

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

G000000	<p>This visit was a Home Health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: April 22-24, 2013 Partial Extended Survey Dates: April 24, 2013</p> <p>Facility Number: 006364</p> <p>Provider Number: 157259</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor - Team Leader Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 63 Home Health Aide Only: 65 Personal Care Only: 0 Total: 128</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN,</p>	G000000		
---------	--	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260
--	--

(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
	RN  April 29, 2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/24/2013
NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G000121	<p><b>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on document review, observation, and interview, the agency failed to ensure appropriate infection control measures were followed during 1 of 1 home visits with a Registered Nurse with the potential to affect all the patients seen by employee L, Registered Nurse (RN). (Home Visit #1)</p> <p>The findings include:</p> <p>1. The Centers for Disease Control and Prevention (CDC) document titled "Medication Preparation Questions" dated 3/2/2011 states, "Medications should be drawn up in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed. Examples of contaminated items that should not be placed in or near the medication preparation area include: used equipment such as syringes, needles, IV tubing, blood collection tubes, needle holders (e.g., Vacutainer® holder), or other soiled equipment or materials that</p>	G000121	The Administrator/DHCS will ensure the agency meets compliance for infection control by completing the following inservice: 1. Re-education of all Interim nurses trained to administer IV medications for review of the following: a. mixing IV medications in the home setting b. aseptic technique c. infection control in the home setting with emphasis on clean/dirty area in the home setting Completion date: 5/24/132. DHCS/designee will perform on site supervisory visits on all active IV therapy trained nurses at least once in the next 90 days, through August 17, 2013 to observe for aseptic technique, compliance with clean technique in the home setting and randomly, ongoing.	05/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/24/2013
NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260		
(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>have been used in a procedure. In general, any item that could have come in contact with blood or body fluids should not be in the medication preparation area."</p> <p>2. During a home visit on 4/23/13 at 9:32 AM, employee L, RN, opened the alcohol swab package, swabbed the medication vial, drew up the medication in a syringe, and placed the alcohol swab on a newspaper. Then the RN picked up the alcohol swab from the newspaper, swabbed the second medication vial, drew up the medication in the same syringe, and placed the alcohol swab on the newspaper. Then employee L picked up the alcohol swab from the newspaper, swabbed the third medication vial, and drew up the medication in the same syringe. Employee L used a new alcohol swab to clean the Intravenous (IV) bag, then injected the medication into the IV bag for the patient's infusion. Employee L asked employee K, RN, for another alcohol swab. Then employee L cleaned the IV site, connected the IV tubing to the site, and began the infusion.</p> <p>3. On 4/24/13 at 8:15 PM, employee A, Administrator, indicated the RN soul have used a total of three alcohol swabs,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260
--	--

(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
	one for each medication vial.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

N000000	<p>This visit was for a home health state relicensure survey.</p> <p>Survey Dates: April 22-24, 2013</p> <p>Facility Number: 006364</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor - Team Leader</p> <p style="padding-left: 150px;">Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 63 Home Health Aide Only: 65 Personal Care Only: 0 Total: 128</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: right;">April 29, 2013</p>	N000000		
---------	---	---------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260
--	--

(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
N000543	<p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.</p> <p>Based on document review, observation, and interview, the agency failed to ensure the registered nurse used appropriate preventative infection control measures 1 of 1 home visits with a Registered Nurse with the potential to affect all the patients seen by employee L, Registered Nurse (RN). (Home Visit #1)</p> <p>The findings include:</p> <p>1. The Centers for Disease Control and Prevention (CDC) document titled "Medication Preparation Questions" dated 3/2/2011 states, "Medications should be drawn up in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed. Examples of contaminated items that should not be placed in or near the medication preparation area include: used equipment such as syringes, needles, IV tubing, blood collection tubes, needle holders (e.g., Vacutainer® holder), or other soiled equipment or materials that</p>	N000543	<p>The Administrator/DHCS will ensure the agency meets compliance for infection control by completing the following inservice: 1. Re-education of all Interim nurses trained to administer IV medications for review of the following: a. mixing IV medications in the home setting b. aseptic technique c. infection control in the home setting with emphasis on clean/dirty area in the home setting Completion date: 5/24/132. DHCS/designee will perform on site supervisory visits on all active IV therapy trained nurses at least once in the next 90 days, through August 17, 2013 to observe for aseptic technique, compliance with clean technique in the home setting and randomly, ongoing.</p>	05/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/24/2013
NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260		
(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>have been used in a procedure. In general, any item that could have come in contact with blood or body fluids should not be in the medication preparation area."</p> <p>2. During a home visit on 4/23/13 at 9:32 AM, employee L, RN, opened the alcohol swab package, swabbed the medication vial, drew up the medication in a syringe, and placed the alcohol swab on a newspaper. Then the RN picked up the alcohol swab from the newspaper, swabbed the second medication vial, drew up the medication in the same syringe, and placed the alcohol swab on the newspaper. Then employee L picked up the alcohol swab from the newspaper, swabbed the third medication vial, and drew up the medication in the same syringe. Employee L used a new alcohol swab to clean the Intravenous (IV) bag, then injected the medication into the IV bag for the patient's infusion. Employee L asked employee K, RN, for another alcohol swab. Then employee L cleaned the IV site, connected the IV tubing to the site, and began the infusion.</p> <p>3. On 4/24/13 at 8:15 PM, employee A, Administrator, indicated the RN soul have used a total of three alcohol swabs,</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157259	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8803 N MERIDIAN STE 300 INDIANAPOLIS, IN 46260
--	--

(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
	one for each medication vial.			