

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 N MERIDIAN ST STE 700 INDIANAPOLIS, IN 46204
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G000000	<p>This visit was a Home Health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: October 28 - November 1, 2013 Partial Extended Survey Dates: October 30 - November 1, 2013</p> <p>Facility Number: 005333</p> <p>Medicaid Number: 200120720A</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor Janet Brandt, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 4,111 Home Health Aide Only: 6 Personal Care Only: 0 Total: 4,117</p> <p>Sample: RR w/HV: 10 RR w/o HV: 10 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.

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G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on policy and document review, observation, and interview, the agency failed to ensure staff followed infection control policies and procedures during 4 of 10 home visits with the potential to affect all the patients seen by the agency. (#6, #7, #8 and #9)</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "Standards Precautions" states, "IV. 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 . . . 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</p>	G000121	In regards to G121 Infection Control Policies IC 1.04, IC 1.14 and Central Venous Access Device: Tunneled and Non-Tunneled Insertion, Assessment and Management IV 1.01 and Clean Technique IC.102 were reviewed by the Infection Prevention for appropriateness in Home Health Care. No changes were necessary. All staff will be educated specifically in regards to Hand Hygiene, Clean Technique and RN's will do education on Central Venous Catheter Dressing Changes. Education will consist of CDC hand hygiene video, PowerPoint for CVC dressing change and a PowerPoint on Infection Control prior to December 1, 2013. A quiz will be used to assess understanding of infection control. Home Health Aides will receive education on "Assisting with ADLs and Bathing". A quiz will assess the knowledge level of the aides. Home Health Care will be adding a barrier to their home care bags to use during home visits. Prior to December 15, 2013, all supervisors and managers will have completed training and be validated to complete the quarterly	12/01/2013	

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	<p>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 contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. The policy titled "Clean Technique" policy number IC.102 with an approval/effective date of 01/97 states, "Use barriers as necessary to cover work surfaces to prevent cross contamination."</p> <p>3. The policy titled "Hand Hygiene" policy number IC 1.14 with an effective date of 12/10 states, "4. Perform hand hygiene after contact with intact skin ... 5.</p>		<p>observations. IU Health Home Health Care covers a significant portion of Central Indiana with branches in Muncie, Lafayette, and Tipton as well as Indianapolis. Quarterly monitoring beginning 1st quarter of 2014 will consist of observations of all staff by Home Health Care management team. Hand hygiene, clean technique and CVC dressing changes observations of all staff will be completed for 2 quarters, repeated every 6 months for a year with results shared at management meetings and reviewed at the quarterly Infection Control Committee meeting for review and follow up. Thereafter, observations will be completed during the annual supervisor rounds. Any staff that fails to meet observation guidelines will receive individual remediation and a subsequent observation the following quarter. All staff must complete their mandatory annual eLMS education module "Infection Control Annual Education" yearly.</p>		

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	<p>Perform hand hygiene before insertion or manipulation of any invasive devices."</p> <p>4. The policy / document titled "Bathing" by Mosby's Textbook for Nursing Assistants undated states,"Rules For Bathing ... Wash from the cleanest to the dirtiest areas."</p> <p>5. The policy titled "Standard And Transmission - Based Isolation Precautions" with an effective date of 06/12 states,"Procedures ... Use of Gloves ... a. Hand hygiene must be performed immediately prior to putting gloves on and after removing gloves."</p> <p>6. During a home visit on 10/29/13 at 9:43 AM, employee M, Registered Nurse (RN), gelled hands, put a mask on their face, gelled hands, donned clean gloves that were sitting in a pile without a barrier under the glove pile, and removed the PICC line dressing. Then the RN removed gloves, gelled hands, donned sterile gloves, and preformed PICC cleaning care.</p> <p>7. During a home visit on 10/29/13 at 11:30 AM, employee VVV, Home Health Aide (HHA), gelled hands, put gloves on, assisted patient clean body from top to bottom, and cleaned peri-area. Then the HHA rinsed body with water and</p>						

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	<p>discarded rag onto shower / bathtub floor. Then the HHA picked up the rag and rinsed it off with running water out of the shower faucet and hung the rag on a towel / handbar next to the patient to air dry. While the HHA turned their back from the patient to remove gloves and don clean gloves, the patient picked up the hanging rag and wiped their face off with it.</p> <p>During an interview on 10/30/13 at 1:39 PM, employee HHHHH, Manager Quality & Health Information, indicated that the HHA could have put the rag out of the patient's reach.</p> <p>8. During a home visit on 10/29/13 at 2:05 PM, employee J, RN, with gloves already donned on hands, cleaned the pediatric scale with the sanitizing wipe after the patient's weight was measured. Then the RN dropped the sanitizing wipe on the floor. The RN then picked up the sanitizing wipe from the floor, and proceeded to clean their stethoscope with the same sanitizing wipe.</p> <p>During an interview on 10/30/13 at 1:53 PM, employee KKKKK, Infection Preventative Specialist, indicated the wipe that fell on the floor should have been thrown away. Employee KKKKK further indicated a new wipe would be</p>						

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	<p>needed to clean the stethoscope.</p> <p>9. During a home visit on 10/29/13 at 3:23 PM, employee H, RN, gelled hands, opened a kit for starting / inserting an IV, put the tourniquet on the patient's right arm, and touched the patient's right arm with the RN's bare hands. Then the RN put on the gloves that were included in the kit without gelling hands. The RN then swabbed the patient's right arm with alcohol, inserted the needle into the patient's vein in their right arm, flushed the site, covered the site with tegaderm, swabbed the IV port with alcohol, connected the IV tubing to the port line, and began the infusion.</p> <p>During an interview on 10/30/13 at 1:56 PM, employee KKKKK, Infection Preventative Specialist, indicated the RN should have gelled hands with hand sanitizer before donning gloves for needle insertion.</p>			

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G000159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, the agency failed to ensure the plan of care contained the tasks the home health aide was to perform for 2 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients that receive home health aide services. (#2 and 7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2 contained a plan of care for the certification period 10/23 -12/21/13 with orders for home health aides services that identified the frequency and duration the aide was to provide services. The plan of care failed to evidence the tasks the aide was to perform. 2. Clinical record #7 contained a plan of care for the certification period 9/19 - 	G000159	<p>Summary statement: The agency ensures the plan of care contains the tasks the home health aid is to perform per current policies; Record of Care RC.105 Home Health Aide Care Planning and Provision of Care PC.109 Care Planning Process.Action planned:1. Clinical leaders reviewed pertinent policies: Record of Care RC.105 Home Health Aide Care Planning and Provision of Care PC.109 Care Planning Process, no changes were recommended for either policy. 2. Policy RC.105 was developed February 1997, last reviewed and updated on August 2011, and was designed to communicate guidelines for home health aide care planning 3. Policy PC.109 was developed February 1997, last reviewed and updated on June 2012, and was designed to provide clinical direction regarding the care planning development and documentation to the clinicians providing direct patient care. 4.</p>	11/27/2013			

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	11/17/13 with orders for home health aides services that identified the frequency and duration the aide was to provide services. The plan of care failed to evidence the tasks the aide was to perform.		The agency's care plan interventions have been revised to include language specifying tasks the home health aide should perform each visit, indicating the frequency and duration of each task. 5. Clinical leaders plan to educate clinical staff (RNs, LPNs, Therapists, HHAs) on the home health aide care plan changes and re-educate clinical staff on the procedures stated in these policies specifically regarding patient specific tasks or interventions, frequency, and duration. How the actions will improve the processes: Anticipated outcome of this education is that all clinical staff will be fully aware of the rationale for developing, following, and documenting to the Home Health Aide care plan. Procedures for implementing the plan of correction for this deficiency:1. This education, provided via written educational materials and interactive discussion of the materials with clinical team members, is scheduled for completion by 11-27-13. 2. Education and discussion will take place at each branch location's next scheduled staff meeting; Indianapolis on 11-21-13, Lafayette on 11-20-13, Muncie on 11-20-13, and Tipton on 11-27-13. 3. Clinical staff will be required to sign a statement indicating he/she has reviewed the educational materials and		

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			understands the expectation of developing, following, and documenting to the Home Health Aide care plan. 4. This notification/documentation requirement is currently in effect, per policy, however staff awareness of the current policy guidelines will be specifically documented after each location's staff meeting, no later than 11-27-13. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The Home Health Aide who conducted the HHA visits for the patients associated with Clinical Record #2 and Clinical Record #7 was counseled on November 12, 2013 by the Clinical Manager. Items reviewed included Agency policies regarding following the care plan, coordination of care and documentation to the Home Health Aide care plan. Home health aide documentation is audited on a quarterly basis at Indiana University Health Home Care (IUHHC), and is part of the Clinical Record Review process to monitor for improvement opportunities. Our Indianapolis Adult Med Surg (AMS) Nursing division scored 100 % for following and documenting to the HHA care plan in 2012. In the first 2 quarters of 2013 the AMS score is 90 % (the Q3 results are pending audit results). This item will remain on the audit tool, with	

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			a goal of sustaining 100% for 3 consecutive quarters following the implementation of the education and changes included in this plan of correction. Results of the Clinical Record Reviews will be documented and reviewed in the Agency's Process Improvement meetings. The Quality Manager will be responsible for this action.		

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G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record review and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 1 of 20 clinical records reviewed with the potential to affect all patients of the agency. (#7)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #7, start of care 9/19/13, contained a home health certification and plan of care for the certification period 9/19/13 - 11/17/13 with orders for Skilled Nursing. A Skilled Nursing Routine Visit note completed by employee R, Registered Nurse, on 9/23/13 indicates the patient's blood pressure was 171/82 with a radial pulse of 60 beats per minute. The document further indicates the patient has a pacemaker and internal defibrillator. The record failed to evidence the physician was notified of the high blood pressure. 2. During an interview on 11/1/13 at 3:50 PM, employee IIIII, Nurse Auditor, indicated there were no call orders for 	G000164	<p>Summary statement: The agency ensures the physician is promptly notified of any changes in the patient's condition or status per current Provision of Care Policies (PC.106, Patient Assessment/Reassessment and PC.109 Care Planning Process). Action planned: 1. Clinical leadership reviewed Policies PC.106 and PC.109, and no changes were indicated. 2. Policy PC.106 was developed January 1997, last reviewed and updated August 2013, and was designed to communicate the standards and time frames within which a patient is assessed and reassessed. 3. Policy PC.109 was developed December 2000 and updated July 2012, and was designed to provide direction regarding the physician's plan of care, clinical care planning documentation, and documentation of clinician communication with the patient's physician. 4. Clinical leaders plan to re-educate all clinical staff on the procedures stated in these policies, specifically regarding notifying the physician of any changes in the patient's status and condition and documenting every instance of communication in the patient's medical record. How the actions will improve the</p>	11/27/2013	

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	blood pressure on the plan of care. Employee IIII further indicated they could not locate within the patient's chart where the MD was notified of the elevated blood pressure.		processes: Anticipated outcome of this education is that all clinical staff will be fully aware of the rationale for and requirement to notify the physician of any change in the patient's status and condition and will appropriately document this communication to the physician in the patient's medical record. Procedures for implementing the plan of correction for this deficiency:1. This re-education, provided via written educational materials and interactive discussion of the materials with clinician team members, is scheduled for completion by 11-27-13.2. Education and discussion will take place at each branch location's next scheduled staff meeting; Indianapolis on 11-21-13, Lafayette on 11-20-13, Muncie on 11-20-13, and Tipton on 11-27-13.3. Clinical staff will be required to sign a statement indicating he/she has reviewed the educational materials and understands the expectation of contacting the physician regarding any patient status and condition change and documenting this communication within the patient's medical record.4. This notification/documentation requirement is currently in effect, per policy, however staff awareness of the current policy guidelines will be specifically documented after each location's staff meeting, no later than		

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			11-27-13. The Clinical Manager will be responsible for overseeing completion of these corrective actions to ensure that this deficiency is resolved. The Registered Nurse who conducted the routine SN visit on 9-23-2013 for the patient associated with Clinical Record #7 was counseled on November 12, 2013 by the Clinical Manager. Items reviewed included Agency policies regarding patient assessment, coordination of care, and timely physician notification of changes in patient condition. Documentation of Care Coordination is audited on a quarterly basis at Indiana University Health Home Care (IUHHC), and is part of the Clinical Record Review process to monitor for improvement opportunities. Our Indianapolis Adult Med Surg Nursing division scored 71 % for Care Coordination documentation in 2012. This rate has improved to 97 % during the first half of 2013. In addition to monitoring for Care Coordination, IUHHC will include "MD notification of change in patient condition" into the Clinical Record Review process beginning with the next audit scheduled for January 2014. This item will be included until a score of 100 % is sustained for 3 consecutive quarters. Results of the Clinical Record Reviews will be documented and reviewed in the Agency's Process		

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			Improvement meetings. The Quality Manager will be responsible for this action.	

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G000236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Plan of Care (POC) in the clinical record listed the correct Start of Care (SOC) date for 1 of 20 records reviewed with the potential to affect all the agency's patients. (#3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The policy titled "Entries Into Client Records" policy number RC.103 with an approval/effective date of 01/97 states, "All entries must reflect the date care / service was provided, including the month, date and year." Clinical record #3 included POCs for the certification periods 7/17/13 to 9/14/13 and 9/15/13 to 11/13/13 that identified the SOC date was 7/16/13. The patient's home care consent was signed by 	G000236	<p>It is the policy of Indiana University Health Home Care to ensure the Plan of Care entered into the clinical record reflects the date care/service was provided. A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services at Indiana University Health Home Care. In addition to the plan of care, the clinical record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Because all patients of Indiana University Health Home Care are potentially affected by the cited deficiency, the Manager of Quality and Health Information conducted an audit of over ten percent of the</p>	11/11/2013	

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	<p>the patient and witness on 7/17/13. The referral for home care was dated 7/16/13. The Recertification Summary indicated the patient was admitted on 7/16/13. The Skilled Nursing (SN) Admission Evaluation was dated on 7/17/13 by the SN. The IUHHC Rehospital Risk Assessment document was dated 7/17/13 with a service of SN Infusion Admission.</p> <p>3. On 10/31/13 at 11:27 AM, employee HHHHH, Manager Quality & Health Information, indicated the SOC date was not correct. It should be 7/17/13.</p>		<p>Agency's census, including all branch locations (100 charts). The audit was conducted on November 8, 2013. The Start of Care date was validated by comparing it to the Certification Period date. This audit resulted in a finding of a 100 percent compliance rate. The Agency therefore has a high level of confidence that no other patients were affected. The Start of Care date for clinical record #3 was amended to the correct date of July 17, 2013. This correction occurred on November 12, 2013. All Start of Care dates will be verified by comparison to the Certification Period date prior to the Plan of Care being incorporated into the patient's clinical record. This process was implemented on November 11, 2013. The Manager of Quality and Health Information is responsible for this Plan of Correction. Effective November 11, 2013, a quality assurance program was implemented under the supervision of the Manager of Quality and Health Information to monitor continued compliance. The Manager of Quality and Health Information, or designated Quality representative, will perform quarterly chart audits on a minimum of ten percent of the Agency's active census to validate the correct Start of Care date by comparing it to the Certification Period date. Deficiencies will be corrected</p>		

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			immediately and findings will be documented and reviewed in our Agency Process Improvement meetings. This quality assurance program will remain in effect until results show three consecutive quarters at 100 percent compliance.		

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N000000	<p>This visit was for a home health state relicensure survey.</p> <p>Survey Dates: October 28 - November 1, 2013</p> <p>Facility Number: 005333</p> <p>Medicaid Number: 200120720A</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor Janet Brandt, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 4,111 Home Health Aide Only: 6 Personal Care Only: 0 Total: 4,117</p> <p>Sample: RR w/HV: 10 RR w/o HV: 10 Total: 20</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 6, 2013</p>	N000000		

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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 policy and document review, observation, and interview, the agency failed to ensure staff followed infection control policies and procedures during 4 of 10 home visits with the potential to affect all the patients seen by the agency. (#6, #7, #8 and #9)</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "Standards Precautions" states, "IV. 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 . . . 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</p>	N000470	In regards to N470 Infection Control Policies IC 1.04, IC 1.14 and Central Venous Access Device: Tunneled and Non-Tunneled Insertion, Assessment and Management IV 1.01 and Clean Technique IC.102 were reviewed by the Infection Prevention for appropriateness in Home Health Care. No changes were necessary. All staff will be educated specifically in regards to Hand Hygiene, Clean Technique and RN's will do education on Central Venous Catheter Dressing Changes. Education will consist of CDC hand hygiene video, PowerPoint for CVC dressing change and a PowerPoint on Infection Control prior to December 1, 2013. A quiz will be used to assess understanding of infection control. Home Health Aides will receive education on "Assisting with ADLs and Bathing". A quiz will assess the knowledge level of the aides. Home Health Care will be adding a barrier to their home care bags to use during home visits. Prior to December 15, 2013, all supervisors and managers will have completed training and be validated to	12/01/2013			

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	<p>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 contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. The policy titled "Clean Technique" policy number IC.102 with an approval/effective date of 01/97 states, "Use barriers as necessary to cover work surfaces to prevent cross contamination."</p> <p>3. The policy titled "Hand Hygiene" policy number IC 1.14 with an effective date of 12/10 states, "4. Perform hand hygiene after contact with intact skin ... 5.</p>		<p>complete the quarterly observations. IU Health Home Health Care covers a significant portion of Central Indiana with branches in Muncie, Lafayette, and Tipton as well as Indianapolis. Quarterly monitoring beginning 1st quarter of 2014 will consist of observations of all staff by Home Health Care management team. Hand hygiene, clean technique and CVC dressing changes observations of all staff will be completed for 2 quarters, repeated every 6 months for a year with results shared at management meetings and reviewed at the quarterly Infection Control Committee meeting for review and follow up. Thereafter, observations will be completed during the annual supervisor rounds. Any staff that fails to meet observation guidelines will receive individual remediation and a subsequent observation the following quarter. All staff must complete their mandatory annual eLMS education module "Infection Control Annual Education" yearly.</p>		

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	<p>Perform hand hygiene before insertion or manipulation of any invasive devices."</p> <p>4. The policy / document titled "Bathing" by Mosby's Textbook for Nursing Assistants undated states, "Rules For Bathing ... Wash from the cleanest to the dirtiest areas."</p> <p>5. The policy titled "Standard And Transmission - Based Isolation Precautions" with an effective date of 06/12 states, "Procedures ... Use of Gloves ... a. Hand hygiene must be performed immediately prior to putting gloves on and after removing gloves."</p> <p>6. During a home visit on 10/29/13 at 9:43 AM, employee M, Registered Nurse (RN), gelled hands, put a mask on their face, gelled hands, donned clean gloves that were sitting in a pile without a barrier under the glove pile, and removed the PICC line dressing. Then the RN removed gloves, gelled hands, donned sterile gloves, and preformed PICC cleaning care.</p> <p>7. During a home visit on 10/29/13 at 11:30 AM, employee VVV, Home Health Aide (HHA), gelled hands, put gloves on, assisted patient clean body from top to bottom, and cleaned peri-area. Then the HHA rinsed body with water and</p>			

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	<p>discarded rag onto shower / bathtub floor. Then the HHA picked up the rag and rinsed it off with running water out of the shower faucet and hung the rag on a towel / handbar next to the patient to air dry. While the HHA turned their back from the patient to remove gloves and don clean gloves, the patient picked up the hanging rag and wiped their face off with it.</p> <p>During an interview on 10/30/13 at 1:39 PM, employee HHHHH, Manager Quality & Health Information, indicated that the HHA could have put the rag out of the patient's reach.</p> <p>8. During a home visit on 10/29/13 at 2:05 PM, employee J, RN, with gloves already donned on hands, cleaned the pediatric scale with the sanitizing wipe after the patient's weight was measured. Then the RN dropped the sanitizing wipe on the floor. The RN then picked up the sanitizing wipe from the floor, and proceeded to clean their stethoscope with the same sanitizing wipe.</p> <p>During an interview on 10/30/13 at 1:53 PM, employee KKKKK, Infection Preventative Specialist, indicated the wipe that fell on the floor should have been thrown away. Employee KKKKK further indicated a new wipe would be</p>						

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	<p>needed to clean the stethoscope.</p> <p>9. During a home visit on 10/29/13 at 3:23 PM, employee H, RN, gelled hands, opened a kit for starting / inserting an IV, put the tourniquet on the patient's right arm, and touched the patient's right arm with the RN's bare hands. Then the RN put on the gloves that were included in the kit without gelling hands. The RN then swabbed the patient's right arm with alcohol, inserted the needle into the patient's vein in their right arm, flushed the site, covered the site with tegaderm, swabbed the IV port with alcohol, connected the IV tubing to the port line, and began the infusion.</p> <p>During an interview on 10/30/13 at 1:56 PM, employee KKKKK, Infection Preventative Specialist, indicated the RN should have gelled hands with hand sanitizer before donning gloves for needle insertion.</p>			

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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> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record review, the agency failed to ensure the plan of care contained the tasks the home health aide was to perform for 2 of 3 records reviewed of patients receiving home health aide services with the potential to affect all patients that receive home health aide services. (#2 and 7)</p> <p>Findings include:</p>	N000524	Summary statement: The agency ensures the plan of care contains the tasks the home health aide is to perform per current policies; Record of Care RC.105 Home Health Aide Care Planning and Provision of Care PC.109 Care Planning Process.Action planned:1. Clinical leaders reviewed pertinent policies: Record of Care RC.105 Home Health Aide Care Planning and Provision of Care PC.109 Care Planning Process, no changes were recommended for either	11/27/2013			

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	<p>1. Clinical record #2 contained a plan of care for the certification period 10/23 -12/21/13 with orders for home health aides services that identified the frequency and duration the aide was to provide services. The plan of care failed to evidence the tasks the aide was to perform.</p> <p>2. Clinical record #7 contained a plan of care for the certification period 9/19 - 11/17/13 with orders for home health aides services that identified the frequency and duration the aide was to provide services. The plan of care failed to evidence the tasks the aide was to perform.</p>		<p>policy. 2. Policy RC.105 was developed February 1997, last reviewed and updated on August 2011, and was designed to communicate guidelines for home health aide care planning 3. Policy PC.109 was developed February 1997, last reviewed and updated on June 2012, and was designed to provide clinical direction regarding the care planning development and documentation to the clinicians providing direct patient care. 4. The agency's care plan interventions have been revised to include language specifying tasks the home health aide should perform each visit, indicating the frequency and duration of each task. 5. Clinical leaders plan to educate clinical staff (RNs, LPNs, Therapists, HHAs) on the home health aide care plan changes and re-educate clinical staff on the procedures stated in these policies specifically regarding patient specific tasks or interventions, frequency, and duration. How the actions will improve the processes: Anticipated outcome of this education is that all clinical staff will be fully aware of the rationale for developing, following, and documenting to the Home Health Aide care plan. Procedures for implementing the plan of correction for this deficiency:1. This education, provided via written educational materials and</p>	

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			<p>interactive discussion of the materials with clinical team members, is scheduled for completion by 11-27-13. 2. Education and discussion will take place at each branch location's next scheduled staff meeting; Indianapolis on 11-21-13, Lafayette on 11-20-13, Muncie on 11-20-13, and Tipton on 11-27-13. 3. Clinical staff will be required to sign a statement indicating he/she has reviewed the educational materials and understands the expectation of developing, following, and documenting to the Home Health Aide care plan. 4. This notification/documentation requirement is currently in effect, per policy, however staff awareness of the current policy guidelines will be specifically documented after each location's staff meeting, no later than 11-27-13. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The Home Health Aide who conducted the HHA visits for the patients associated with Clinical Record #2 and Clinical Record #7 was counseled on November 12, 2013 by the Clinical Manager. Items reviewed included Agency policies regarding following the care plan, coordination of care and documentation to the Home Health Aide care plan. Home health aide documentation is</p>	

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			audited on a quarterly basis at Indiana University Health Home Care (IUHHC), and is part of the Clinical Record Review process to monitor for improvement opportunities. Our Indianapolis Adult Med Surg (AMS) Nursing division scored 100 % for following and documenting to the HHA care plan in 2012. In the first 2 quarters of 2013 the AMS score is 90 % (the Q3 results are pending audit results). This item will remain on the audit tool, with a goal of sustaining 100% for 3 consecutive quarters following the implementation of the education and changes included in this plan of correction. Results of the Clinical Record Reviews will be documented and reviewed in the Agency's Process Improvement meetings. The Quality Manager will be responsible for this action.	

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review and interview, the home health agency failed to ensure the physician was notified regarding changes in the patient's condition for 1 of 20 clinical records reviewed with the potential to affect all patients of the agency. (#7)</p> <p>Findings include:</p> <p>1. Clinical record #7, start of care 9/19/13, contained a home health certification and plan of care for the certification period 9/19/13 - 11/17/13 with orders for Skilled Nursing. A Skilled Nursing Routine Visit note completed by employee R, Registered Nurse, on 9/23/13 indicates the patient's blood pressure was 171/82 with a radial pulse of 60 beats per minute. The document further indicates the patient has a pacemaker and internal defibrillator. The record failed to evidence the physician was notified of the high blood pressure.</p>	N000527	<p>Summary statement: The agency ensures the physician is promptly notified of any changes in the patient's condition or status per current Provision of Care Policies (PC.106, Patient Assessment/Reassessment and PC.109 Care Planning Process). Action planned: 1. Clinical leadership reviewed Policies PC.106 and PC.109, and no changes were indicated. 2. Policy PC.106 was developed January 1997, last reviewed and updated August 2013, and was designed to communicate the standards and time frames within which a patient is assessed and reassessed. 3. Policy PC.109 was developed December 2000 and updated July 2012, and was designed to provide direction regarding the physician's plan of care, clinical care planning documentation, and documentation of clinician communication with the patient's physician. 4. Clinical leaders plan to re-educate all clinical staff on the procedures stated in these policies, specifically regarding notifying the physician of any changes in the patient's status and condition and documenting</p>	11/27/2013			

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	2. During an interview on 11/1/13 at 3:50 PM, employee IIIII, Nurse Auditor, indicated there were no call orders for blood pressure on the plan of care. Employee IIIII further indicated they could not locate within the patient's chart where the MD was notified of the elevated blood pressure.		every instance of communication in the patient's medical record. How the actions will improve the processes: Anticipated outcome of this education is that all clinical staff will be fully aware of the rationale for and requirement to notify the physician of any change in the patient's status and condition and will appropriately document this communication to the physician in the patient's medical record. Procedures for implementing the plan of correction for this deficiency:1. This re-education, provided via written educational materials and interactive discussion of the materials with clinician team members, is scheduled for completion by 11-27-13.2. Education and discussion will take place at each branch location's next scheduled staff meeting; Indianapolis on 11-21-13, Lafayette on 11-20-13, Muncie on 11-20-13, and Tipton on 11-27-13.3. Clinical staff will be required to sign a statement indicating he/she has reviewed the educational materials and understands the expectation of contacting the physician regarding any patient status and condition change and documenting this communication within the patient's medical record.4. This notification/documentation requirement is currently in effect, per policy, however staff awareness of the current policy		

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			<p>guidelines will be specifically documented after each location's staff meeting, no later than 11-27-13. The Clinical Manager will be responsible for overseeing completion of these corrective actions to ensure that this deficiency is resolved. The Registered Nurse who conducted the routine SN visit on 9-23-2013 for the patient associated with Clinical Record #7 was counseled on November 12, 2013 by the Clinical Manager. Items reviewed included Agency policies regarding patient assessment, coordination of care, and timely physician notification of changes in patient condition. Documentation of Care Coordination is audited on a quarterly basis at Indiana University Health Home Care (IUHHC), and is part of the Clinical Record Review process to monitor for improvement opportunities. Our Indianapolis Adult Med Surg Nursing division scored 71 % for Care Coordination documentation in 2012. This rate has improved to 97 % during the first half of 2013. In addition to monitoring for Care Coordination, IUHHC will include "MD notification of change in patient condition" into the Clinical Record Review process beginning with the next audit scheduled for January 2014. This item will be included until a score of 100% is sustained for 3 consecutive quarters. Results of</p>	

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			the Clinical Record Reviews will be documented and reviewed in the Agency's Process Improvement meetings. The Quality Manager will be responsible for this action.	

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N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <ol style="list-style-type: none"> (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the Plan of Care (POC) in the clinical record listed the correct Start of Care (SOC) date for 1 of 20 records reviewed with the potential to affect all the agency's patients. (#3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The policy titled "Entries Into Client Records" policy number RC.103 with an approval/effective date of 01/97 states, "All entries must reflect the date care / service was provided, including the 	N000608	It is the policy of Indiana University Health Home Care to ensure the Plan of Care entered into the clinical record reflects the date care/service was provided. A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services at Indiana University Health Home Care. In addition to the plan of care, the clinical record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent	11/11/2013

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	<p>month, date and year."</p> <p>2. Clinical record #3 included POCs for the certification periods 7/17/13 to 9/14/13 and 9/15/13 to 11/13/13 that identified the SOC date was 7/16/13. The patient's home care consent was signed by the patient and witness on 7/17/13. The referral for home care was dated 7/16/13. The Recertification Summary indicated the patient was admitted on 7/16/13. The Skilled Nursing (SN) Admission Evaluation was dated on 7/17/13 by the SN. The IUHHC Rehospital Risk Assessment document was dated 7/17/13 with a service of SN Infusion Admission.</p> <p>3. On 10/31/13 at 11:27 AM, employee HHHHH, Manager Quality & Health Information, indicated the SOC date was not correct. It should be 7/17/13.</p>		<p>to the attending physician; and a discharge summary. Because all patients of Indiana University Health Home Care are potentially affected by the cited deficiency, the Manager of Quality and Health Information conducted an audit of over ten percent of the Agency's census, including all branch locations (100 charts). The audit was conducted on November 8, 2013. The Start of Care date was validated by comparing it to the Certification Period date. This audit resulted in a finding of a 100 percent compliance rate. The Agency therefore has a high level of confidence that no other patients were affected. The Start of Care date for clinical record #3 was amended to the correct date of July 17, 2013. This correction occurred on November 12, 2013. All Start of Care dates will be verified by comparison to the Certification Period date prior to the Plan of Care being incorporated into the patient's clinical record. This process was implemented on November 11, 2013. The Manager of Quality and Health Information is responsible for this Plan of Correction. Effective November 11, 2013, a quality assurance program was implemented under the supervision of the Manager of Quality and Health Information to monitor continued compliance. The Manager of Quality and Health Information, or designated</p>		

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			Quality representative, will perform quarterly chart audits on a minimum of ten percent of the Agency's active census to validate the correct Start of Care date by comparing it to the Certification Period date. Deficiencies will be corrected immediately and findings will be documented and reviewed in our Agency Process Improvement meetings. This quality assurance program will remain in effect until results show three consecutive quarters at 100 percent compliance.	