

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

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

G 000 Bldg. 00	<p>This was a Home Health Federal Recertification Survey. This was a fully extended survey.</p> <p>Survey Dates: 4/16/15 to 4/21/15</p> <p>Facility Number: IN011167</p> <p>Medicaid Number: 200838680</p> <p>Agency Census: Unduplicated 12 month census: 266 Active Patients: 134</p> <p>Sample: RR w/HV: 6 RR w/o HV: 6 Total: 12</p> <p>Advanced Home Healthcare Inc. is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning April 21, 2015, - April 21, 2017, due to being found out of compliance with Conditions of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision and 484.30 Skilled Nursing Services.</p>	G 000		
-----------------------	---	-------	--	--

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: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

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

G 110 Bldg. 00	<p>QA: JE 04/30/15</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on observation, clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives in 12 of 12 clinical records (#'s 1-12).</p> <p>Findings include</p> <p>1. The admission book given to the patients failed to include an updated July 2013 version of the 2004 Indiana Advanced Directives document in the admission folder that was distributed to all the agencies patients at the start of care.</p>	G 110	<p>The Clinical Management team has in serviced the nursing staff on the updated, July 1, 2013, Advance Directive for the State of Indiana. The admitting staff member will advise the patient in advance, concerning policies on advance directives including a description of Indiana Law. Written information will be included in the Start of Care packet and givento the patient before care is provided. All current patients will be given the updated July 1, 2013 Indiana Advance Directive Brochure with patientsignature/representative signature of delivery. Developed form for patient/representative to sign to ensure updated Indiana Advanced Directives Brochure by</p>	05/21/2015
-----------------------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. On 4/21/15 at 6:00 PM, Employee A, administrator, acknowledged the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013).</p> <p>3. During a Home Visit observation on 4/16/15 at 11:00 AM with patient #1, start of care (SOC) 2/5/15, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>4. During a Home Visit observation on 4/16/15 at 12:15 PM with patient #2, SOC 2/26/15, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>5. During a Home Visit observation on 4/16/15 at 1:30 PM with patient #3, SOC 9/3/14, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>6. During a Home Visit observation on 4/17/15 at 11:00 AM with patient #4, SOC 2/21/15, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p>		<p>RN to be returned to office for tracking and trending of compliance for delivery of updated information regarding Advanced Directive choices. The Performance Improvement Manager/designee developed the following:</p> <ul style="list-style-type: none"> · Developed audit tool for patient confirmation of July 1, 2013 Indiana Advance Directives Brochure · Developed tracking and trending tool for submission of signed delivery of updated Indiana Advanced Directives by RN field staff · 100% Clinical audit performed of all active patients for evidence the patient received the updated information on Advance Directives. · Development of Focus Performance Improvement Plan to monitor compliance of delivery of July 1, 2013 Indiana Advanced Directive Brochure for new admission using PDSA format with Establishing Tracking and Trending of Performance Improvement plan with audits to be performed monthly for all new admissions to achieve 100% benchmark, for not less than 3 months. At that time, quarterly audits will be performed. The Administrator/designee will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>7. During a Home Visit observation on 4/17/15 at 12:15 PM with patient #5, SOC 6/6/14, the home folder contained an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>8. During a Home Visit observation on 4/17/15 at 1:30 PM with patient #6, SOC 5/28/14, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>9. Clinical record #1, SOC 2/5/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record #2, SOC 2/26/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>11. Clinical record #3, SOC 9/3/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>12. Clinical record #4, SOC 2/21/15,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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 contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>13. Clinical record #5, SOC 6/6/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>14. Clinical record #6, SOC 5/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>15. Clinical record #7, SOC 9/16/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>16. Clinical record #8, SOC 3/12/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
	17. Clinical record #9, SOC 12/13/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.			
	18. Clinical record #10, SOC 4/8/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.			
	19. Clinical record 11, SOC 9/25/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.			
	20. Clinical record #12, SOC 9/13/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.			
	21. Agency policy titled "ADMISSION DOCUMENTS", dated October 2011, states, " PURPOSE To ensure organizational compliance with the Patient Bill of Rights and regulatory requirements ... 3. A copy of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
G 121 Bldg. 00	<p>organization's policy on patient Advance Directives including a description of an individual's right under state law (whether statutory or as recognized by the courts of a state) and how such rights are implemented by the organization "</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, interview, and review of policy and procedures, the agency failed to ensure staff had provided services in accordance to their own infection control bag technique policy in 1 of 6 home visit observations (employee E, Registered Nurse (RN)).</p> <p>Findings:</p> <p>1. During a home visit observation on 4/16/15 at 2:45 PM to patient #3 with employee E, RN, the nurse was observed to hang the nursing bag on the back of patient #3's kitchen chair. The chair was short and nursing bag strap was long; the bag rested on the patient's floor during the entire home visit.</p>	G 121	The Clinical Management Team will in-service 100% of the field staff on infection control and bag technique with a return demonstration by the staff member. The policy on bag technique and infection control will be given to each field staff employee describing the procedure for maintaining a clean nursing bag/computer bag and preventing cross contamination. Any new field staff employee will be in serviced during orientation on bag technique/infection control with a return demonstration. Agency Policy for maintaining a clean nursing bag/computer bag and preventing cross contamination to be distributed to all field staff at orientation and during in-service education. All	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. Interview on 4/20/15 at 4:15 PM, the agency's administrator and DON agreed that employee E, RN, should not have allowed her bag to rest on patent #3's floor during the home visit.</p> <p>5. The agencies policy titled "Bag Technique", dated October 2010, states, "Purpose: To describe the procedure for maintaining a clean nursing bag/computer bag and preventing cross contamination ... Bag Technique ... The bag will never be placed on the floor"</p>		<p>current field staff to perform competency of bag technique with use of agency bag technique and infection control policies. Identified staff not compliant with bag technique/infection control will have on site supervisory visit performed by Clinical Management Team Member within next 30 days to ensure compliance with agency policy. Performance Improvement Manager/designee to develop the following:</p> <ul style="list-style-type: none"> ·Develop a time schedule for direct observation supervisory visit by Clinical Management team members of all field staff member. ·Clinical Management Team to ensure competency of bag technique and infection control measures per completion of competency during orientation and prior to any onsite care performed, then every 6 months to ensure that this deficiency is corrected until 100% compliance by all field staff. ·Development of a tracking and trending tool using PDSA format for monthly establishment of onsite supervisory visits performed with compliance by Clinical Management Team member documentation ·Evidence of field staff compliance with 100% competency will be maintqined in the employee personnel file. The human resource staff will notify the clinical teammanager of 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
G 156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on clinical record review, agency policy review, and interview, it was determined the agency failed to ensure missed visits were documented and/or notified physician of missed visits and completed wound care as ordered for 2 of 12 records reviewed (See G 158); failed to ensure the plan of care addressed all pertinent patient conditions in 1 of 12 records reviewed (see G 159); failed to ensure physical therapy orders on the plan of care included the specific procedures and modalities to be used and the amount, frequency and duration the plan of care for 1 of 12 patients (see G 161); and failed to ensure the patient received treatments as ordered by	G 156	100% audits of personnel files on a monthly basis. ·Continue with audit of personnel files until threshold of 100% is met for not less than three months then reduction of audits to quarterly by Human Resource Staff to ensure compliance with agency policy. The Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur. The Clinical Management Team has scheduled In-services for all field staff members regarding acceptance to patients, Plan of Care and Medical Supervision. Patient care will follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine. Medical orders may authorize the frequency of visits for each service. It is the responsibility of the Clinician to alert the physician to any changes that suggest a need to alter the plan of care. If fewer visits are provided than ordered by the physician, the physician must be notified. The Clinician will maintain documentation in the clinical record indicating that the physician was notified and is	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>physician to 1 of 12 records reviewed (see G 165).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p>		<p>aware of the missed visit. The Plan of care will include all pertinent diagnosis , mental status, types of service 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. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Any changes to the Plan of Care are to be approved by the physician and documented in the clinical record. Identified charts deficient corrected to meet agency policy and regulatory requirements. Contractual therapy companies to be in serviced of required documentation on therapy treatment plan of care with MD contact documented for approval, need for missed visit withrational and md contact of noncompliance with Plan of care and documentation of services with MD contact. Developed of agency audit tool for chart review for monitoring of identified deficient conditional /standard regulations to monitor assurance of regulatory requirements. The Performance Improvement Manager/designee will perform</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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 following</p> <ul style="list-style-type: none"> ·30% of all active patient charts will be audited for evidence that there is 100% threshold compliance that the Plan of Care is being followed and that the physician is notified of any changes that occur. · 100% clinical review of identified RN/LPN field staff members patient assignments for compliance with established Plan of Care and resolution of any identified areas of non compliance ·Development of Performance Improvement Plan with focus review for tracking and trending of noncompliance with Plan of Care identified above using PDSA format to monitor compliance ·Revision of agency audit tools to incorporate accurate development of Plan of care at SOC and Recertification process to monitor compliance with collaboration with MD/patient/patient representative for agreement with Plan of Care and Implementation of care s/p Clinical review of Plan of Care ·Development of focus Performance Improvement Plan using PDSA format for tracking and trending monthly for accurate documentation of Plan of Care at SOC/Recert to meet 100% threshold for not less than 3 months then quarterly for one year. <p>The Administrator/designee will be responsible for monitoring</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
G 158 Bldg. 00	<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, agency document review, and interview, the agency failed to ensure the treatments and frequency of visits ordered on the plan of care (POC) were met and/or ensure the physician was notified of missed visits for 2 of 12 patients (patient #1 and 4).</p> <p>Findings:</p> <p>1. Clinical record #1, start of care (SOC) date 2/5/15, contained a POC dated 2/5/15-4/5/15 that stated, " ... skilled nurse (SN) 1 time (x)/week (wk) x 1 wk, 2 x/wk x 3 wks, 1 x/wk x 5 wks ", the clinical record failed to evidence a SN visit was conducted during the week of 3/1/15 - 3/7/15.</p>	G 158	<p>these corrective actions to ensure that this deficiency will not recur. For the purpose of any allegation that Advanced Home Health Care, Inc. is not in substantial compliance with the regulations set forth, this plan of correction constitutes Advanced Home Health Care's credible allegation of correction and compliance</p> <p>The Clinical Management Team has inserviced all clinicians providing direct patient care regarding Acceptance of patients, Plan of Care and Medical Supervision. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine. The written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as patient's condition warrants. All clinicians involved in the patient's care will contribute to the plan of care. The patient and family/caregiver will participate in decisions regarding the plan of care whenever possible. The clinical plan of care includes: Pertinent primary and secondary diagnoses; Food or drug allergies; Homebound status;</p>	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A. Clinical record patient #1, start of care (SOC) 2/5/15, contained a POC dated 2/5/15-4/5/15, with orders for Incision/wound care: skilled nurse visit, cleanse to coccyx with wound cleansers and pat dry - apply thin duoderm to protect, measure once a week and record.</p> <p>B. Skilled Nurse (SN) note dated, 2/13/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>C. SN note dated 2/18/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>D. SN Clinical note, dated, 2/20/15, completed by employee J, RN, no wound care to coccyx performed, does state, " ... CNS checks are normal and incision lines to bilateral left ankle covered with 4x4 - bacitracin to sites first ... ", there are no physician orders in the medical record for the SN to provide this treatment provided to left ankle.</p> <p>E. SN note dated, 2/24/15 completed by employee J, RN, failed to evidence wound care to coccyx was performed. Documentation evidenced, Incision sited to outer right ankle healing well with new dressing and neosporin to site and</p>		<p>Goals/outcomes to be achieved; Patient's mental status;Functional limitations; activities permitted; Safety measures; Nutritional requirements; Medications and treatments; Specific procedures to be performed by therapies, including amount, frequency, and duration; Supplies and equipment required; Discharge or referral plans, Discharge teaching, frequency and duration of visits; Prognosis; rehabilitation potential; Other appropriate items such as precautions and contraindications. Based on the assessment and conclusions, the plan of care will include, but will not be limited to: Identified patient problems and needs; Reasonable, measurable, and individualized goals; Specific services to be provided, Actions to be taken to meet the patient goals, Type, frequency, and duration of said actions; equipment and supplies; Prognosis. A 60 day summary - a compilation of the pertinent factors of a patient's clinical and progress notes will be sent to the physician at least every 60 days. Missed visits will be documented and are-visit initiated within the Medicare week if possible. The Physician will be notified of all missed visits and delay in service, to include:</p> <ol style="list-style-type: none"> 1. Rationale for the missed visit 2. Rationale for the delay in services . <p>The Staffing coordinator will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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>rewrapped with ace wrap. The record failed to evidence there were orders for the SN to provide this treatment to right ankle.</p> <p>F. SN note dated 2/25/15 completed by employee J, RN, failed to evidence wound care to coccyx was performed. The nurse documented that new bandages were applied to right bilateral incision sites with no signs of infection. The record failed to evidence orders for the SN to provide this treatment to incision sites.</p> <p>G. SN note dated 3/9/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>H. SN note dated 3/12/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>I. SN note dated 3/16/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>J. SN note dated 3/20/15 completed by employee J, RN, failed to evidence wound care to the coccyx was provided. The nurse documented that Medihoney was placed on wounds to right foot with granulation tissue forming. The record failed to evidence physician orders for</p>		<p>assign and track visit frequency compliance in the electronic system that populates physician orders by discipline and visit frequency in the scheduler. The staffing coordinator is responsible for assigning, monitoring and updating the automated scheduling system for frequency compliance with the Plan of Care. Clinical Management Team will monitor implementation and compliance of agency policy on Care provided following a written Plan of Care by performing concurrent review of clinical records ensuring that care delivery is consistent with the Plan of Care including:</p> <ul style="list-style-type: none"> ·Ordered services initiated by all disciplines ·Frequency and duration of visits ·Treatments are initiated by all disciplines <p>Performance Improvement Manager/designee will perform the following:</p> <ul style="list-style-type: none"> ·30% of all active patient charts will be audited for evidence that there is 100% threshold compliance that the Plan of Care is being followed and that the physician is notified of any changes that occur. ·Development of Performance Improvement Plan with focus review to track and trend noncompliance with Plan of Care identified above using PDSA format to monitor compliance monthly to meet 100% threshold 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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>this treatment.</p> <p>K. SN Clinical note, dated, 3/23/15, completed by employee J, RN, no coccyx wound care provided, does state, " ... Medihoney to old suture sites to right foot ... ABD pads to bilateral heels after sites cleansed with betadine and allowed to dry. Betadine to left great toe as well. Bilateral heels wrapped with kerlix and secured with tape. Ace wraps to bilateral feet ... ", there are no physician orders in the medical record for the SN to provide these treatments.</p> <p>L. SN note dated 3/27/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>M. SN note dated 4/1/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>N. SN note dated 4/3/15 completed by employee D, licensed practical nurse (LPN), failed to evidence wound care was provided this SN visit. The LPN documented the left Distal Heel was painted with betadine with site left open to air. The Left Distal Great Toe was painted with betadine with site left open to air. The Right Distal Heel was painted with betadine, covered with abd pad and secured with kerlix and tape. The Right</p>		<p>for not less than three months then quarterly for one year. The Administrator/designee will be responsible for monitoring these corrective actions to ensure that this deficiency will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>Medial Foot Cleaning/Irrigation Method NS with medihoney applied covered by a 2x2 gauze wrapped with kerlix. Right Lateral Heel Cleaned/Irrigation NS with medihoney applied covered by a 2x2 gauze. Right Lateral Foot Cleaned with NS medihoney applied and covered with a 2x2 left open to air. The record failed to evidence orders for these wound care treatments.</p> <p>O. SN note dated 4/7/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit. The nurse documented bilateral heel sites covered with eschar, painted with betadine and kept dry. Left great toe site with eschar ... painted with betadine and kept dry. The record failed to evidence any orders for these wound care treatments.</p> <p>P. SN note dated 4/10/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>Q. SN note dated 4/13/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit. The nurse documented wound care was provided to the Left Distal Heel, Left Distal Great Toe, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>orders for the wound care.</p> <p>R. SN note dated 4/16/15 completed by employee D, LPN, failed to evidence wound care was provided this SN visit. The nurse documented wound care was provided to the Left Distal Heel, Left Distal Great Toe, Right Distal Heel, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence orders for these treatments.</p> <p>S. During a home visit observation on 4/16/15, at 12:50 PM, employee D, (LPN), was observed to perform wound care to left and right heels and left great toe.</p> <p>T. On 4/16/15 at 1: 10 PM, employee D, LPN, indicated only the wounds to feet were being addressed.</p> <p>2. Clinical record #4, SOC 9/25/14, included agency forms titled "ATTEMPTED VISIT/MISSED VISIT" dated 10/28/14 and 11/25/14 for occupational therapy visits that identified the physician was not notified of the missed visits dated 10/14/14 and 11/11/14.</p> <p>3. During interview on 4/21/15 at 10:00 AM, employee A, director of nursing (DON), indicated there were no notes</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
G 159 Bldg. 00	(skilled nursing visit notes, communication notes, physician orders, or call logs) in the electronic medical record (EMR) for patient #1 indicating why no visit was made the week of 3/1/15 - 3/7/15 and indicated she would contact the nurse to look into what happened and agrees patient #4 does have missed visits that were not sent to physician. 4. Agency document titled " RE: Performance Standards ", dated October 3, 2013, states, " ... Communication - if delay in providing service to be communicated to supervisor, the physician is to be notified, and both are to be documented on a call log in the patient record" 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,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>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, observation, and interview, the agency failed to ensure the plan of care addressed all pertinent patient conditions in 1 of 12 (#4) clinical records reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a Home visit observation on 4/17/15 at 11:00 AM to patient #4, a dark, red, purple raised area about the size of a quarter was observed on the patient's left great toe. 2. Clinical record #4, start of care, 2/21/15, included a plan of care for the certification period, 2/21/15 - 4/21/15 that failed to include the area to left great toe. 3. Phone interview on 4/21/15 at 3:10 PM with RN, employee L, the employee indicated he was just watching the area. 	G 159	<p>The Clinical Management Team will in-service all clinicians providing direct patient care on agency policy "Care Planning Process" including but not limited to:</p> <ul style="list-style-type: none"> ·All pertinent diagnosis, mental status, types of service equipment required. ·Frequency of visits, prognosis, rehab potential, functional limitations, activities permitted ·Nutritional requirements ·Medications and treatments, allergies ·Homebound status ·Goals/outcomes to be achieved ·Safety Measures ·Specific procedures to be performed by therapies, including amount, frequency, duration ·Prognosis, rehabilitation potential ·Instructions for timely discharge or referral ·Any other appropriate items <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine. The written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as patients condition warrants. All clinicians involved in</p>	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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 patient's care will contribute to the plan of care. The patient and family/caregiver will participate in decisions regarding the plan of care whenever possible. Based on the assessment and conclusions, the plan of care will include, but will not be limited to: Identified patient problems and needs; Reasonable, measurable, and individualized goals; Specific services to be provided, Actions to be taken to meet the patient goals, Type , frequency, and duration of said actions; equipment and supplies; Prognosis. A 60 day summary - a compilation- of the pertinent factors of a patient's clinical and progress notes will be sent to the physician at least every 60days. Performance Improvement Manager/designee will perform the following:</p> <ul style="list-style-type: none"> ·30% of all active patient charts will be audited for evidence that there is 100% threshold compliance that the Plan of Care is being followed and documentation of physician notification of changes inpatient status. ·Development of Performance Improvement Plan with focus review to track and trend noncompliance with Plan of Care identified above using PDSA format to monitor compliance monthly to meet 100% threshold for not less than three months then quarterly for one year. Administrator/Design will be 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015	
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322			
(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
G 161 Bldg. 00	<p>484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on clinical record and policy review, the agency failed to ensure physical therapy orders on the plan of care included the specific procedures and modalities to be used and the amount, frequency and duration the plan of care (POC) for 1 of 12 patients (patient #6).</p> <p>Findings:</p> <p>1. Clinical record #6, start of care 5/28/14, contained a POC for the certification period with orders for physical therapy twice a week for 6 weeks. The POC failed to evidence the therapy orders included the specific procedures and modalities to be used and the amount, frequency and duration.</p> <p>2. Agency document titled "Care Planning ", dated October 2013, states, " ... 3. Based on the assessment and conclusions, the plan of care will include, but will not be limited to ... C. Specific services to be provided ... E. Type,</p>			G 161	<p>responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>The Clinical Management Team will in-service all therapists as to therapy orders. Orders for therapy services will include the specific procedures and modalities to be used and the amount, frequency and duration of the therapy ordered. Modalities include any physical agent applied to produce therapeutic changes to biologic tissue and include, but are not limited to, Thermal, acoustic, light, mechanical, or electric energy. Procedures are defined as a manner of effecting change through the application of clinical skills and/or services that attempt to improve function. This can be achieved through exercise or training and must include active interventions between the therapist and the patient. Measureable goals are set for the patient and evaluated at each visit as to whether or not patient is progressing toward goals. Reevaluations are performed at least every 30 days to reassess patient's needs/goals Status changes or ineffective therapy</p>		05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
G 165 Bldg. 00	<p>frequency, and duration of above actions ... "</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record review, agency document review, and interview, the agency failed to ensure, the registered nurse (RN), employee J and licensed practical nurse (LPN), employee D, provided wound care treatments as ordered on the plan of care (POC) for 1</p>	G 165	<p>treatment will be documented and reported to thePhysician. Performance Improvement Manager/Designee to perform thefollowing: ·Assigned therapy staff to ensure therapy visit frequency is being followed ·10% clinical audit of all active therapy clinical records to ensure compliance withdevelopment of Plan of Care per agencypolicy and regulatory standards ·Development of Performance Improvement Plan using PDSA format to monitor compliance by therapist of agency policy and regulatory standards on monthly basis to meet 100% threshold for not less than three months then quarterly for one year. Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>The Clinical Management Team has in serviced the agency staff that drugs and treatments are administered by agency staff only as ordered by the physician. Any change in treatment will generate a physician order. Verbal orders must be signed and dated by the</p>	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of 12 patients (patient #1) with the potential to affect all patient's receiving care from employee D or J.</p> <p>Findings:</p> <p>1. Clinical record patient #1, start of care (SOC) 2/5/15, contained a POC dated 2/5/15-4/5/15, with orders for Incision/wound care: skilled nurse visit, cleanse to coccyx with wound cleansers and pat dry - apply thin duoderm to protect, measure once a week and record.</p> <p>A. Skilled Nurse (SN) note dated, 2/13/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>B. SN note dated 2/18/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>C. SN Clinical note, dated, 2/20/15, completed by employee J, RN, no wound care to coccyx performed, does state, " ... CNS checks are normal and incision lines to bilateral left ankle covered with 4x4 - bacitracin to sites first ... ", there are no physician orders in the medical record for the SN to provide this treatment provided to left ankle.</p> <p>D. SN note dated, 2/24/15 completed by</p>		<p>nurse or qualified therapist who is furnishing or supervising the ordered service at the time it is given. It is the RN's or therapist's responsibility to make any necessary revisions to the Plan of Care based on that order. Orders signed by the nurse or therapist are then sent to the physician by fax, mail, or personally. Orders are tracked by date and resent after 5 days. All physician orders must be included in the patient's clinical record. All Plans of Care are to be signed and dated, and in the clinical record within 30 days. Clinical Management Team will monitor implementation and compliance of agency policy on Care provided following a written Plan of Care by performing concurrent review of clinical records ensuring that care delivery is consistent with the Plan of Care including:</p> <ul style="list-style-type: none"> ·Ordered services initiated by all disciplines ·Frequency and duration of visits ·Treatments are initiated by all disciplines <p>Performance Improvement Manager/designee will perform the following:</p> <ul style="list-style-type: none"> ·30% of all active patient charts will be audited for evidence that there is 100% threshold compliance that the Plan of Care is being followed and that the physician is notified of any changes that occur. ·100% review of identified 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015	
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322			
(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>employee J, RN, failed to evidence wound care to coccyx was performed. Documentation evidenced, Incision sited to outer right ankle healing well with new dressing and neosporin to site and rewrapped with ace wrap. The record failed to evidence there were orders for the SN to provide this treatment to right ankle.</p> <p>E. SN note dated 2/25/15 completed by employee J, RN, failed to evidence wound care to coccyx was performed. The nurse documented that new bandages were applied to right bilateral incision sites with no signs of infection. The record failed to evidence orders for the SN to provide this treatment to incision sites.</p> <p>F. SN note dated 3/9/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>G. SN note dated 3/12/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>H. SN note dated 3/16/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>I. SN note dated 3/20/15 completed by employee J, RN, failed to evidence</p>		<p>RN/LPN field staffmember assigned patient assignments for compliance with established Plan of Care and resolution of any areas of non compliance.</p> <ul style="list-style-type: none"> Development of focus Performance Improvement Plan using PDSA format for tracking and trending monthly of compliance with agency policy and regulatory requirement for development and updating of Plan of Care at SOC/Recertification to meet 100%threshold for not less than 3 months then quarterly for one year <p>The Administrator and Agency supervisor will be responsible for monitoring this corrective action to ensure that the deficiency iscorrected and will not recur.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>wound care to the coccyx was provided. The nurse documented that Medihoney was placed on wounds to right foot with granulation tissue forming. The record failed to evidence physician orders for this treatment.</p> <p>J. SN Clinical note, dated, 3/23/15, completed by employee J, RN, no coccyx wound care provided, does state, " ... Medihoney to old suture sites to right foot ... ABD pads to bilateral heels after sites cleansed with betadine and allowed to dry. Betadine to left great toe as well. Bilateral heels wrapped with kerlix and secured with tape. Ace wraps to bilateral feet ... ", there are no physician orders in the medical record for the SN to provide these treatments.</p> <p>K. SN note dated 3/27/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>L. SN note dated 4/1/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>M. SN note dated 4/3/15 completed by employee D, licensed practical nurse (LPN), failed to evidence wound care was provided this SN visit. The LPN documented the left Distal Heel was painted with betadine with site left open</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to air. The Left Distal Great Toe was painted with betadine with site left open to air. The Right Distal Heel was painted with betadine, covered with abd pad and secured with kerlix and tape. The Right Medial Foot Cleaning/Irrigation Method NS with medihoney applied covered by a 2x2 gauze wrapped with kerlix. Right Lateral Heel Cleaned/Irrigation NS with medihoney applied covered by a 2x2 gauze. Right Lateral Foot Cleaned with NS medihoney applied and covered with a 2x2 left open to air. The record failed to evidence orders for these wound care treatments.</p> <p>N. SN note dated 4/7/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit. The nurse documented bilateral heel sites covered with eschar, painted with betadine and kept dry. Left great toe site with eschar ... painted with betadine and kept dry. The record failed to evidence any orders for these wound care treatments.</p> <p>O. SN note dated 4/10/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>P. SN note dated 4/13/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
G 168 Bldg. 00	<p>The nurse documented wound care was provided to the Left Distal Heel, Left Distal Great Toe, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence orders for the wound care.</p> <p>Q. SN note dated 4/16/15 completed by employee D, LPN, failed to evidence wound care was provided this SN visit. The nurse documented wound care was provided to the Left Distal Heel, Left Distal Great Toe, Right Distal Heel, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence orders for these treatments.</p> <p>2. During a home visit observation on 4/16/15, at 12:50 PM, employee D, (LPN), was observed to perform wound care to left and right heels and left great toe.</p> <p>3. On 4/16/15 at 1: 10 PM, employee D, LPN, indicated only the wounds to feet were being addressed.</p> <p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record review, agency</p>	G 168	The Clinical Management Team has in serviced all nurses on Skilled Nursing Services. The	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>policy review, observation, and interview, it was determined the agency failed to ensure the registered nurse revised the plan of care in 1 of 12 records reviewed (see G 173), failed to ensure the registered nurse notified the physician for changes in the patient's condition for 1 of 12 records reviewed (see G 176), and failed to ensure the licensed practical nurse (LPN) provided services according to the agency policies in 1 of 12 records reviewed (see G 179).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.30 Skilled Nursing Services.</p>		<p>agency furnishes skilled nursing services by or under the supervision of a Registered nurse and in accordance with the Plan of care. The Registered Nurse will make the initial evaluation visit and regularly reevaluate the patient's nursing needs. The Registered nurse will initiate the Plan of care and the necessary revisions, furnish those services requiring substantial and specialized nursing skill, initiate appropriate preventive and rehabilitative nursing procedures. The RN will prepare clinical and progress notes, coordinate services, inform the physician and other personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs. The RN will participate in in-service programs and supervise and teach other nursing personnel. Clinicians will follow agency policies for monitoring patient's response/reporting to physician. Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient. During each home visit, clinician will monitor response to care and document response. If changes occur regarding diagnosis, or treatment, the physician will be contacted the same day. Clinical Management Team will monitor implementation and compliance of agency policy on Care provided</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>following a written Plan of Care by performing concurrent review of clinical records ensuring that care delivery is consistent with the Plan of Care including:</p> <ul style="list-style-type: none"> · Ordered services initiated by all disciplines · Frequency and duration of visits · Treatments are initiated by all disciplines <p>Performance Improvement Manager/designee will perform the following:</p> <ul style="list-style-type: none"> · 30% of all active patient charts will be audited for evidence that there is 100% threshold compliance that the Plan of Care being revised at recertification with appropriate diagnosis, treatments and physician updated on patient's condition with establishing Plan of Care. · Develop Performance Improvement Plan for focus audits using PDSA format to be performed monthly to meet 100% threshold compliance of agency policy and regulatory requirements for not less than three months then quarterly. <p>The Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>For the purpose of any allegation that Advanced Home Health Care, Inc. is not in substantial compliance with the regulations set forth, this plan of correction</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
G 173 Bldg. 00	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN), employee J, updated the Plan of Care (POC) with the correct diagnosis and patient for 1 of 12 patients (#1)</p> <p>Findings include</p> <p>1. Clinical record # 1, start of care date 2/5/15, contained a POC dated 2/5/15 - 4/5/15 and 4/6/15 - 6/4/15, that failed to evidence all the diagnoses from the the 2/5/15 - 4/5/15 POC and was not updated to reflect that the patient no longer had a pressure ulcer.</p> <p>2. Interview on 4/21/15 at 1:00 PM, employee J, registered nurse case manager, stated, she/he did not realize the POC had not been updated correctly as it was an oversight and in fact the wound to patient #1's coccyx had healed shortly after the SOC.</p>	G 173	<p>constitutes Advanced Home Health Care's credible allegation of correction and compliance</p> <p>The Clinical Management Team will in-service all Registered Nurses on the Duties of a Registered Nurse. The RN is responsible for the following:</p> <ul style="list-style-type: none"> ·Completes an initial assessment of the patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness (es). ·Regularly re-evaluates patient nursing needs. ·Initiates the plan of care and makes necessary revisions as patient status and needs change. ·Uses health assessment data to determine nursing diagnosis. ·Develops a care plan, which establishes goals based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician. ·Counsels the patient and family in meeting nursing and related needs. ·Provides health care instructions to the patient as appropriate per assessment and plan of care. 	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
			<ul style="list-style-type: none"> ·Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient. ·Acts as case manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload. ·Prepares clinical notes and updates the primary physician when necessary and at least every 60 days. ·Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition;obtains/receives physician's orders as required. ·Communicates with community health related persons to coordinate the care plan ·Ensures that arrangements for equipment and other necessary items and services are available. ·Instructs, supervises and evaluates home health aide care provided every two weeks. ·Supervises LPN every month. <p>All registered nurses will re-sign a job description. Clinical Management Team will monitor implementation and compliance of agency policy on Careprovided following a written Plan of Care by performing concurrent review ofclinical records ensuring that care delivery is consistent with the Plan of Care including:</p> <ul style="list-style-type: none"> ·Ordered services initiated by all disciplines ·Frequency and duration of 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
G 176 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on clinical record, observation, agency policy review and interview, the	G 176	visits ·Treatments are initiated by all disciplines The Performance Improvement Manager /designee will perform the following: ·Audit 30% of all active clinical records forevidence that there is 100% compliance that the RN is performing duties per job description and according to policy with delivery of care per established Planof care and in compliance with regulations with resolution of all areas not meeting compliance. ·Development of a Performance Improvement Planusing PDSA format for tracking and trending of establishing and revision to Plan of Care at recertification per agency policy and regulatory requirements monthly for 100% threshold fornot less than three months then quarterly for one year. Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The Clinical Management Team will in-service all Registered	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>agency failed to ensure the registered nurse (RN), employee J, notified the physician of changes in the patient's condition in 1 of 12 (#1) clinical records reviewed, with the potential to effect all patients cared for by employee J.</p> <p>Findings:</p> <p>1. Clinical record patient #1, start of care (SOC) 2/5/15, evidenced no skilled nursing (SN) clinical notes, coordination of care, or phone log showing communication to physician regarding status of coccyx wound.</p> <p>Clinical record evidenced the coccyx wound was no longer addressed after 2/18/15 SN clinical note and no subsequent notes to indicate the coccyx wound remained.</p> <p>2. Home visit observation on 4/16/15, at 12:50 PM, to patient #1, employee D, licensed practical nurse (LPN), indicated the wound to coccyx was healed and only the wounds to feet were being addressed.</p> <p>3. On 4/21/15 at 12:20 PM, employee A, administrator, indicated the doctor had not been notified of the healed wound.</p> <p>4. Agency policy titled " MONITORING PATIENT'S RESPONSE/REPORTING</p>		<p>Nurses on Duties of a Registered Nurse. The RN is responsible for the following:</p> <ul style="list-style-type: none"> ·Completes an initial assessment of the patientand family to determine home care needs. Provides a complete physical assessment and history of current andprevious illness (es). ·Regularly re-evaluates patient nursing needs. ·Initiate the plan of care and makes necessary revisions as patient status and needs change. ·Uses health assessment data to determine nursing diagnosis. ·Develops a care plan, which establishes goalsbased on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing procedures. Administers medications and treatments as prescribed by thephysician. ·Counsels the patient and family in meetingnursing and related needs. ·Provides health care instructions to the patient as appropriate per assessment and plan of care. ·Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient. ·Acts as case manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload. ·Prepares clinical notes and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
	TO PHYSICIAN ", dated, October 2011, states, " ... PURPOSE To provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe ad appropriate care for the patient ... PROCEDURE 1. During each home visit, the clinician will monitor the patient's response to care against the established goals ... 3. The patient's physician will be contacted on the same day when any of the following occur: A. Significant changes in the patient's condition ... E. Changes that have occurred regarding diagnosis, or treatment (including procedures, medications, precautions, and limitations) "		updates the primary physician when necessary and at least every 60 days. ·Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition;obtains/receives physician's orders as required. ·Communicates with community health related persons to coordinate the care plan ·Ensures that arrangements for equipment and other necessary items and services are available. ·Instructs, supervises and evaluates home health aide care provided every two weeks. ·Supervises LPN every month. In addition to the above, the RN will monitor the patient's response to care against the established goals including, but not limited to: ·Care interventions ·Medications ·Teaching The RN will lead case conferences at the start of care and at least every 60 days to review and discuss all multidisciplinary cases. The care will be evaluated to determine achievement of goals. The patient's physician will be contacted on the same day when any of the following occur: ·Significant changes in the patient's condition ·Significant changes in the patient's psychosocial status, family/caregiver support, home environment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
G 179	484.30(b) DUTIES OF THE LICENSED PRACTICAL		<ul style="list-style-type: none"> ·Inability to achieve goals within the specified time frame. ·Changes in the patient's expected response to treatment or medications ·Changes that have occurred regarding diagnosis, prognosis, or treatment ·When there is a problem implementing the plan of care. ·When results are received for relevant laboratory tests ordered ·When patient is to be discharged from the organization or a specific service is to be discontinued The Performance Improvement Manager /designee will perform the following <ul style="list-style-type: none"> ·Audit 30% of all active clinical records forevidence that there is 100% compliance of RN field staff performing duties according to policy and in compliance with regulations. ·Development of Performance Improvement focusreview using PDSA format monthly to track and trend ensurance of RN compliance with agency policy and regulatory requirement to meet 100% threshold for not less than 3 months then quarterly for one year. The Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency does not recur. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
Bldg. 00	<p>NURSE</p> <p>The licensed practical nurse furnishes services in accordance with agency policy. Based on observation, clinical record review, interview and policy review, the agency failed to ensure the licensed practical nurse (LPN) had followed the agency's own, Ongoing Assessments and Monitoring Patient's Response/Reporting to Physician Policies in 1 of 12 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"> Home visit observation on 4/16/15 at 12:50 PM, to patient #1, observed employee D, licensed practical nurse (LPN), patient #1 was asked by LPN how was his/her appetite, patient 1 responded, only eating fruit at this time, because he/she has been depressed this week. LPN stated, that patient #1 should watch how much fruit is being eaten due to being diabetic. The patient's mental state was not addressed this visit. Clinical Record #1, start of care date 2/5/15, failed to evidence documentation of patient #1 stating he/she was depressed or reporting that finding to anyone else. Interview with employee A, director of 	G 179	<p>The Clinical Management Team has in-serviced all nurses on the Duties of a Licensed Practical nurse. The LPN is responsible for providing direct patient care under the supervision of a registered nurse. Responsibilities include following the plan of care, providing treatments, and working collaboratively with the members of the team to help meet positive patient care outcomes. LPN implements the plan of care initiated by the registered nurse; Provides accurate and timely documentation consistent with the plan of care; Assesses and provides patient and family/caregiver education and information pertinent to diagnosis and plan of care; Participates in coordination of home health services, appropriately reporting the identified needs for other disciplines to the registered nurse and/or clinical supervisor; uses equipment and supplies effectively and efficiently; participates in personal and professional growth and development; performs other duties as assigned by the registered nurse. Clinical notes to include the following; Blood pressure, pulse, respirations, temperature; Weight (once a week, if indicated by disease process); Pain status when</p>	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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>nursing (DON), agreed the LPN, employee D, should have contacted the registered nurse (RN) case manager or another supervising RN in the office. Also that the LPN should have assessed and documented the patients mental status when the patient stated he/she was feeling depressed.</p> <p>4. Agency policy titled "Ongoing Assessments", dated October 2011, states, " During each home visit the appropriate clinician will re-evaluate the patient according to the problem identified during the initial visit and thereafter ... the clinician will reassess the patient for ... H. Mental status ... L. ... patient needs and problems"</p> <p>5. Agency policy titled " MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN", dated October 2011, states, " Clinicians will monitor, document, and report the patient's response to care and treatment provided on each home visit.</p>		<p>applicable; breath sounds; skin integrity; bowel sounds, elimination (urinary and bowel); appetite/diet,nutritional status; mental status; functional status; safety/home environment;patient and family/caregiver support; progress toward goals and patient needs and problems; compliance to treatment and/or medications; patient's response to care; changes in patient condition; changes in patient diagnosis; changes in patient's care environmentor support systems. The LPN will be supervised by a registered nurse at least monthly. Performance Improvement Manager/designee will perform thefollowing:</p> <ul style="list-style-type: none"> -Clinical review of 30% of all active patients serviced by LPN field staff for evidence of compliance with agency policy for on going assessment with reporting of patient's change in condition to MD with resolution of any non compliance with agency policy. -Development of Performance Improvement Plan using PDSA format to track and trend compliance with agency policy to meet 100% threshold for not less than three months then quarterly for 1 years <p>The Administer and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 000 Bldg. 00	<p>This was a Home Health Federal Relicensure Survey.</p> <p>Survey Dates: 4/16/15 to 4/21/15</p> <p>Facility Number: IN011167</p> <p>Medicaid Number: 200838680</p> <p>Agency Census: Unduplicated 12 month census: 266 Active Patients: 134</p> <p>Sample: RR w/HV: 6 RR w/o HV: 6 Total: 12</p> <p>QA: JE 04/30/15</p>	N 000		
N 458 Bldg. 00	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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 job, including the following:</p> <ol style="list-style-type: none"> (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. <p>Based on employee record review, interview, agency policy review and Indiana Code, the agency failed to ensure all employees had criminal history checks in compliance with Indiana Code 16-27-2, in 7 of 13, (A, D, E, G, H, J, and L) employee records reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Record A included a document titled "SAFESCREENER.COM PRO! Background Screening Report" dated 9/3/13. The document failed to evidence the search was a life time search, included all counties in Indiana, and included the county in which the person lived if they lived out of state in the last 2 years. 2. Record D included a document titled "SAFESCREENER.COM PRO! Background Screening Report" dated 1/14/15. The document failed to 	N 458	<p>The Human Resource Department has secured an account through the State of Indiana, whereby a Limited Criminal history background check will be performed on all current Advanced Home Health Care, Inc. Administrative and field employees. All identified personnel files will audited for resolution and compliance with criminal history background checks. New employees who will be seeing home care patients will have a criminal history background check as part of their new hire orientation and prior to seeing home care patients. The Criminal history background covers the entire state of Indiana, including all counties for life time. A copy of the limited criminal history pursuant to IC 16-27-2 will be placed in the employee personnel file.</p> <p>Performance Improvement Manager/designee will perform 100%review of all administrative and field staff employees with resolution of any identified personnel files not in compliance with state regulatory statute. Development of</p>	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>evidence the search was a life time search, included all counties in Indiana, and included the county in which the person lived if they lived out of state in the last 2 years.</p> <p>3. Record E included a document titled "SAFESCREENER.COM PRO! Background Screening Report" dated 9/28/12. The document failed to evidence the search was a life time search, included all counties in Indiana, and included the county in which the person lived if they lived out of state in the last 2 years.</p> <p>4. Record G, included a document titled "SAFESCREENER.COM PRO! Background Screening Report" dated 11/19/13. The document failed to evidence the search was a life time search, included all counties in Indiana, and included the county in which the person lived if they lived out of state in the last 2 years.</p> <p>5. Record H included a document titled "SAFESCREENER.COM PRO! Background Screening Report" dated</p>		<p>PerformanceImprovement Plan using PDSA format to track and trend compliance with agency policy to meet 100% threshold for not less than three months then quarterly for 1 year. Administrator and Agency Supervisor will be responsible for monitoring this corrective action to ensure that the deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2/27/15. The document failed to evidence the search was a life time search, included all counties in Indiana, and included the county in which the person lived if they lived out of state in the last 2 years.</p> <p>6. Record J included a document titled "SAFESCREENER.COM PRO! Background Screening Report" dated 9/17/14. The document failed to evidence the search was a life time search, included all counties in Indiana, and included the county in which the person lived if they lived out of state in the last 2 years.</p> <p>7. Record L included a document titled "SAFESCREENER.COM PRO! Background Screening Report" dated 10/25/13. The document failed to evidence the search was a life time search, included all counties in Indiana, and included the county in which the person lived if they lived out of state in the last 2 years.</p> <p>8. Interview on 4/21/15 at 4:30 PM, employee A, director of nursing, was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 470 Bldg. 00	<p>unaware the background checks were not in compliance and that SAFESCREENER.COM PRO! is the primary company the agency uses for criminal history checks.</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of policy and procedures, the agency failed to ensure staff had provided services in accordance to their own infection control bag technique policy in 1 of 6 home visit observations (employee E, Registered Nurse (RN)).</p> <p>Findings:</p> <p>1. During a home visit observation on 4/16/15 at 2:45 PM to patient #3 with employee E, RN, the nurse was observed to hang the nursing bag on the back of patient #3's kitchen chair. The chair was short and nursing bag strap was long; the bag rested on the patient's floor during the entire home visit.</p> <p>2. Interview on 4/20/15 at 4:15 PM, the</p>	N 470	The Clinical Management Team will in-service 100% of the field staff on infection control and bag technique with a return demonstration by the staff member. The policy on bag technique and infection control will be given to each field staff employee describing the procedure for maintaining a clean nursing bag/computer bag and preventing cross contamination. Any new field staff employee will be in serviced during orientation on bag technique/infection control with a return demonstration. Agency Policy for maintaining a clean nursing bag/computer bag and preventing cross contamination to be distributed to all field staff at orientation and during in-service education. All current field staff to perform competency of bag technique with use of agency bag technique	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>agency's administrator and DON agreed that employee E, RN, should not have allowed her bag to rest on patent #3's floor during the home visit.</p> <p>5. The agencies policy titled "Bag Technique", dated October 2010, states, "Purpose: To describe the procedure for maintaining a clean nursing bag/computer bag and preventing cross contamination ... Bag Technique ... The bag will never be placed on the floor"</p>		<p>and infection control policies. Identified staff not compliant with bag technique /infection control will have on site supervisory visit performed by Clinical Management Team Member within next 30 days to ensure compliance with agency policy. Performance Improvement Manager/designee to develop the following: Performance Improvement Manager/designee to develop the following:</p> <ul style="list-style-type: none"> ·Develop a time schedule for direct observation supervisory visit by Clinical Management team members of all field staff member. ·Clinical Management Team to ensure competency of bag technique and infection control measures per completion of competency during orientation and prior to any onsite care performed, then every 6 months to ensure that this deficiency is corrected until 100% compliance by all field staff. ·Development of a tracking and trending tool using PDSA format for monthly establishment of onsite supervisory visits performed with compliance by Clinical Management Team member documentation ·Evidence of field staff compliance with 100% competency will be maintained in the employee personnel file. The human resource staff will notify the clinical team manager of 100% audits of personnel files on 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
N 518 Bldg. 00	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on observation, clinical record review, interview, and agency document review, the agency failed to ensure patients were provided the current Advanced Directives in 12 of 12 clinical records (#'s 1-12).</p> <p>Findings include</p> <p>1. The admission book given to the patients failed to include an updated July</p>	N 518	<p>a monthly basis. ·Continue with audit of personnel files until threshold of 100% is met for not less than three months then reduction of audits to quarterly by Human Resource Staff to ensure compliance with agency policy. The Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.</p> <p>The Clinical Management team has in serviced the nursing staff on the updated, July 1, 2013, Advance Directive for the State of Indiana. The admitting staff member will advise the patient in advance, concerning policies on advance directives including a description of Indiana Law. Written information will be included in the Start of Care packet and givento the patient before care is provided. All current patients will be given the</p>	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>2013 version of the 2004 Indiana Advanced Directives document in the admission folder that was distributed to all the agencies patients at the start of care.</p> <p>2. On 4/21/15 at 6:00 PM, Employee A, administrator, acknowledged the advanced directives were not the effective and current Indiana advanced directives (effective May 2004 and revised July 1, 2013).</p> <p>3. During a Home Visit observation on 4/16/15 at 11:00 AM with patient #1, start of care (SOC) 2/5/15, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>4. During a Home Visit observation on 4/16/15 at 12:15 PM with patient #2, SOC 2/26/15, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>5. During a Home Visit observation on 4/16/15 at 1:30 PM with patient #3, SOC 9/3/14, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>6. During a Home Visit observation on</p>		<p>updated July 1, 2013 Indiana Advance Directive Brochure with patient signature/representative signature of delivery. Developed form for patient/representative to sign to ensure updated Indiana Advanced Directives Brochure by RN to be returned to office for tracking and trending of compliance for delivery of updated information regarding Advanced Directive choices. The Performance Improvement Manager/designed developed the following:</p> <ul style="list-style-type: none"> ·Developed audit tool for patient confirmation of July 1, 2013 Indiana Advance Directives Brochure ·Developed tracking and trending tool for submission of signed delivery of updated Indiana Advanced Directives by RN field staff ·100% Clinical audit performed of all active patients for evidence the patient received the updated information on Advance Directives. ·Development of Focus Performance Improvement Plan to monitor compliance of delivery of July 1, 2013 Indiana Advanced Directive Brochure for new admission using PDSA format with Establishing Tracking and Trending of Performance Improvement plan with audits to be performed monthly for all new admissions to achieve 100% benchmark, for not less than 3 months. At that time, quarterly 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>4/17/15 at 11:00 AM with patient #4, SOC 2/21/15, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>7. During a Home Visit observation on 4/17/15 at 12:15 PM with patient #5, SOC 6/6/14, the home folder contained an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>8. During a Home Visit observation on 4/17/15 at 1:30 PM with patient #6, SOC 5/28/14, the home folder was observed to contain an unrevised, May 2004 copy of the Indiana Advanced Directives.</p> <p>9. Clinical record #1, SOC 2/5/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>10. Clinical record #2, SOC 2/26/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>11. Clinical record #3, SOC 9/3/14, failed to contain an updated July 1, 2013,</p>		<p>audits will be performed. The Administrator/designee will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>12. Clinical record #4, SOC 2/21/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>13. Clinical record #5, SOC 6/6/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>14. Clinical record #6, SOC 5/28/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>15. Clinical record #7, SOC 9/16/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>16. Clinical record #8, SOC 3/12/15,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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 contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>17. Clinical record #9, SOC 12/13/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>18. Clinical record #10, SOC 4/8/15, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>19. Clinical record 11, SOC 9/25/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>20. Clinical record #12, SOC 9/13/14, failed to contain an updated July 1, 2013, version of the 2004 Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 522 Bldg. 00	<p>21. Agency policy titled "ADMISSION DOCUMENTS", dated October 2011, states, " PURPOSE To ensure organizational compliance with the Patient Bill of Rights and regulatory requirements ... 3. A copy of the organization's policy on patient Advance Directives including a description of an individual's right under state law (whether statutory or as recognized by the courts of a state) and how such rights are implemented by the organization "</p> <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, agency document review, and interview, the agency failed to ensure the treatments and frequency of visits ordered on the plan of care (POC) were met and/or ensure the physician was notified of missed visits for 2 of 12 patients (patient #1 and 4).</p> <p>Findings:</p> <p>1. Clinical record #1, start of care (SOC) date 2/5/15, contained a POC dated 2/5/15-4/5/15 that stated, " ... skilled nurse (SN) 1 time (x)/week (wk) x 1 wk, 2 x/wk x 3 wks, 1 x/wk x 5 wks ", the</p>	N 522	The Clinical Management Team has inserviced all clinicians providing direct patient care regarding Acceptance of patients, Plan of Care and Medical Supervision. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine. The written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as patient's condition warrants. All clinicians involved in the patient's care will contribute to the plan of care. The patient and family/caregiver will participate in decisions regarding the plan of	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015	
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED				STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322			
(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>clinical record failed to evidence a SN visit was conducted during the week of 3/1/15 - 3/7/15.</p> <p>A. Clinical record patient #1, start of care (SOC) 2/5/15, contained a POC dated 2/5/15-4/5/15, with orders for Incision/wound care: skilled nurse visit, cleanse to coccyx with wound cleansers and pat dry - apply thin duoderm to protect, measure once a week and record.</p> <p>B. Skilled Nurse (SN) note dated, 2/13/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>C. SN note dated 2/18/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>D. SN Clinical note, dated, 2/20/15, completed by employee J, RN, no wound care to coccyx performed, does state, " ... CNS checks are normal and incision lines to bilateral left ankle covered with 4x4 - bacitracin to sites first ... ", there are no physician orders in the medical record for the SN to provide this treatment provided to left ankle.</p> <p>E. SN note dated, 2/24/15 completed by employee J, RN, failed to evidence wound care to coccyx was performed.</p>		<p>care whenever possible. The clinical plan of care includes: Pertinent primary and secondary diagnoses; Food or drug allergies; Homebound status; Goals/outcomes to be achieved; Patient's mental status; Functional limitations; activities permitted; Safety measures; Nutritional requirements; Medications and treatments; Specific procedures to be performed by therapies, including amount, frequency, and duration; Supplies and equipment required; Discharge or referral plans, Discharge teaching, frequency and duration of visits; Prognosis; rehabilitation potential; Other appropriate items such as precautions and contraindications. Based on the assessment and conclusions, the plan of care will include, but will not be limited to: Identified patient problems and needs; Reasonable, measurable, and individualized goals; Specific services to be provided, Actions to be taken to meet the patient goals, Type, frequency, and duration of said actions; equipment and supplies; Prognosis. A 60 day summary - a compilation- of the pertinent factors of a patient's clinical and progress notes will be sent to the physician at least every 60 days. Missed visits will be documented and a re-visit initiated within the Medicare week if possible. The Physician will be notified of all missed visits and delay in service,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>Documentation evidenced, Incision sited to outer right ankle healing well with new dressing and neosporin to site and rewrapped with ace wrap. The record failed to evidence there were orders for the SN to provide this treatment to right ankle.</p> <p>F. SN note dated 2/25/15 completed by employee J, RN, failed to evidence wound care to coccyx was performed. The nurse documented that new bandages were applied to right bilateral incision sites with no signs of infection. The record failed to evidence orders for the SN to provide this treatment to incision sites.</p> <p>G. SN note dated 3/9/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>H. SN note dated 3/12/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>I. SN note dated 3/16/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>J. SN note dated 3/20/15 completed by employee J, RN, failed to evidence wound care to the coccyx was provided. The nurse documented that Medihoney</p>		<p>to include:</p> <ol style="list-style-type: none"> 1.Rationale for missed visit 2.Rationale for the delay in services <p>The Staffing coordinator will assign and track visit requery compliance in the electronic system that populates physician ordersby discipline and visit frequency in the scheduler. The staffing coordinator is responsible for assigning, monitoring and updating the automated scheduling system for frequency compliance with the Plan of Care. Clinical Management Team will monitor implementation and compliance of agency policy on Care provided following a written Plan of Care by performing concurrent review of clinical records ensuring that care delivery is consistent with the Plan of Care including:</p> <ul style="list-style-type: none"> ·Ordered services initiated by all disciplines ·Frequency and duration of visits ·Treatments are initiated by all disciplines <p>Performance Improvement Manager/designee will perform thefollowing:</p> <ul style="list-style-type: none"> ·30% of all active patient charts will be audited for evidence that there is 100% threshold compliance that the Plan of Care is being followed and that the physician is notified of any changes that occur. ·Development of Performance Improvement Plan with focus 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was placed on wounds to right foot with granulation tissue forming. The record failed to evidence physician orders for this treatment.</p> <p>K. SN Clinical note, dated, 3/23/15, completed by employee J, RN, no coccyx wound care provided, does state, " ... Medihoney to old suture sites to right foot ... ABD pads to bilateral heels after sites cleansed with betadine and allowed to dry. Betadine to left great toe as well. Bilateral heels wrapped with kerlix and secured with tape. Ace wraps to bilateral feet ... ", there are no physician orders in the medical record for the SN to provide these treatments.</p> <p>L. SN note dated 3/27/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>M. SN note dated 4/1/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>N. SN note dated 4/3/15 completed by employee D, licensed practical nurse (LPN), failed to evidence wound care was provided this SN visit. The LPN documented the left Distal Heel was painted with betadine with site left open to air. The Left Distal Great Toe was painted with betadine with site left open</p>		<p>review to track and trend noncompliance with Plan of Care identified above using PDSA format to monitor compliance monthly to meet 100% threshold for not less than three months then quarterly for one year. The Administrator/designee will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to air. The Right Distal Heel was painted with betadine, covered with abd pad and secured with kerlix and tape. The Right Medial Foot Cleaning/Irrigation Method NS with medihoney applied covered by a 2x2 gauze wrapped with kerlix. Right Lateral Heel Cleaned/Irrigation NS with medihoney applied covered by a 2x2 gauze. Right Lateral Foot Cleaned with NS medihoney applied and covered with a 2x2 left open to air. The record failed to evidence orders for these wound care treatments.</p> <p>O. SN note dated 4/7/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit. The nurse documented bilateral heel sites covered with eschar, painted with betadine and kept dry. Left great toe site with eschar ... painted with betadine and kept dry. The record failed to evidence any orders for these wound care treatments.</p> <p>P. SN note dated 4/10/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>Q. SN note dated 4/13/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit. The nurse documented wound care was provided to the Left Distal Heel, Left</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>Distal Great Toe, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence orders for the wound care.</p> <p>R. SN note dated 4/16/15 completed by employee D, LPN, failed to evidence wound care was provided this SN visit. The nurse documented wound care was provided to the Left Distal Heel, Left Distal Great Toe, Right Distal Heel, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence orders for these treatments.</p> <p>S. During a home visit observation on 4/16/15, at 12:50 PM, employee D, (LPN), was observed to perform wound care to left and right heels and left great toe.</p> <p>T. On 4/16/15 at 1: 10 PM, employee D, LPN, indicated only the wounds to feet were being addressed.</p> <p>2. Clinical record #4, SOC 9/25/14, included agency forms titled "ATTEMPTED VISIT/MISSED VISIT" dated 10/28/14 and 11/25/14 for occupational therapy visits that identified the physician was not notified of the missed visits dated 10/14/14 and 11/11/14.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 524 Bldg. 00	<p>3. During interview on 4/21/15 at 10:00 AM, employee A, director of nursing (DON), indicated there were no notes (skilled nursing visit notes, communication notes, physician orders, or call logs) in the electronic medical record (EMR) for patient #1 indicating why no visit was made the week of 3/1/15 - 3/7/15 and indicated she would contact the nurse to look into what happened and agrees patient #4 does have missed visits that were not sent to physician.</p> <p>4. Agency document titled " RE: Performance Standards ", dated October 3, 2013, states, " ... Communication - if delay in providing service to be communicated to supervisor, the physician is to be notified, and both are to be documented on a call log in the patient record"</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (i) Mental status. (ii) Types of services and equipment required.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>(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, observation, and interview, the agency failed to ensure the plan of care addressed all pertinent patient conditions and therapy orders included modality orders including length of treatment in 2 of 12 (#4 and 6) clinical records reviewed.</p> <p>Findings:</p> <p>1. During a Home visit observation on 4/17/15 at 11:00 AM to patient #4, a dark, red, purple raised area about the size of a quarter was observed on the patient's left great toe.</p> <p>A. Clinical record #4, start of care, 2/21/15, included a plan of care for the certification period, 2/21/15 - 4/21/15 that failed to include the area to left great toe.</p> <p>B. Phone interview on 4/21/15 at 3:10</p>	N 524	<p>The Clinical Management Team will in-service all clinicians providing direct patient care on agency policy "Care Planning Process" including but not limited to:</p> <ul style="list-style-type: none"> ·All pertinent diagnosis, mental status, types of service equipment required. ·Frequency of visits, prognosis, rehab potential, functional limitations, activities permitted ·Nutritional requirements ·Medications and treatments, allergies ·Homebound status ·Goals/outcomes to be achieved ·Safety Measures ·Specific procedures to be performed by therapies, including amount, frequency, duration ·Prognosis, rehabilitation potential ·Instructions for timely discharge or referral ·Any other appropriate items <p>Care follows a written plan of care</p>	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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>PM with RN, employee L, the employee indicated he was just watching the area.</p> <p>2. Clinical record #6, start of care 5/28/14, contained a POC for the certification period with orders for physical therapy twice a week for 6 weeks. The POC failed to evidence the therapy modalities specifying length of treatment.</p> <p>3. Agency document titled "Care Planning ", dated October 2013, states, " ... 3. Based on the assessment and conclusions, the plan of care will include, but will not be limited to ... C. Specific services to be provided ... E. Type, frequency, and duration of above actions"</p>		<p>established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicine. The written plan of care will be initiated within 5 days of start of care and updated at least every 60 days or as patients condition warrants. All clinicians involved in the patient's care will contribute to the plan of care. The patient and family/caregiver will participate in decisions regarding the plan of care whenever possible. Based on the assessment and conclusions, the plan of care will include, but will not be limited to: Identified patient problems and needs; Reasonable,measurable, and individualized goals; Specific services to be provided, Actions to be taken to meet the patient goals, Type , frequency, and duration of said actions; equipment and supplies; Prognosis. A 60 day summary - a compilation- of the pertinent factors of a patient's clinical and progress notes will be sent to the physician at least every 60 days. Performance Improvement Manager/designee will perform the following:</p> <ul style="list-style-type: none"> ·30% of all active patient charts will be audited for evidence that there is 100% threshold compliance that the Plan of Care is being followed and documentation of physician notification of changes inpatient status. ·Development of Performance Improvement Plan with focus 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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	
N 537 Bldg. 00	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review, agency document review, and interview, the agency failed to ensure, the registered nurse (RN), employee J and licensed practical nurse (LPN), employee D, provided wound care treatments as ordered on the plan of care (POC) for 1 of 12 patients (patient #1) with the potential to affect all patient's receiving care from employee D or J.</p> <p>Findings:</p> <p>1. Clinical record patient #1, start of care (SOC) 2/5/15, contained a POC dated 2/5/15-4/5/15, with orders for Incision/wound care: skilled nurse visit, cleanse to coccyx with wound cleansers</p>	N 537	<p>review to track and trend noncompliance with Plan of Care identified above using PDSA format to monitor compliance monthly to meet 100% threshold for not less than three months then quarterly for one year. Administrator/Design will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>The Clinical Management Team has in serviced the agency staff that drugs and treatments are administered by agency staff only as ordered by the physician. Any change in treatment will generate a physician order. Verbal orders must be signed and dated by the nurse or qualified therapist who is furnishing or supervising the ordered service at the time it is given. It is the RN's or therapist's responsibility to make any necessary revisions to the Plan of Care based on that order. Orders signed by the nurse or therapist are then sent to the physician by fax, mail, or personally. Orders are tracked by date and resent after 5 days. All physician orders must be included in the patient's clinical record. All Plans of Care</p>	05/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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 pat dry - apply thin duoderm to protect, measure once a week and record.</p> <p>A. Skilled Nurse (SN) note dated, 2/13/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>B. SN note dated 2/18/15 completed by employee J, RN, failed to evidence wound care was provided.</p> <p>C. SN Clinical note, dated, 2/20/15, completed by employee J, RN, no wound care to coccyx performed, does state, " ... CNS checks are normal and incision lines to bilateral left ankle covered with 4x4 - bacitracin to sites first ... ", there are no physician orders in the medical record for the SN to provide this treatment provided to left ankle.</p> <p>D. SN note dated, 2/24/15 completed by employee J, RN, failed to evidence wound care to coccyx was performed. Documentation evidenced, Incision sited to outer right ankle healing well with new dressing and neosporin to site and rewrapped with ace wrap. The record failed to evidence there were orders for the SN to provide this treatment to right ankle.</p> <p>E. SN note dated 2/25/15 completed by</p>		<p>are to be signed and dated, and in the clinical record within 30 days. Clinical Management Team will monitor implementation and compliance of agency policy on Care provided following a written Plan of Care by performing concurrent review of clinical records ensuring that care delivery is consistent with the Plan of Care including:</p> <ul style="list-style-type: none"> ·Ordered services initiated by all disciplines ·Frequency and duration of visits ·Treatments are initiated by all disciplines <p>Performance Improvement Manager/designee will perform thefollowing:</p> <ul style="list-style-type: none"> ·30% of all active patient charts will be auditedfor evidence that there is 100% threshold compliance that the Plan of Care isbeing followed and that the physician is notified of any changes that occur. ·100% review of identified RN/LPN field staffmember assigned patient assignments for compliance with established Plan ofCare and resolution of any areas of non compliance. ·Development of focus Performance Improvement Plan using PDSA format for tracking and trending monthly of compliance with agency policy and regulatory requirement for development and updating of Plan of Care at SOC/Recertification to meet 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>employee J, RN, failed to evidence wound care to coccyx was performed. The nurse documented that new bandages were applied to right bilateral incision sites with no signs of infection. The record failed to evidence orders for the SN to provide this treatment to incision sites.</p> <p>F. SN note dated 3/9/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>G. SN note dated 3/12/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>H. SN note dated 3/16/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>I. SN note dated 3/20/15 completed by employee J, RN, failed to evidence wound care to the coccyx was provided. The nurse documented that Medihoney was placed on wounds to right foot with granulation tissue forming. The record failed to evidence physician orders for this treatment.</p> <p>J. SN Clinical note, dated, 3/23/15, completed by employee J, RN, no coccyx wound care provided, does state, " ... Medihoney to old suture sites to right</p>		<p>100% threshold for not less than 3 months then quarterly for one year</p> <p>The Administrator and Agency supervisor will be responsible for monitoring this corrective action to ensure that the deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>foot ... ABD pads to bilateral heels after sites cleansed with betadine and allowed to dry. Betadine to left great toe as well. Bilateral heels wrapped with kerlix and secured with tape. Ace wraps to bilateral feet ... ", there are no physician orders in the medical record for the SN to provide these treatments.</p> <p>K. SN note dated 3/27/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>L. SN note dated 4/1/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>M. SN note dated 4/3/15 completed by employee D, licensed practical nurse (LPN), failed to evidence wound care was provided this SN visit. The LPN documented the left Distal Heel was painted with betadine with site left open to air. The Left Distal Great Toe was painted with betadine with site left open to air. The Right Distal Heel was painted with betadine, covered with abd pad and secured with kerlix and tape. The Right Medial Foot Cleaning/Irrigation Method NS with medihoney applied covered by a 2x2 gauze wrapped with kerlix. Right Lateral Heel Cleaned/Irrigation NS with medihoney applied covered by a 2x2 gauze. Right Lateral Foot Cleaned with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>NS medihoney applied and covered with a 2x2 left open to air. The record failed to evidence orders for these wound care treatments.</p> <p>N. SN note dated 4/7/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit. The nurse documented bilateral heel sites covered with eschar, painted with betadine and kept dry. Left great toe site with eschar ... painted with betadine and kept dry. The record failed to evidence any orders for these wound care treatments.</p> <p>O. SN note dated 4/10/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit.</p> <p>P. SN note dated 4/13/15 completed by employee J, RN, failed to evidence wound care was provided this SN visit. The nurse documented wound care was provided to the Left Distal Heel, Left Distal Great Toe, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence orders for the wound care.</p> <p>Q. SN note dated 4/16/15 completed by employee D, LPN, failed to evidence wound care was provided this SN visit. The nurse documented wound care was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 542 Bldg. 00	<p>provided to the Left Distal Heel, Left Distal Great Toe, Right Distal Heel, Right Medial Foot, Right Lateral Heel, and Right Lateral Foot. The record failed to evidence orders for these treatments.</p> <p>2. During a home visit observation on 4/16/15, at 12:50 PM, employee D, (LPN), was observed to perform wound care to left and right heels and left great toe.</p> <p>3. On 4/16/15 at 1: 10 PM, employee D, LPN, indicated only the wounds to feet were being addressed.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN), employee J, updated the Plan of Care (POC) with the correct diagnosis and patient for 1 of 12 patients (#1)</p> <p>Findings include</p>	N 542	The Clinical Management Team will in-service all Registered Nurses on the Duties of a Registered Nurse. The RN is responsible for the following: ·Completes an initial assessment of the patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness (es).	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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. Clinical record # 1, start of care date 2/5/15, contained a POC dated 2/5/15 - 4/5/15 and 4/6/15 - 6/4/15, that filed to evidence all the diagnoses from the the 2/5/15 - 4/5/15 POC and was not updated to reflect that the patient no longer had a pressure ulcer.</p> <p>2. Interview on 4/21/15 at 1:00 PM, employee J, registered nurse case manager, stated, she/he did not realize the POC had not been updated correctly an it was an oversight and in fact the the wound to patient #1's coccyx had healed shortly after the SOC.</p>		<ul style="list-style-type: none"> ·Regularly re-evaluates patient nursing needs. ·Initiate the plan of care and makes necessary revisions as patient status and needs change. ·Uses health assessment data to determine nursing diagnosis. ·Develops a care plan, which establishes goals based on nursing diagnosis and incorporates therapeutic, preventive, and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician. ·Counsels the patient and family in meeting nursing and related needs. ·Provides health care instructions to the patient as appropriate per assessment and plan of care. ·Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient. ·Acts as case manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload. ·Prepares clinical notes and updates the primary physician when necessary and at least every 60 days. ·Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition;obtains/receives physician's orders as required. ·Communicates with community 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>health related persons to coordinate the care plan</p> <ul style="list-style-type: none"> ·Ensures that arrangements for equipment and other necessary items and services are available. ·Instructs, supervises and evaluates home health aide care provided every two weeks. ·Supervises LPN every month. <p>All registered nurses will re-sign a job description. Clinical Management Team will monitor implementation and compliance of agency policy on care provided following a written Plan of Care by performing concurrent review of clinical records ensuring that care delivery is consistent with the Plan of Care including:</p> <ul style="list-style-type: none"> ·Ordered services initiated by all disciplines ·Frequency and duration of visits ·Treatments are initiated by all disciplines <p>The Performance Improvement Manager/designee will perform the following:</p> <ul style="list-style-type: none"> ·Audit 30% of all active clinical records for evidence that there is 100% compliance that the RN is performing duties per job description and according to policy with delivery of care per established Plan of care and in compliance with regulations with resolution of all areas not meeting compliance. ·Development of a Performance Improvement Plan using PDSA format for tracking and trending of establishing and revision to Plan 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 544 Bldg. 00	<p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes.</p> <p>Based on clinical record, observation, agency policy review and interview, the agency failed to ensure the registered nurse (RN), employee J, notified the physician of changes in the patient's condition in 1 of 12 (#1) clinical records reviewed, with the potential to effect all patients cared for by employee J.</p> <p>Findings:</p> <p>1. Clinical record patient #1, start of care (SOC) 2/5/15, evidenced no skilled nursing (SN) clinical notes, coordination of care, or phone log showing communication to physician regarding status of coccyx wound.</p>	N 544	<p>of Care at recertification per agency policy and regulatory requirements monthly for 100% threshold for not less than three months then quarterly for one year.</p> <p>The Administrator and Agency supervisor will be responsible for monitoring this corrective action to ensure that the deficiency is corrected and will not recur.</p> <p>The Clinical Management Team will in-service all Registered Nurses on Duties of a Registered Nurse. The RN is responsible for the following:</p> <ul style="list-style-type: none"> ·Completes an initial assessment of the patient and family to determine home care needs. Provides a complete physical assessment and history of current and previous illness (es). ·Regularly re-evaluates patient nursing needs. ·Initiate the plan of care and makes necessary revisions as patient status and needs change. ·Uses health assessment data to determine nursing diagnosis. ·Develops a care plan, which establishes goals based on nursing diagnosis and 	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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>Clinical record evidenced the coccyx wound was no longer addressed after 2/18/15 SN clinical note and no subsequent notes to indicate the coccyx wound remained.</p> <p>2. Home visit observation on 4/16/15, at 12:50 PM, to patient #1, employee D, licensed practical nurse (LPN), indicated the wound to coccyx was healed and only the wounds to feet were being addressed.</p> <p>3. On 4/21/15 at 12:20 PM, employee A, administrator, indicated the doctor had not been notified of the healed wound.</p> <p>4. Agency policy titled " MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN ", dated, October 2011, states, " ... PURPOSE To provide guidelines for monitoring the patient's response to care, and for reporting to the patient's physician ... Clinicians will establish and maintain ongoing communication with the physician to ensure safe ad appropriate care for the patient ... PROCEDURE 1. During each home visit, the clinician will monitor the patient's response to care against the established goals ... 3. The patient's physician will be contacted on the same day when any of the following occur: A. Significant changes in the patient's condition ... E. Changes that have</p>		<p>incorporates therapeutic, preventive, andrehabilitative nursing procedures. Administers medications and treatments as prescribed by the physician.</p> <ul style="list-style-type: none"> ·Counsels the patient and family in meeting nursing and related needs. ·Provides health care instructions to the patient as appropriate per assessment and plan of care. ·Identifies discharge planning needs as part of the care plan development and implements prior to discharge of the patient. ·Acts as case manager when assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload. ·Prepares clinical notes and updates the primary physician when necessary and at least every 60 days. ·Communicates with the physician regarding the patient's needs and reports any changes in the patient's condition;obtains/receives physician's orders as required. ·Communicates with community health related persons to coordinate the care plan ·Ensures that arrangements for equipment and other necessary items and services are available. ·Instructs, supervises and evaluates home health aide care provided every two weeks. ·Supervises LPN every month. <p>In addition to the above, the RN</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
	occurred regarding diagnosis, or treatment (including procedures, medications, precautions, and limitations) ... "		<p>will monitor the patient's response to care against the established goals including, but not limited to:</p> <ul style="list-style-type: none"> ·Care interventions ·Medications ·Teaching <p>The RN will lead case conferences at the start of care and at least every 60 days to review and discuss all multidisciplinary cases. The care will be evaluated to determine achievement of goals. The patient's physician will be contacted on the same day when any of the following occur:</p> <ul style="list-style-type: none"> ·Significant changes in the patient's condition ·Significant changes in the patient's psychosocial status, family/caregiver support, home environment. ·Inability to achieve goals within the specified time frame. ·Changes in the patient's expected response to treat mentor medications ·Changes that have occurred regarding diagnosis, prognosis, or treatment ·When there is a problem implementing the plan of care. ·When results are received for relevant laboratory tests ordered ·When patient is to be discharged from the organization or a specific service is to be discontinued <p>The Performance Improvement Manager /designee will perform the following</p> <ul style="list-style-type: none"> ·Audit 30% of all active clinical 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 547 Bldg. 00	<p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on clinical record review, policy review, and interview, the agency failed to ensure physician's verbal, telephone, and plan of care (POC) orders were signed by the physician within the time frame stated in the agency's policy for 6 (#1,2, 3, 6, 7 and 11) of 12 records reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care (SOC), 2/5/15, contained a POC dated 2/5/15 - 4/5/15, was not signed by the physician. 2. Clinical record # 2, SOC 2/26/15, contained a 	N 547	<p>records for evidence that there is 100% compliance of RN field staff performing duties according to policy and in compliance with regulations. ·Development of Performance Improvement focus review using PDSA format monthly to track and trend ensurance of RN compliance with agency policy and regulatory requirement to meet 100% threshold for notless than 3 months then quarterly for one year. The Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency does not recur.</p> <p>The Clinical Management Team has in serviced all staff members on the policy on acceptance and verification of physician orders. Orders will be obtained from a licensed physician for care and services to be provided to home health care patients. Orders will be taken only by professional, licensed home health personnel (registered nurse or qualified therapist). A qualified individual</p>	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>POC, dated 2/26/15 to 4/26/15 that was not signed by the physician.</p> <p>3. Interview with director of nursing, employee A, states patient #2's POC was sent to the wrong physician and that is why the POC has not been signed, it was mailed to the patient's admitting ER physician by error.</p> <p>4. Clinical record #3, SOC 9/3/14, contained a POC, dated 3/2/15 - 4/30/15 that was not signed by the physician.</p> <p>5. Clinical record #6, SOC 5/28/14, contained physician orders that were not signed within 30 days.</p> <p>A. A POC dated, 1/23/15 - 3/23/15, was signed on 4/20/15 by physician, after the agency's 30 day policy.</p> <p>B. Agency document titled "PT Eval" dated 2/18/15, was signed on 4/20/15 by physician, after the agency's 30 day policy.</p> <p>C. A post hospitalization physician order to continue home physical therapy dated 2/18/15, was signed on 4/20/15, after the agency's 30 day policy.</p> <p>D. A physician order stating " ... SN: PRNx2 Complications/Med Changes Correction to SN frequency for cert period 11/24/14 1/22/15; SN 1W9 + 2 PRN visits ... PT: 3x/wk x 3wks CONTINUE PT SERVICES FOR 3W3 EFFECTIVE WEEK OF 01/02/15 ... " SIGNED BY RN on 2/12/15, was signed on 4/20/15 by physician, after the agency's 30 day policy.</p> <p>6. Clinical record #7, 9/16/14 contained a POC dated 3/15/15 - 5/13/15, that was signed by the physician on 4/21/15, after the agency's 30 day policy.</p> <p>7. Clinical record #11, 9/25/14 contained physician orders that were not signed within 30 days.</p> <p>A. Agency document titled "OT Eval" dated 10/10/14, was signed not signed by the physician.</p> <p>B. A transfer on 12/23/14, was signed by the physician on 2/4/15.</p>		<p>will review each order or prescription before care is provided. The sole exception for verification will be with emergency orders or prescriptions where a delay for verification would likely result in an adverse result for the patient. An order or prescription will be verified when there is a question or discrepancy in the order/prescription and when the order is communicated by someone other than the physician or his/her agent. The order or prescription reviewed may be the original order, a facsimile copy, or the direct transcription of a verbal order. All telephone orders will be received and processed in accordance with state and federal laws and regulations. All telephone orders or verbal orders will be "read back" to the physician or designee to assure accuracy. Orders will be documented on a form provided by Advanced Home Health Care, Inc, dated and signed by the professional receiving the order. A copy of the physician's order will be kept in the clinical record. The original of the order form will be delivered to the physician for signature. Signed orders will be in the clinical record within 30 days of initiation of care or interim orders.</p> <p>The Performance Improvement Manager /designee will audit 30% of all active patient charts for evidence of 100% compliance for no less than 3 months to ensure</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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
N 553 Bldg. 00	<p>C. A POC dated 9/25/14, 11/24/14 - 1/22/15, was signed on 2/16/15, after the agency's 30 day policy.</p> <p>8. Interview on 4/21/15, at 11:20 AM with employee A, director of nursing, expressed displeasure of physician taking so long signing orders.</p> <p>9. Interview on 4/21/15, at 11:25 AM with employee R, administrative assistant, Discussed how orders where handled and steps taken to get physician signatures. Explained use of order tracking and fax tracking method used in the office.</p> <p>10. Agency policy titled "PHYSICIAN PARTICIPATION IN THE PLAN OF CARE", dated October 2011, states, " ... The attending physician's verbal orders will be obtained at the time the plan of care is established ... The attending physician will sign the plan of care/treatment within 30 days ... "</p> <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 observation, clinical record review, interview and policy review, the agency failed to ensure the licensed practical nurse (LPN) had followed the agency's own, Ongoing Assessments and Monitoring Patient's Response/Reporting to Physician Policies in 1 of 12 records</p>	N 553	<p>that orders are received within 30 days of initiation of care or of the interim order. After that time, 10% of all active patient charts will be audited quarterly. Development of Performance Improvement Plan using PDSA format to track and trend compliance with agency policy to meet 100% threshold for not less than three months then quarterly for 1 years The Administrator and Agency Supervisor will be responsible for monitoring this corrective action to ensure that the deficiency is corrected and will not recur.</p> <p>The Clinical Management Team has in-serviced all nurses on the Duties of a Licensed Practical nurse. The LPN is responsible for providing direct patient care under the supervision of a registered nurse. Responsibilities include following the plan of care, providing treatments, and working</p>	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322		
(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>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"> 1. Home visit observation on 4/16/15 at 12:50 PM, to patient #1, observed employee D, licensed practical nurse (LPN), patient #1 was asked by LPN how was his/her appetite, patient 1 responded, only eating fruit at this time, because he/she has been depressed this week. LPN stated, that patient #1 should watch how much fruit is being eaten due to being diabetic. The patient's mental state was not addressed this visit. 2. Clinical Record #1, start of care date 2/5/15, failed to evidence documentation of patient #1 stating he/she was depressed or reporting that finding to anyone else. 3. Interview with employee A, director of nursing (DON), agreed the LPN, employee D, should have contacted the registered nurse (RN) case manager or another supervising RN in the office. Also that the LPN should have assessed and documented the patients mental status when the patient stated he/she was feeling depressed. 4. Agency policy titled "Ongoing 		<p>collaboratively with the members of the team to help meet positive patient care outcomes. LPN implements the plan of care initiated by the registered nurse; Provides accurate and timely documentation consistent with the plan of care; Assesses and provides patient and family/caregiver education and information pertinent to diagnosis and plan of care; Participates in coordination of home health services, appropriately reporting the identified needs for other disciplines to the registered nurse and/or clinical supervisor; uses equipment and supplies effectively and efficiently; participates in personal and professional growth and development; performs other duties as assigned by the registered nurse. Clinical notes to include the following; Blood pressure, pulse, respirations, temperature; Weight (once a week, if indicated by disease process); Pain status when applicable; breath sounds; skin integrity; bowel sounds, elimination (urinary and bowel); appetite/diet, nutritional status; mental status; functional status; safety/home environment; patient and family/caregiver support; progress toward goals and patient needs and problems; compliance to treatment and/or medications; patient's response to care; changes in patient condition; changes in patient diagnosis;</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVANCED HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2834 B 45TH ST HIGHLAND, IN 46322
--	---

(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>Assessments", dated October 2011, states, " During each home visit the appropriate clinician will re-evaluate the patient according to the problem identified during the initial visit and thereafter ... the clinician will reassess the patient for ... H. Mental status ... L. ... patient needs and problems"</p> <p>5. Agency policy titled " MONITORING PATIENT'S RESPONSE/REPORTING TO PHYSICIAN", dated October 2011, states, " Clinicians will monitor, document, and report the patient's response to care and treatment provided on each home visit.</p>		<p>changes in patient's care environment or support systems. The LPN will be supervised by a registered nurse at least monthly. Performance Improvement Manager/designee will perform thefollowing: Clinical review of 30% of all active patients serviced by LPN field staff for evidence of compliance with agency policy for on going assessment with reporting of patient's change in condition to MD with resolution of any non compliance with agency policy.</p> <p>·Development of Performance Improvement Plan using PDSA format to track and trend compliance with agency policy to meet 100% threshold for not less than three months then quarterly for 1 years</p> <p>The Administrator and Agency Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	