

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2013
NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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G0000	<p>This was a federal home health recertification survey. This was a partial extended survey.</p> <p>Facility #: 005998</p> <p>Survey Dates: 1-16-13, 1-17-13, and 1-18-13</p> <p>Medicaid Vendor #: 200217590</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>January 23, 2013</p>	G0000			

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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G0102	<p><b>484.10(a)(1)</b> <b>NOTICE OF RIGHTS</b> The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.</p> <p>Based on clinical record review and interview, the agency failed to ensure a patient had been informed of their rights in advance of furnishing care in 1 (# 6) of 10 records reviewed creating the potential to affect all of the agency's new admissions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 6 included a plan of care with a start of care date of 12-17-12. The record evidenced the agency had provided services starting on 12-18-12. The record included an "Admission Document" document that evidenced the patient had acknowledged receipt of the patient rights on 1-3-13.</li> <li>2. The administrator, employee A, indicated, on 1-18-13 at 8:40 AM, the patient rights were given to each patient during the initial evaluation visit and she was unable to provide an explanation as to why the receipt of the patient rights evidenced a 1-3-13 date in this record.</li> </ol>	G0102	<p>The administrator has inserviced all nursing staff that all admission documents must be electronically signed and sent to office during admission visit to avoid additional date stamps being added to admission documents. When nurses are saving the admission documents for their review, the document was getting date stamped with current date versus the date documents were completed. 10 % of all clinical records will be audited quarterly for evidence of appropriate signatures and dates. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/31/2013	

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G0108	<p><b>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</b></p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient had been informed, in advance, of the disciplines that would furnish care and the proposed frequency of visits in 1 (# 10) of 10 records reviewed creating the potential to affect all new admissions to the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 10 included a plan of care with a start of care date of 11-15-12 that identified the physician had ordered skilled nurse services 1 time per week and home health aide services 2 times per day for 9 weeks. The record included a "Family Home Medical/Need A Nurse Patient Authorization" form, dated 11-13-12, that informed the patient home health aide services would be provided two times per day. The form</p>	G0108	The administrator will inservice all nursing staff that any additional disciplines added after admission documents are completed must also document that the patient has been informed in advance changes in the care that is being furnished. They must also document that the patient has been advised in advance the discipline and frequency of the visits proposed and advise the patient and document any change in the plan of care before the change is made.10 % of all clinical records will be audited quarterly for evidence that the patient has been advised of disciplines furnishing care and have been advised prior to care or changes in care have begun.The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	01/31/2013			

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	<p>failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>2. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 1-18-13 at 11:00 AM.</p>			

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G0121	<p><b>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, agency policy review, and interview, the agency failed to ensure employees cleansed hands and changed gloves in accordance with the agency's own infection control policies and procedures in 4 (#s 1, 2, 3, and 4) of 5 home visit observations creating the potential for the transmission of disease causing organisms among staff and the agency's 112 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's undated "Prevention of Occupational Exposure to Bloodborne Pathogens" policy number 1113 states, "Universal Precautions will be observed to prevent contact with blood or other potentially infectious materials . . . The employees are to use appropriate personal protective equipment."</li> <li>2. 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</li> </ol>	G0121	<p>The administrator will inservice and train all staff on accepted standards of practice regarding: Universal Precautions and Infection control as defined by CDC Guidelines for Hand Hygiene in Health Care Settings (MMWR October 25, 2002) and CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). Infection control will be added and monitored through Quality Assurance program All staff will be supervised providing direct patient care monthly to ensure that guidelines are being followed as instructed. During supervisory visits, patients will be asked about staff adherence to hand washing policy. All staff will return demonstrate training received and will sign written statements regarding the value of, and support for the adherence to recommended hand hygiene practices. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/31/2013			

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	<p>to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>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. 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). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . 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 . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. 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>			

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	<p>3. A home visit was made to patient number 1 with employee G, a home health aide, on 1-16-13 at 1:25 PM. The aide was observed to provide a shower bath and assistance with other personal care tasks.</p> <p>A. The aide was observed to don clean gloves without cleansing her hands. The aide assisted the patient to the shower in a shower chair after assisting the patient to disrobe. The aide was observed to wash the patient's upper body and, using a clean washcloth, washed the patient's upper legs and front perineal area. The aide assisted the patient to stand and washed the patient's buttocks and rectal area. The aide commented there was a small amount of stool on the patient's rectal area. The aide then rinsed the patient's lower body with a shower wand. The aide assisted the patient to sit and continued to rinse the patient's entire body with the shower wand touching the patient's chest and arms. The aide failed to change her gloves or wash her hands after washing the patient's buttocks and rectal area.</p> <p>B. Without changing her gloves, the aide obtained a bath sponge and washed the patient's face and hair. The aide dried the patient's face, hair, upper body, legs,</p>						

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	<p>and feet. The aide, wearing the same gloves, applied cream to the patient's buttocks, deodorant to the underarms, and a topical spray medication to the feet and under the breasts.</p> <p>C. Without changing her gloves, the aide obtained the patient's teeth from a denture cup, rinsed them, and placed them in the patient's mouth. The aide then applied a topical antibiotic ointment to reddened areas on the patient's lower legs, right arm, and chest. The aide then assisted the patient to don clothing and assisted the patient to a lift chair.</p> <p>D. Without changing gloves, the aide picked up the towels on the bathroom floor and then blew her own nose. The aide then picked up the washcloth used to cleanse the patient's rectal area, rinsed it, and hung it up to dry. The aide then removed her gloves and washed her hands.</p> <p>4. A home visit was made to patient number 2 with employee E, a home health aide, on 1-16-13 at 2:20 PM. The aide was observed to provide a shower bath and assistance with other personal care tasks.</p> <p>A. The aide was observed to don clean gloves without cleansing her hands.</p>				

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	<p>The aide assisted the patient into the shower after the patient disrobed. The patient washed the upper body, legs, and feet and the aide washed the patient's back and rear perineal area. Without changing her gloves or cleansing her hands, the aide assisted the patient to stand and rinsed the patient's body with the shower wand. The patient sat back down and the aide handed the patient a bath sponge with scented soap and the process was repeated.</p> <p>B. Without changing her gloves or cleansing her hands, the aide handed the patient a clean washcloth that the patient used to wash the patient's own face. The aide then washed and rinsed the patient's hair. The aide then assisted the patient out of the shower and dried the patient's back and hair.</p> <p>C. Without changing her gloves or cleansing her hands, the aide applied 2 different types of lotion to the patient's face, back, and legs. The aide applied deodorant to the patient's underarms. The aide assisted the patient with donning a housecoat. The patient then ambulated to the bedroom and the aide assisted the patient to dress.</p> <p>5. A home visit was made to patient number 3 with employee C, a registered nurse (RN), on 1-17-13 at 8:25 AM. The</p>						

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	<p>RN was observed to fill the patient's medication planner.</p> <p>A. The RN was observed to cleanse her hands and reach into her nursing bag to obtain refills of medications for the patient. The RN then obtained the basket of pills to prepare them to fill the medication planner.</p> <p>B. The RN was observed to prepare 11 different medications and place them into the medication planner. The RN poured the pills out into her bare hands, placed 1 (or the required number) in each box and then poured the remaining pills back into the medication bottle if she had poured more than was needed into her hand.</p> <p>C. After the medication planner had been filled, the RN placed the planners and the medication bottles into a cabinet in the patient's kitchen. Without cleansing her hands, the RN then reached into her nursing bag and obtained equipment to take the patient's vital signs.</p> <p>D. The RN cleaned the equipment used to take the vital signs and replaced the equipment into her nursing bag. The RN obtained gloves from her bag and donned them without cleansing her hands. The RN assessed the patient's lower</p>			

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	<p>extremities.</p> <p>6. A home visit was made to patient number 4 with employee F, a home health aide, on 1-17-13 at 9:30 AM. The aide was observed to provide a bed bath to the patient.</p> <p>A. The aide was observed to don clean gloves without cleansing her hands. The aide prepared a basin of water, assisted the patient to sit on the side of the bed, and placed the patient's feet into the basin of water to soak. After 10 minutes, the aide removed the patient's feet from the basin, dumped the water into the toilet, and flushed.</p> <p>B. Without changing her gloves or cleansing her hands, the aide prepared 2 basins of water to give the patient a bath. The aide washed, rinsed, and dried the patient's face and arms. The aide then assisted the patient to stand and removed the patient's gown and Depends undergarment. The aide assisted the patient back into the bed and washed, rinsed, and dried the patient's breasts, abdomen, and legs. The aide was observed to wash, rinse, and dry the patient's front perineal area.</p> <p>C. Without changing her gloves or cleaning her hands, the aide applied</p>				

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	<p>powder under the patient's breasts and arms, and applied Nystatin powder under the abdominal fold. The aide applied lotion to the legs and feet. The aide then assisted the patient to stand and washed the patient's buttocks and rectal area. The aide then applied a topical cream to the patient's rectal area and lotion to the patient's back, arms, and chest. The aide assisted the patient to don a gown and back to bed.</p> <p>D. The aide removed her gloves and, without cleansing her hands, assisted the patient to perform exercises on the lower extremities. The aide without wearing gloves assisted the patient to stand and applied a cream to the patient's face.</p> <p>7. The administrator, employee A, indicated, on 1-17-13 at 11:10 AM, the above-stated observations were not in compliance with agency policies and/or practices. The administrator stated, "We have inserviced the aides and they have been educated."</p>						

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G0158	<p><b>484.18</b> ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure visits and treatments had been provided in accordance with the plans of care in 4 (#s 1, 4, 8, and 9) of 10 records reviewed creating the potential to affect all of the agency's 112 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care, established by the physician for the certification period 11-16-12 to 1-4-13, that states, "RN [registered nurse] to delegate and train HHA [home health aide] on blood glucose meter . . . HHA Orders: . . . Assist pt with checkin [sic] BS [blood sugar] every Tuesday."</p> <p>A. Home health aide visit notes, dated 11-20-12, 11-27-12, 12-4-12, 12-11-12, 12-18-12, 12-25-12, 1-1-13, 1-8-13, and 1-15-13, failed to evidence the home health aide had checked the patient's blood sugar as ordered by the physician.</p> <p>B. The administrator, employee A,</p>	G0158	The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care. Nurses must review all written plans of care before care is being provided and HHAs must review all HHA assignment sheets before care is provided. All care provided must be documented in the clinical record. If services are interrupted or do not comply with the written plan of care, documentation must be generated to reflect these changes. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care and clinical notes reflect care provided. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	01/31/2013			

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	<p>indicated, on 1-18-13 at 11:00 AM, the home health aide had checked the patient's blood sugar every Tuesday but the documentation was kept in a notebook in the patient's home.</p> <p>2. During a home visit to patient number 4, on 1-17-13 at 9:30 AM, employee F, a home health aide, was observed to apply Nystatin powder under the patient's abdominal fold and apply Magic Butt Cream to the patient's rectal area.</p> <p>A. The plan of care, established by the physician for the certification period 11-29-12 to 1-27-13, failed to evidence an order for the application of the Nystatin or the Magic Butt Cream.</p> <p>B. The administrator, employee A, stated, on 1-18-13 at 11:05 AM, "The RN has never directed the aides to use the Nystatin or Magic Butt Cream."</p> <p>3. Clinical record number 8 included a plan of care established by the physician for the certification period 12-27-12 to 2-24-13 that evidenced home health aide services were to be provided 3 times per week starting 12-27-12.</p> <p>A. The record evidenced the first home health aide visit was provided on 1-4-13.</p>						

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	<p>B. The administrator, employee A, stated, on 1-18-13 at 11:10 AM, "The [family member] canceled and did not want services to start until after the holidays." The administrator was unable to provide any documentation of the delay in the start of services.</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 10-30-12 to 12-28-12 that evidenced home health aide services were to be provided 3 times per week.</p> <p>A. The record evidenced the first home health aide visit was provided on 11-12-12.</p> <p>B. The administrator, employee A, indicated, on 1-18-13 at 11:15 AM, the aide services did not start until the patient had been evaluated.</p> <p>5. The agency's 12-1-09 "Care Plans" policy number 141 states, "Doctors' orders are required for home health services . . . The written plan of treatment (485) is required for home health services to continue. These are doctors' orders for home health services."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2013
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G0229	<p><b>484.36(d)(2) SUPERVISION</b></p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure supervisory visits had been made at least every 2 weeks in 2 (#s 1 and 3) of 3 records reviewed of patients that received skilled nurse and home health aide services creating the potential to affect all of the agency's current patients that receive skilled nurse and home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 1 evidenced the agency provided skilled nursing 2 to 5 times per month and home health aide services 14 to 21 times per week during the certification period 11-16-12 to 1-4-13. The record evidenced the registered nurse (RN), employee C, had made a supervisory visit on 12-13-12 and not again until 1-3-13, a period of 3 weeks between supervisory visits.</li> </ol> <p>The administrator, employee A, indicated, on 1-18-13 at 8:30 AM, the supervisory visit had been missed due to inclement weather but that it had not been</p>	G0229	<p>The administrator will inservice all nursing staff on required frequency of supervisory visits. The charting documentation system will also be updated to incorporate supervisory notes within the daily clinical note to increase accuracy of supervisory visit documentation. 10 % of all clinical records will be audited quarterly for evidence that a supervisory visit has been made timely. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	01/31/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2013
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	<p>re-scheduled.</p> <p>2. Clinical record number 3 evidenced the agency provided skilled nursing 2 to 5 times per month and home health aide services 3 to 5 times per week during the certification period 11-23-12 to 1-21-13. The record evidenced the RN, employee C, had made a supervisory visit on 11-26-12 and not again until 12-18-12, a period of 3 weeks and 1 day between supervisory visits.</p> <p>The administrator, employee A, indicated, on 1-18-13 at 11:05 AM, a supervisory visit had been completed on 12-4-12 but that it had not been documented.</p> <p>3. The agency's 12-1-09 "Supervision of Services" policy number 133 states, "Patients receiving skilled services and home health aide services will receive and [sic] In-Home supervisory visit every 2 weeks by a RN."</p>				

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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G0321	<p><b>484.20(a)</b> <b>ENCODING OASIS DATA</b> The HHA must encode and be capable of transmitting OASIS data for each agency patient within 7 days of completing an OASIS data set.</p> <p>Based on Indiana State Department of Health (ISDH) document review and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completion (M 0090) in 4 (patients # 3, 11, 12, and 13) of 46 transmissions reviewed creating the potential to affect all of the agency's Medicaid skilled patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. An ISDH document dated 1-10-13 evidenced the agency had completed a recertification reassessment on 7-25-12 for patient number 3. The document evidenced the OASIS data had not been transmitted until 10-11-12.</li> <li>2. An ISDH document dated 1-10-13 evidenced the agency had completed a recertification reassessment on 7-25-12 for patient number 11. The document evidenced the OASIS data had not been transmitted until 10-17-12.</li> <li>3. An ISDH document dated 1-10-13 evidenced the agency had completed a start of care assessment on 9-17-12 for</li> </ol>	G0321	The administrator has reviewed current OASIS data collection and transmission procedure. Recent addition of new software (11/26/2012) has corrected the untimeliness issue of OASIS data transmission. OASIS data is collected within the daily visit note and can now be transmitted within 7 day window. All OASIS records will be tracked through current software reporting to ensure timely collection and transmission. All patients who require OASIS collection and transmission will be audited monthly to ensure collection and transmission timeliness. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	01/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2013
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	<p>patient number 12. The document evidenced the OASIS data had not been transmitted until 11-5-12.</p> <p>4. An ISDH documented dated 1-10-13 evidenced the agency had completed a recertification reassessment on 7-24-12 for patient number 13. The document evidenced the OASIS data had not been transmitted until 9-28-12.</p> <p>5. The administrator, employee A, indicated, on 1-16-13 at 11:15 AM, she was aware of some problems with OASIS data transmission.</p>				

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G0337	<p><b>484.55(c) DRUG REGIMEN REVIEW</b></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 clinical record review and interview, the agency failed to ensure comprehensive assessments included a review of all medications the patients were known to be taking in 4 (#s 1, 3, 7, and 9) of 10 record reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 included a recertification comprehensive assessment dated 1-3-13. The record failed to evidence the comprehensive assessment included a review of all medications the patient was known to be taking.</li> <li>2. Clinical record number 3 included a recertification comprehensive assessment dated 11-21-12. The record failed to evidence the comprehensive assessment included a review of all medications the patient was known to be taking.</li> <li>3. Clinical record number 7 included a start of care comprehensive assessment dated 11-20-12. The record failed to</li> </ol>	G0337	<p>The administrator has contacted current software company. Drug regimen reviews did not appear to have been completed because software regenerates new date stamp on each medication profile every time a nurse/user enters medication profile. This has been changed to have date of comprehensive assessment and medication profile date stamped permanently after drug regimen review completed. All nurses inserviced on need to complete drug regimen review with each comprehensive assessment. 10% of all clinical records will be audited quarterly for evidence that a drug regimen review has been completed with comprehensive assessment. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	01/31/2013			

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	<p>evidence the comprehensive assessment included a review of all medications the patient was known to be taking.</p> <p>4. Clinical record number 9 included a recertification comprehensive assessment dated 12-28-12. The record failed to evidence the comprehensive assessment included a review of all medications the patient was known to be taking.</p> <p>5. The administrator, employee A, indicated, on 1-18-13 at 8:25 AM, the comprehensive assessments did include a review of all medications, but the agency's new computer program was not capturing the fact.</p>			

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N0000	<p>This was a home health State re-licensure survey.</p> <p>Facility #: 005998</p> <p>Survey Dates: 1-16-13, 1-17-13, and 1-18-13</p> <p>Medicaid Vendor #: 200217590</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>January 23, 2013</p>			N0000			

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N0464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on</p>						

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712			
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	<p>a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file review and interview, the agency failed to ensure annual evaluations for TB had been completed in 2 (files C and I) of 7 files reviewed of staff employed for longer than 1 year creating the potential to affect all of the agency's 112 current patients.</p> <p>The findings include:</p> <p>1. Personnel file C evidenced the individual had been hired on 3-2-09 to provide nursing services on behalf of the agency. The file included a chest x-ray dated 12-1-11. The file failed to evidence a tuberculosis screening had been completed annually.</p> <p>A. Employee C indicated, on 1-18-13 at 1:15 PM, her physician had ordered the chest ex-ray in lieu of the skin test due to a medical condition.</p> <p>B. The administrator, employee A,</p>	N0464	The administrator has implemented a new tracking system to monitor TB skin testing on all new and current employees. For all employees who requires chest xray, a risk assessment tool has been implemented and will be performed annually. 10 % of all personnell files will be monitored quarterly to ensure TB skin tests have been performed when indicated.The administrator will be responsible for monitoring these corrective action to ensure that this deficiency is corrected and will not recur.	01/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2013
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	<p>indicated, on 1-18-13 at 1:15 PM, a risk assessment had not been completed on employee C since the employee's chest x-ray in December 2011.</p> <p>2. Personnel file I evidenced the individual had been hired on 10-19-11 to provide home health aide services on behalf of the agency. The file evidenced a TB skin test dated 10-21-11 and 10-24-11. The file failed to evidence any further TB skin tests had been administered.</p> <p>The office manager, employee K, indicated, on 1-18-13 at 1:20 PM, the employee had a TB skin test in July but that she could not find the documentation.</p>				

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management 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 cleansed hands and changed gloves in accordance with the agency's own infection control policies and procedures in 4 (#s 1, 2, 3, and 4) of 5 home visit observations creating the potential for the transmission of disease causing organisms among staff and the agency's 112 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The agency's undated "Prevention of Occupational Exposure to Bloodborne Pathogens" policy number 1113 states, "Universal Precautions will be observed to prevent contact with blood or other potentially infectious materials . . . The employees are to use appropriate personal protective equipment."</li> <li>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</li> </ol>	N0470	<p>The administrator will inservice and train all staff on accepted standards of practice regarding: Universal Precautions and Infection control as defined by CDC Guidelines for Hand Hygiene in Health Care Settings (MMWR October 25, 2002) and CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). Infection control will be added and monitored through Quality Assurance program All staff will be supervised providing direct patient care monthly to ensure that guidelines are being followed as instructed. During supervisory visits, patients will be asked about staff adherence to hand washing policy. All staff will return demonstrate training received and will sign written statements regarding the value of, and support for the adherence to recommended hand hygiene practices. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur</p>	01/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2013
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	<p>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 . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, 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. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . 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 . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. 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</p>			

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	<p>contaminated intact skin . . . could occur.</p> <p>3. A home visit was made to patient number 1 with employee G, a home health aide, on 1-16-13 at 1:25 PM. The aide was observed to provide a shower bath and assistance with other personal care tasks.</p> <p>A. The aide was observed to don clean gloves without cleansing her hands. The aide assisted the patient to the shower in a shower chair after assisting the patient to disrobe. The aide was observed to wash the patient's upper body and, using a clean washcloth, washed the patient's upper legs and front perineal area. The aide assisted the patient to stand and washed the patient's buttocks and rectal area. The aide commented there was a small amount of stool on the patient's rectal area. The aide then rinsed the patient's lower body with a shower wand. The aide assisted the patient to sit and continued to rinse the patient's entire body with the shower wand touching the patient's chest and arms. The aide failed to change her gloves or wash her hands after washing the patient's buttocks and rectal area.</p> <p>B. Without changing her gloves, the aide obtained a bath sponge and washed the patient's face and hair. The aide dried</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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	<p>the patient's face, hair, upper body, legs, and feet. The aide, wearing the same gloves, applied cream to the patient's buttocks, deodorant to the underarms, and a topical spray medication to the feet and under the breasts.</p> <p>C. Without changing her gloves, the aide obtained the patient's teeth from a denture cup, rinsed them, and placed them in the patient's mouth. The aide then applied a topical antibiotic ointment to reddened areas on the patient's lower legs, right arm, and chest. The aide then assisted the patient to don clothing and assisted the patient to a lift chair.</p> <p>D. Without changing gloves, the aide picked up the towels on the bathroom floor and then blew her own nose. The aide then picked up the washcloth used to cleanse the patient's rectal area, rinsed it, and hung it up to dry. The aide then removed her gloves and washed her hands.</p> <p>4. A home visit was made to patient number 2 with employee E, a home health aide, on 1-16-13 at 2:20 PM. The aide was observed to provide a shower bath and assistance with other personal care tasks.</p> <p>A. The aide was observed to don</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2013
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	<p>clean gloves without cleansing her hands. The aide assisted the patient into the shower after the patient disrobed. The patient washed the upper body, legs, and feet and the aide washed the patient's back and rear perineal area. Without changing her gloves or cleansing her hands, the aide assisted the patient to stand and rinsed the patient's body with the shower wand. The patient sat back down and the aide handed the patient a bath sponge with scented soap and the process was repeated.</p> <p>B. Without changing her gloves or cleansing her hands, the aide handed the patient a clean washcloth that the patient used to wash the patient's own face. The aide then washed and rinsed the patient's hair. The aide then assisted the patient out of the shower and dried the patient's back and hair.</p> <p>C. Without changing her gloves or cleansing her hands, the aide applied 2 different types of lotion to the patient's face, back, and legs. The aide applied deodorant to the patient's underarms. The aide assisted the patient with donning a housecoat. The patient then ambulated to the bedroom and the aide assisted the patient to dress.</p> <p>5. A home visit was made to patient number 3 with employee C, a registered</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2013
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	<p>nurse (RN), on 1-17-13 at 8:25 AM. The RN was observed to fill the patient's medication planner.</p> <p>A. The RN was observed to cleanse her hands and reach into her nursing bag to obtain refills of medications for the patient. The RN then obtained the basket of pills to prepare them to fill the medication planner.</p> <p>B. The RN was observed to prepare 11 different medications and place them into the medication planner. The RN poured the pills out into her bare hands, placed 1 (or the required number) in each box and then poured the remaining pills back into the medication bottle if she had poured more than was needed into her hand.</p> <p>C. After the medication planner had been filled, the RN placed the planners and the medication bottles into a cabinet in the patient's kitchen. Without cleansing her hands, the RN then reached into her nursing bag and obtained equipment to take the patient's vital signs.</p> <p>D. The RN cleaned the equipment used to take the vital signs and replaced the equipment into her nursing bag. The RN obtained gloves from her bag and donned them without cleansing her hands.</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	<p>The RN assessed the patient's lower extremities.</p> <p>6. A home visit was made to patient number 4 with employee F, a home health aide, on 1-17-13 at 9:30 AM. The aide was observed to provide a bed bath to the patient.</p> <p>A. The aide was observed to don clean gloves without cleansing her hands. The aide prepared a basin of water, assisted the patient to sit on the side of the bed, and placed the patient's feet into the basin of water to soak. After 10 minutes, the aide removed the patient's feet from the basin, dumped the water into the toilet, and flushed.</p> <p>B. Without changing her gloves or cleansing her hands, the aide prepared 2 basins of water to give the patient a bath. The aide washed, rinsed, and dried the patient's face and arms. The aide then assisted the patient to stand and removed the patient's gown and Depends undergarment. The aide assisted the patient back into the bed and washed, rinsed, and dried the patient's breasts, abdomen, and legs. The aide was observed to wash, rinse, and dry the patient's front perineal area.</p> <p>C. Without changing her gloves or</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712			
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	<p>cleaning her hands, the aide applied powder under the patient's breasts and arms, and applied Nystatin powder under the abdominal fold. The aide applied lotion to the legs and feet. The aide then assisted the patient to stand and washed the patient's buttocks and rectal area. The aide then applied a topical cream to the patient's rectal area and lotion to the patient's back, arms, and chest. The aide assisted the patient to don a gown and back to bed.</p> <p>D. The aide removed her gloves and, without cleansing her hands, assisted the patient to perform exercises on the lower extremities. The aide without wearing gloves assisted the patient to stand and applied a cream to the patient's face.</p> <p>7. The administrator, employee A, indicated, on 1-17-13 at 11:10 AM, the above-stated observations were not in compliance with agency policies and/or practices. The administrator stated, "We have inserviced the aides and they have been educated."</p>						

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712			
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N0494	<p>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on clinical record review and interview, the agency failed to ensure a patient had been informed of their rights in advance of furnishing care in 1 (# 6) of 10 records reviewed creating the potential to affect all of the agency's new admissions.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a plan of care with a start of care date of 12-17-12. The record evidenced the agency had provided services starting on 12-18-12. The record included an "Admission Document" document that evidenced the patient had acknowledged receipt of the patient rights on 1-3-13.</p>	N0494	The administrator has inserviced all nursing staff that all admission documents must be electronically signed and sent to office during admission visit to avoid additional date stamps being added to admission documents. When nurses are saving the admission documents for their review, the document was getting date stamped with current date versus the date documents were completed. 10 % of all clinical records will be audited quarterly for evidence of appropriate signatures and dates. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	01/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2013
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	2. The administrator, employee A, indicated, on 1-18-13 at 8:40 AM, the patient rights were given to each patient during the initial evaluation visit and she was unable to provide an explanation as to why the receipt of the patient rights evidenced a 1-3-13 date in this record.			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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N0504	<p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record review and interview, the agency failed to ensure the patient had been informed, in advance, of the disciplines that would furnish care and the proposed frequency of visits in 1 (# 10) of 10 records reviewed creating the potential to affect all new admissions to the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 10 included a plan of care with a start of care date of 11-15-12 that identified the physician had ordered skilled nurse services 1 time per week and home health aide services 2 times per day for 9 weeks. The record included a "Family Home Medical/Need A Nurse Patient Authorization" form, dated 11-13-12, that informed the patient home health aide services would be provided two times per day. The form</p>	N0504	The administrator will inservice all nursing staff that any additional disciplines added after admission documents are completed must also document that the patient has been informed in advance changes in the care that is being furnished. They must also document that the patient has been advised in advance the discipline and frequency of the visits proposed and advise the patient and document any change in the plan of care before the change is made. 10 % of all clinical records will be audited quarterly for evidence that the patient has been advised of disciplines furnishing care and have been advised prior to care or changes in care have begun. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	01/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2013
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	<p>failed to evidence the patient had been informed of the skilled nurse services that would be provided.</p> <p>2. The administrator, employee A, was unable to provide any additional documentation and/or information when asked on 1-18-13 at 11:00 AM.</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712		
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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure visits and treatments had been provided in accordance with the plans of care in 4 (#s 1, 4, 8, and 9) of 10 records reviewed creating the potential to affect all of the agency's 112 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care, established by the physician for the certification period 11-16-12 to 1-4-13, that states, "RN [registered nurse] to delegate and train HHA [home health aide] on blood glucose meter . . . HHA Orders: . . . Assist pt with checkin [sic] BS [blood sugar] every Tuesday."</p> <p>A. Home health aide visit notes, dated 11-20-12, 11-27-12, 12-4-12, 12-11-12, 12-18-12, 12-25-12, 1-1-13, 1-8-13, and 1-15-13, failed to evidence the home health aide had checked the patient's blood sugar as ordered by the physician.</p> <p>B. The administrator, employee A,</p>	N0522	The administrator will re-train all staff (via inservice) on all care being provided must follow a written plan of care. Nurses must review all written plans of care before care is being provided and HHAs must review all HHA assignment sheets before care is provided. All care provided must be documented in the clinical record. If services are interrupted or do not comply with the written plan of care, documentation must be generated to reflect these changes. 10% of all charts will be audited quarterly to ensure care being provided follows a written plan of care. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	01/31/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/18/2013
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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712
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	<p>indicated, on 1-18-13 at 11:00 AM, the home health aide had checked the patient's blood sugar every Tuesday but the documentation was kept in a notebook in the patient's home.</p> <p>2. During a home visit to patient number 4, on 1-17-13 at 9:30 AM, employee F, a home health aide, was observed to apply Nystatin powder under the patient's abdominal fold and apply Magic Butt Cream to the patient's rectal area.</p> <p>A. The plan of care, established by the physician for the certification period 11-29-12 to 1-27-13, failed to evidence an order for the application of the Nystatin or the Magic Butt Cream.</p> <p>B. The administrator, employee A, stated, on 1-18-13 at 11:05 AM, "The RN has never directed the aides to use the Nystatin or Magic Butt Cream."</p> <p>3. Clinical record number 8 included a plan of care established by the physician for the certification period 12-27-12 to 2-24-13 that evidenced home health aide services were to be provided 3 times per week starting 12-27-12.</p> <p>A. The record evidenced the first home health aide visit was provided on 1-4-13.</p>			

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	<p>B. The administrator, employee A, stated, on 1-18-13 at 11:10 AM, "The [family member] canceled and did not want services to start until after the holidays." The administrator was unable to provide any documentation of the delay in the start of services.</p> <p>4. Clinical record number 9 included a plan of care established by the physician for the certification period 10-30-12 to 12-28-12 that evidenced home health aide services were to be provided 3 times per week.</p> <p>A. The record evidenced the first home health aide visit was provided on 11-12-12.</p> <p>B. The administrator, employee A, indicated, on 1-18-13 at 11:15 AM, the aide services did not start until the patient had been evaluated.</p> <p>5. The agency's 12-1-09 "Care Plans" policy number 141 states, "Doctors' orders are required for home health services . . . The written plan of treatment (485) is required for home health services to continue. These are doctors' orders for home health services."</p>			

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NAME OF PROVIDER OR SUPPLIER  NEED A NURSE, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2318 W FRANKLIN EVANSVILLE, IN 47712			
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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure supervisory visits had been made at least every 2 weeks as required by agency policy in 2 (#s 1 and 3) of 3 records reviewed of patients that received skilled nurse and home health aide services creating the potential to affect all of the agency's current patients that receive skilled nurse and home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 evidenced the agency provided skilled nursing 2 to 5 times per month and home health aide services 14 to 21 times per week during the certification period 11-16-12 to 1-4-13. The record evidenced the registered nurse (RN), employee C, had made a supervisory visit on 12-13-12 and not again until 1-3-13, a period of 3 weeks between supervisory visits.</p>	N0606	The administrator will inservice all nursing staff on required frequency of supervisory visits. The charting documentation system will also be updated to incorporate supervisory notes within the daily clinical note to increase accuracy of supervisory visit documentation. 10 % of all clinical records will be audited quarterly for evidence that a supervisory visit has been made timely. The administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	01/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K007	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/18/2013
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	<p>The administrator, employee A, indicated, on 1-18-13 at 8:30 AM, the supervisory visit had been missed due to inclement weather but that it had not been re-scheduled.</p> <p>2. Clinical record number 3 evidenced the agency provided skilled nursing 2 to 5 times per month and home health aide services 3 to 5 times per week during the certification period 11-23-12 to 1-21-13. The record evidenced the RN, employee C, had made a supervisory visit on 11-26-12 and not again until 12-18-12, a period of 3 weeks and 1 day between supervisory visits.</p> <p>The administrator, employee A, indicated, on 1-18-13 at 11:05 AM, a supervisory visit had been completed on 12-4-12 but that it had not been documented.</p> <p>3. The agency's 12-1-09 "Supervision of Services" policy number 133 states, "Patients receiving skilled services and home health aide services will receive and [sic] In-Home supervisory visit every 2 weeks by a RN."</p>				