

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157550	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2012
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE AT HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10700 PARK PL SAINT JOHN, IN 46373
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G0000	<p>This was a federal home health recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 8/15/12 - 8/17/12</p> <p>Facility #: 3435</p> <p>Medicaid #: 200451170</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Skilled unduplicated census: 67 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">August 23, 2012</p>	G0000	<p>Providence Home Health Care, here by submits it's Plan of Correction pursuant to the State and Federal rules and regulations governing the licensing and certification of home health care agencies. It is the Indiana State Department of Health's ("ISDH") and the Centers for Medicare and Medicaid Services' ("CMS") stated position that an agency submitting a Plan of Correction ("POC") must respond to each alleged violation, regardless of whether the agency denies or disagrees with a factual or legal allegation contained in the survey. It is ISDH's and CMS's position that even if the agency has requested Informal Dispute Resolution ("IDR") and has set forth specific grounds for its disputes, the agency must still provide a POC for each disputed tag. It is ISDH's position and CMS's position that failure to provide the POC may result in fines, probations, or loss of the Agency's license.</p> <p>In order to comply with these procedural requirements, the Agency has responded to each alleged deficiency below. These responses are made only for informational purposes of establishing the Agency's compliance, and do not constitute an admission or agreement with the allegations contained in the survey. the Agency denies any and all wrong doing and/or liability arising out of or relating to those</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			<p>factual or legal allegations contained in the survey dated August 15, 2012 thru August 17, 2012.</p> <p>This being said, no admission of guilt or concession of agreement should be implied by the lack of administrative or other appeal in this instance by the Agency or by the descriptions of means to correct the alleged and disputed deficiencies. To the extent that such legal or administrative appeal becomes available to the Agency at a later time, the Agency hereby reserves the right to pursue all formal and informal administrative, civil, and legal processes available in contesting the allegations contained in this survey.</p>		

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G0121	<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.</p> <p>Based on observation, CDC document review, agency document review, policy review, and staff interview, the agency failed to ensure it had followed its own polices regarding the infection log and infection control for 2 of 10 of the agency's current 16 patients (clinical record #4 and 9).</p> <p>Findings</p> <p>Regarding infection control</p> <p>1. At a home visit observation on 8/16/12 at 2:50 PM, Employee G, home health aide, was observed to don the left hand glove and then pick up trash on the floor with the right hand which was not gloved. At that time, Employee G gloved the the right hand and proceeded to take the patient's temperature with an oral thermometer. Employee G emptied the Foley catheter bag into the toilet and touched the Foley drain port to the inside of the toilet seat. The Foley drain port was not cleansed at this time and was returned to the closed position.</p>	G0121	<p>G121 The clinical supervisor completed an in-service and policy review on infection control standards on August 17, 2012 with employee G (See Attachment #4). At the end of the in-service the employee completed a return demonstration on hand washing skills (See Attachment #5)and was given a written test on infection control standards, CDC CAUTI guidelines(See Attachment #6) and hand-washing. The clinical supervisor has been instructed and given an infection control log sheet (See Attachment #7) for logging all infection control surveillance reports August 17, 2012. All staff has been in-serviced on infection control reporting. The quality improvement coordinator will run an electronic report from the physician orders and medications orders for any patient who may have an antibiotic ordered. A log sheet will be used to track and maintain the surveillance reports (See Attachment #8). Surveillance reports will be</p>	08/20/2012			

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	<p>On 8/16/12 at 3:05 PM, Employee B, the director of nursing, indicated Employee G did not ensure infection control techniques were observed.</p> <p>2. The agency policy titled "Hand Hygiene" with an effective date of 12/10 stated, "Hand decontamination using an alcohol - based hand rub should be performed A. before having direct contact with the patients ... F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... Handwashing using soap and water should be performed ... when hands are visibly dirty or contaminated."</p> <p>3. The document titled "2009 CAUTI guidelines" on page 13 retrieved on 8/20/12 from the Center for Disease Control website: http://www.cdc.gov/hicpac/pdf/cauti/cautiguide2009final.pdf stated, "Empty the collecting bag [Foley Bag] regularly using a separate, clean collecting container for each patient; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container."</p> <p>Regarding infection control log</p> <p>4. Clinical record #9, start of care 3/11/12, with a certification period of 5/10/12 - 7/8/12, included a plan of care</p>		<p>completed by the quality improvement coordinator or the clinical supervisors. 100% of patient's orders will be audited weekly for 8 weeks starting August 20, 2012, then monthly. Report will be given every quarter to the infection control committee, QIC and PAC starting with the 3rd quarter reports (See Attachment #8). Home health aides will be supervised with unannounced visits by the clinical supervisor for hand hygiene and infection control issues, skills will be observed and documented (See Attachments #5 & #6). Supervisory visit results will be reported to the QI coordinator monthly and QIC and PAC quarterly. The director of clinical services or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>with physician orders for treatment of infection. This was evidenced by the following document:</p> <p>a. A clinical document titled "Treatment / order / in condition" stated, "New medications begin date 5/23/12 Bactroban 2 % topical every 1 day. Apply Bactroban 2% cream to right shin wounds daily with dressing change."</p> <p>b. A agency document titled "Infection log patient" with a date of 2012 documented infections from 1/02/12 - 7/30/12. This log failed to evidence patient #9 had an order for bactroban on 5/23/12.</p> <p>c. On 8/17/12 at 3 PM, the director of nursing indicated the infection control log failed to document clinical record #9's use of bactroban.</p> <p>5. The agency policy titled "Evaluating and maintaining records of infections among patients" with an effective date of 12/10 stated, "All patients with a new, actual or suspected infection will have a patient infection report completed within 24 hours of discovery."</p>				

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G0141	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>Based on personnel file review, policy review, and interview, the agency failed to ensure the policy was followed regarding a physical examination that evidenced the employee was free of communicable disease and there was a physical examination on file for 2 of 15 personnel files reviewed (Files E and L) with the potential to affect all of the agency's 16 active patients.</p> <p>The findings</p> <ol style="list-style-type: none"> Personnel file E, date of hire 3/9/11 and first patient contact 3/11/11, a registered nurse, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease. Personnel file L, date of hire 7/6/11 and first patient contact 7/11/11, a physical therapist, failed to evidence a pre-employment physical examination. On 8/17/12 at 3:10 PM, Employee B, the director of nursing, indicated the file 	G0141	<p>G141 The director of clinical service has educated the human resource coordinator on Aug 20,2012 on the requirements for human resource files as mandated by federal, state and local regulations.The human resource coordinator will audit all employee files of the agency to ensure that documentation is present stating the employee is free from communicable disease.(See Attachment #1) Employee E and L have been seen by the agency medical director and documentation is present in their employee files stating they are free of communicable disease (See Attachment #2) on August 27, 2012. The human resource coordinator will audit 100% of the agencies human resource files by 9/21/12 (See Attachment #1). Any file missing the documentation that states the employee is free from communicable disease and has been employed less than 6 months will be evaluated by the medical director. The human resource</p>	08/27/2012			

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	<p>E lacked a pre-employment physical examination that identified the employee was free of communicable disease and employee L had not obtained a physical examination prior to caring for patients.</p> <p>4. The agency policy titled "Categories / Qualifications of Personnel" with an effective date of 12 / 10 stated, "Health requirements 1. Clinical staff: All new staff providing patient care and rehires who have not been employed by the organization for over 6 months, must undergo a physical screening before they are employed or re-employed, in accordance with other organization policies and federal, state, and local requirements."</p>		<p>coordinator will develop a tracking tool for each new employee (See Attachment #3).The employee files will be audited 10% each month and corrected with any missing documentation. A report will be given every quarter at the quality improvement and PAC meeting. The administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0000	<p>This visit was for a state home health relicensure survey.</p> <p>Survey Dates: 8/15/12 - 8/17/12</p> <p>Facility #: 3435</p> <p>Medicaid #: 200451170</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Skilled unduplicated census: 67 patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">August 23, 2012</p>	N0000	<p>Providence Home Health Care, here by submits it's Plan of Correction pursuant to the State and Federal rules and regulations governing the licensing and certification of home health care agencies. It is the Indiana State Department of Health's ("ISDH") and the Centers for Medicare and Medicaid Services' ("CMS") stated position that an agency submitting a Plan of Correction ("POC") must respond to each alleged violation, regardless of whether the agency denies or disagrees with a factual or legal allegation contained in the survey. It is ISDH's and CMS's position that even if the agency has requested Informal Dispute Resolution ("IDR") and has set forth specific grounds for its disputes, the agency must still provide a POC for each disputed tag. It is ISDH's position and CMS's position that failure to provide the POC may result in fines, probations, or loss of the Agency's license.</p> <p>In order to comply with these procedural requirements, the Agency has responded to each alleged deficiency below. These responses are made only for informational purposes of establishing the Agency's compliance, and do not constitute an admission or agreement with the allegations contained in the survey. the Agency denies any and all wrong doing and/or liability arising out of or relating to those</p>		

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N0462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review, policy review, and interview, the agency failed to ensure the policy was followed regarding a physical examination that evidenced the employee was free of communicable disease and there was a physical examination on file for 2 of 15 personnel files reviewed (Files E and L) with the potential to affect all of the agency's 16 active patients.</p> <p>The findings</p> <p>1. Personnel file E, date of hire 3/9/11 and first patient contact 3/11/11, a registered nurse, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease.</p> <p>2. Personnel file L, date of hire 7/6/11 and first patient contact 7/11/11, a physical therapist, failed to evidence a</p>	N0462	<p>N462The director of clinical service has educated the human resource coordinator on Aug 20,2012 on the requirements for human resource files as mandated by federal, state and local regulations.The human resource coordinator will audit all employee files of the agency to ensure that documentation is present stating the employee is free from communicable disease.(See Attachment #1) Employee E and L have been seen by the agency medical director and documentation is present in their employee files stating they are free of communicable disease (See Attachment #2) on August 27, 2012. The human resource coordinator will audit 100% of the agencies human resource files by 9/21/12 (See Attachment #1). Any file missing the documentation that states the employee is free</p>	08/27/2012

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	<p>pre-employment physical examination.</p> <p>3. On 8/17/12 at 3:10 PM, Employee B, the director of nursing, indicated the file E lacked a pre-employment physical examination that identified the employee was free of communicable disease and employee L had not obtained a physical examination prior to caring for patients.</p> <p>4. The agency policy titled "Categories / Qualifications of Personnel" with an effective date of 12 / 10 stated, "Health requirements 1. Clinical staff: All new staff providing patient care and rehires who have not been employed by the organization for over 6 months, must undergo a physical screening before they are employed or re-employed, in accordance with other organization policies and federal, state, and local requirements."</p>		<p>from communicable disease and has been employed less than 6 months will be evaluated by the medical director. The human resource coordinator will develop a tracking tool for each new employee (See Attachment #3).The employee files will be audited 10% each month and corrected with any missing documentation. A report will be given every quarter at the quality improvement and PAC meeting. The administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, CDC document review, agency document review, policy review, and staff interview, the agency failed to ensure it had followed its own polices regarding the infection log and infection control for 2 of 10 of the agency's current 16 patients (clinical record #4 and 9).</p> <p>Findings</p> <p>Regarding infection control</p> <p>1. At a home visit observation on 8/16/12 at 2:50 PM, Employee G, home health aide, was observed to don the left hand glove and then pick up trash on the floor with the right hand which was not gloved. At that time, Employee G gloved the the right hand and proceeded to take the patient's temperature with an oral thermometer. Employee G emptied the Foley catheter bag into the toilet and touched the Foley drain port to the inside of the toilet seat. The Foley drain port was not cleansed at this time and was returned to the closed position.</p>	N0470	<p>N 470 The clinical supervisor completed an in-service and policy review on infection control standards on August 17, 2012 with employee G (See Attachment #4). At the end of the in-service the employee completed a return demonstration on hand washing skills (See Attachment #5)and was given a written test on infection control standards, CDC CAUTI guidelines(See Attachment #6) and hand-washing. The clinical supervisor has been instructed and given an infection control log sheet (See Attachment #7) for logging all infection control surveillance reports August 17, 2012. All staff has been in-serviced on infection control reporting. The quality improvement coordinator will run an electronic report from the physician orders and medications orders for any patient who may have an antibiotic ordered. A log sheet will be used to track and maintain the surveillance reports (See Attachment #8).</p>	08/20/2012			

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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>5/10/12 - 7/8/12, included a plan of care with physician orders for treatment of infection. This was evidenced by the following document:</p> <p>a. A clinical document titled "Treatment / order / in condition" stated, "New medications begin date 5/23/12 Bactroban 2 % topical every 1 day. Apply Bactroban 2% cream to right shin wounds daily with dressing change."</p> <p>b. A agency document titled "Infection log patient" with a date of 2012 documented infections from 1/02/12 - 7/30/12. This log failed to evidence patient #9 had an order for bactroban on 5/23/12.</p> <p>c. On 8/17/12 at 3 PM, the director of nursing indicated the infection control log failed to document clinical record #9's use of bactroban.</p> <p>5. The agency policy titled "Evaluating and maintaining records of infections among patients" with an effective date of 12/10 stated, "All patients with a new, actual or suspected infection will have a patient infection report completed within 24 hours of discovery."</p>				

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