

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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 federal home health recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 6-10-13, 6-11-13, and 6-12-13.</p> <p>Facility #: 009556</p> <p>Medicaid Vendor #: 200130650A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census: 101 skilled patients 19 home health aide only 0 personal services patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>June 17, 2013</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:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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><b>484.12(c)</b> <b>COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> 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, interview, and review of agency policy, the agency failed to ensure staff provided services in accordance with the agency's infection control policies and procedures and the Centers for Disease Control (CDC) Standard Precautions in 3 (#s 4 and 5) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among staff and the agency's 120 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's undated "Infection Control" policy states, "Universal Precautions shall be practiced at all times to reduce the risk in the event of exposure to infectious disease. Universal Precautions must be consistently used for all activities involving contact with blood, tissue and body fluids or equipment or materials which may have been contaminated by these substances."</li> <li>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand</li> </ol>	G000121	<p>G121 The Agency's Infection Control policy was up-dated to include Standard Precautions in addition to Universal Precautions following the CDC recommended Standard Precautions. The Hand Hygiene policy and procedure was also updated to reflect Standard Precautions. The Administrator has in-serviced agency personnel on July 1 and 2, 2013. The Case Manager I/ DON will be making 2 random home visits per month. These will be made during staff scheduled visits, to observe that home care staff is using Standard Precautions and proper hand hygiene per agency policy and procedures. This will also be checked annually at their evaluation time. The Administrator will be responsible for monitoring the corrective actions to ensure that the deficiency is corrected.</p>	07/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>Hygiene. IV.A.1. 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 from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. Employee E, a home health aide, was observed to provide a bed bath to patient number 1 during a home visit on 6-12-13 at 9:40 AM central time (CT).</p> <p>A. The aide was observed to wash her hands, take the patient's vital signs, and prepare the bath water. The aide donned clean gloves without cleansing her hands. The aide was observed to assist the patient to bathe the upper body. The aide assisted the patient to don a clean gown and proceeded to wash the patient's groin, perineal area, penis, and testicles. The aide provided catheter care to the patient's indwelling urinary catheter. After completing the catheter care, the aide continued the bath by washing the patient's lower extremities. The aide did obtain a clean washcloth but failed to change her gloves after providing care to the patient's perineal area.</p> <p>B. Still wearing the same gloves, the aide assisted the patient to turn to the left side and washed the patient's back and applied lotion. A small amount of feces was observed around the patient's rectal area and on the pad under the patient. The aide cleansed this area with wipes</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(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>and, without changing her gloves, applied lotion to the area. The aide then changed her gloves without cleansing her hands.</p> <p>C. The aide assisted the patient to turn to the right side. Observation again noted a small amount of feces around the rectal area. The aide cleansed the area again and, without cleansing her hands, assisted the patient to roll to the back. The aide then emptied the bath water and placed the trash into the trash container. The aide removed her gloves but failed to cleanse her hands. The aide placed the patient's bedside table within reach and obtained oral care supplies. The aide donned clean gloves without cleansing her hands and removed the oral care supplies from the patient. The aide removed her gloves and cleansed her hands.</p> <p>4. Employee G, a registered nurse (RN), was observed to perform a dressing change on patient number 2 during a home visit on 6-12-13 at 11:45 AM, CT.</p> <p>A. The RN was observed to take the patient's vital signs and listen to the patient's lungs and abdomen. The RN was observed to remove a thermometer from the patient's mouth and take a radial pulse. The RN prepared the dressing change supplies obtaining the supplies</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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 a bag kept in the patient's home. The RN then donned clean gloves without cleansing her hands.</p> <p>B. The RN was observed to remove a small dressing from the patient's posterior right leg and cleanse the wound. The RN removed her gloves, cleansed her hands, and donned clean gloves. The RN cut the foam and telfa to size and applied the clean dressing. The RN gathered the trash and disposed of it. The RN removed her gloves and, without cleansing her hands, charted on the nurse's note. The RN then put away the supplies and washed her hands.</p> <p>5. The above-stated observations were discussed with the agency's alternate administrator, employee F, and the alternate supervising nurse, employee H, on 6-12-13 at 1:15 PM, CT. The employees indicated the aide and the RN had not provided services in accordance with the agency's infection control policy.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(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>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.</p> <p>Based on clinical record review and interview, the agency failed to ensure the home health aide had provided services as ordered by the physician in 1 (# 1) of 3 records reviewed of patients that received home health aide services creating the potential to affect all of the agency's patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 4-30-13 to 6-28-13. The plan of care states, "Home Health Aide 2 visits per week [for 1 week] and 3 visits per week for 7 weeks . . . partial / complete bed bath, catheter care."</p> <p>"Home Health Aide Activity Notes", dated 5-1-13, 5-3-13, 5-6-13, 5-8-13, 5-10-13, 5-13-13, 5-15-13, 5-17-13, 5-20-13, 5-22-13, 5-24-13, 5-29-13, and 5-31-13, failed to evidence the home health aide had completed the catheter care.</p>	G000158	G 0158 The Administrator reviewed the process of the 485 POC orders following it through to the Home Health Aide patients Aide care plan, then following thru to the Aide Activity note. The Home Health Aide and Case Managers were in-serviced by the Administrator on July 1 and 2, 2013 that they are to review and follow Doctor orders and care plans for each individual patient. The Home Health Aide activity notes will be checked weekly by the DON/Case Manager for following Doctor orders and care plans. This will also be checked during the Clinical Record Review on a quarterly basis. The DON and QA will be responsible for monitoring these corrective actions.	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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
	2. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(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			
G000161	<p><b>484.18(a)</b> <b>PLAN OF CARE</b> Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on clinical record and agency policy review, interview, and observation, the agency failed to ensure orders for therapy services included the modalities to be used in 1 (# 3) of 5 records reviewed of patients that received therapy services creating the potential to affect all of the agency's patients that receive therapy services.</p> <p>The findings include:</p> <p>1. A home visit was made to patient number 3 on 6-11-13 at 9:05 AM, Central Time (CT) with employee I, a speech language pathologist (SLP). The SLP was observed to apply an electrical stimulation device (Vital Stim) to the patient's bilateral cheeks.</p> <p>A. The orders for the SLP services, found on the "Speech Therapy Evaluation &amp; Plan of Care" dated 4-26-13, failed to include the use of the electrical stimulation therapy.</p> <p>B. An interim order dated 6-6-13 states, "Speech therapist to use NMES [unknown] with treatments." The order</p>	G000161	G161 The Human Resource Manager and the DON in-serviced the SLP on the components needed when writing Doctor orders and reviewed the process of orders to the physician and to the agency. The communication of the orders to the agency and patient was also reviewed. The orientation process was reviewed for all contracted therapy personnel and updated to include the doctor orders During the Quarterly Record Review 2% of therapy records will be monitored for evidence of proper Doctor order components and Physician Plan of Care orders reflect the patient's treatments. The Human Resource Director and the Quality Assurance nurse will be monitoring this corrective action.	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>failed to evidence the settings to be used, the placement of the therapy, and the length of time the therapy was to be used.</p> <p>2. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.</p> <p>3. The agency's 11-1-10 "Physician's Plan of Treatment/Change Orders" policy states, "The nurse and appropriate agency personnel shall participate in the development of the plan, which shall include: . . . Orders for treatments and treatment modalities."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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
G000179	<p><b>484.30(b)</b> <b>DUTIES OF THE LICENSED PRACTICAL NURSE</b> The licensed practical nurse furnishes services in accordance with agency policy. Based on clinical record and agency policy review and interview, the agency failed to ensure the licensed practical nurse (LPN) had followed the agency's own LPN standards of practice in 3 (#s 2, 7, and 9) of 10 records reviewed creating the potential to affect all of the agency's patients that receive LPN services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's undated "LPN Practice Standards" policy states, "Can contact physician independently, but under the direction of the RN manager to report patient conditions, change of status, etc."</li> <li>2. Clinical record number 2 evidenced a "Communication Log", signed and dated by employee K, an LPN, on 6-7-13. The note states, "Have left message on [name of physician] for him to contact patient with results of lab work." The record failed to evidence the LPN had consulted with the supervising registered nurse (RN).</li> <li>3. Clinical record number 7 evidenced a "Communication Log" signed and dated by employee K, an LPN, on 12-12-12.</li> </ol>	G000179	G179 The Administrator in-serviced the nursing staff that communication and direction of the RN Case Manager for physician contact by the LPN must be documented in the patient's chart either in the visit note or in a communication note when directed to contact the patient's physician. During the Quarterly Record Review 10% of the records will be reviewed for evidence of this documentation. This will be monitored by the DON and the Quality Assurance Nurse.	07/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The note evidenced the LPN had contacted the physician regarding medication dosages. The record failed to evidence the LPN had consulted with the supervising RN.</p> <p>4. Clinical record number 9 evidenced a "Communication Log" signed and dated by employee K, an LPN on 1-17-13. The note evidenced the LPN had reported to the physician that the patient had fallen. The record failed to evidence the LPN had consulted with the supervising RN.</p> <p>5. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(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			
G000224	<p>484.36(c)(1) ASSIGNMENT &amp; DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on clinical record review and interview, the agency failed to ensure written home health aide instructions included services ordered by the physician on the plan of care in 1 (# 1) of 3 records reviewed of patients that received home health aide services creating the potential to affect all of the agency's patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 4-30-13 to 6-28-13 that states, "Home Health Aide 2 visits per week [for 1 week] and 3 visits per week for 7 weeks . . . partial/complete bed bath, catheter care."</p> <p>The record evidenced written instructions for the home health aide prepared by employee J, a registered nurse, on 4-7-13. The instructions failed to include catheter care as ordered by the physician on the plan of care.</p>	G000224	G224 The Administrator in-serviced Nursing personnel to first make sure Doctor orders for all disciplines are included on all the care plans for the patient. That duties ordered by the physician for the Home Health Aide to do are included on the Home Health Aide care plan for each individual patient and the Home Health aide follows these orders and documents the care on their activity note for that patient. Evidence of this will be reviewed during the Quarterly Medical Record review on 10% of the records in which 2% will have Home Health Aide services. This will also be reviewed by the Case Managers when re certifying care for patients with Home Health Aide services. This will be monitored by the DON and the Quality Assurance Nurse.	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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	
	2. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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	
G000331	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on clinical record review and interview, the agency failed to ensure the initial assessment was complete and identified care and support needs in 1 (# 8) of 10 records reviewed creating the potential to affect all of the agency's future patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 8 included an initial assessment completed by the registered nurse (RN), employee H, on 11-26-12. The assessment states, "Has had surgery to have pancreas removed due to mass . . . has had Type I diabetes for ten years and has many exacerbations of hypo [low] and hyperglycemia [high blood sugar] . . . has blurred vision at times. Has neuropathy pain in legs freq [frequently]."</li> </ol> <p>A. The record evidenced a plan of care for the certification period 11-26-12 to 1-24-13 that includes an order for Glucagon 1 milligram "as needed, injection, reason: low blood sugar, not</p>	G000331	G331 The Administrator has in-serviced the Nursing staff on the importance of assessing and identifying all patient care needs and needed supports are identified during the initial assessment and that these are documented in the patient's record. Evidence of this will be monitored during the Quarterly Record review in which 10% of the records reviewed will be monitored since an RN opens all cases for admission to the agency. This will be monitored by the DON and the Quality Assurance nurse.	07/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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>relieved by food or pt [patient] unable to swallow." (Glucagon is an injectable drug used to raise blood sugar values in severe low blood sugar exacerbations.)</p> <p>B. The initial assessment failed to evidence the RN had assessed if the patient used any method to check the blood sugar, how often, what the readings were, the latest episode of either hypo- or hyperglycemia, how the episodes were addressed/resolved, etc.</p> <p>C. The record included a discharge comprehensive assessment dated 12-18-12 that evidenced the patient had utilized a hospital emergency department since the start of care for emergent care for hypo/hyperglycemia without hospital admission.</p> <p>2. Employee H, the RN, stated, on 6-12-13 at 1:30 PM, Central Time, "I did ask about the blood sugar readings. I just did not document it in the assessment."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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
G000339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record review and interview, the agency failed to ensure comprehensive assessments had been updated the last 5 days of every 60 day period in 3 (#s 1, 7, and 9) of 5 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency' patients receiving services longer than 60 days.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 1 evidenced a start of care date of 11-1-12 and that the physician had ordered services be continued for every certification period thereafter. The record failed to evidence the comprehensive assessment had been updated the last 5 days of the 11-1-12 to 12-30-12 and 12-31-12 to 2-28-13 sixty day recertification periods.</li> <li>2. Clinical record number 7 evidenced a</li> </ol>	G000339	G0339 The Administrator in-serviced the nursing and therapy personnel that OASIS assessments have to be done the last 4 days of the 60 day certification period by the RN or therapist. Unless the beneficiary elected transfer or significant change in condition resulting in a new case mix assessment or discharge. The DON will be reviewing nursing schedules weekly for needed OASIS visits to assure they are done in a timely basis. Also during the Quarterly Record Review 3% of the 10% of records reviewed will be checked for evidence of the timeliness of the OASIS completion.,This will be monitored by the DON and the Quality Assurance Nurse.	07/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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>start of care date of 1-19-12 and that the physician had ordered services be continued through 1-12-13, at which time the patient was discharged. The record failed to evidence the comprehensive assessment had been updated the last 5 days of the 3-19-12 to 5-17-12 sixty day recertification period.</p> <p>3. Clinical record number 9 evidenced a start of care date of 1-17-13 and that the physician had ordered services be continued for every certification period thereafter. The record failed to evidence the comprehensive assessment had been updated the last 5 days of the 1-17-13 to 3-17-13 sixty day recertification period.</p> <p>4. The above-stated observations were discussed with the agency's alternate administrator, employee F, and the alternate supervising nurse, employee H, on 6-12-13 at 1:15 PM, CT. The alternate administrator indicated the reasons were possibly related to new employees and computer issues.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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>This was a State home health relicensure survey.</p> <p>Survey Dates: 6-10-13, 6-11-13, and 6-12-13.</p> <p>Facility #: 009556</p> <p>Medicaid Vendor #: 200130650A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency census: 101 skilled patients 19 home health aide only 0 personal services patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>June 17, 2013</p>	N000000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>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, interview, and review of agency policy, the agency failed to ensure staff provided services in accordance with the agency's infection control policies and procedures and the Centers for Disease Control (CDC) Standard Precautions in 3 (#s 4 and 5) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among staff and the agency's 120 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's undated "Infection Control" policy states, "Universal Precautions shall be practiced at all times to reduce the risk in the event of exposure to infectious disease. Universal Precautions must be consistently used for all activities involving contact with blood, tissue and body fluids or equipment or materials which may have been contaminated by these substances."</li> <li>2. The Centers for Disease Control "Standards Precautions" states, "IV.</li> </ol>	N000470	<p>N0470 The Agency's Infection Control policy was up-dated to include Standard Precautions in addition to Universal Precautions following the CDC recommended Standard Precautions. The Hand Hygiene policy and procedure was also updated to reflect Standard Precautions. The Administrator has in-serviced agency personnel on July 1 and 2, 2013. The Case Manager I/ DON will be making 2 random home visits per month. These will be made during staff scheduled visits, to observe that home care staff is using Standard Precautions and proper hand hygiene per agency policy and procedures. This will also be checked annually at their evaluation time. The Administrator will be responsible for monitoring the corrective actions to ensure that the deficiency is corrected.</p>	07/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. 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 from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. Employee E, a home health aide, was observed to provide a bed bath to patient number 1 during a home visit on 6-12-13 at 9:40 AM central time (CT).</p> <p>A. The aide was observed to wash her hands, take the patient's vital signs, and prepare the bath water. The aide donned clean gloves without cleansing her hands. The aide was observed to assist the patient to bathe the upper body. The aide assisted the patient to don a clean gown and proceeded to wash the patient's groin, perineal area, penis, and testicles. The aide provided catheter care to the patient's indwelling urinary catheter. After completing the catheter care, the aide continued the bath by washing the patient's lower extremities. The aide did obtain a clean washcloth but failed to change her gloves after providing care to the patient's perineal area.</p> <p>B. Still wearing the same gloves, the aide assisted the patient to turn to the left side and washed the patient's back and applied lotion. A small amount of feces was observed around the patient's rectal area and on the pad under the patient.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The aide cleansed this area with wipes and, without changing her gloves, applied lotion to the area. The aide then changed her gloves without cleansing her hands.</p> <p>C. The aide assisted the patient to turn to the right side. Observation again noted a small amount of feces around the rectal area. The aide cleansed the area again and, without cleansing her hands, assisted the patient to roll to the back. The aide then emptied the bath water and placed the trash into the trash container. The aide removed her gloves but failed to cleanse her hands. The aide placed the patient's bedside table within reach and obtained oral care supplies. The aide donned clean gloves without cleansing her hands and removed the oral care supplies from the patient. The aide removed her gloves and cleansed her hands.</p> <p>4. Employee G, a registered nurse (RN), was observed to perform a dressing change on patient number 2 during a home visit on 6-12-13 at 11:45 AM, CT.</p> <p>A. The RN was observed to take the patient's vital signs and listen to the patient's lungs and abdomen. The RN was observed to remove a thermometer from the patient's mouth and take a radial pulse. The RN prepared the dressing</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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>change supplies obtaining the supplies from a bag kept in the patient's home. The RN then donned clean gloves without cleansing her hands.</p> <p>B. The RN was observed to remove a small dressing from the patient's posterior right leg and cleanse the wound. The RN removed her gloves, cleansed her hands, and donned clean gloves. The RN cut the foam and telfa to size and applied the clean dressing. The RN gathered the trash and disposed of it. The RN removed her gloves and, without cleansing her hands, charted on the nurse's note. The RN then put away the supplies and washed her hands.</p> <p>5. The above-stated observations were discussed with the agency's alternate administrator, employee F, and the alternate supervising nurse, employee H, on 6-12-13 at 1:15 PM, CT. The employees indicated the aide and the RN had not provided services in accordance with the agency's infection control policy.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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 and interview, the agency failed to ensure the home health aide had provided services as ordered by the physician in 1 (# 1) of 3 records reviewed of patients that received home health aide services creating the potential to affect all of the agency's patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 4-30-13 to 6-28-13. The plan of care states, "Home Health Aide 2 visits per week [for 1 week] and 3 visits per week for 7 weeks . . . partial / complete bed bath, catheter care."</p> <p>"Home Health Aide Activity Notes", dated 5-1-13, 5-3-13, 5-6-13, 5-8-13, 5-10-13, 5-13-13, 5-15-13, 5-17-13, 5-20-13, 5-22-13, 5-24-13, 5-29-13, and 5-31-13, failed to evidence the home health aide had completed the catheter care.</p>	N000522	N 0522 The Administrator reviewed the process of the 485 POC orders following it through to the Home Health Aide patients Aide care plan, then following thru to the Aide Activity note. The Home Health Aide and Case Managers were in-serviced by the Administrator on July 1 and 2, 2013 that they are to review and follow Doctor orders and care plans for each individual patient. The Home Health Aide activity notes will be checked weekly by the DON/Case Manager for following Doctor orders and care plans. This will also be checked during the Clinical Record Review on a quarterly basis. The DON and Quality Assurance will be responsible for monitoring these corrective actions.	07/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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	
	2. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(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			
N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record and agency policy review, interview, and observation, the agency failed to ensure orders for therapy services included the modalities to be used in 1 (# 3) of 5 records reviewed of patients that received therapy services creating the potential to affect all of the agency's patients that receive therapy services.</p> <p>The findings include:</p>	N000524	N 0524 The Human Resource Manager and the DON in-serviced the SLP on the components needed when writing Doctor orders and reviewed the process of orders to the physician and to the agency. The communication of the orders to the agency and patient was also reviewed. The orientation process was reviewed for all contracted therapy personnel and updated to include the doctor orders During the Quarterly Record Review 2% of therapy	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>1. A home visit was made to patient number 3 on 6-11-13 at 9:05 AM, Central Time (CT) with employee I, a speech language pathologist (SLP). The SLP was observed to apply an electrical stimulation device (Vital Stim) to the patient's bilateral cheeks.</p> <p>A. The orders for the SLP services, found on the "Speech Therapy Evaluation &amp; Plan of Care" dated 4-26-13, failed to include the use of the electrical stimulation therapy.</p> <p>B. An interim order dated 6-6-13 states, "Speech therapist to use NMES [unknown] with treatments." The order failed to evidence the settings to be used, the placement of the therapy, and the length of time the therapy was to be used.</p> <p>2. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.</p> <p>3. The agency's 11-1-10 "Physician's Plan of Treatment/Change Orders" policy states, "The nurse and appropriate agency personnel shall participate in the development of the plan, which shall include: . . . Orders for treatments and</p>		<p>records will be monitored for evidence of proper Doctor order components and Physician Plan of Care orders reflect the patient's treatments. The Human Resource Director and the Quality Assurance nurse will be monitoring this corrective action.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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	
	treatment modalities."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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	
N000540	<p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on clinical record review and interview, the agency failed to ensure the initial assessment was complete and identified care and support needs in 1 (# 8) of 10 records reviewed creating the potential to affect all of the agency's future patients.</p> <p>The findings include:</p> <p>1. Clinical record number 8 included an initial assessment completed by the registered nurse (RN), employee H, on 11-26-12. The assessment states, "Has had surgery to have pancreas removed due to mass . . . has had Type I diabetes for ten years and has many exacerbations of hypo [low] and hyperglycemia [high blood sugar] . . . has blurred vision at times. Has neuropathy pain in legs freq [frequently]."</p> <p>A. The record evidenced a plan of care for the certification period 11-26-12 to 1-24-13 that includes an order for Glucagon 1 milligram "as needed, injection, reason: low blood sugar, not</p>	N000540	N 0540 The Administrator has in-serviced the Nursing staff on the importance of assessing and identifying all patient care needs and needed supports are identified during the initial assessment and that these are documented in the patient's record. Evidence of this will be monitored during the Quarterly Record review in which 10% of the records reviewed will be monitored since an RN opens all cases for admission to the agency. This will be monitored by the DON and the Quality Assurance nurse.	07/05/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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>relieved by food or pt [patient] unable to swallow." (Glucagon is an injectable drug used to raise blood sugar values in severe low blood sugar exacerbations.)</p> <p>B. The initial assessment failed to evidence the RN had assessed if the patient used any method to check the blood sugar, how often, what the readings were, the latest episode of either hypo- or hyperglycemia, how the episodes were addressed/resolved, etc.</p> <p>C. The record included a discharge comprehensive assessment dated 12-18-12 that evidenced the patient had utilized a hospital emergency department since the start of care for emergent care for hypo/hyperglycemia without hospital admission.</p> <p>2. Employee H, the RN, stated, on 6-12-13 at 1:30 PM, Central Time, "I did ask about the blood sugar readings. I just did not document it in the assessment."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(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			
N000550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review and interview, the agency failed to ensure written home health aide instructions included services ordered by the physician on the plan of care in 1 (# 1) of 3 records reviewed of patients that received home health aide services creating the potential to affect all of the agency's patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a plan of care established by the physician for the certification period 4-30-13 to 6-28-13 that states, "Home Health Aide 2 visits per week [for 1 week] and 3 visits per week for 7 weeks . . . partial/complete bed bath, catheter care."</p> <p>The record evidenced written instructions for the home health aide prepared by employee J, a registered nurse, on 4-7-13. The instructions failed to include catheter care as ordered by the physician on the plan of care.</p>	N000550	N 0550 The Administrator reviewed the process of the 485 POC orders following it through to the Home Health Aide patients Aide care plan, then following thru to the Aide Activity note. The Home Health Aide and Case Managers were in-serviced by the Administrator on July 1 and 2, 2013 that they are to review and follow Doctor orders and care plans for each individual patient. The Home Health Aide activity notes will be checked weekly by the DON/Case Manager for following Doctor orders and care plans. This will also be checked during the Clinical Record Review on a quarterly basis. The DON and QA will be responsible for monitoring these corrective actions.	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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
	2. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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
N000553	<p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies. Based on clinical record and agency policy review and interview, the agency failed to ensure the licensed practical nurse (LPN) had followed the agency's own LPN standards of practice in 3 (#s 2, 7, and 9) of 10 records reviewed creating the potential to affect all of the agency's patients that receive LPN services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's undated "LPN Practice Standards" policy states, "Can contact physician independently, but under the direction of the RN manager to report patient conditions, change of status, etc."</li> <li>2. Clinical record number 2 evidenced a "Communication Log", signed and dated by employee K, an LPN, on 6-7-13. The note states, "Have left message on [name of physician] for him to contact patient with results of lab work." The record failed to evidence the LPN had consulted with the supervising registered nurse (RN).</li> </ol>	N000553	N 0553 The Administrator in-serviced the nursing staff that communication and direction of the RN Case Manager for physician contact by the LPN must be documented in the patient's chart either in the visit note or in a communication note when directed to contact the patient's physician. During the Quarterly Record Review 10% of the records will be reviewed for evidence of this documentation. This will be monitored by the DON and the Quality Assurance Nurse.	07/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512
---	--

(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. Clinical record number 7 evidenced a "Communication Log" signed and dated by employee K, an LPN, on 12-12-12. The note evidenced the LPN had contacted the physician regarding medication dosages. The record failed to evidence the LPN had consulted with the supervising RN.</p> <p>4. Clinical record number 9 evidenced a "Communication Log" signed and dated by employee K, an LPN on 1-17-13. The note evidenced the LPN had reported to the physician that the patient had fallen. The record failed to evidence the LPN had consulted with the supervising RN.</p> <p>5. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013	
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512			
(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			
N000559	<p>410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse. Based on clinical record and agency policy review and interview, the agency failed to ensure the licensed practical nurse (LPN) had followed the agency's own LPN standards of practice in 3 (#s 2, 7, and 9) of 10 records reviewed creating the potential to affect all of the agency's patients that receive LPN services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The agency's undated "LPN Practice Standards" policy states, "Can contact physician independently, but under the direction of the RN manager to report patient conditions, change of status, etc."</li> <li>2. Clinical record number 2 evidenced a "Communication Log", signed and dated by employee K, an LPN, on 6-7-13. The note states, "Have left message on [name of physician] for him to contact patient with results of lab work." The record failed to evidence the LPN had consulted with the supervising registered nurse</li> </ol>	N000559	N 0559 The Administrator in-serviced the nursing staff that communication and direction of the RN Case Manager for physician contact by the LPN must be documented in the patient's chart either in the visit note or in a communication note when directed to contact the patient's physician. During the Quarterly Record Review 10% of the records will be reviewed for evidence of this documentation. This will be monitored by the DON and the Quality Assurance Nurse.	07/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/12/2013
NAME OF PROVIDER OR SUPPLIER  GUARDIAN ANGEL HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 11617 E SR 67 PO BOX 95 BICKNELL, IN 47512		
(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>(RN).</p> <p>3. Clinical record number 7 evidenced a "Communication Log" signed and dated by employee K, an LPN, on 12-12-12. The note evidenced the LPN had contacted the physician regarding medication dosages. The record failed to evidence the LPN had consulted with the supervising RN.</p> <p>4. Clinical record number 9 evidenced a "Communication Log" signed and dated by employee K, an LPN on 1-17-13. The note evidenced the LPN had reported to the physician that the patient had fallen. The record failed to evidence the LPN had consulted with the supervising RN.</p> <p>5. The alternate administrator, employee F, and the alternate supervising nurse, employee H, were unable to provide any additional documentation and/or information when asked on on 6-12-13 at 1:15 PM, CT.</p>				