

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
--------------------	--	---------------	---	----------------------

G000000	<p>This was a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: October 27, 28, 29, and 30, 2014. Partial Extended Dates: October 27, 28, 29, and 30, 2014.</p> <p>Facility Number: IN011300</p> <p>Medicaid Number: 200848450</p> <p>Surveyors: Miriam Bennett, RN, BSN, PHNS Michelle Weiss, RN, MSN, PHNS</p> <p>Census Service Type: Skilled: 2152 Home Health Aide Only: 0 Personal Care Only: 0 Total: 2152</p> <p>Sample: RR w/HV: 9 RR w/o HV: 11 Total: 20</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
G000121	<p>November 6, 2014</p> <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 observation, policy review, and interview, the agency failed to ensure all staff followed infection control guidelines for 2 of 10 home visit observations, and failed to ensure the registered nurse (RN) followed the wound measurement policy for 1 of 4 clinical records reviewed of patients receiving wound care, creating the potential to affect all the agency's patients. (#1, 2, and 8)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation with patient #1 on 10/28/14 at 9:45 AM, employee H, a registered nurse, placed the nursing bag on chair in patients home. Employee H failed to place a barrier under the nursing bag. 2. During home visit observation with patient #2 on 10/28/14 at 11:30 AM, employee F, a licensed practical nurse, 	G000121	The agency will ensure all staff follow infection control guidelines by reeducation and in servicing all clinical staff. The infection control policy will be reviewed with clinical staff to include but not limited to bag technique, nd washing, and wound measurementsAll nursing staff will be reeducated on wound measurements, timing of measurements as well as documentation of wound measurements. 10% of all discharged charts will be reviewed each quarter for documentation of wound measurements	11/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>was observed assessing the patient's vital signs. After cleaning the equipment used, employee F removed their gloves and donned a new pair of gloves. Employee F failed to use hand gel or wash hands in between glove change.</p> <p>3. During interview on 10/28/14 at 4:35 PM, employee B indicated the policy is to place the nursing bag on a barrier or hang it on a door. Employee B also indicated employees should wash hands or use hand gel in between glove changes.</p> <p>4. Clinical record #8, start of care date 8/29/14, contained a plan of care dated 8/29-10/27/14 with principal diagnosis of Pressure Ulcer, buttock, and orders for Skilled Nursing 3 times a week for 3 weeks, 2 times a week for 2 weeks, 1 time a week for 3 weeks, and 3 as needed visits if dressing becomes soiled or dislodged. The record failed to evidence the wound was measured the weeks of 9/14-9/20/14, and 9/28-10/4/14. The Skilled Nurse Visit Notes dated 9/15, 9/16, 9/18, 9/29, and 10/2/14 failed to evidence the wound was measured.</p> <p>5. During interview on 10/29/14 at 3:00 PM, employee A indicated wounds are to be measured weekly.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
G000134	<p>6. The agency's undated policy titled "Wound Measurement," no number, states "Wounds are to be measured once per week, as well as admission, recertification, and resumption and discharge."</p> <p>7. The agency's undated policy titled "Clinician Bag," # N-120, states "When in a client's home, place the bag on a clean and dry surface."</p> <p>8. The agency's undated policy titled "Infection Control and Infectious Waste Standards," no number, states "1. Wash hands thoroughly before and after contact with the patient/client, and after removing gloves."</p> <p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on employee file review, job description review, policy review, and interview, the administrator failed to ensure the agency checked skills competencies on date of hire (DOH) for 1 of 2 Home Health Aide (HHA) files reviewed (M), criminal background checks were completed within 3 days of starting patient care for 1 of 7 employee</p>	G000134	The agency will utilize employee skills competency evaluation for all HHA new hires immediately. Current employee files will have a skills competency checklist completed by 12/7/2014The Indiana Association for Home and Hospice Skills Check List will be used for each hireOngoing competency skills check list will be completed yearly and kept in	12/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>files reviewed (M), and the appropriate job description was signed by the licensed practical nurse (LPN) for 1 of 1 LPN file reviewed (F), creating the potential to affect all the agency's patients. (F and M)</p> <p>Findings include</p> <ol style="list-style-type: none"> Employee file F, a LPN, date of hire (DOH) 2/25/14, contained a job description titled "Registered Nurse" and was signed on 2/7/14. <p>During interview on 10/10/29/14 at 4:35 PM, employee B indicated the employee (F) is a LPN.</p> <ol style="list-style-type: none"> Employee file M, a HHA, DOH 11/11/11, and first patient contact date 11/14/11, failed to evidence a skills competency was completed at DOH and failed to evidence the criminal background check was completed until 11/25/11. <p>During interview on 10/29/14 at 9:00 AM, employee B indicated the HHA (employee M) had not been seeing patients for awhile due to schooling.</p> <ol style="list-style-type: none"> The agency's job description titled "Certified Home Health Aide," states, "Demonstrates competency in the 		<p>the employee's file. The DON or designee will be responsible for completion of skills evaluation/checklist. All employees without a skills competency form completed will not be allowed to participate in patient care visits until the skills competency is complete. 100% of all employee files will be reviewed for proper job description by administrator or executive assistant or office manager.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>following areas: performs duties as assigned by case manager or DON as ordered by a physician, takes accurate vital signs as assigned, ensures that changes in the patient's clinical status are communicated/doc. to team, coordinates care planning and delivery with physician, pt., family and team member, assists the patient with ADL and personal care & shows techniques to increase indep. [independence], assists the patient with transfers, ambulation and bed mobility as necessary, helps with the assessment of the patient for durable medical equipment needs, performs all duties in a manner that optimizes patient safety and welfare, properly assesses pain and communicated with team regarding changes, educates the patient and the family regarding safety, ... adheres to agency policies, procedures & all government laws, regulations, and standards."</p> <p>4. The agency's undated policy titled "Employee Skills/Competency Evaluation," not numbered, states, "5. A Home Health Aide skills competency evaluation must be completed satisfactorily prior to patient care being performed. The competency must be evaluated by a Registered Nurse with 1 year of home health care and 2 years of nursing experience. The Indiana</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/30/2014	
NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237			
(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			
G000158	<p>Association for Home Care and Hospice Skills Check List will be used. ... Ongoing: ... 2. Annual skills competencies will be completed during the performance review period. 3. Skills competency will be documented and kept in the employee personnel file. ... Skills competency checklist shall include, but not be limited to: 1. Specific job responsibilities and skills."</p> <p>5. The agency's undated policy titled "Criminal Background Check/National Sexual Offense Registry Check," not numbered, states, "Procedure: A. The agency will apply, not more than three (3) business days after the date that the employee begins to provide services for a copy of the employee's limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review, policy review, and interview, the agency failed</p>	G000158	The agency will ensure all clinical staff will be reeducated and in	11/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>to ensure home health aide (HHA) services were provided as ordered and failed to inform the physician of the missed visit for 1 of 5 records reviewed of patients receiving HHA services, creating the potential to affect all the agency's patients. (#14)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record #14, start of care date 4/11/14, contained a plan of care dated 6/10-8/8/14 with orders for HHA 2 times a week for 8 weeks to begin 6/15/14. The record failed to evidence a HHA visit was provided the week of 6/29-7/5/14. The record also failed to evidence a missed visit note. 2. During interview on 10/27/14 at 4:20 PM, employee B indicated the aide did not make a visit the week of 6/29-7/5 and there are no missed visit notes. 3. The agency's undated policy titled "Missed Visits," not numbered, states, "The procedure to follow for a missed visit is: Compete a "Missed Visit" Form ... Notification to the MD can be by telephone call or fax by the clinician who missed the visit or Director of Nursing or designee." 		<p>serviced on informing the physician office of any missed visitsNotification to the MD can be by telephone call or fax by the clinician who missed the visit or DON or designeeThe Missed Visit Policy will be reviewed with all clinical staff.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
--------------------	--	---------------	---	----------------------

G000172	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record review, policy review, and interview, the agency failed to ensure the nursing staff evaluated the patient's wound for 1 of 4 clinical records reviewed of patients receiving wound care, creating the potential to affect all the agency's patients. (#8)</p> <p>Findings include</p> <p>1. Clinical record #8, start of care date 8/29/14, contained a plan of care dated 8/29-10/27/14 with principal diagnosis of Pressure Ulcer, buttock, and orders for Skilled Nursing 3 times a week for 3 weeks, 2 times a week for 2 weeks, 1 time a week for 3 weeks, and 3 as needed visits if dressing becomes soiled or dislodged. The record failed to evidence the wound was measured the weeks of 9/14-9/20/14, and 9/28-10/4/14. The Skilled Nurse Visit Notes dated 9/15, 9/16, 9/18, 9/29, and 10/2/14 failed to evidence the wound was measured.</p> <p>2. During interview on 10/29/14 at 3:00 PM, employee A indicated wounds are to be measured weekly.</p> <p>6. The agency's undated policy titled "Wound Measurement," no number,</p>	G000172	The agency will ensure the nursing staff evaluates a patient's wound by documentation of wound measurements. The Wound Care Policy will be reviewed with nursing staff and reeducation on wound measurements will be performed.	12/07/2014
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
G000212	<p>states "Wounds are to be measured once per week, as well as admission, recertification, and resumption and discharge."</p> <p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. Based on employee file review, job description review, policy review, and interview, the agency failed to ensure home health aide (HHA) skills competencies were completed at date of hire (DOH) and before patient contact for 1 of 2 HHA files reviewed, creating the potential to affect all the agency's patients. (L and M)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Employee file M, a HHA, DOH 11/11/11 and first patient contact date 11/14/11, failed to evidence a skills competency was completed at DOH. 2. During interview on 10/29/14 at 9:00 AM, employee B indicated the HHA (employee M) has not been seeing patients for awhile due to schooling. 	G000212	The agency will utilize a skills competency check list for the HHAs. The check list will meet regulatory guidelines. All newly hired employees will have a skills competency check list prior to any patient contact. Current employee files will have a competency check list completed by 12/7/2014. All employees without a skills competency check list will not be allowed to complete patient care visits until the competency check list is completed. The agency will begin utilizing the Indiana Association for Home Health and Hospice Skills check list. The competency check list will be completed by the agency DON or her designee	12/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>3. The agency's job description titled "Certified Home Health Aide," states, "Demonstrates competency in the following areas: performs duties as assigned by case manager or DON as ordered by a physician, takes accurate vital signs as assigned, ensures that changes in the patient's clinical status are communicated/doc. to team, coordinates care planning and delivery with physician, pt., family and team member, assists the patient with ADL and personal care & shows techniques to increase indep. [independence], assists the patient with transfers, ambulation and bed mobility as necessary, helps with the assessment of the patient for durable medical equipment needs, performs all duties in a manner that optimizes patient safety and welfare, properly assesses pain and communicated with team regarding changes, educates the patient and the family regarding safety, ... adheres to agency policies, procedures & all government laws, regulations, and standards."</p> <p>4. The agency's undated policy titled "Employee Skills/Competency Evaluation," not numbered, states, "5. A Home Health Aide skills competency evaluation must be completed satisfactorily prior to patient care being performed. The competency must be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
G000340	<p>evaluated by a Registered Nurse with 1 year of home health care and 2 years of nursing experience. The Indiana Association for Home Care and Hospice Skills Check List will be used. ... Ongoing: ... 2. Annual skills competencies will be completed during the performance review period. 3. Skills competency will be documented and kept in the employee personnel file. ... Skills competency checklist shall include, but not be limited to: 1. Specific job responsibilities and skills."</p> <p>484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse (RN) completed an Outcome Assessment and Information Set (OASIS) Resumption of Care (ROC) assessment following the patient's hospitalization for 1 of 1 clinical record reviewed for a patient with a hospital stay with the potential to affect all the agency's patients who are</p>	G000340	The agency will ensure the clinical staff to be reeducated and in-serviced on correctly selecting the appropriate visit type to include the correct service code is used. Reeducation to clinical staff on OASIS timing will also be complete.	12/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/30/2014	
NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237			
(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			
N000000	<p>hospitalized. (#14)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record #14, start of care date 4/11/14, contained a plan of care dated 6/10-8/8/14. The record evidenced patient #14 was admitted to the hospital on 7/2/14 and discharge instructions from the hospital evidenced the patient was sent home on 7/4/14. The record failed to evidence the RN completed a ROC assessment within 48 hours of returning home. The RN did not visit the patient until 7/7/14. 2. During interview on 10/27/14 at 4:00 PM, employee A indicated there is not an OASIS ROC in the computer, only the follow up visit assessment on 7/7/14. 3. The agency's undated policy titled "OASIS Time Points," not numbered, states "OASIS data are collected at the following time points. .. Resumption of care following inpatient facility stay. ... At the resumption of care, the comprehensive assessment must be completed within 48 hours of return home after inpatient facility discharge." <p>This was a home health state licensure</p>	N000000					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
N000446	<p>survey.</p> <p>Survey Dates: October 27, 28, 29, and 30, 2014.</p> <p>Facility Number: IN011300</p> <p>Medicaid Number: 200848450</p> <p>Surveyors: Miriam Bennett, RN, BSN, PHNS Michelle Weiss, RN, MSN, PHNS</p> <p>Census Service Type: Skilled: 2152 Home Health Aide Only: 0 Personal Care Only: 0 Total: 2152</p> <p>Sample: RR w/HV: 9 RR w/o HV: 11 Total: 20</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 6, 2014</p> <p>410 IAC 17-12-1(c)(3) Home health agency administration/management</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following:</p> <p>(3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on employee file review, job description review, policy review, and interview, the administrator failed to ensure the agency checked skills competencies on date of hire (DOH) for 1 of 2 Home Health Aide (HHA) files reviewed (M), criminal background checks were completed within 3 days of starting patient care for 1 of 7 employee files reviewed (M), and the appropriate job description was signed by the licensed practical nurse (LPN) for 1 of 1 LPN file reviewed (F), creating the potential to affect all the agency's patients. (F and M)</p> <p>Findings include</p> <p>1. Employee file F, a LPN, date of hire (DOH) 2/25/14, contained a job description titled "Registered Nurse" and was signed on 2/7/14.</p> <p>During interview on 10/10/29/14 at 4:35 PM, employee B indicated the employee (F) is a LPN.</p>	N000446	<p>The administrator shall employ qualified personnel and ensure adequate staff education and evaluation by utilizing skills competencies checklist for HHAs. The checklist will meet regulatory guidelines. 100% of the employee files will be reviewed for completeness and compliance. 100% of all employee files will be reviewed for proper job description, Completion date 11/15/2014 It will be the responsibility of the Administrator / Executive assistant or office manager to ensure each file is complete. 100% of all current employee background checks will be reviewed to meet guidelines. All future employees hired will have the background check prior to starting any patient care. The agency will begin utilizing employee skills competency check list for all new hires. All current employee files will be reviewed and a skills competency check list will be initiated. All employees without a skills competency form completed will not be allowed to complete patient care visits until the skills competency evaluation is complete. The DON or designee</p>	11/15/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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. Employee file M, a HHA, DOH 11/11/11, and first patient contact date 11/14/11, failed to evidence a skills competency was completed at DOH and failed to evidence the criminal background check was completed until 11/25/11.</p> <p>During interview on 10/29/14 at 9:00 AM, employee B indicated the HHA (employee M) had not been seeing patients for awhile due to schooling.</p> <p>3. The agency's job description titled "Certified Home Health Aide," states, "Demonstrates competency in the following areas: performs duties as assigned by case manager or DON as ordered by a physician, takes accurate vital signs as assigned, ensures that changes in the patient's clinical status are communicated/doc. to team, coordinates care planning and delivery with physician, pt., family and team member, assists the patient with ADL and personal care & shows techniques to increase indep. [independence], assists the patient with transfers, ambulation and bed mobility as necessary, helps with the assessment of the patient for durable medical equipment needs, performs all duties in a manner that optimizes patient safety and welfare, properly assesses pain and communicated with team regarding</p>		will be responsible for completion of skills competency check list.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>changes, educates the patient and the family regarding safety, ... adheres to agency policies, procedures & all government laws, regulations, and standards."</p> <p>4. The agency's undated policy titled "Employee Skills/Competency Evaluation," not numbered, states, "5. A Home Health Aide skills competency evaluation must be completed satisfactorily prior to patient care being performed. The competency must be evaluated by a Registered Nurse with 1 year of home health care and 2 years of nursing experience. The Indiana Association for Home Care and Hospice Skills Check List will be used. ... Ongoing: ... 2. Annual skills competencies will be completed during the performance review period. 3. Skills competency will be documented and kept in the employee personnel file. ... Skills competency checklist shall include, but not be limited to: 1. Specific job responsibilities and skills."</p> <p>5. The agency's undated policy titled "Criminal Background Check/National Sexual Offense Registry Check," not numbered, states, "Procedure: A. The agency will apply, not more than three (3) business days after the date that the employee begins to provide services for a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
N000470	<p>copy of the employee's limited criminal history from the Indiana central repository for criminal history information under IC 10-13-3."</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 observation, policy review, and interview, the agency failed to ensure all staff followed infection control guidelines for 2 of 10 home visit observations creating the potential to affect all the agency's patients. (#1 and 2)</p> <p>Findings include</p> <p>1. During home visit observation with patient #1 on 10/28/14 at 9:45 AM, employee H, a registered nurse, placed nursing bag on chair in patients home. Employee H failed to place a barrier</p>	N000470	Infection control guidelines will be met by staff in-service and reeducation within 30 days. Reeducation of the policy will be reviewed by staff. in-service will include infection control guidelines, including but not limited to bag technique and hand washing.	12/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>under the nursing bag.</p> <p>2. During home visit observation with patient #2 on 10/28/14 at 11:30 AM, employee F, a licensed practical nurse, was observed assessing the patient's vital signs. After cleaning the equipment used, employee F removed their gloves and donned a new pair of gloves. Employee F failed to use hand gel or wash hands in between glove change.</p> <p>3. During interview on 10/28/14 at 4:35 PM, employee B indicated the policy is to place the nursing bag on a barrier or hang it on a door. Employee B also indicated employees should wash hands or use hand gel in between glove changes.</p> <p>4. The agency's undated policy titled "Clinician Bag," # N-120, states "When in a client's home, place the bag on a clean and dry surface."</p> <p>5. The agency's undated policy titled "Infection Control and Infectious Waste Standards," no number, states "1. Wash hands thoroughly before and after contact with the patient/client, and after removing gloves."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure home health aide (HHA) services were provided as ordered and failed to inform the physician of the missed visit for 1 of 5 records reviewed of patients receiving HHA services, creating the potential to affect all the agency's patients. (#14)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record #14, start of care date 4/11/14, contained a plan of care dated 6/10-8/8/14 with orders for HHA 2 times a week for 8 weeks to begin 6/15/14. The record failed to evidence a HHA visit was provided the week of 6/29-7/5/14. The record also failed to evidence a missed visit note. 2. During interview on 10/27/14 at 4:20 PM, employee B indicated the aide did not make a visit the week of 6/29-7/5 and there are no missed visit notes. 3. The agency's undated policy titled "Missed Visits," not numbered, states, 	N000522	Missed visit policy to be reviewed with clinical staff. Management will ensure clinicians are aware to indicate a missed visit and communicate with physician office.	11/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
N000541	<p>"The procedure to follow for a missed visit is: Compete a "Missed Visit" Form ... Notification to the MD can be by telephone call or fax by the clinician who missed the visit or Director of Nursing or designee."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse (RN) reevaluated the patient's needs after returning home from a hospitalization for 1 of 1 clinical record reviewed for a patient with a hospital stay with the potential to affect all the agency's patients who are hospitalized. (#14)</p> <p>Findings include</p> <p>1. Clinical record #14, start of care date 4/11/14, contained a plan of care dated 6/10-8/8/14. The record evidenced patient #14 was admitted to the hospital on 7/2/14 and discharge instructions from the hospital evidenced the patient was sent home on 7/4/14. The record failed</p>	N000541	Management to reeducate clinical staff on correctly selecting the appropriate visit type to ensure the correct service code is used. Education with clinical staff on OASIS timing. Policy to also be reviewed with clinical staff.	12/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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
N000596	<p>to evidence the RN reassessed the patient's needs within 48 hours of returning home. The RN did not visit the patient until 7/7/14.</p> <p>2. During interview on 10/27/14 at 4:00 PM, employee A indicated there is not an assessment after a hospitalization in the computer, only the follow up visit assessment on 7/7/14.</p> <p>3. The agency's undated policy titled "OASIS Time Points," not numbered, states "OASIS data are collected at the following time points. ... Resumption of care following inpatient facility stay. ... At the resumption of care, the comprehensive assessment must be completed within 48 hours of return home after inpatient facility discharge."</p> <p>410 IAC 17-14-1(I)(A) Scope of Services Rule 14 Sec. 1(I) 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 Based on employee file review, job</p>	N000596	Agency will begin utilizing	12/07/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>description review, policy review, and interview, the agency failed to ensure home health aide (HHA) skills competencies were completed at date of hire (DOH) and before patient contact for 1 of 2 HHA files reviewed, creating the potential to affect all the agency's patients. (L and M)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Employee file M, a HHA, DOH 11/11/11 and first patient contact date 11/14/11, failed to evidence a skills competency was completed at DOH. 2. During interview on 10/29/14 at 9:00 AM, employee B indicated the HHA (employee M) has not been seeing patients for awhile due to schooling. 3. The agency's job description titled "Certified Home Health Aide," states, "Demonstrates competency in the following areas: performs duties as assigned by case manager or DON as ordered by a physician, takes accurate vital signs as assigned, ensures that changes in the patient's clinical status are communicated/doc. to team, coordinates care planning and delivery with physician, pt., family and team member, assists the patient with ADL and personal care & shows techniques to increase 		<p>employee skills competency evaluation for all new hires. Current employee files will have a skills competency check list completed. All employees without skills competency check list completed will not be allowed to complete patient care until the check list is complete.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237
---	--

(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>indep. [independence], assists the patient with transfers, ambulation and bed mobility as necessary, helps with the assessment of the patient for durable medical equipment needs, performs all duties in a manner that optimizes patient safety and welfare, properly assesses pain and communicated with team regarding changes, educates the patient and the family regarding safety, ... adheres to agency policies, procedures & all government laws, regulations, and standards."</p> <p>4. The agency's undated policy titled "Employee Skills/Competency Evaluation," not numbered, states, "5. A Home Health Aide skills competency evaluation must be completed satisfactorily prior to patient care being performed. The competency must be evaluated by a Registered Nurse with 1 year of home health care and 2 years of nursing experience. The Indiana Association for Home Care and Hospice Skills Check List will be used. ... Ongoing: ... 2. Annual skills competencies will be completed during the performance review period. 3. Skills competency will be documented and kept in the employee personnel file. ... Skills competency checklist shall include, but not be limited to: 1. Specific job responsibilities and skills."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157585	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/30/2014
NAME OF PROVIDER OR SUPPLIER ALPHA HOME PHYSICAL THERAPY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4455 SOUTHPORT CROSSING WAY INDIANAPOLIS, IN 46237		
(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	