn) that size ... "</p> <p>3. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> <p>4. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team</p> |   | is corrected and will not recur.  |   |  |   |  |

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|                    | of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Regularly re-evaluate the patient's nursing needs." |               |   |                      |

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| N000542   | <p>410 IAC 17-14-1(a)(1)(C)<br/>Scope of Services<br/>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:<br/>(C) Initiate the plan of care and necessary revisions.</p> <p>Based on observation, clinical record and policy review, and interview, the Registered Nurse failed to ensure the plan of care had been updated and included all types of services and equipment required, frequency of visits, nutritional requirements, medications and treatments for 5 of 10 records reviewed creating the potential to affect all 102 patients receiving services. (# 1, 2, 4, 5, and 6)</p> <p>Findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period of 01/19/14 to 03/19/14 that stated, "RN [registered nurse] for supervision of home health aide [HHA] per State and Federal Regulations." Addendum 21 on the plan of care stated, "SN [skilled nurse] up to 2 hours a day, up to 3 days a week." The clinical record failed to evidence a home health aide was in the home.</p> <p>During a home visit on 03/12/14 at 10:00 AM, the patient was observed to</p> | N000542   | The DON has in-serviced the professional staff on following the POC, ensuring that all treatments, equipment, medications and disciplines are documented on the POC and followed. Education provided on documenting on the POC the frequency and duration of services, missed visit reporting and documentation and the need to report all changes in patient condition to the physician. The clinical records have audited for the above deficiencies and have been addressed with the appropriate professional. The clinical documentation will be reviewed by theDON for compliance with the POC and proper notification of changes in condition. An RN homecare consultant has been hired to assist with education and oversight. 10% of the clinical records will be audited quarterly for compliance with the POC and notification of patient changes in condition, and appropriate documentation and notification of missed visits. The DON will be responsible for monitoring the corrective actions to ensure this deficiency is corrected and will | 04/11/2014  |  |   |  |

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|                    | <p>have a lymphedema sleeve on her right leg. The patient indicated she had been receiving lymphedema treatments for 2 hours 3 times a week for several months. The patient indicated that the nurse obtains leg measurements and vital signs before and after treatments. The patient also provided a jar of medicated ointment called Triamcinolone that was to be applied to affected areas on her legs on an as needed basis. Employee B, a licensed practical nurse (LPN), indicated she provided these services 3 times a week and applied the ointment on an as needed basis. The plan of care failed to evidence the lymphedema treatment, location of the bilateral lower extremity measurements, orders for vital signs to be done before and after treatments, and the medicated cream with directions for use.</p> <p>2. Clinical record number 2 included a plan of care established by the physician for the certification periods of 12/23/13 to 02/20/14 and 02/21/14 to 04/21/14. Both plans of care included a clinical addendum that stated, "Small skin tear on left coccyx that is healing. Foam boarder dressing and cream applied to area by HHA [home health aide]." The plan of care failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> |               | not recur.  |                      |

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|   | <p>a. A home visit was made to the patient on 03/12/14 at 11:15 AM. The patient was observed lying in bed with a specialty inflatable mattress pad in place. The plan of care failed to evidence the inflatable mattress pad.</p> <p>b. The "Clinical Addendum" on the plan of care stated, "HHA [home health aide] up to 10 hours a day, up to 7 days a week ... aide interventions ... ATTC (attendant care) interventions ... " The Comprehensive Assessment dated 02/17/14 stated, "up to 112 hrs [hours] per mo [month] x 2 months." The plan of care failed to evidence a specific frequency of visits for the HHA and attendant care services. The plan of care failed to evidence a skilled nurse would assess, treat, and monitor the patient's skin.</p> <p>3. Clinical record number 4 included a plan of care established by the physician for the certification period 01/19/14 to 03/19/14. The clinical record evidenced the patient received bolus enteral feedings per gastric tube. The plan of care failed to evidence the type, volume, and frequency of the enteral feeding; instructions for nursing interventions; and management of the enteral feeding tube.</p> <p>4. Clinical record number 5 included a</p> |   |   |                      |   |

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|                    | <p>plan of care established by the physician for the certification periods 12/27/13 to 02/24/14 and 02/25/14 to 04/25/14 with orders for HHA up to 8 hours a day, up to 7 days a week. The clinical record evidenced an attendant was in the home. The clinical record failed to evidence the plan of care had specific frequency of visits for the HHA and failed to include the frequency and duties of the attendant care services.</p> <p>5. Clinical record number 6 included a plan of care established by the physician for the certification period of 01/02/14 to 03/02/14 with orders for skilled nursing to see patient every other week for medication set up. Clinical record evidenced the patient self catheterizes with a 14 French caude catheter and that the patient receives attendant care services from an outside agency. The plan of care failed to evidence the patient self catheterizes with a 14 French Claude catheter and the patient was receiving attendant care services from an outside agency.</p> <p>6. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>7. A policy titled "Patient Care:</p> |               |   |                      |

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|  | <p>Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Regularly re-evaluate the patient's nursing needs ... Coordinate patient services between other care providers as necessary ... Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs ... Shall accept and carry out physician ... orders (oral and written) ... Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems.</p> <p>8. A policy titled "Administration and Patient Care: Plan of Care [485]" dated 11/29/12 stated "The patient's plan of care is developed by a physician, in consultation with the home health professional staff, and with patient's participation ... Type of home health care services and equipment required ... nursing services needed, frequency of nursing services, medications, diet, home</p> |  |  |  |
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|                    | health aide services with frequency, medical supplies / appliances necessary , any other appropriate items ... changes in the plan of care are documented through written and signed plans of modification or, if changes are requested orally, are reduced to writing ... Staff members promptly inform the physician of any changes that suggest a need to alter the patient's plan of care." |               |   |                      |

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| N000546   | <p>410 IAC 17-14-1(a)(1)(G)<br/>Scope of Services<br/>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:<br/>(G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record and policy review, and interview, the agency failed to ensure the Registered Nurse informed the physician of changes in the patient's condition for 3 of 10 clinical records reviewed creating the potential to affect all of the agency's 102 patients. (# 2, 7, 9)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 12/23/13 to 02/20/14.</p> <p>a. A home health aide visit note dated 01/07/14 at 8:50 AM stated "Patient was vomiting all evening, notified the nurse at the office ... "</p> <p>b. A home health aide visit note dated 01/07/14 at 9:45 AM stated</p> | N000546   | The DON has conducted in-services with all nursing staff to address the regulations, policies and procedures on following the established plan of care, evaluating and re-evaluating the patient's on going needs and notifying the physician in any change in patient condition and/or needs;the process of reporting changes and needs to the physician. Travel charts have been established to include all necessary documents including the POC. The clinical records have been audited with education provided to the nursing staff on noted deficiencies. An RN homecare consultant has been hired to assist with education and oversight.Documentation will be reviewed by the DON for compliance with the POC and regulations concerning notification of change in condition. 10% of the clinical records will be audited quarterly for compliance.The DON will be | 04/11/2014  |  |   |  |

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|   | <p>"Patient was vomiting ... packed things up to go to hospital. Notified office."</p> <p>c. A home health aide visit note dated 01/07/14 at 4:45 PM stated "Patient vomited 3 times; notified the office ... "</p> <p>d. The clinical record failed to evidence that the office / case manager / skilled nurse notified the physician of the change in patient's condition.</p> <p>2. Clinical record number 7 included a plan of care established by the physician for the certification period of 01/30/14 to 03/30/14.</p> <p>a. A skilled nursing note dated 02/12/14 stated that a consulting specialty physician for the patient changed the psychotropic medication from Zoloft to Abilify due to diarrhea. The clinical record failed to evidence that the patients attending physician was notified of the medication change or of the symptoms that resulted in the change being made by the specialty physician.</p> <p>b. A skilled nursing note dated 02/19/14 stated that the patient had a fever greater than 100 F. The nurse documented that she advised the patients caregiver to notify the doctor. The clinical record failed to evidence that the</p> |   | responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.  |   |  |   |  |

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|---|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>LIFE CARE MEDICAL SOLUTIONS INC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>25 ARTIST DRIVE<br>NASHVILLE, IN 47448 |  |   |  |
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|   | <p>skilled nurse had notified the attending physician.</p> <p>3. Clinical record number 9 included a plan of care established by the physician for the certification period 02/06/14 to 04/06/14. The plan of care included a diagnosis of a seizure disorder.</p> <p>a. The plan of care included medications of Kepra, Topamax, and Phenobarbital, to control seizure activity and skilled nursing to assess the patient for changes in neurological status at each visit.</p> <p>b. Skilled nursing notes dated 02/10, 02/12, 02/13, and 03/03 to 03/09/14 identified the patient had separate episodes of seizure activity. The clinical record failed to evidence the skilled nurse notified the patient's attending physician of the number of episodes of seizure activity.</p> <p>4. The Director of Nursing and the Administrator was not able to provide any further documentation or information when asked on 03/17/14 at 4:00 PM.</p> <p>5. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct</p> |   |   |   |  |   |  |

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|  | care and / or case management for a team of agency patients in accordance with the Indiana State Nurse Practice Act and agency policy ... Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs ... Shall accept and carry out physician ... orders (oral and written) ...Shall check all medicines the patient is known to be taking and promptly report any problems to the person responsible for the medical component of the patient's care, including, but not limited to, changes in status, worsening of condition, and the development of additional medical problems." |  |  |  |
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| N000550   | <p>410 IAC 17-14-1(a)(1)(K)<br/>Scope of Services<br/>Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br/>(K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the home health aide and attendant care written care instructions completed by the registered nurse did not duplicate services for each shift / visit provided in a 24 hour day, 7 days a week in 1 of 10 records reviewed creating the potential to affect all of the agency's current 102 patients. (# 2)</p> <p>Findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period of 12/23/13 to 02/20/14 that identified the patient was receiving services from a home health aide (HHA) up to 10 hours a day, up to 7 days per week as well as attendant care interventions. The plan of care also included the patient was incontinent of bowel and bladder, hearing limitations, wheelchair and bedside commode, left foot contracture and may apply non medicated protective cream to skin daily</p> | N000550   | The DON and Administrator and RN homecare consultant has in-serviced the RN case managers on coordination of the home health aide and attendant care services to provide coordinated care and defined duties for each with an established frequency and duration. In-service has been provided to the direct care staff on its use. The clinical documentation has been audited and personnel have been educated on deficiencies noted. Documentation will be reviewed by the DON for compliance with coordinated care plans for the home health aide and defined tasks, frequency and duration. 10% of the clinical records will be audited quarterly for compliance. The DON will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. | 04/11/2014           |   |

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|   | <p>PRN (if necessary), and the patient was an aspiration and choking risk that required 1:1 at meals. The clinical record included home health aide visits that varied for 1 hour in the morning, 3 to 7 hours late morning to mid afternoon altering with attendant care services, 2 to 3 hours in the evening followed by attendant care services during sleeping hours.</p> <p>a. The plan of care included "Aide Interventions: assist with bathing [tub, shower, chair, bed bath, partial, complete). Assist with dressing. Assist with hair care. Assist with shampoo. Assist with skin care; may apply non medicated protective cream to skin daily PRN. Assist with foot care. Assist with nail care. Assist with oral care. Check skin for pressure areas. Assist with meal preparation. Assist with meal set up. Encourage fluids. Do laundry. Clean kitchen, bedroom, bathroom. Make bed, change bed linens. Maintain fall precautions. Maintain safe and clean environment."</p> <p>b. The plan of care included "ATTC [attendant care] Aide Interventions: assist with bathing [tub, shower, chair, bed bath, partial, complete). Assist with dressing. Assist with hair care. Assist with shampoo. Assist with skin care;</p> |   |   |   |  |   |  |

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|                    | <p>may apply non medicated protective cream to skin daily PRN. Assist with foot care. Assist with nail care. Assist with oral care. Check skin for pressure areas. Assist with meal preparation. Assist with meal set up. Encourage fluids. Do laundry. Clean kitchen, bedroom, bathroom. Make bed, change bed linens. Maintain fall precautions. Maintain safe and clean environment. Run errands as requested."</p> <p>c. A "Home Health Aide Care Plan" was revised on 12/18/13 and 02/17/14 to include the HHA was to provide bathing assistance per patient request, hygiene assistance such as assist with dressing, hair care, shampoo, foot care, and nail care per patient request. Personal care, skin care, check for ulcers, oral care, and toileting assistance "AM" and "PM." The HHA care plan failed to evidence specific duties to be performed by the HHA during each provided shift. The home health aide care plan failed to evidence specific frequency and duration of visits, the patient's hearing limitations, and requirement of 1:1 at meals.</p> <p>d. A "485 Non-skilled Plan of Care Worksheet" dated 02/17/14 stated the patient was receiving attendant care services up to 112 hours per month for 2 months.</p> |               |   |                      |

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|   | <p>e. A "Patient Assessment Form" included the preferred service days to be Monday through Sunday. Personal care assessment form included assistance with showers, bath chair, shampoo, brushing hair, fingernails, toenails, brushing teeth, floss, toileting, transferring, housekeeping, transportation, and meals. The personal care assessment form failed to evidence specific duties to be performed by the personal service attendant during each provided shift.</p> <p>6. The Director of Nursing (DoN) and the Administrator was not able to provide any further documentation or information when asked on 03/14/14 at 3:00 PM.</p> <p>7. A policy titled "Patient Care: Registered Nurse / Case Manager - Responsibilities" dated 11/31/12 stated "Registered Nurse shall provide direct care and / or case management for a team of agency patients ... Coordinate patient services between other care providers as necessary ... assign staff to provide care to the patient ... home health aide and or other individuals ... delegate duties and tasks ... as appropriate ... "</p> |   |   |   |  |   |  |