

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
N0000	<p>This visit was a home health relicensure survey.</p> <p>Survey date: June 21, 22, and 25, 2012</p> <p>Facility #005352</p> <p>Medicaid Vendor: # 100265450A</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>Census: 91 Home Visits: 3</p> <p>Quality Review; Linda Dubak, R.N. July 6, 2012</p>	N0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
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 a tuberculosis evaluation may not:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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>(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 record review and interview, the agency failed to ensure that all persons having direct patient contact were evaluated for tuberculosis in 1 of 6 personnel record reviewed, (employee E), with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Personnel file E, date of hire 10/19/11 and first patient contact 10/19/11 with patient #1, failed to evidence the employee had documentation of a negative tuberculosis screening completed within the previous twelve months, a negative chest x ray report, or a two step tuberculosis screening was completed at hire. The file included a document titled "Tuberculosis Examination" and evidenced an initial mantoux was administered on 10/14/11 and read on 10/17/11 and the second step was administered on 11/3/11 and read 4 days later on 11/7/11.</p>	N0464	It is the intent all persons having direct patient contact are evaluated for TB. Personnel File "E" employee was terminated on 7/10/12 due to employee moving outside of service area. All employee personnel files will be audited by the HR Manager for TB testing compliance and the results reported to the Patient Care Coordinator (PCC) for further action as needed. This initial audit will be completed by the end of 7/18/12. The HR Mgr. will report monthly to the QI Committee any TB testing done for new and current employees. All clinicians involved in TB screening for new & current employees will be in-serviced on the TB Policy referencing the 2011 CDC Core Curriculum by Connie Temple, PCC, on 7/23/12. The QI Committee will receive a monthly audit from the HR Mgr. concerning TB screening for new & current employees. The HR Mgr. is responsible for TB screening compliance of new & current employees.	07/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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>2. On 6/22/12 at 5 PM, employee M indicated file E did not have any contain any other documentation to demonstrate employee E had a negative of a previous tuberculosis screening tuberculin skin test had been applied any time during the previous twelve months and the result was negative.</p> <p>3. The agency policy titled "Health Screening Policy" with an effective date of 9/04, provided by the administrator on June 25, 2012 whom indicated the policy was current, which stated, "A tuberculin skin test shall be required upon employment for all employees who provide direct client care."</p> <p>4. The agency policy titled "Tuberculosis Testing" void of an effective date and provided by the administrator on June 25, 2012 whom indicated the policy was current, which stated, "An employee or agent of Physician's HomeCare, Inc. who will have direct client contact must complete a tuberculosis test in the same manner as required by the state department for licensed home health agency employees and agents."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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	
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 and interview, the agency failed to ensure employees provided services in accordance with infection control policies and procedures for the Centers for Disease Control "Standard Precautions" in 1 (employee I) of 2 skilled nurse visits observed creating the potential for the transfer of disease causing organisms among all the patients to which the employee rendered care, their family members and the other staff that provided care to the patients, and all of the current 91 patients of the agency.</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" states, " IV. Standard Precautions . . . IV.A. Hand Hygiene. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens</p>	N0470	<p>It is the intent of Physicians Homecare, Inc. to ensure employees providing service do so in accordance with Infection Control Policies and Procedures referencing the CDC "Standard Precautions".Registered Nurse employee "1" was counseled and a review of the Hand Hygiene Policy and Procedures conducted.Patient # 3 will be monitored by the assigned case manager and any symptoms of infection will be reported to the physician and Patient Care Coordinator (PCC) immediately.All Clinicians and Aides will be in-serviced concerning the updated Hand Hygiene Policy and Procedures. The Clinicians and support staff will be in-serviced on 7/23/12 and the Home Health Aides on 8/1/12.</p>	08/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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>from contaminated hands to surfaces . . .</p> <p>IV.A.3. Perform hand hygiene: . . .</p> <p>IV.A.3.b. After contact with excretions, mucous membranes, . . . IV.A.3.d. If hands will be moving from a contaminated body site to a clean body site during patient care."</p> <p>2. During a home visit on 6/22/12 at 1 PM, with employee I, a registered nurse, verbalized she had forgotten her hand hygiene supplies in her car. Prior to providing wound care to patient # 3, employee I was observed to wash her hands in the patients bathroom sink and used the patient's bar soap to cleanse her hands.</p> <p>3. On 6/25/12 at 10 AM, the director of nursing indicated the staff are not to use patients bar soap and that the was not approved hand hygiene technique.</p> <p>4. On June 25, 2012 at 11:42 AM, the administrator indicated the agency does not conduct supervisory visits of the registered nurses to monitor for staff compliance and competence with standard infection control practices and that the agency does not have an approved and implemented infection control policy.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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			
N0486	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record review and interview, the agency failed to ensure communication occurred with the other providers providing services for 2 of 2 records reviewed of patients who received services from other providers (patients 1 and 6) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. The clinical record number 1 evidenced a start of care assessment dated 3/31/12 evidenced the patient was a quadriplegic and lived alone. The plan of care dated 3/31/12 through 5/29/12 evidenced only aide services were ordered; three hours every morning and two hours every evening throughout the certification period. The record failed to evidence any communication /case conferences to coordinate the patient's care with the other agency providing services.</p> <p>On June 22, 2012 at 2:42 PM, the administrator indicated the patient had other providers in the home through Area IV and that she did not know who those providers were and there was no evidence</p>	N0486	<p>It is the intent of Physicians Homecare, Inc. to ensure communication with other providers of service for shared patients. A Care Coordination between Agencies form was developed with a policy and procedure for use. Clinical Record # 1 and #6 patients will have Care Coordination between Agencies forms faxed to the agencies also providing services by 7/18/12. Case Managers will review all patients for shared provider services and a Care Coordination between Agencies form faxed to the shared provider service to be completed by 8/6/12. The Medical Records Clerk will be responsible for faxing and tracking returned Care Coordination forms. Any non-compliance by the shared provider will be reported to the Patient Care Coordinator (PCC) for follow up. The PCC will report ongoing status of shared providers returning the completed faxed forms to the monthly QI Committee. All clinicians involved in case management, support staff and aides will be in-serviced on the purpose and use of the Care Coordination between Agencies form. Clinicians and support staff will be in-serviced on 7/23/12 and home health aides will be in-serviced on 8/1/12.</p>	08/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(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>of coordination of care with the other agency providing services for patient #1.</p> <p>2. The clinical record number 6 evidenced a start of care assessment dated 5/22/12 indicated the patient received personal and attendant care through another home health agency. The record failed to evidence effective communication / case conferences to coordinate the patient's care with the other agency providing the patient services.</p> <p>On 6/25/12 at 10:35 AM, the director of nursing indicated there was no evidence of coordination of care with the other agency providing services for patient #6.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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			
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:</p> <p>Based on clinical record review and interview, the agency failed to ensure care was provided as ordered on the physician ordered plan of care in 2 of 5 (patient 1 and 5) active clinical records reviewed of patients with orders for home health aide services creating the potential for treatment omission and affect all the patients of the agency.</p> <p>Findings include:</p> <p>1. The clinical record number 1 evidenced a start of care assessment dated 3/31/12 evidenced the patient was a quadriplegic and lived alone. The plan of care dated 3/31/12 through 5/29/12 evidenced only aide services were ordered; three hours every morning and two hours every evening for assistance with activities of daily living, daily throughout the certification period. The clinical record evidenced aide visit notes dated 5/7/12 for the time period 7 AM to 10 AM and 7 PM to 9 PM; visit notes dated 5/8/12 and for the time period of 7 AM to 10 AM and 7 PM to 9 PM; visit notes dated 5/9/12 for the time period 7</p>	N0522	<p>It is the intent of Physicians Homecare, Inc. to ensure care is provided as ordered on the physicians order Plan of Care. Clinical Record #1 patient notes have been amended to document care given. The amended notes will be attached to the original notes in the patient's medical record. The Home Health Aide was counseled by the Home Health Aide Scheduler on 7/2/12 for failure to document care that the patient confirms was given on 5/7/12, 5/8/12, 5/9/12, and 5/11/12. The Home Health Aide Scheduler will monitor each Home Health Aide Activity Note for documentation of care given and report to the Quality Improvement Committee the monthly audit outcome. Clinical Record #5 did have an initial order on the Plan of Care for home health aides but the patient declined home health aide services and a discontinue order had been written on 6/8/12.</p>	08/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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>AM to 10 AM, and 7 PM to 9 PM; and a visit note dated 5/11/12 for the time period 7 AM to 10 AM. These visit notes were completed and contained the signature of employee E, a home health aide, and the patient. The notes failed to evidence the employee offered and provided any ordered care during these visits.</p> <p>On June 21, 2012 at 10:40 AM, the administrator indicated she did not know why there was not care provided to the patient on May 7, 8, 9, and 11, 2012.</p> <p>2. Clinical record #5, start of care 5/30/12 included a plan of care established by the physician for the certification period 5/20/12 through 7/28/12 with orders for a skilled nurse 1 times a week for 5 weeks and a home health aide two times a week for 9 weeks. The plan of care failed to evidence the services of a home health aide were provided as ordered.</p> <p>On June 25, 2012 at 9:50 AM, employee A indicated after review of the clinical record, the patient declined an aide and the clinical record did not evidence a physician order to discontinue the order for aide services.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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	
N0545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse coordinated services with other providers providing patient's services for 2 of 2 records reviewed of patients identified as received services from other providers (patients 1 and 6) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. The clinical record number 1 evidenced a start of care assessment dated 3/31/12 evidenced the patient was a quadriplegic and lived alone. The plan of care dated 3/31/12 through 5/29/12 evidenced only aide services were ordered; three hours every morning and two hours every evening throughout the certification period. The record failed to evidence any communication /case conferences to coordinate the patient's care with the other agency providing services.</p> <p>On June 22, 2012 at 2:42 PM, the</p>	N0545	<p>It is the intent of Physicians Homecare, Inc. to ensure communication with other providers of service for shared patients. A Care Coordination between Agencies form was developed with a policy and procedure for use. Clinical Record # 1 and #6 patients will have Care Coordination between Agencies forms faxed to the agencies also providing services by 7/18/12. Case Managers will review all patients for shared provider services and a Care Coordination between Agencies form faxed to the shared provider service to be completed by 8/6/12. The Medical Records Clerk will be responsible for faxing and tracking returned Care Coordination forms. Any non-compliance by the shared provider will be reported to the Patient Care Coordinator (PCC) for follow up. The PCC will report ongoing status of shared providers returning the completed faxed forms to the monthly QI Committee. All clinicians involved in case management, support staff and aides will be in-serviced on the purpose and use of the Care Coordination between Agencies form. Clinicians and</p>	08/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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>administrator indicated the patient had other providers in the home through Area IV and that she did not know who those providers were and there was no evidence of coordination of care with the other agency providing services for patient #1.</p> <p>2. The clinical record number 6 evidenced a start of care assessment dated 5/22/12 indicated the patient received personal and attendant care through another home health agency. The record failed to evidence effective communication / case conferences to coordinate the patient's care with the other agency providing the patient services.</p> <p>On 6/25/12 at 10:35 AM, the director of nursing indicated there was no evidence of coordination of care with the other agency providing services for patient #6.</p>		<p>support staff will be in-serviced on 7/23/12 and home health aides will be in-serviced on 8/1/12.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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			
N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and</p> <p>Based on personnel file and policy review, and staff interview, the agency failed to ensure the home health aide competency evaluation addressed all of the subject areas found at 410 IAC 17-14-1(h) for 3 (Files E, G, and H) of 6 home health aide files reviewed with the potential to effect all 91 current patients.</p> <p>The findings include:</p> <p>1. On June 21, 2012 at 1:30 PM, the administrator indicated the aides' competency of skills was completed by different registered nurses. She indicated she educated and reviewed onsite and used the durable medical supply distributor that is in the same building for skills that could be done in the office. The administrator indicated she does not make home visits or complete any part of the competency in the home. She indicated she assigned different registered nurses to complete the skills check off with the aide</p>	N0596	<p>It is the intent of Physicians Homecare, Inc. (PHI) to ensure the Home Health Aides Competency Evaluation is completed prior to independent patient contact. The Policy and Procedure for Home Health Aide Competency was reviewed and revised and will be reviewed with the clinical staff during the in-service on 7/23/12. Personnel file "E" employee was terminated on 7/10/12 due to moving outside of the PHI service area. Personnel file "G" employee became state certified as a CNA on 4/7/12. The employee will demonstrate competency in bed bath and mobility skills by 8/1/12 per the Administrator. Personnel file "H" employee will demonstrate competency in bed bath and vital sign skills by 8/1/12 per the Administrator. The Case Mangers will be assessing competency of home health aides throughout the year as per Federal & State supervisory regulations. The HR Mgr. will audit all home health aide employee files for</p>	08/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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>in a patients home when needed.</p> <p>2. On June 21, 2012 at 12:30 PM, the director of nursing indicated she did not conduct any of the skills check off for the aides, that those duties were completed by the administrator.</p> <p>3. On June 25, 2012 at 11:15 AM, the administrator indicated she indicated there was no agency policy or procedure that stated how the staff were actually to be tested and observed, and how the agency expected the registered nurse to evaluate the skills of the aides.</p> <p>4. The policy titled "Home Health Aide Competency Policy" with effective date 9/04, provided by the director of nursing on 6/25/12, stated, "Individuals working under the job description of home health aide, must be certified and or demonstrate competency prior to being independently placed in the field with clients. ... The aide must possess necessary training and or experience prior too employment. ... The aide must be able to complete: ... The IAHHC [Indiana Association of Home Care] Aide checklist for Skills Demonstration developed by IAHHC with no more than one unsuccessful area."</p> <p>5. Personnel file E, date of hire 10/19/11, evidenced the document titled "Certified</p>		documentation of competency evidenced by a completed IAHHC Aide Checklist for Skills Demonstration. The HR Mgr. will report the audit results to the QI Committee. The HR Mgr. will monitor all newly hired aides for complete documentation of skills competency prior to the Home Health Aide Scheduler placing the aide independently with patients. The Administrator is responsible for the Home Health Aide Competency program.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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			
	Home Health / Hospice Aide Check List" that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The list included the skills: 1) Mobility - ambulation: Assist, cane, walker, crutches. 2) ROM [range of motion]: Upper and Lower active, passive. 3) Transfer: Assist, wheelchair, or bed to chair. 4) Positioning: In a bed. In a chair. 5) Personal Care: Oral: Dentures, natural teeth, gum care. 6) Bed bath. 7) Bath shower, Tub, or sponge bath. 8) Nail Care Finger / Toes - soak, file. 9) Hair: Shampoo, bed sink, or bathtub. 10) Prevention of Skin Breakdown: Recognition of pressure areas appropriate massage techniques. 11) Bodily functions - toileting, bathroom, bedpan, urinal, bedside commode, dwelling catheter. 12) Vital Signs: Temperature, respiration, and pulse. 13) Fluid Balance: Measurement In-take Output. 14) Environmental Services: Linen Change: Bed Occupied with patient, bed unoccupied. 15) Universal Precautions, as written by the agency, are used and followed. 16) Medication Assistance						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>competent client, mentally incompetent." The document indicated by dated signature of employee K, a registered nurse, the individual was evaluated on 10/19/11. The document failed to evidence the individual completed the skill of giving a bed bath and mobility - ambulation assistance with a cane, walker, or crutches. These required areas were left blank.</p> <p>6. Personnel file G, date of hire 11/23/11, evidenced an application for employment, dated 10/31/11, which failed to evidence any experience as a home health or hospice aide, or as a nurse aide assistant. The file included the document titled "Certified Home Health / Hospice Aide Check List" that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The list included the skills: 1) Mobility - ambulation: Assist, cane, walker, crutches. 2) ROM [range of motion]: Upper and Lower active, passive. 3) Transfer: Assist, wheelchair, or bed to chair. 4) Positioning: In a bed. In a chair.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>5) Personal Care: Oral: Dentures, natural teeth, gum care. 6) Bed bath. 7) Bath shower, Tub, or sponge bath. 8) Nail Care Finger / Toes - soak, file. 9) Hair: Shampoo, bed sink, or bathtub. 10) Prevention of Skin Breakdown: Recognition of pressure areas appropriate massage techniques. 11) Bodily functions - toileting, bathroom, bedpan, urinal, bedside commode, dwelling catheter. 12) Vital Signs: Temperature, respiration, and pulse. 13) Fluid Balance: Measurement In-take Out- put. 14) Environmental Services: Linen Change: Bed Occupied with patient, bed unoccupied. 15) Universal Precautions, as written by the agency, are used and followed. 16) Medication Assistance competent client, mentally incompetent." The document indicated by dated signature, employee L, a registered nurse whom was no longer employed by the agency, evaluated the individual on 11/29/11. The document failed to evidence the individual completed the skill of giving a bed bath and mobility - ambulation assistance with a cane, walker, or crutches. The required bed bath was left blank and the area of the form identified "Mobility" contained a hand written entry and stated, "w/c [wheelchair] and the required items were left blank."</p> <p>7. Personnel file H, date of hire 2/16/12,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	evidenced a document titled "Certified Home Health / Hospice Aide Check List" that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The list included the skills: 1) Mobility - ambulation: Assist, cane, walker, crutches. 2) ROM [range of motion]: Upper and Lower active, passive. 3) Transfer: Assist, wheelchair, or bed to chair. 4) Positioning: In a bed. In a chair. 5) Personal Care: Oral: Dentures, natural teeth, gum care. 6) Bed bath. 7) Bath shower, Tub, or sponge bath. 8) Nail Care Finger / Toes - soak, file. 9) Hair: Shampoo, bed sink, or bathtub. 10) Prevention of Skin Breakdown: Recognition of pressure areas appropriate massage techniques. 11) Bodily functions - toileting, bathroom, bedpan, urinal, bedside commode, dwelling catheter. 12) Vital Signs: Temperature, respiration, and pulse. 13) Fluid Balance: Measurement In-take Output. 14) Environmental Services: Linen Change: Bed Occupied with patient, bed unoccupied. 15) Universal Precautions, as written by the agency, are used and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(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>followed. 16) Medication Assistance competent client, mentally incompetent." The document indicated by dated signature, the administrator evaluated the individual on a portion of the skills on 2/21/12 and then employee L, a registered nurse, evaluated another portion of the skills on 2/28/12. The document failed to evidence the individual completed the skill of giving a bed bath and vital signs, the area identified and stated, "Bed bath" was left blank and the area identified as "Vital Signs" contained a hand written entry and stated, "Do Not do in this agency."</p> <p>8. Clinical record number 1 evidenced a document titled "Home Health Aide Care Plan" that and stated, "Bath - Max to total care." The record evidenced employee G rendered home health aide services on May 5, 2012 from 7 PM through 9 PM and May 13, 2012 from 7 AM through 10 AM, May 19, 2012 from 7 AM through 10 AM and 7 PM through 9 PM. The record evidenced employee H rendered home health aide services on May 3, 2012 from 7 AM through 10 AM, May 10, 2012 from 7 AM through 10 AM and 7 PM through 9 PM, May 17, 2012 from 7 through 10 AM, and May 19, 2012 from 7 through 9 PM.</p> <p>9. Clinical record number 2 evidenced</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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	
	employee E provided aide services to the patient on May 4, 7, 11, 14, 16, 18, 21, 2012 and June 1, 4, 7, 8, 11, 2012; employee G provided aide services on May 3, 10, 17, 24, and 31, 2012; and employee H provided aide services on June 15, 2012.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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			
N0598	<p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on personnel file and policy review, and interview, the agency failed to ensure documentation of the home health aide competency evaluation was accurate and met the requirements for 3 (Files E, G, and H) of 6 home health aide files reviewed with the potential to effect all 91 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> On June 21, 2012 at 1:30 PM, the administrator indicated the aides' competency of skills was completed by different registered nurses. She indicated she educated and reviewed onsite and used the durable medical supply distributor that is in the same building for skills that could be done in the office. The administrator indicated she does not make home visits or complete any part of the competency in the home. She indicated she assigned different registered nurses to complete the skills check off with the aide in a patients home when needed. On June 21, 2012 at 12:30 PM, the director of nursing indicated she did not 	N0598	<p>It is the intent of Physicians Homecare, Inc. (PHI) to ensure the Home Health Aides Competency Evaluation is completed prior to independent patient contact. The Policy and Procedure for Home Health Aide Competency was reviewed and revised and will be reviewed with the clinical staff during the in-service on 7/23/12. Personnel file "E" employee was terminated on 7/10/12 due to moving outside of the PHI service area. Personnel file "G" employee became state certified as a CNA on 4/7/12. The employee will demonstrate competency in bed bath and mobility skills by 8/1/12 per the Administrator. Personnel file "H" employee will demonstrate competency in bed bath and vital sign skills by 8/1/12 per the Administrator. The Case Mangers will be assessing competency of home health aides throughout the year as per Federal & State supervisory regulations. The HR Mgr. will audit all home health aide employee files for documentation of competency evidenced by a completed IAHC Aide Checklist for Skills Demonstration. The HR Mgr. will report the audit results to the QI</p>	08/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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>conduct any of the skills check off for the aides, that those duties were completed by the administrator.</p> <p>3. On June 25, 2012 at 11:15 AM, the administrator indicated she indicated there was no agency policy or procedure that stated how the staff were actually to be tested and observed, and how the agency expected the registered nurse to evaluate the skills of the aides.</p> <p>4. The policy titled "Home Health Aide Competency Policy" with effective date 9/04, provided by the director of nursing on 6/25/12, stated, "Individuals working under the job description of home health aide, must be certified and or demonstrate competency prior to being independently placed in the field with clients. ... The aide must possess necessary training and or experience prior too employment. ... The aide must be able to complete: ... The IAHHC [Indiana Association of Home Care] Aide checklist for Skills Demonstration developed by IAHHC with no more than one unsuccessful area."</p> <p>5. Personnel file E, date of hire 10/19/11, evidenced the document titled "Certified Home Health / Hospice Aide Check List" that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must</p>		Committee. The HR Mgr. will monitor all newly hired aides for complete documentation of skills competency prior to the Home Health Aide Scheduler placing the aide independently with patients. The Administrator is responsible for the Home Health Aide Competency program.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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>be performed on a client or a pseudo - client." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The list included the skills: 1) Mobility - ambulation: Assist, cane, walker, crutches. 2) ROM [range of motion]: Upper and Lower active, passive. 3) Transfer: Assist, wheelchair, or bed to chair. 4) Positioning: In a bed. In a chair. 5) Personal Care: Oral: Dentures, natural teeth, gum care. 6) Bed bath. 7) Bath shower, Tub, or sponge bath. 8) Nail Care Finger / Toes - soak, file. 9) Hair: Shampoo, bed sink, or bathtub. 10) Prevention of Skin Breakdown: Recognition of pressure areas appropriate massage techniques. 11) Bodily functions - toileting, bathroom, bedpan, urinal, bedside commode, dwelling catheter. 12) Vital Signs: Temperature, respiration, and pulse. 13) Fluid Balance: Measurement In-take Output. 14) Environmental Services: Linen Change: Bed Occupied with patient, bed unoccupied. 15) Universal Precautions, as written by the agency, are used and followed. 16) Medication Assistance competent client, mentally incompetent." The document indicated by dated signature of employee K, a registered nurse, the individual was evaluated on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(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>10/19/11. The document failed to evidence the individual completed the skill of giving a bed bath and mobility - ambulation assistance with a cane, walker, or crutches. These required areas were left blank.</p> <p>6. Personnel file G, date of hire 11/23/11, evidenced an application for employment, dated 10/31/11, which failed to evidence any experience as a home health or hospice aide, or as a nurse aide assistant. The file included the document titled "Certified Home Health / Hospice Aide Check List" that states, "Check skills being demonstrated. Initial and date when each skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The list included the skills: 1) Mobility - ambulation: Assist, cane, walker, crutches. 2) ROM [range of motion]: Upper and Lower active, passive. 3) Transfer: Assist, wheelchair, or bed to chair. 4) Positioning: In a bed. In a chair. 5) Personal Care: Oral: Dentures, natural teeth, gum care. 6) Bed bath. 7) Bath shower, Tub, or sponge bath. 8) Nail Care Finger / Toes - soak, file. 9) Hair:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(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>Shampoo, bed sink, or bathtub. 10) Prevention of Skin Breakdown: Recognition of pressure areas appropriate massage techniques. 11) Bodily functions - toileting, bathroom, bedpan, urinal, bedside commode, dwelling catheter. 12) Vital Signs: Temperature, respiration, and pulse. 13) Fluid Balance: Measurement In-take Out- put. 14) Environmental Services: Linen Change: Bed Occupied with patient, bed unoccupied. 15) Universal Precautions, as written by the agency, are used and followed. 16) Medication Assistance competent client, mentally incompetent." The document indicated by dated signature, employee L, a registered nurse whom was no longer employed by the agency, evaluated the individual on 11/29/11. The document failed to evidence the individual completed the skill of giving a bed bath and mobility - ambulation assistance with a cane, walker, or crutches. The required bed bath was left blank and the area of the form identified "Mobility" contained a hand written entry and stated, "w/c [wheelchair] and the required items were left blank."</p> <p>7. Personnel file H, date of hire 2/16/12, evidenced a document titled "Certified Home Health / Hospice Aide Check List" that states, "Check skills being demonstrated. Initial and date when each</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905			
(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>skill is evaluated. ... * Mandated - Must be performed on a client or a pseudo - client." The document contained a list of skills to be tested. Preceding each skill grouping there is an asterisk preceding the group indicating that the skill was to be completed and evaluated on a client or pseudo - client. The list included the skills: 1) Mobility - ambulation: Assist, cane, walker, crutches. 2) ROM [range of motion]: Upper and Lower active, passive. 3) Transfer: Assist, wheelchair, or bed to chair. 4) Positioning: In a bed. In a chair. 5) Personal Care: Oral: Dentures, natural teeth, gum care. 6) Bed bath. 7) Bath shower, Tub, or sponge bath. 8) Nail Care Finger / Toes - soak, file. 9) Hair: Shampoo, bed sink, or bathtub. 10) Prevention of Skin Breakdown: Recognition of pressure areas appropriate massage techniques. 11) Bodily functions - toileting, bathroom, bedpan, urinal, bedside commode, dwelling catheter. 12) Vital Signs: Temperature, respiration, and pulse. 13) Fluid Balance: Measurement In-take Output. 14) Environmental Services: Linen Change: Bed Occupied with patient, bed unoccupied. 15) Universal Precautions, as written by the agency, are used and followed. 16) Medication Assistance competent client, mentally incompetent." The document indicated by dated signature, the administrator evaluated the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905
---	---

(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>individual on a portion of the skills on 2/21/12 and then employee L, a registered nurse, evaluated another portion of the skills on 2/28/12. The document failed to evidence the individual completed the skill of giving a bed bath and vital signs, the area identified and stated, "Bed bath" was left blank and the area identified as "Vital Signs" contained a hand written entry and stated, "Do Not do in this agency."</p> <p>8. Clinical record number 1 evidenced a document titled "Home Health Aide Care Plan" that and stated, "Bath - Max to total care." The record evidenced employee G rendered home health aide services on May 5, 2012 from 7 PM through 9 PM and May 13, 2012 from 7 AM through 10 AM, May 19, 2012 from 7 AM through 10 AM and 7 PM through 9 PM. The record evidenced employee H rendered home health aide services on May 3, 2012 from 7 AM through 10 AM, May 10, 2012 from 7 AM through 10 AM and 7 PM through 9 PM, May 17, 2012 from 7 through 10 AM, and May 19, 2012 from 7 through 9 PM.</p> <p>9. Clinical record number 2 evidenced employee E provided aide services to the patient on May 4, 7, 11, 14, 16, 18, 21, 2012 and June 1, 4, 7, 8, 11, 2012; employee G provided aide services on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/25/2012
NAME OF PROVIDER OR SUPPLIER PHYSICIANS HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 210 PROFESSIONAL CT LAFAYETTE, IN 47905		
(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	
	May 3, 10, 17, 24, and 31, 2012; and employee H provided aide services on June 15, 2012.				