

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157634	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/21/2014
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NAME OF PROVIDER OR SUPPLIER  SUNRISE HOME HEALTH CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2711 W LINCOLN HIGHWAY MERRILLVILLE, IN 46410
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G000000	<p>This visit was for a home health recertification survey. This was a partial extended survey.</p> <p>The survey was partial extended 11-19, 11-20, and 11-21-2014.</p> <p>Dates of survey: 11-17, 11-18, 11-19, 11-20 and 11-21-2014</p> <p>Facility #: IN012486</p> <p>Medicaid Vendor #: 201035510</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: 187 Skilled unduplicated admission last 12 months 61 Active patients 0 Home Health Aide only 0 Personal Service Attendant</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 25, 2014</p>	G000000		

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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G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on review of infection control log, review of agency policy, and interview, the agency failed to implement its policy requiring investigation and documentation of follow-up actions in relation to infection log entries for 2 of 2 sampled patients with agency infection log entries ( patient # 1 and 8) with the potential to affect agency's 61 active patients.</p> <p>Findings include:</p> <p>1. Review of agency patient infection log included a report for patient #1 dated 10-3-14 for cellulitis. The form indicated patient 1 was treated with minocycline 100 mg (milligrams) p.o. (by</p>	G000121	<p>G-121 Action Steps to ensure completion:  All direct and contracted staff will be provided orientation and education on the organization's policy on Infection Control, and Infection Control Log, which will establish a date monitoring and collecting system to detect infection. The agency hence forth will attempt to identify the infection such as Home Care (Agency acquired), from the community (Community acquired) or during a recent inpatient facility stay (Nosocomial). The resolution and response to the treatment involved for the patient will be investigated such as verifying the medication, the right drug, the right patient, right dose, right route,</p>	12/12/2014

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	<p>mouth) BID (twice a day) for 10 days. The areas provided for patient response / resolution, precautions/ppe (personal protective equipment) in use, patient / family teaching were blank.</p> <p>2. Review of agency patient infection log included a report for patient 8 dated 6-6-14 for left great toe infection. The form indicated patient 8 was treated with cipro (no dose indicated) BID for 10 days. The areas provided for patient response/resolution, precautions/ppe in use, patient / family teaching were blank.</p> <p>3. Agency policy " Infection Control Plan", last reviewed/ revised 10-14, stated, "Agency will attempt to identify the source of the infection ... agency acquired ... community acquired ... or nosocomial ... The agency will identify follow-up actions taken as a result of identified infections."</p> <p>4. During interview with the Administrator on 11-21-14 at 2:30 PM, the Administrator indicated Administrator acted as Infection Control Officer for the agency and verified the findings above. The Administrator indicated the infection control log entries for patients 1 and 8 lacked an investigation to include an attempt to identify the source of the reported</p>		<p>right time. Proper precautions such as PPE and teaching to family/patient with understanding.</p> <p>Date of Compliance Orientation and education will be provided and documented on 12/12/14.</p> <p>Responsible for correction – Kathy Housty RN, ADON and Michael Dodson RN, Administrator</p> <p>Monitoring Process to prevent Reoccurrences: Policies will be reviewed and analyzed in light of Infection Control Log and updated as needed to address areas of concern. All changes to Policy and Procedures will be communicated to employees and clients appropriately. 100% of patients will be reviewed for infection upon start of care and during the episode of home care beginning 11/21/14 to insure Infection Control surveillance is being implemented by documenting on the Infection Control Log form, by identifying the type of infection, treatment and response/ resolution to the infection.</p>	

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G000144	<p>infections, the patient's response to interventions / resolution of the infection, precautions/ppe in use, or patient / family teaching as required by agency policy and accepted infection control standards and principles. On 11-20-14, in response to inquiry regarding patient 1's infection control log entry, the agency obtained documentation from the patient's physician's nurse practitioner indicating the minocycline had been prescribed for left lower leg cellulitis. The Administrator indicated a complete investigation and follow-up should have occurred as soon as the infection log entries were created and should have included patient #1 and 8's response to treatment and resolution of the investigation.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical record evidenced communications by all personnel furnishing services to establish effective interchange, reporting, and coordination of patient care for 2 of 5 records reviewed of patients receiving more than</p>	G000144	<p>G-144 Coordination of Services Action: All direct and contracted staff will be provided educationto coordinate care between the interdisciplinary team members also careconferences will be held as necessary to establish interchange, reporting and coordinatedevaluation between all</p>	12/12/2014

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	<p>one service (patients # 5 and 9) with the potential to affect all agency patients receiving more than one service.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #5, start of care 10-22-14, included a plan of care for the certification period of 10-22 to 12-20-14 with orders for services from skilled nursing, physical therapy, occupational therapy, and home health aide. The clinical record failed to evidence any documentation of coordination of agency personnel's efforts to support the objectives in the patient's plan of care</li> <li>Clinical record #9, start of care 5-29-14, included a plan of care for the certification period of 5-29 to 7-17-14 with orders for services from skilled nursing and physical therapy. The clinical record failed to evidence any documentation of coordination of agency personnel's efforts to support the objectives in the patient's plan of care.</li> <li>Agency policy "Coordination of Client Services", last reviewed / revised 10-14, stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care ... Ongoing care</li> </ol>		<p>disciplines involved in the clients care.</p> <p>Care conferences will be documented on the client caseconference form, case communication document or in the progress notes. A written summary report of services will be provided, shall be sent to the physician at least every 60 days.</p> <p>Date of Completion: Orientation and education provided and documented by 12/12/14.</p> <p>Responsible for correction – Michael Dodson RN, Administrator Monitor to prevent reoccurrence: The primary care nurse/casemanager or therapist will assume responsibility by updating/changing the Care Plan and communicating changes to caregivers within 24 hours following the conference or change. The physician will be contacted with his/her approval for that change is necessary and to alert physician to changes in client condition. Active records will be reviewed on an ongoing basis by the ADON or designated Registered Nurse / Therapist. Case Conference meeting minutes will be monitored following care conference.</p>	

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G000159	<p>conferences shall be conducted to evaluate the client's status and progress ... Care conferences will be documented on the Care Conference Summary form or in the progress notes."</p> <p>4. During interview with the Alternate Director of Nursing (ADoN) on 11-21-14 at 1:00 PM, the ADoN indicated the above clinical records lacked documentation in the clinical record or agency meeting minutes to evidence effective coordination of patient care. The agency practice is for clinicians to call each other or use email to share information related to coordination of efforts to support the objectives in the patients' plan of care, but the agency does not maintain documentation of these exchanges nor does it create case conference meeting minutes following its weekly meetings to discuss patients.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely</p>			

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	<p>discharge or referral, and any other appropriate items.</p> <p>Based on observation, clinical record review, review of policy, and interview, the agency failed to ensure the plan of care included all equipment required as per agency policy for 1 of 5 home visit patients (patient #5) with the potential to affect the agency's 61 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During home visit to patient 5 on 11-20-14 at 4:15 PM, oxygen equipment and a hospital bed was observed in the home. The patients clinical record included a start of care of 10-22-14 and a plan of care with certification period 10-22 to 12-20-14, but the plan of care failed to list oxygen equipment or the hospital bed as durable medical equipment.</li> <li>2. Agency policy "Plan of Care", last reviewed/revised 10-14, stated "The Plan of Care shall be completed in full to include ... m. equipment required."</li> <li>3. During interview with the Administrator on 11-20-14 at 5:15 PM, the Administrator verified the above findings and indicated staff did not consistently document the durable medical equipment in the patients' home.</li> </ol>	G000159	<p>G-159</p> <p>Action steps to ensure Compliance: All direct or contracted staff will be provided orientation and education on the Plan of Care by addressing the care, treatment services to be provided and DME that may be needed for the patient and charted accordingly.</p> <p>Date of Completion – Orientation and education provided will be provided on 12/12/14. Patient #5 –Oxygen equipment/hospital bed was added to record 12/2/14.</p> <p>Responsible for Correction – Michael Dodson RN, Administrator and Kathy Housty RN/ADON</p> <p>Monitoring process to prevent reoccurrence - The Plan of Care will be developed and all appropriate information will be collected, such as medical supplies and equipment required by nursing and therapy staff. Plan of care will reviewed by nursing staff.</p>	12/12/2014

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G000165	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record review, review of agency policy, and interview, the agency failed to ensure agency staff administered drugs only as ordered by the physician for 1 of 10 clinical records (patient #1) with the potential to affect agency's 61 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #1, start of care 8-25-14, included a plan of care for the certification period of 8-25 to 10-23-14. The medication administration record (MAR) included the patient's administration of minocycline 100 mg (milligram) p.o. (by mouth) BID (twice a day) for 10 days from 10-3 to 10-12-14. The clinical record failed to evidence a physician order for this medication.</li> <li>Agency policy "Plan of Care", last reviewed / revised 10-14, stated, "Home care services are furnished under the supervision and direction of the client's physician ... "</li> </ol>	G000165	<p>G 165 Action Steps to ensure compliance: All direct and contracted licensed staff will verify medication orders and treatments before administering to clients. When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given, then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. All orders must contain the name of the drug, dosage, route of administration and directions for use. The orders may not contain dangerous abbreviations, acronyms or symbols that may contribute medication or treatment errors.</p> <p>Date of Completion: Orientation and education will be provided by 12/12/14 and documented. Clinical record #1 order verified and case communication on 12/7/14. Responsible for correction – Kathy Housty RN/ADON Monitoring process to prevent reoccurrence: When agency staff obtain</p>	12/12/2014

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G000173	<p>3. During interview with the Alternate Director of Nursing (ADoN) on 11-21-14 at 1:00 PM, the ADoN verified the above findings and indicated the agency had updated the MAR when patient 1 began taking minocycline which was prescribed by a consulting physician. The correct agency procedure should have been to obtain a physician order from patient 1's attending physician, but the agency failed to do so when the patient reported taking the minocycline.</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review, review of agency policy, and interview, the agency failed to ensure the registered nurse initiated a necessary revision to the plan of care related to a new medication taken by the patient for 1 of 10 clinical records (patient #1) with the potential to affect agency's 61 active patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8-25-14, included a plan of care for the certification period of 8-25 to 10-23-14. The medication administration record</p>	G000173	<p>verbal/telephone orders from the physician they must inform the supervising nurse/therapist of the change. The process and procedure will be to obtain a physician order from the patient's primary physician.</p> <p>G - 173 Action steps to ensure compliance: Registered nurse to assume responsibility and accountability for the practice of professional nursing and develop the Plan of Care that incorporates analysis of data and current scientific findings and by verifying medications and orders under the supervision and the direction of the client's physician.</p> <p>Date of Completion: Orientation and education will be provided by 12/12/14 and documented. Patient #1 order was verified and case communication on 12/7/14.</p>	12/12/2014

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	<p>(MAR) included the patient's administration of minocycline 100 (milligram) p.o. (by mouth) BID (twice a day) for 10 days from 10-3 to 10-12-14. The clinical record failed to evidence a physician order for this medication.</p> <p>2. Agency policy "Plan of Care", last reviewed / revised 10-14, states, "Home care services are furnished under the supervision and direction of the client's physician. ... the plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty (60) days."</p> <p>3. Agency policy "Skilled Nursing Services", last reviewed / revised 10-14, states, "The registered nurse: ... c. initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan."</p> <p>4. During interview with the Alternate Director of Nursing (ADoN) on 11-21-14 at 1:00 PM, the ADoN verified the above findings and indicated the agency had updated the MAR but failed to obtain a physician order from patient #1's attending physician when patient #1 reported the minocycline.</p>		<p>Responsible for correction – Michael Dodson RN, Administrator and Kathy Housty RN/ADON</p> <p>Monitoring process to prevent reoccurrences: The Plan of Care/485 will be reviewed by the attending physician and is based on a comprehensive assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment, medications and services to be provided so that the Plan of Care will be consistently reviewed to ensure that the client's needs are met and will be updated as necessary, but at least every 60 days and reviewed by the patients physician.</p>	

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N000000	<p>This visit was for a home health state re-licensure survey.</p> <p>Survey dates: 11-17, 11-18, 11-19, 11-20 and 11-21-2014</p> <p>Facility # IN012486</p> <p>Medicaid #: 100264890A</p> <p>Surveyor: Deborah Franco, RN, PHNS</p> <p>Census: 187 Skilled unduplicated admission last 12 months 61 Active patients 0 Home Health Aide only 0 Personal Service Attendant</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 25, 2014</p>	N000000		

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N000464	<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</p>			

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	<p>was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on a tuberculosis evaluation may not:</p> <p>(A) work in the home health agency; or</p> <p>(B) provide direct patient contact; unless approved by a physician to work.</p> <p>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:</p> <p>(A) working for the home health agency; or</p> <p>(B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on policy review, personnel file review, and interview, the agency failed to ensure two step TB tests were administered upon hire and TB tests were read between 48 to 72 hours for 3 of 6 (B, D, and F) employee files reviewed with potential to affect agency's 61 active patients.</p> <p>Findings include:</p> <p>1. A policy last reviewed / revised 10-14 titled "Infection Control Plan" stated, "The agency has developed an Infection Control Plan that conforms to OSHA regulations, CDC guidelines, JCAHO, CHAP, and ACHC requirements, state and local regulations and commonly accepted Standards of Practice."</p> <p>2. A policy last reviewed / revised 10-14 titled "Employment Health Requirements" stated, "A ... staff member</p>	N000464	<p>N-464</p> <p>Action Steps to ensure compliance: The agency will provide, at no cost to the employee apre-employment TB Mantoux skin test. Ifthe employee does not have documentation of a negative Mantoux test within theprevious 12 months they must have the test repeated within one to three weeksof the first test. The two-step testingprogram is required for all who do not meet the above guidelines.</p> <p>Date of completion: 12/3/14</p> <p>Personnel, B, D, F, were given TB Mantoux on 12/1/14 andwere read on 12/3/14 as per OSHA regulations, CDC guidelines local regulationsand standards of practice.</p> <p>Responsible for Correction: Michael Dodson RN, Administrator</p> <p>Monitoring process to prevent reoccurrence:</p>	12/03/2014

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	<p>who has accepted employment with the agency must submit the following: a. Negative results from a Mantoux test [a tuberculosis skin test] completed no more than one year prior to applying for the staff position, and annually thereafter. If the applicant has not had a prior Mantoux test completed within one year prior to employment, they must either submit to a two-part Mantoux test with first part of test being completed prior to any patient contact."</p> <p>3. Personnel file B, a registered nurse and Alternate Director of Nursing, was hired on 4-16-14 and the personnel file contained a record of a Tuberculin (TB) skin test administered 4-14-14 at "9 AM" and read on 4-16-14 at "8 AM", less than 48 hours after administration, with result of 0 mm (millimeters) induration. The personnel file lacked documentation of a previous negative TB skin test within one year of hire. Prior to exit the facility presented a TB skin test for Employee B from previous employer with date of administration 2-1-14, no time of administration recorded. The form had a pre-printed line "72 hour read date" with 2-4-14 written in, result was 0 mm induration.</p> <p>4. Personnel file D, a Licensed Practical Nurse, was hired on 2-10-14. The</p>		<p>The agency will provide at time of employment to all healthcare personnel a Mantoux tuberculin skin test. If the employee does not have documentation of a negative Mantoux test within the previous 12 months, they must have the test repeated within one to three weeks of the first test. This two-step testing program is required for all who do not meet above guidelines. The agency will keep all health records/information in the employee's file and will be kept confidential and made available to authorized personnel only. The Mantoux TB test will be given annually per guidelines/policy.</p>	

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	<p>personnel file contained a record of a new hire TB skin test administered on 2-7-14 at "3 PM" and read on 2-9-14, no time of reading recorded, with result of 0 mm induration. It was, therefore, unable to be determined if the test was read between 48 and 72 hours.</p> <p>5. Personnel file F, a Home Health Aide (HHA), was hired on 5-7-13 with first patient contact of 5-7-13. The personnel file contained an annual TB skin test administered 5-19-14 at "2 PM" and read on 5-21-14 at 12:15 PM, with result of 0 mm induration. This test was read less than 48 hours after administration and was given 12 days after first patient contact.</p> <p>6. During interview with the Administrator on 11-21-14 at 2:30 PM, the Administrator verified the above findings and indicated the agency followed CDC (Centers for Disease Control) guidelines for their Infection Control Program including the facility Tuberculosis Control Plan. The Administrator (also the agency Infection Control Officer) was not aware of the CDC recommendation that TB skin tests be read between 48 hours and 72 hours of administration to be reliable. Regarding Employee B, the Administrator indicated the agency should have had the</p>			

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N000470	<p>documentation of a previous valid negative TB skin test within 12 months of hire for Employee B in order to do a one-step TB skin test. The agency did not obtain this documentation until 11-20-14, more than 6 months after employee's first patient contact and, therefore, the agency could not rely on this TB skin test. To comply with agency policy and CDC guidelines, Employee B must have produced the previous negative test at hire or taken a two-step TB skin test. The Administrator indicated absent documentation of time of administration and time of reading of a TB skin test could not be a reliable determination that the results were read between 48 hours and 72 hours as per CDC guidelines, and that forms that have pre-printed determinations of a TB skin test reading "72 hour read date" could not be accurate and reliable without the time of administration and read recorded.</p> <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. Based on review of infection control log,</p>	N000470	N-470	12/12/2014

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	<p>review of agency policy, and interview, the agency failed to implement its policy requiring investigation and documentation of follow-up actions in relation to infection log entries for 2 of 2 sampled patients with agency infection log entries ( patient # 1 and 8) with the potential to affect agency's 61 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of agency patient infection log included a report for patient #1 dated 10-3-14 for cellulitis. The form indicated patient 1 was treated with minocycline 100 mg (milligrams) p.o. (by mouth) BID (twice a day) for 10 days. The areas provided for patient response / resolution, precautions/ppe (personal protective equipment) in use, patient / family teaching were blank.</li> <li>2. Review of agency patient infection log included a report for patient 8 dated 6-6-14 for left great toe infection. The form indicated patient 8 was treated with cipro (no dose indicated) BID for 10 days. The areas provided for patient response/resolution, precautions/ppe in use, patient / family teaching were blank.</li> <li>3. Agency policy " Infection Control Plan", last reviewed/ revised 10-14,</li> </ol>		<p>Action Steps to ensure completion:</p> <p>All direct and contracted staff will be provided orientationand education on the organization's policy on Infection Control, and InfectionControl Log, which will establish a date monitoring and collecting system todetect infection. The agency hence forthwill attempt to identify the infection such as Home Care (Agency acquired),from the community (Community acquired) or during a recent inpatient facilitystay (nosocomial). The resolution and response to the treatment involved forthe patient will be investigated such as verifying the medication, the righdrug, the right patient, right dose, right route, right time. Proper precautions such as PPE and teachingto family/patient with understanding.</p> <p>Date of Compliance Orientation and education will be provided and documented on12/12/14.</p> <p>Responsible for correction – Kathy Housty RN, ADON and Michael Dodson RN, Administrator</p> <p>Monitoring Process to prevent Reoccurrences: Policies will be reviewed and analyzed in light of InfectionControl Log and updated as needed to address areas of concern. All changes to Policy and Procedures</p>	

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	<p>stated, "Agency will attempt to identify the source of the infection ... agency acquired ... community acquired ... or nosocomial ... The agency will identify follow-up actions taken as a result of identified infections."</p> <p>4. During interview with the Administrator on 11-21-14 at 2:30 PM, the Administrator indicated Administrator acted as Infection Control Officer for the agency and verified the findings above. The Administrator indicated the infection control log entries for patients 1 and 8 lacked an investigation to include an attempt to identify the source of the reported infections, the patient's response to interventions / resolution of the infection, precautions/ppe in use, or patient / family teaching as required by agency policy and accepted infection control standards and principles. On 11-20-14, in response to inquiry regarding patient 1's infection control log entry, the agency obtained documentation from the patient's physician's nurse practitioner indicating the minocycline had been prescribed for left lower leg cellulitis. The Administrator indicated a complete investigation and follow-up should have occurred as soon as the infection log entries were created and should have included patient #1 and 8's response to</p>		<p>will be communicated to employees and clients appropriately.</p> <p>100% of patients will be reviewed for infection upon start of care and during the episode of home care beginning 11/21/14 to insure Infection Control surveillance is being implemented by documenting on the Infection Control Log form, by identifying the type of infection, treatment and response/ resolution to the infection.</p>	

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N000484	<p>treatment and resolution of the investigation.</p> <p>410 IAC 17-12-2(g) Q A and performance improvement 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. Based on clinical record review, policy review, and interview, the agency failed to ensure the clinical record evidenced communications by all personnel furnishing services to establish effective interchange, reporting, and coordination of patient care for 2 of 5 records reviewed of patients receiving more than one service (patients # 5 and 9) with the potential to affect all agency patients receiving more than one service.</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care 10-22-14, included a plan of care for the certification period of 10-22 to 12-20-14 with orders for services from skilled nursing, physical therapy, occupational therapy, and home health aide. The clinical record failed to evidence any documentation of coordination of agency</p>	N000484	<p>N-484 Action Steps to Compliance: All direct and contracted staff will be provided education to coordinate care between the interdisciplinary team members also care conferences will be held as necessary to establish interchange, reporting and coordinated evaluation between all disciplines involved in the clients care. Care conferences will be documented on the client case conference form, case communication document or in the progress notes. A written summary report of services will be provided, shall be sent to the physician at least every 60 days.</p> <p>Date of Completion: Orientation and education provided and documented by 12/12/14.</p> <p>Responsible for correction – Michael Dodson RN, Administrator</p>	12/12/2014

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	<p>personnel's efforts to support the objectives in the patient's plan of care</p> <p>2. Clinical record #9, start of care 5-29-14, included a plan of care for the certification period of 5-29 to 7-17-14 with orders for services from skilled nursing and physical therapy. The clinical record failed to evidence any documentation of coordination of agency personnel's efforts to support the objectives in the patient's plan of care.</p> <p>3. Agency policy "Coordination of Client Services", last reviewed / revised 10-14, stated, "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care ... Ongoing care conferences shall be conducted to evaluate the client's status and progress ... Care conferences will be documented on the Care Conference Summary form or in the progress notes."</p> <p>4. During interview with the Alternate Director of Nursing (ADoN) on 11-21-14 at 1:00 PM, the ADoN indicated the above clinical records lacked documentation in the clinical record or agency meeting minutes to evidence effective coordination of patient care. The agency practice is for clinicians to</p>		<p>Monitor to prevent reoccurrence: The primary care nurse/casemanager or therapist will assume responsibility by updating/changing the CarePlan and communicating changes to caregivers within 24 hours following the conference or change. The physician will be contacted with his/her approval for that change is necessary and to alert physician to changes in client condition. Active records will be reviewed on an ongoing basis by the ADON or designated Registered Nurse / Therapist. Case Conference meeting minutes will be monitored following care conference and implementation will start 12/5/14.</p>	

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N000524	<p>call each other or use email to share information related to coordination of efforts to support the objectives in the patients' plan of care, but the agency does not maintain documentation of these exchanges nor does it create case conference meeting minutes following its weekly meetings to discuss patients.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, clinical record review, review of policy, and interview, the agency failed to ensure the plan of</p>	N000524	<p>N-524</p> <p>Action steps to ensure Compliance: All direct or contracted staff will be</p>	12/12/2014

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N000537	<p>care included all equipment required as per agency policy for 1 of 5 home visit patients (patient #5) with the potential to affect the agency's 61 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During home visit to patient 5 on 11-20-14 at 4:15 PM, oxygen equipment and a hospital bed was observed in the home. The patients clinical record included a start of care of 10-22-14 and a plan of care with certification period 10-22 to 12-20-14, but the plan of care failed to list oxygen equipment or the hospital bed as durable medical equipment.</li> <li>2. Agency policy "Plan of Care", last reviewed/revised 10-14, stated "The Plan of Care shall be completed in full to include ... m. equipment required."</li> <li>3. During interview with the Administrator on 11-20-14 at 5:15 PM, the Administrator verified the above findings and indicated staff did not consistently document the durable medical equipment in the patients' home.</li> </ol> <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</p>		<p>provided orientation and education on the Plan of Care by addressing the care, treatment services to be provided and DME that may be needed for the patient upon Start of Care and during the episode of Home Care.</p> <p>Date of Completion – Orientation and education provided will be provided on 12/12/14. Patient #5 –Oxygen equipment/hospital bed was added to record 12/2/14.</p> <p>Responsible for Correction – Michael Dodson RN, Administrator and Kathy Housty RN/ADON</p> <p>Monitoring process to prevent reoccurrence - The Plan of Care will be developed and all appropriate information will be collected, such as medical supplies and equipment required by nursing and therapy staff. Plan of care will reviewed by nursing staff and sent to the physician for review.</p>	

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	<p>nurse in accordance with the medical plan of care as follows: Based on clinical record review, review of agency policy, and interview, the agency failed to ensure agency staff administered drugs only as ordered by the physician for 1 of 10 clinical records (patient #1) with the potential to affect agency's 61 active patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #1, start of care 8-25-14, included a plan of care for the certification period of 8-25 to 10-23-14. The medication administration record (MAR) included the patient's administration of minocycline 100 mg (milligram) p.o. (by mouth) BID (twice a day) for 10 days from 10-3 to 10-12-14. The clinical record failed to evidence a physician order for this medication.</li> <li>2. Agency policy "Plan of Care", last reviewed / revised 10-14, stated, "Home care services are furnished under the supervision and direction of the client's physician ... "</li> <li>3. During interview with the Alternate Director of Nursing (ADoN) on 11-21-14 at 1:00 PM, the ADoN verified the above findings and indicated the agency had updated the MAR when patient 1 began</li> </ol>	N000537	<p>N-537 Action Steps to ensure compliance: All direct and contracted licensed staff will verify medication orders and treatments before administering to clients. When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given, then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. All orders must contain the name of the drug, dosage, route of administration and directions for use. The orders may not contain dangerous abbreviations, acronyms or signals that may contribute medication or treatment errors.</p> <p>Date of Completion: Orientation and education will be provided by 12/12/14 and documented. Clinical record #1 order verified and case communication on 12/7/14. Responsible for correction – Kathy Housty RN/ADON Monitoring process to prevent reoccurrence: When agency staff obtain verbal/telephone orders from the physician they must inform the supervising nurse/therapist of the change. The process and procedure will be to obtain a physician order from the patient's primary physician.</p>	12/12/2014

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N000542	<p>taking minocycline which was prescribed by a consulting physician. The correct agency procedure should have been to obtain a physician order from patient 1's attending physician, but the agency failed to do so when the patient reported taking the minocycline.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services 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: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record review, review of agency policy, and interview, the agency failed to ensure the registered nurse initiated a necessary revision to the plan of care related to a new medication taken by the patient for 1 of 10 clinical records (patient #1) with the potential to affect agency's 61 active patients.</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 8-25-14, included a plan of care for the certification period of 8-25 to 10-23-14. The medication administration record (MAR) included the patient's administration of minocycline 100 (milligram) p.o. (by mouth) BID (twice a day) for 10 days from 10-3 to 10-12-14.</p>	N000542	<p>N - 542 Action steps to ensure compliance: Registered nurse to assume responsibility and accountability for the practice of professional nursing and develop the Plan of Care that incorporates analysis of data and current scientific findings and by verifying medications and orders under the supervision and the direction of the client's physician.</p> <p>Date of Completion: Orientation and education will be provided by 12/12/14 and documented. Patient #1 order was verified and case communication on 12/7/14. Responsible for correction – Michael Dodson RN, Administrator and Kathy Housty RN/ADON Monitoring process to prevent reoccurrences: The Plan of Care/485 will be reviewed by the attending physician and is based on a comprehensive</p>	12/12/2014

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NAME OF PROVIDER OR SUPPLIER  SUNRISE HOME HEALTH CARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2711 W LINCOLN HIGHWAY MERRILLVILLE, IN 46410
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(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>The clinical record failed to evidence a physician order for this medication.</p> <p>2. Agency policy "Plan of Care", last reviewed / revised 10-14, states, "Home care services are furnished under the supervision and direction of the client's physician. ... the plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty (60) days."</p> <p>3. Agency policy "Skilled Nursing Services", last reviewed / revised 10-14, states, "The registered nurse: ... c. initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan."</p> <p>4. During interview with the Alternate Director of Nursing (ADoN) on 11-21-14 at 1:00 PM, the ADoN verified the above findings and indicated the agency had updated the MAR but failed to obtain a physician order from patient #1's attending physician when patient #1 reported the minocycline.</p>		<p>assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment, medications and services to be provided so that the Plan of Care will be consistently reviewed to ensure that the client's needs are met and will be updated as necessary, but at least every 60 days and reviewed by the patient's physician.</p>	