

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/08/2013
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NAME OF PROVIDER OR SUPPLIER UNITED HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7212 N SHADELAND AVE STE 100 INDIANAPOLIS, IN 46250
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N000000	<p>This visit was for a home health state relicensure survey.</p> <p>Survey Dates: October 4-8, 2013</p> <p>Facility Number: 012120</p> <p>Surveyors: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 31 Home Health Aide Only: 78 Personal Care Only: 0 Total: 109</p> <p>Sample: RR w/HV: 3 RR w/o HV: 2 Total: 5</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 23, 2013</p>	N000000		

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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N000470	<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 policy review, interview, and observation, the agency failed to ensure the registered nurse washed hands between glove changes for 1 of 1 home visits with a registered nurse (employee D) with the potential to affect all patients receiving services from employee D.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 10/7/13 at 11 AM, employee D was observed providing wound care to patient #3. Employee D washed her hands, assessed the patient, applied gel to her hands, and laid a paper towel on the bed for a barrier. The nurse placed supplies on the paper towel, applied gel to her hands, donned gloves, cleaned the site, measured the wound, and removed gloves. The employee donned clean gloves without washing or applying gel to her hands and taped a new dressing to the wound. The employee removed her gloves and washed hands. On 10/7/13 at 1:50 PM, the alternate 	N000470	Employee D has been re instructed on correct hand washing protocol to be followed in the provision of wound care to include washing hands between glove changes. Employee D will be competency checked on hand washing protocol on 10/29/2013. All nurses will satisfactorily complete the policy review and an in-service on correct handwashing protocol to be followed in the provision of wound care by 11/23/2013. The Director of Nursing will perform annual supervisory visits of nurses to evaluate compliance with the handwashing protocol. This is on going. The Director of Nursing will be responsible for ensuring compliance with this state rule.	10/29/2013			

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	<p>administrator indicated the registered nurse needed to gel her hands between glove changes.</p> <p>3. The undated policy titled "OSHA Infection Control / Exposure Control Plan" states, "Patient infection control procedures shall include, but not be limited to: ... f. Frequent hand washing by home health care employees: ... after removing gloves."</p>			

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N000606	<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 policy review, the agency failed to ensure the registered nurse assured the home health aide was performing all the tasks assigned on the aide care plan during home health aide supervisory visits for 1 of 4 records reviewed (#3) of patients receiving home health aide services with the potential to affect all the patients receiving aide services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3 evidenced an Aide Plan of Care, effective 9/20/13, that listed "light laundry" to be completed each visit. Aide visit notes dated 9/20/13, 9/24-27/13, 9/30/13, and 10/4/13 failed to evidence the aide performed light laundry during the visit. The record evidenced the registered nurse made a supervisory on 9/27/13. 2. The undated policy titled "Home Health Aide: Documentation" states, "3. The designated Registered Nurse / 	N000606	<p>United Home Healthcare will ensure that the home health aides follow and are compliant with the tasks as assigned on the home health aide care plan. The agency process to ensure compliance with the home health aide care plan is as follows: 1) At time of admission and recertification the RN Case Manager creates and or updates the home health aide plan of care based on physician orders. 2) The home health aide plan of care is reviewed with the home health aide prior to the aide going to the home. 3) The RN Case Manager makes the home health aide supervisory visits in accordance with regulatory requirements. During the supervisory visits, the RN Case Manager evaluates the home health aide for compliance with the home health aide plan of care. 4) The agency has initiated the following documentation review processes. Home health aide documentation is reviewed for the following: a) correct patient name, b) correct dates, time of service, and c) correct patient/caregiver and employee</p>	11/23/2013			

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	Therapist or designated person is responsible for reviewing the Home Health Aide's charting before it is placed in the chart."		signatures.5) The RN Case Manager or Designated nurse will review the visit notes for compliance with the home health aide plan of care.6) The RN Case Managers will follow up with the home health aides on any ommisions and or discrepancies providing education and direction to the home health aide.7) The RN Case Managers will be in serviced on their documentation review responsibilities and process. 8) Clinical Record #3 has been addressed in the following manner: The RN Case Manager has consulted the client who indicated he did not want laundry done daily. The client indicated he wanted his laundry washed on an "as requested" basis per patient request. The Home Health Aide Plan of Care was modified and the home health aide informed of the change. (Date corrected: 10/29/13)9) At time of the home health aide supervisory visits all RN Case Managers will be inserviced to evaluate employee compliance with the Home Health Aide Plan of Care and to provide direction and guidance to the employee to ensure patient needs are met and the employee is providing care in accordance with the Home Health Aide Plan of Care.10) The Agency will conduct a focus audit of the home health aide documentation. The audit will focus on the home health aides compliance with the Home		

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			Health Aide Plan of Care. The agency will conduct an audit of 100% of the Home Health Aide Care Plans. 11) Any documentation discrepancies will be identified. The home health aides will be re-educated on assigned tasks. 12) The Agency will continue their 10% quarterly review of clinical records on an on-going basis.13) The Director of Nursing is responsible for ensuring on-going compliance with this State Rule.		

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N000610	<p>410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.</p> <p>Based on clinical record review, the agency failed to ensure all documents included in the patient record were dated for 1 of 5 records reviewed (#3) with the potential to affect all the agency ' s patients.</p> <p>Findings include:</p> <p>Clinical record #3 included a "Home Health Admission Service Agreement" signed by patient #3 that failed to evidence a date indicating when the patient signed the document.</p>	N000610	<p>United Home Health Care will ensure that all clinical records are complete and appropriately authenticated and dated. The RN Case Manager has reviewed the admission consent form for clinical record #3 with the client/caregiver and obtained signatures and dates. (11/10/13) RN Case Managers were in-serviced on the importance of obtaining correct signatures and dates. The Agency audits 100% of new admissions to ensure all consent forms are documented, signed, and dated. The Director of Nursing is responsible for ensuring compliance with this State Rule.</p>	11/20/2013			