

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2014
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NAME OF PROVIDER OR SUPPLIER  AT-HOME CARE OF HARRISON COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1263 HOSPITAL DR STE 140 NW CORYDON, IN 47112
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G000000	<p>This was a federal home health recertification survey. This survey was partial extended on 6/4/2014.</p> <p>Survey dates: 6/3/2014-6/6/2014</p> <p>Facility #: IN006098</p> <p>Medicaid #: 100265910A</p> <p>Surveyor: Nina Koch, RN, PHNS</p> <p>Census 227 Active Patients 43</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 17, 2014</p>	G000000		
G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency</p>	G000158	Administrator/supervising RN inserviced the clinical staff on	06/19/2014

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>policy review and interview, the agency failed to ensure wound care was provided as ordered in 1 (#7) of 12 records reviewed creating the potential to affect all of the agency's 43 current patients.</p> <p>Findings Include:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 4-15-2014 to 6-13-2014 with orders for the skilled nurse to provide wound care to bilateral lower extremity and great toe stasis ulcers. The nurse was to cleanse wounds with soap and water, apply skin prep, restor (calcium alginate dressing), apply soft sorb to right lower extremity wound #1 and secure with mifix tape. Left lower extremity wound #2 apply restore and comfel ( hydrococolloid) dressing; right great toe wound #3 cover with comfel dressing.</p> <p>A. A skilled nursing visit note dated 4-15-2014 evidenced the RN (registered nurse) cleaned wounds #1 and #2 with chlorhexadine, applied silver alginate dressing to wound #1 and secured both dressings with coban and kerlix. The clinical record failed to evidence orders for chlorhexadine, silver alginate dressing, coban, or kerlix and failed to evidence treatment was provided to</p>		<p>06/12/2014 during a staff meeting/case conference. Met with nursing staff on 6/19/2014 for follow up meeting/inservice. Clinicians will administer all wound care as ordered in plan of care, without substitutions or omissions, effective immediately. Treatment of wounds will be documented as performed on each individual visit. A minimum of once weekly, wounds will be measured and photographed (if consented obtained) as part of the medical record. Administrator/Supervising RN will monitor for consistency with wound care orders for a minimum of 3 months via random chart audits to assure staff are following the policy.</p>				

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	<p>wound #3.</p> <p>B. A skilled nursing note dated 4-18-2014 evidenced the LPN ( licensed practical nurse) secured the dressing to wound #2 with stockinette and stabilized the dressing to wound #3 with conform. The record failed to evidence the LPN applied comfel to wound #3 as ordered and failed to evidence physician orders for stockinette and conform gauze.</p> <p>C. Skilled nursing notes dated 4-28-2014, 4-30-2014, and 5-12-2014 failed to evidence the RN provided treatment to wound #3. The skilled nursing note dated 5-14-2014 evidenced wound #3 was still present.</p> <p>D. A skilled nursing note dated 5-21-2014 evidenced the RN washed wound #3 with soap and water and left open to air. The clinical record filed to evidence physician orders to leave wound #3 to right great toe open to air.</p> <p>2. Employee K, administrator, on 6-5-2014 at 2:30 PM, indicated the wound care for patient #7 was not provided as ordered on the plan of care.</p> <p>3. An agency policy titled " Wound, Ostomy and Skin Care" dated 1-9-2002, revised 10-17-2013, states, "Please</p>			

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G000170	<p>evaluate shallow leg ulcers that need local treatment and contact physician for an order before proceeding."</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure wound care was provided as ordered in 1 (#7) of 12 records reviewed creating the potential to affect all of the agency's 43 current patients.</p> <p>Findings Include:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 4-15-2014 to 6-13-2014 with orders for the skilled nurse to provide wound care to bilateral lower extremity and great toe stasis ulcers. The nurse was to cleanse wounds with soap and water, apply skin prep, restor (calcium alginate dressing), apply soft sorb to right lower extremity wound #1 and secure with mefix tape. Left lower extremity wound #2 apply restore and comfel ( hydrococolloid) dressing; right great toe wound #3 cover with comfel dressing.</p> <p>A. A skilled nursing visit note dated 4-15-2014 evidenced the RN (registered</p>	G000170	<p>Administrator/supervising RN inserviced the clinical staff on 06/12/2014 during a staff meeting/case conference. Met with nursing staff on 6/19/2014 for follow up meeting/inservice. Clinicians will administer all wound care as ordered in plan of care, without substitutions or omissions, effective immediately. Treatment of wounds will be documented as performed on each individual visit. A minimum of once weekly, wounds will be measured and photographed (if consented obtained) as part of the medical record. Administrator/Supervising RN will monitor for consistency with wound care orders for a minimum of 3 months via random chart audits to assure staff are following the policy.</p>	06/19/2014			

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	<p>nurse) cleaned wounds #1 and #2 with chlorhexadine, applied silver alginate dressing to wound #1 and secured both dressings with coban and kerlix. The clinical record failed to evidence orders for chlorhexadine, silver alginate dressing, coban, or kerlix and failed to evidence treatment was provided to wound #3.</p> <p>B. A skilled nursing note dated 4-18-2014 evidenced the LPN ( licensed practical nurse) secured the dressing to wound #2 with stockinette and stabilized the dressing to wound #3 with conform. The record failed to evidence the LPN applied comfel to wound #3 as ordered and failed to evidence physician orders for stockinette and conform gauze.</p> <p>C. Skilled nursing notes dated 4-28-2014, 4-30-2014, and 5-12-2014 failed to evidence the RN provided treatment to wound #3. The skilled nursing note dated 5-14-2014 evidenced wound #3 was still present.</p> <p>D. A skilled nursing note dated 5-21-2014 evidenced the RN washed wound #3 with soap and water and left open to air. The clinical record filed to evidence physician orders to leave wound #3 to right great toe open to air.</p>			

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G000321	<p>2. Employee K, administrator, on 6-5-2014 at 2:30 PM, indicated the wound care for patient #7 was not provided as ordered on the plan of care.</p> <p>3. An agency policy titled " Wound, Ostomy and Skin Care" dated 1-9-2002, revised 10-17-2013, states, "Please evaluate shallow leg ulcers that need local treatment and contact physician for an order before proceeding."</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. Based on Indiana State Department of Health (ISDH) document review, clinical record review, and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completion in 7 (#s 1, 2, 4, 8, 10, 11, and 12 ) of 12 records reviewed creating the potential to</p>	G000321	Administrator/supervising RN inserviced the clinical staff on 06/12/2014 during a staff meeting/case conference. Met with nursing staff on 6/19/2014 for follow up meeting/inserve. OASIS will be completed by clinicians and submitted for supervisor review within 5 days.	06/19/2014

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	<p>affect all of the agency's patients that require OASIS to be transmitted.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. An ISDH document dated 5-30-2014 evidenced a start of care assessment had been completed on 1-18-2014 for patient number 1. The document evidenced the OASIS data had not been transmitted until 2-20-2014</li> <li>2. An ISDH document dated 5-30-2014 evidenced a resumption of care assessment completed on 1-11-2014 and a recertification of care assessment completed on 1-16-2014 for patient number 2. The document evidenced the OASIS data had not been transmitted until 2-18-2014</li> <li>3. An ISDH document dated 5-30-2014 evidenced a recertification assessment had been completed on 1-17-2014 for patient number 4. The document evidenced the OASIS data had not been transmitted until 2-20-2014.</li> <li>4. An ISDH document dated 5-30-2014 evidenced a recertification assessment had been completed on 12/27/2013 for patient number 8. The document evidenced the OASIS data had not been transmitted until 2-5-2014.</li> </ol>		At least weekly, OASIS forms will be transmitted by Administer/designee.				

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	<p>5. An ISDH document dated 5-30-2014 evidenced a transfer assessment completed on 1/6/2014, a resumption of care assessment completed on 1/10/2014, and a second transfer assessment completed on 1-15-2014 for patient number 10. The document evidenced the OASIS data had not been transmitted until 2-18-2014.</p> <p>6. An ISDH document dated 5-30-2014 evidenced a recertification of care assessment completed on 1-3-2014 for patient number 11. The document evidenced the OASIS data had not been transmitted until 2-18-2014.</p> <p>7. An ISDH document dated 5-30-2014 evidenced a recertification of care assessment completed on 12-31-2013 for patient number 12. The document evidenced the OASIS data had not been transmitted until 2-5-2014.</p> <p>8. Employee A, administrator, was unable to provide any additional documentation and/or information when interviewed on 6-5-2014 at 9:30 AM. She stated she was aware there were instances of late OASIS data submission by the agency.</p>			

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N000000	<p>This was a state relicensure survey.</p> <p>Survey dates: 6/3/2014-6/6/2014</p> <p>Facility #: IN006098</p> <p>Medicaid #: 100265910A</p> <p>Surveyor: Nina Koch, RN, PHNS</p> <p>Census 227 Active Patients 43</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 17, 2014</p>	N000000		
N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure wound care was provided as ordered in 1 (#7) of 12 records reviewed creating the potential to affect all of the agency's 43 current patients.</p>	N000522	<p>Administrator/supervising RN inserviced the clinical staff on 06/12/2014 during a staff meeting/case conference. Met with nursing staff on 6/19/2014 for follow up meeting/inserve. Clinicians will administer all</p>	06/19/2014

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	<p>Findings Include:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 4-15-2014 to 6-13-2014 with orders for the skilled nurse to provide wound care to bilateral lower extremity and great toe stasis ulcers. The nurse was to cleanse wounds with soap and water, apply skin prep, restor (calcium alginate dressing), apply soft sorb to right lower extremity wound #1 and secure with mefix tape. Left lower extremity wound #2 apply restore and comfel ( hydrococolloid) dressing; right great toe wound #3 cover with comfel dressing.</p> <p>A. A skilled nursing visit note dated 4-15-2014 evidenced the RN (registered nurse) cleaned wounds #1 and #2 with chlorhexadine, applied silver alginate dressing to wound #1 and secured both dressings with coban and kerlix. The clinical record failed to evidence orders for chlorhexadine, silver alginate dressing, coban, or kerlix and failed to evidence treatment was provided to wound #3.</p> <p>B. A skilled nursing note dated 4-18-2014 evidenced the LPN ( licensed practical nurse) secured the dressing to wound #2 with stockinette and stabilized</p>		<p>wound care as ordered in plan of care, without substitutions or omissions, effective immediately. Treatment of wounds will be documented as performed on each individual visit. A minimum of once weekly, wounds will be measured and photographed (if consented obtained) as part of the medical record. Administrator/Supervising RN will monitor for consistency with wound care orders for a minimum of 3 months via random chart audits to assure staff are following the policy.</p>				

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	<p>the dressing to wound #3 with conform. The record failed to evidence the LPN applied comfel to wound #3 as ordered and failed to evidence physician orders for stockinette and conform gauze.</p> <p>C. Skilled nursing notes dated 4-28-2014, 4-30-2014, and 5-12-2014 failed to evidence the RN provided treatment to wound #3. The skilled nursing note dated 5-14-2014 evidenced wound #3 was still present.</p> <p>D. A skilled nursing note dated 5-21-2014 evidenced the RN washed wound #3 with soap and water and left open to air. The clinical record filed to evidence physician orders to leave wound #3 to right great toe open to air.</p> <p>2. Employee K, administrator, on 6-5-2014 at 2:30 PM, indicated the wound care for patient #7 was not provided as ordered on the plan of care.</p> <p>3. An agency policy titled " Wound, Ostomy and Skin Care" dated 1-9-2002, revised 10-17-2013, states, "Please evaluate shallow leg ulcers that need local treatment and contact physician for an order before proceeding."</p>			

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure wound care was provided as ordered in 1 (#7) of 12 records reviewed creating the potential to affect all of the agency's 43 current patients.</p> <p>Findings Include:</p> <p>1. Clinical record number 7 included a plan of care established by the physician for the certification period 4-15-2014 to 6-13-2014 with orders for the skilled nurse to provide wound care to bilateral lower extremity and great toe stasis ulcers. The nurse was to cleanse wounds with soap and water, apply skin prep, restor (calcium alginate dressing), apply soft sorb to right lower extremity wound #1 and secure with mifix tape. Left lower extremity wound #2 apply restore</p>	N000537	<p>Administrator/supervising RN inserviced the clinical staff on 06/12/2014 during a staff meeting/case conference. Met with nursing staff on 6/19/2014 for follow up meeting/inservice. Clinicians will administer all wound care as ordered in plan of care, without substitutions or omissions, effective immediately. Treatment of wounds will be documented as performed on each individual visit. A minimum of once weekly, wounds will be measured and photographed (if consented obtained) as part of the medical record. Administrator/Supervising RN will monitor for consistency with wound care orders for a minimum of 3 months via random chart audits to assure staff are following the policy.</p>	06/19/2014

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	<p>and comfel ( hydrococolloid) dressing; right great toe wound #3 cover with comfel dressing.</p> <p>A. A skilled nursing visit note dated 4-15-2014 evidenced the RN (registered nurse) cleaned wounds #1 and #2 with chlorhexadine, applied silver alginate dressing to wound #1 and secured both dressings with coban and kerlix. The clinical record failed to evidence orders for chlorhexadine, silver alginate dressing, coban, or kerlix and failed to evidence treatment was provided to wound #3.</p> <p>B. A skilled nursing note dated 4-18-2014 evidenced the LPN ( licensed practical nurse) secured the dressing to wound #2 with stockinette and stabilized the dressing to wound #3 with conform. The record failed to evidence the LPN applied comfel to wound #3 as ordered and failed to evidence physician orders for stockinette and conform gauze.</p> <p>C. Skilled nursing notes dated 4-28-2014, 4-30-2014, and 5-12-2014 failed to evidence the RN provided treatment to wound #3. The skilled nursing note dated 5-14-2014 evidenced wound #3 was still present.</p> <p>D. A skilled nursing note dated 5-21-</p>			

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	<p>2014 evidenced the RN washed wound #3 with soap and water and left open to air. The clinical record filed to evidence physician orders to leave wound #3 to right great toe open to air.</p> <p>2. Employee K, administrator, on 6-5-2014 at 2:30 PM, indicated the wound care for patient #7 was not provided as ordered on the plan of care.</p> <p>3. An agency policy titled " Wound, Ostomy and Skin Care" dated 1-9-2002, revised 10-17-2013, states, "Please evaluate shallow leg ulcers that need local treatment and contact physician for an order before proceeding."</p>				