

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157621	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2012
NAME OF PROVIDER OR SUPPLIER BETTER LIVING HOME HEALTH CARE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 112 W PINKNEY ST PRINCETON, IN 47670		
(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	
G0000	<p>This was a federal home health recertification survey.</p> <p>Facility #: 012101</p> <p>Survey Dates: 8-27-12, 8-28-12, and 8-29-12</p> <p>Medicaid Vendor #: 200951600A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Linda Dubak, R.N. 08/05/2012</p>	G0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, interview, and agency policy review, the agency failed to ensure it had provided services in accordance with its own infection control policies and procedures in 5 (#s 1, 2, 3, 4, & 5) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among staff and the agency's 44 current patients.</p> <p>The findings include:</p> <p>1. The agency's 03/09 "Infection/Exposure Control Plan" policy number 4013 states, "The agency will . . . comply with all applicable state, federal regulations."</p> <p>A. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from</p>	G0121	<p>1. The Agency's clinical field staff will receive mandatory education including handouts and competency testing regarding: a. CDC guidelines for Infection Control & Standard Precautions hand hygiene; correct sequencing of washing hands, donning and removing gloves, including appropriate times to cleanse hands, don gloves, change gloves, and cleanse non-disposable equipment. b. the Agency's Infection Control policies 4013, 4014, 4016, and 4017. c. All handouts will be distributed by 9-28-12.2. The Agency's clinical field staff will demonstrate industry standards and accepted infection control measures by: a. Successfully demonstrating the correct sequencing of washing hands, donning and removing gloves, including appropriate times to cleanse hands, don gloves, change gloves, and clean non-disposable equipment. b. 100% of the nurses will be competency checked by 9-28-12. c. 100% of the remaining field staff will be competency checked by 11-28-12.3. The Administrator will be responsible for assuring all</p>	11/28/2012
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	<p>contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>B. The agency's 03/09 "Universal Body Substance Precaution" policy</p>		<p>competency evaluations are carried out.4. The Administrator will schedule home visits on 10% of clinical field staff quarterly to observe for continued compliance with accepted infection control practices. Any staff member observed to be out of compliance shall receive immediate re-education and be reassessed.5. All home visits for infection control shall be documented in the personnel record of each employee as well as the Quality Assurance Annual Plan and records for infection control monitoring.</p>	

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	<p>number 4014 states, "Agency personnel will adhere to the following precautions All personnel must use appropriate personal protective equipment when exposed to blood or other potentially infectious materials . . . Procedure. General Precautions: 1. Handwashing: Handwashing will be performed to prevent cross-contamination between patients/clients and personnel. A. Hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly before and after patient/client contact, if contaminated with body substances, before and after gloves are worn . . . 2. Gloves: . . . A. Gloves are to be worn by all agency staff when direct contact with any body substance is anticipated (blood, urine, pus, feces, saliva, drainage of any kind) . . . Equipment/Non-disposable instruments: . . . 3. Medical Equipment/Supplies: A. Any non-disposable equipment returned to agency stock will be thoroughly wiped down with an agency-approved disinfectant by the person responsible for its use. After proper cleaning, the equipment may be returned to stock for patient/client use."</p> <p>C. The agency's 03/09 "Personal Protective Equipment" policy number 4016 states, "Gloves will be worn when it can be reasonably anticipated that</p>			

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	<p>personnel may have contact with blood or other potentially infectious materials; when performing vascular access procedures; and then handling or touching contaminated items or surfaces . . . Disposable gloves will be removed and discarded after contact with each person, fluid item, surface . . . Hands must be washed immediately or as soon as feasible after removal of gloves or any other personal protective equipment."</p> <p>D. The agency's 03/09 "Handwashing" policy number 4017 states, "Personnel providing care/service in the home setting will wash their hands: . . . before and after each contact with a patient/client . . . Before and after gloves are used."</p> <p>2. Home visit number 1 was conducted on 8-27-12 at 1:55 PM with employee L, a home health aide. The aide was observed to provide a partial bath to patient number 1. The aide was observed to prepare the supplies for the bath including a large container of soapy water to soak the patient's feet. The aide then donned clean gloves without cleansing her hands. The aide assisted the patient with placing the patient's feet in the tub of soapy water. The aide then washed a small rubber toe protector removed from the patient's foot and placed the toe protector on the back of the commode.</p>			

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	<p>Without changing her gloves and cleansing her hands, the aide placed a clean washcloth in the bathroom sink that had been filled with water. The aide handed the washcloth to the patient, and the patient washed their own face.</p> <p>After the bath had been completed, the aide cleaned the bath equipment and gathered the dirty linens and, wearing the same gloves, assisted the patient to don a bathrobe. The aide then her gloves and failed to cleanse her hands. The aide donned clean gloves and hung up the dirty linens to dry. The aide changed her gloves again without cleansing her hands and assisted the patient to don socks.</p> <p>3. Home visit number 2 was conducted on 8-28-12 at 8:50 AM with employee A, a registered nurse (RN). The employee was observed to provide care to patient number 2. The RN was observed to retrieve a pen from her pocket to document on the visit note. The RN was observed to also retrieve her cell phone from her pocket, use it to time a pulse, and return the cell phone to her pocket. The RN was observed to place a plastic cover on the thermometer and place it in the patient's mouth. After the thermometer indicated the procedure was complete the RN removed the thermometer from the patient's mouth</p>			

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	<p>without wearing gloves. Observation noted a small amount of fluid on the cover of the thermometer that dripped as the thermometer was being removed.</p> <p>A. The RN prepared to perform a venipuncture and assembled the supplies from a bag brought into the home by the nurse. The RN then cleansed her hands and touched the arms of the patient's chair to pull it and the patient forward. The RN then donned clean gloves without cleansing her hands.</p> <p>B. After the venipuncture had been completed the RN was observed to reach into her pocket to retrieve a pen to write on the labels to apply to the laboratory tubes that contained the blood specimen.</p> <p>4. Home visit number 3 was conducted on 8-28-12 at 10:40 AM with employee B, an RN. The RN was observed to provide care to patient number 3. The RN was observed to listen to the patient's heart and lungs with a stethoscope and take the patient's temperature. The RN then donned clean gloves without cleansing her hands.</p> <p>A. After completing the assessment, the RN prepared to take a blood sample from the patient to complete a PT/INR (a measure of blood clotting) with a portable</p>			

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	<p>machine. The RN prepared the supplies and machine and then donned clean gloves without cleansing her hands.</p> <p>B. The RN was unable to successfully activate the auto lancet in order to obtain the blood sample from the patient's finger. The RN removed her gloves, and without cleansing her hands, retrieved her cell phone from her pocket. The RN placed a telephone call and placed the phone on the table in the area of the testing equipment. The RN touched the auto lancet and was successful in loading it. The RN then picked up her cell phone with her gloves hand.</p> <p>C. After talking on the phone, the RN changed her gloves and cleansed her hands. The RN then successfully obtained a blood sample and used a pipette to retrieve it. The RN attempted to perform the test but did not have a large enough blood sample and the patient's blood sample clotted before more could be obtained. The RN changed her gloves and cleansed her hands and reached into the case the held the machine to retrieve another lancet.</p> <p>D. After another unsuccessful attempt to obtain enough blood to perform the test, the RN placed the machine into its case without first disinfecting it.</p>						

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	<p>5. Home visit number 4 was conducted on 8-28-12 at 12:10 PM with employee H, a home health aide. The aide was observed to provide a partial bath to patient number 4. The aide washed her hands and donned clean gloves. The aide prepared a large tub of water for soaking the patient's feet. The aide placed the tub of water on the floor on a towel and placed the patient's feet into the water. The aide then prepared water for the rest of the patient's bath, placed a clean washcloth into the water and then handed it to the patient. The patient washed their own face.</p> <p>6. Home visit was number 5 was conducted on 8-29-12 at 12:40 PM with employee M, a licensed practical nurse (LPN). The LPN was observed to provide care to patient number 8. The LPN was observed to take the patient's temperature and then document the results on the visit note while still wearing her gloves. The LPN then changed her gloves and cleansed her hands. The LPN listened to the patient's lungs and heart and documented on the visit note while still wearing her gloves. The LPN again changed gloves without cleansing her hands. She examined the patient's arms and ankles and documented the results on the visit note while still wearing her</p>			

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	<p>gloves. The LPN completed the assessment with questions and continued to document information obtained while wearing her gloves.</p> <p>7. The home visit observations, as stated above, were discussed with the administrator, employee F, and the supervising nurse, employee G, on 8-29-12 at 9:55 AM. The administrator and the supervising nurse indicated the employees had not followed the agency's infection control policies and procedures.</p>			

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G0158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and agency policy review and interview, the agency failed to ensure assessments and skilled nursing visits had been completed per the physician's orders in 3 (#s 2, 5, and 10) of 10 records reviewed creating the potential to affect all of the agency's 44 current patients. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 7-29-12 to 9-26-12 that identified a secondary diagnosis of diabetes mellitus type 2 (DMII) and included orders for the skilled nurse (SN) to "assess . . . S/sx [signs and symptoms] hypo/hyperglycemia [low and high blood sugar]." The record also included an interim physician order, dated 7-16-12, that identified the physician had increased the patient's oral hypoglycemic medication, Metformin, to 1000 milligrams two times per day. A. SN visit notes, dated 8-7-12, 8-9-12, 8-14-12, and 8-16-12, failed to</p>			G0158	<p>1. All nursing field staff shall attend mandatory training regarding: a. Reading the Medical Plan of Care b. Accurately documenting assessments on the nursing notes c. the Agency's Policy 30112. The Supervising Nurse shall be responsible for completion of training by 9-28-12.3. The Supervising Nurse will monitor 10% of all nursing notes quarterly for accurate assessment documentation and initiation of services ordered on the Medical Plan of Care.4. The audit will be kept in the Quality Assurance Annual Plan audit file.</p>		09/28/2012

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	<p>evidence the SN had assessed the patient for signs and symptoms of low and/or high blood sugar.</p> <p>B. The supervising nurse, employee G, indicated, on 8-28-12 at 10:50 AM, the SN visit notes did not evidence documentation the SN had assessed the patient for signs and symptoms of low and/or high blood sugar. The nurse stated, "It's not there."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 7-12-12 to 9-9-12. The plan identified the physician had ordered skilled nursing services every 3 days for 60 days for 5 hours each visit.</p> <p>A. The record failed to evidence any SN visits had been provided the weeks of 7-15-12 and 7-22-12.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 10:55 A, SN visits had not been provided the weeks of 7-15-12 and 7-22-12 due to the payer source. The nurse stated, "We had to wait for prior approval from Medicaid."</p> <p>3. Clinical record number 10 included a plan of care established by the physician for the certification period 7-9-12 to 9-6-12 that identified the physician had</p>						

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	<p>ordered the SN to "assess . . . Endocrine [system] . . . S/S [signs and symptoms] of hypo/hyperglycemia."</p> <p>A. SN visit notes, dated 7-13-12, 7-20-12, 8-8-12, 8-9-12, 8-10-12, 8-13-12, 8-14-12, 8-15-12, and 8-16-12, failed to evidence the SN had assessed the patient's endocrine system or for signs and symptoms of low and/or high blood sugars.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 11:10 AM, the SN visit notes did not evidence the nurse had completed the assessments as ordered.</p> <p>4. The agency's 03/09 "Client Plan of Care" policy number 3011 states, "Better Living services are furnished to clients: A. Under the general supervision of a physician, B. Following a written plan of care established and reviewed every 60 days by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review and interview, the agency failed to ensure plans of care included all types of services the patient received in 2 (#s 1 and 5) of 10 records reviewed creating the potential to affect all of the agency's 44 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 included a start of care comprehensive assessment dated 8-13-12 that identified the patient received homemaker services from another agency. The plan of care, established by the physician for the certification period 8-13-12 to 10-11-12 failed to include the homemaker services provided by the other agency. Clinical record number 5 included a start of care comprehensive assessment dated 7-12-12 that identified the patient 	G0159	<ol style="list-style-type: none"> All nursing field staff shall attend mandatory training regarding: a. Reading the Medical Plan of Care b. Accurately documenting assessments on the nursing note c. the Agency's policy 30112. The Supervising Nurse shall be responsible for completion of training by 9-28-12.3. The Supervising Nurse will monitor 10% of nursing notes quarterly for accurate assessment documentation and initiation of services ordered on the Medical Plan of Care.4. All referrals will include documentation of other known services in the client's home upon receiving the referral.5. 100% of all Medical Plans of Care will be audited by the Supervising Nurse for listing of all other services provided to the client for the next 3 months, then 10% quarterly.6. The audit will be kept in the Quality Assurance Annual Plan audit file. 	09/28/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>received home health aide services from another agency. The plan of care, established by the physician for the certification period 7-12-12 to 9-9-12 failed to include the home health aide services provided by the other agency.</p> <p>3. The supervising nurse, employee G, indicated, on 8-29-12 at 10:55 AM, the plans of care in records numbered 1 and 5 did not include all services the patient received. The nurse stated, "It's not there."</p>				

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G0170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the registered nurse failed to ensure assessments and skilled nursing visits had been provided per the physician's orders in 3 (#s 2, 5, and 10) of 10 records reviewed creating the potential to affect all of the agency's 44 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 7-29-12 to 9-26-12 that identified a secondary diagnosis of diabetes mellitus type 2 (DMII) and included orders for the skilled nurse (SN) to "assess . . . S/sx [signs and symptoms] hypo/hyperglycemia [low and high blood sugar]." The record also included an interim physician order, dated 7-16-12, that identified the physician had increased the patient's oral hypoglycemic medication, Metformin, to 1000 milligrams two times per day.</p> <p>A. SN visit notes, dated 8-7-12, 8-9-12, 8-14-12, and 8-16-12, failed to evidence the SN had assessed the patient for signs and symptoms of low and/or high blood sugar.</p>	G0170	<p>1. All nursing field staff shall attend mandatory training regarding: a. Reading the Medical Plan of Care b. Accurately documenting assessments on the nursing note c. the Agency's Policy 30112. The Supervising Nurse shall be responsible for completion of training by 9-28-12.3. The Supervising Nurse will monitor 10% of nursing notes quarterly for accurate assessment documentation and initiation of services ordered on the Medical Plan of Care.4. All referrals will include documentation of other known services in the client's home upon receiving the referral.5. 100% of all Medical Plans of Care will be audited by the Supervising Nurse for listing of all other services provided to the client for the next 3 months, then 10% quarterly.6. The audit will be kept in the Quality Assurance Annual Plan audit file.</p>	09/28/2012
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	<p>B. The supervising nurse, employee G, indicated, on 8-28-12 at 10:50 AM, the SN visit notes did not evidence documentation the SN had assessed the patient for signs and symptoms of low and/or high blood sugar. The nurse stated, "It's not there."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 7-12-12 to 9-9-12. The plan identified the physician had ordered skilled nursing services every 3 days for 60 days for 5 hours each visit.</p> <p>A. The record failed to evidence any SN visits had been provided the weeks of 7-15-12 and 7-22-12.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 10:55 A, SN visits had not been provided the weeks of 7-15-12 and 7-22-12 due to the payer source. The nurse stated, "We had to wait for prior approval from Medicaid."</p> <p>3. Clinical record number 10 included a plan of care established by the physician for the certification period 7-9-12 to 9-6-12 that identified the physician had ordered the SN to "assess . . . Endocrine [system] . . . S/S [signs and symptoms] of hypo/hyperglycemia."</p>			

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	<p>A. SN visit notes, dated 7-13-12, 7-20-12, 8-8-12, 8-9-12, 8-10-12, 8-13-12, 8-14-12, 8-15-12, and 8-16-12, failed to evidence the SN had assessed the patient's endocrine system or for signs and symptoms of low and/or high blood sugars.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 11:10 AM, the SN visit notes did not evidence the nurse had completed the assessments as ordered.</p> <p>4. The agency's 03/09 "Client Plan of Care" policy number 3011 states, "Better Living services are furnished to clients: A. Under the general supervision of a physician, B. Following a written plan of care established and reviewed every 60 days by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>			

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G0174	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill.</p> <p>Based on observation, interview, and administrative record review, the agency failed to ensure the registered nurse (RN) had the specialized skill to perform a blood test procedure in 1 (patient # 3) of 2 blood test procedures observed creating the potential to affect all of the agency's 44 current patients.</p> <p>The findings include:</p> <p>1. A home visit was conducted on 8-28-12 at 10:40 AM with employee B, an RN. The RN was observed to attempt to complete a blood test on patient number 3.</p> <p>A. The RN was observed to prepare to take a blood sample from patient number 3 to perform a test of the patient's blood clotting. The RN was observed to set up the machine, an "INRatio 2 PT/INR Monitor", and remove a lancet from the case. The machine is used to monitor the clotting time of blood of patients taking oral anticoagulants (blood thinners). The blood sample was to be obtained from the patient's finger using a spring-loaded lancet that had to be prepared for use by pulling out on an orange tab and then</p>	G0174	<p>1. All Registered and Licensed Practical Nurses shall be in-serviced on the use of the PT/INR Monitor machine by performing the following: a. Viewing the manufacturer's interactive CD instructing on the use and competency. b. Demonstrating competence by performing a test and passing the competency check list2. The Supervising Nurse shall be responsible for completion of training by 9-28-12.3. A record of this education shall be kept in the employee record.4. The equipment will be secured by the Supervising Nurse and shall not be authorized for use by any staff member until training and competency evaluation is completed.5. Those individuals who have not successfully completed competency testing shall not be authorized to use the equipment.</p>	09/28/2012

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	<p>pulling off the orange tab when the lancet was loaded.</p> <p>B. The RN was unable to successfully activate the auto lancet in order to stick the patient and obtain the blood sample from the patient's finger after 2 attempts. The RN then made a telephone call to the nursing supervisor to receive instructions on how to activate the auto lancet. After speaking on the phone, the RN pulled out the orange tab until she "heard a click" and then disposed of the orange tab. The RN then successfully stuck the patient on the third attempt and obtained a blood sample, but was unable to obtain enough blood to perform the test. The RN did not have anymore of the auto lancets and completed the blood test by performing a venipuncture on the patient.</p> <p>2. The RN, employee B, indicated, on 8-28-12 at 11:50 AM, the supervising nurse, employee G, had "gone over" how to use the machine the day before. The RN stated, "But we did not talk about how to use the lancet."</p> <p>3. The supervising nurse, employee G, indicated, on 8-28-12 at 2:10 PM, the agency had acquired the monitor approximately 2 weeks ago. The supervising nurse indicated she had not conducted any formal inservices for the</p>				

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	<p>use of the new monitor and that the nurses that had not been evaluated for the competent use of the monitor prior to using the monitor on the patient.</p> <p>4. The agency's "Nursing Meeting Agenda", dated 8-22-12, failed to evidence any inservices for the use of the PT/INR monitor.</p>			

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N0470	<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 agency policy review, the agency failed to ensure it had provided services in accordance with its own infection control policies and procedures in 5 (#s 1, 2, 3, 4, & 5) of 5 home visit observations completed creating the potential for the spread of disease causing organisms among staff and the agency's 44 current patients.</p> <p>The findings include:</p> <p>1. The agency's 03/09 "Infection/Exposure Control Plan" policy number 4013 states, "The agency will . . . comply with all applicable state, federal regulations."</p> <p>A. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and</p>	N0470	<p>1. The Agency's clinical field staff will receive mandatory education including handouts and competency testing regarding: a. CDC guidelines for Infection Control & Standard Precautions hand hygiene; correct sequencing of washing hands, donning and removing gloves, including appropriate times to cleanse hands, don gloves, change gloves and cleanse non-disposable equipment. b. the Agency's Infection Control policies 4013, 4014, 4016, 4017. c. All handouts will be distributed by 9-28-12.2. The Agency's clinical field staff will demonstrate industry standards and accepted infection control measures by: a. Successfully demonstrating the correct sequencing of washing hands, donning and removing gloves, including appropriate times to cleanse hands, don gloves, change gloves, and clean non-disposable equipment. b. 100% of the nurses will be competency checked by 9-28-12. c. 100% of the remaining field staff will be competency checked by 11-28-12.3. The Administrator will</p>	11/28/2012			

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	<p>transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>B. The agency's 03/09 "Universal</p>		<p>be responsible for assuring all competency evaluations are carried out.4. The Administrator will schedule home visits on 10% of clinical field staff quarterly to observe for continued compliance with accepted infection control practices. Any staff member observed to be out of compliance shall receive immediate re-education and be reassessed.5. All home visits for infection control shall be documented in the personnel record of each employee as well as the Quality Assurance Annual Plan and records for infection control monitoring.</p>				

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	<p>"Body Substance Precaution" policy number 4014 states, "Agency personnel will adhere to the following precautions All personnel must use appropriate personal protective equipment when exposed to blood or other potentially infectious materials . . . Procedure. General Precautions: 1. Handwashing: Handwashing will be performed to prevent cross-contamination between patients/clients and personnel. A. Hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly before and after patient/client contact, if contaminated with body substances, before and after gloves are worn . . . 2. Gloves: . . . A. Gloves are to be worn by all agency staff when direct contact with any body substance is anticipated (blood, urine, pus, feces, saliva, drainage of any kind) . . . Equipment/Non-disposable instruments: . . . 3. Medical Equipment/Supplies: A. Any non-disposable equipment returned to agency stock will be thoroughly wiped down with an agency-approved disinfectant by the person responsible for its use. After proper cleaning, the equipment may be returned to stock for patient/client use."</p> <p>C. The agency's 03/09 "Personal Protective Equipment" policy number 4016 states, "Gloves will be worn when it</p>			

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	<p>can be reasonably anticipated that personnel may have contact with blood or other potentially infectious materials; when performing vascular access procedures; and then handling or touching contaminated items or surfaces . . . Disposable gloves will be removed and discarded after contact with each person, fluid item, surface . . . Hands must be washed immediately or as soon as feasible after removal of gloves or any other personal protective equipment."</p> <p>D. The agency's 03/09 "Handwashing" policy number 4017 states, "Personnel providing care/service in the home setting will wash their hands: . . . before and after each contact with a patient/client . . . Before and after gloves are used."</p> <p>2. Home visit number 1 was conducted on 8-27-12 at 1:55 PM with employee L, a home health aide. The aide was observed to provide a partial bath to patient number 1. The aide was observed to prepare the supplies for the bath including a large container of soapy water to soak the patient's feet. The aide then donned clean gloves without cleansing her hands. The aide assisted the patient with placing the patient's feet in the tub of soapy water. The aide then washed a small rubber toe protector removed from the patient's foot and placed the toe</p>			

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	<p>protector on the back of the commode. Without changing her gloves and cleansing her hands, the aide placed a clean washcloth in the bathroom sink that had been filled with water. The aide handed the washcloth to the patient, and the patient washed their own face.</p> <p>After the bath had been completed, the aide cleaned the bath equipment and gathered the dirty linens and, wearing the same gloves, assisted the patient to don a bathrobe. The aide then her gloves and failed to cleanse her hands. The aide donned clean gloves and hung up the dirty linens to dry. The aide changed her gloves again without cleansing her hands and assisted the patient to don socks.</p> <p>3. Home visit number 2 was conducted on 8-28-12 at 8:50 AM with employee A, a registered nurse (RN). The employee was observed to provide care to patient number 2. The RN was observed to retrieve a pen from her pocket to document on the visit note. The RN was observed to also retrieve her cell phone from her pocket, use it to time a pulse, and return the cell phone to her pocket. The RN was observed to place a plastic cover on the thermometer and place it in the patient's mouth. After the thermometer indicated the procedure was complete the RN removed the</p>				

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	<p>thermometer from the patient's mouth without wearing gloves. Observation noted a small amount of fluid on the cover of the thermometer that dripped as the thermometer was being removed.</p> <p>A. The RN prepared to perform a venipuncture and assembled the supplies from a bag brought into the home by the nurse. The RN then cleansed her hands and touched the arms of the patient's chair to pull it and the patient forward. The RN then donned clean gloves without cleansing her hands.</p> <p>B. After the venipuncture had been completed the RN was observed to reach into her pocket to retrieve a pen to write on the labels to apply to the laboratory tubes that contained the blood specimen.</p> <p>4. Home visit number 3 was conducted on 8-28-12 at 10:40 AM with employee B, an RN. The RN was observed to provide care to patient number 3. The RN was observed to listen to the patient's heart and lungs with a stethoscope and take the patient's temperature. The RN then donned clean gloves without cleansing her hands.</p> <p>A. After completing the assessment, the RN prepared to take a blood sample from the patient to complete a PT/INR (a</p>				

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	<p>measure of blood clotting) with a portable machine. The RN prepared the supplies and machine and then donned clean gloves without cleansing her hands.</p> <p>B. The RN was unable to successfully activate the auto lancet in order to obtain the blood sample from the patient's finger. The RN removed her gloves, and without cleansing her hands, retrieved her cell phone from her pocket. The RN placed a telephone call and placed the phone on the table in the area of the testing equipment. The RN touched the auto lancet and was successful in loading it. The RN then picked up her cell phone with her gloves hand.</p> <p>C. After talking on the phone, the RN changed her gloves and cleansed her hands. The RN then successfully obtained a blood sample and used a pipette to retrieve it. The RN attempted to perform the test but did not have a large enough blood sample and the patient's blood sample clotted before more could be obtained. The RN changed her gloves and cleansed her hands and reached into the case she held the machine to retrieve another lancet.</p> <p>D. After another unsuccessful attempt to obtain enough blood to perform the test, the RN placed the machine into its</p>			

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	<p>case without first disinfecting it.</p> <p>5. Home visit number 4 was conducted on 8-28-12 at 12:10 PM with employee H, a home health aide. The aide was observed to provide a partial bath to patient number 4. The aide washed her hands and donned clean gloves. The aide prepared a large tub of water for soaking the patient's feet. The aide placed the tub of water on the floor on a towel and placed the patient's feet into the water. The aide then prepared water for the rest of the patient's bath, placed a clean washcloth into the water and then handed it to the patient. The patient washed their own face.</p> <p>6. Home visit was number 5 was conducted on 8-29-12 at 12:40 PM with employee M, a licensed practical nurse (LPN). The LPN was observed to provide care to patient number 8. The LPN was observed to take the patient's temperature and then document the results on the visit note while still wearing her gloves. The LPN then changed her gloves and cleansed her hands. The LPN listened to the patient's lungs and heart and documented on the visit note while still wearing her gloves. The LPN again changed gloves without cleansing her hands. She examined the patient's arms and ankles and documented the results on</p>				

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	<p>the visit note while still wearing her gloves. The LPN completed the assessment with questions and continued to document information obtained while wearing her gloves.</p> <p>7. The home visit observations, as stated above, were discussed with the administrator, employee F, and the supervising nurse, employee G, on 8-29-12 at 9:55 AM. The administrator and the supervising nurse indicated the employees had not followed the agency's infection control policies and procedures.</p>				

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N0522	<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 and agency policy review and interview, the agency failed to ensure assessments and skilled nursing visits had been completed per the physician's orders in 3 (#s 2, 5, and 10) of 10 records reviewed creating the potential to affect all of the agency's 44 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 7-29-12 to 9-26-12 that identified a secondary diagnosis of diabetes mellitus type 2 (DMII) and included orders for the skilled nurse (SN) to "assess . . . S/sx [signs and symptoms] hypo/hyperglycemia [low and high blood sugar]." The record also included an interim physician order, dated 7-16-12, that identified the physician had increased the patient's oral hypoglycemic medication, Metformin, to 1000 milligrams two times per day.</p> <p>A. SN visit notes, dated 8-7-12, 8-9-12, 8-14-12, and 8-16-12, failed to</p>	N0522	<p>1. All nursing field staff shall attend mandatory training regarding: a. Reading the Medical Plan of Care b. Accurately documenting assessments on the nursing notes c. the Agency's Policy 30112. The Supervising Nurse shall be responsible for completion of training by 9-28-12.3. The Supervising Nurse will monitor 10% of all nursing notes quarterly for accurate assessment documentation and initiation of services ordered on the Medical Plan of Care.4. The audit will be kept in the Quality Assurance Annual Plan audit file.</p>	09/28/2012

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	<p>evidence the SN had assessed the patient for signs and symptoms of low and/or high blood sugar.</p> <p>B. The supervising nurse, employee G, indicated, on 8-28-12 at 10:50 AM, the SN visit notes did not evidence documentation the SN had assessed the patient for signs and symptoms of low and/or high blood sugar. The nurse stated, "It's not there."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 7-12-12 to 9-9-12. The plan identified the physician had ordered skilled nursing services every 3 days for 60 days for 5 hours each visit.</p> <p>A. The record failed to evidence any SN visits had been provided the weeks of 7-15-12 and 7-22-12.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 10:55 A, SN visits had not been provided the weeks of 7-15-12 and 7-22-12 due to the payer source. The nurse stated, "We had to wait for prior approval from Medicaid."</p> <p>3. Clinical record number 10 included a plan of care established by the physician for the certification period 7-9-12 to 9-6-12 that identified the physician had</p>				

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	<p>ordered the SN to "assess . . . Endocrine [system] . . . S/S [signs and symptoms] of hypo/hyperglycemia."</p> <p>A. SN visit notes, dated 7-13-12, 7-20-12, 8-8-12, 8-9-12, 8-10-12, 8-13-12, 8-14-12, 8-15-12, and 8-16-12, failed to evidence the SN had assessed the patient's endocrine system or for signs and symptoms of low and/or high blood sugars.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 11:10 AM, the SN visit notes did not evidence the nurse had completed the assessments as ordered.</p> <p>4. The agency's 03/09 "Client Plan of Care" policy number 3011 states, "Better Living services are furnished to clients: A. Under the general supervision of a physician, B. Following a written plan of care established and reviewed every 60 days by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				

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N0524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review and interview, the agency failed to ensure plans of care included all types of services the patient received in 2 (#s 1 and 5) of 10 records reviewed creating the potential to affect all of the agency's 44 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a start of care comprehensive assessment 	N0524	<p>1. All referrals will include documentation of other known services in the client's home upon receiving the referral.2. The Supervising Nurse will be responsible for auditing 100% of all Medical Plans of Care for listing of all other services provided to the client for the next 3 months, then 10% quarterly.3. The audit results will be kept in the Quality Assurance Annual Plan audit file.</p>	09/28/2012			

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	<p>dated 8-13-12 that identified the patient received homemaker services from another agency. The plan of care, established by the physician for the certification period 8-13-12 to 10-11-12 failed to include the homemaker services provided by the other agency.</p> <p>2. Clinical record number 5 included a start of care comprehensive assessment dated 7-12-12 that identified the patient received home health aide services from another agency. The plan of care, established by the physician for the certification period 7-12-12 to 9-9-12 failed to include the home health aide services provided by the other agency.</p> <p>3. The supervising nurse, employee G, indicated, on 8-29-12 at 10:55 AM, the plans of care in records numbered 1 and 5 did not include all services the patient received. The nurse stated, "It's not there."</p>			

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N0537	<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 and agency policy review and interview, the registered nurse failed to ensure assessments and skilled nursing visits had been provided per the physician's orders in 3 (#s 2, 5, and 10) of 10 records reviewed creating the potential to affect all of the agency's 44 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 7-29-12 to 9-26-12 that identified a secondary diagnosis of diabetes mellitus type 2 (DMII) and included orders for the skilled nurse (SN) to "assess . . . S/sx [signs and symptoms] hypo/hyperglycemia [low and high blood sugar]." The record also included an interim physician order, dated 7-16-12, that identified the physician had increased the patient's oral hypoglycemic medication, Metformin, to 1000 milligrams two times per day.</p> <p>A. SN visit notes, dated 8-7-12, 8-9-12, 8-14-12, and 8-16-12, failed to</p>	N0537	<p>1. All nursing field staff shall attend mandatory training regarding: a. Reading the Medical Plan of Care b. Accurately documenting assessments on the nursing note c. the Agency's Policy 30112. The Supervising Nurse shall be responsible for completion of training by 9-28-12.3. The Supervising Nurse will monitor 10% of nursing notes quarterly for accurate assessment documentation and initiation of services ordered on the Medical Plan of Care.4. All referrals will include documentation of other known services in the client's home upon receiving the referral.5. The Supervising Nurse will be responsible for auditing 100% of all Medical Plans of Care for listing of all other services provided to the client for the next 3 months, then 10% quarterly.6. The audit will be kept in the Quality Assurance Annual Plan audit file.</p>	09/28/2012			

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	<p>evidence the SN had assessed the patient for signs and symptoms of low and/or high blood sugar.</p> <p>B. The supervising nurse, employee G, indicated, on 8-28-12 at 10:50 AM, the SN visit notes did not evidence documentation the SN had assessed the patient for signs and symptoms of low and/or high blood sugar. The nurse stated, "It's not there."</p> <p>2. Clinical record number 5 included a plan of care established by the physician for the certification period 7-12-12 to 9-9-12. The plan identified the physician had ordered skilled nursing services every 3 days for 60 days for 5 hours each visit.</p> <p>A. The record failed to evidence any SN visits had been provided the weeks of 7-15-12 and 7-22-12.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 10:55 A, SN visits had not been provided the weeks of 7-15-12 and 7-22-12 due to the payer source. The nurse stated, "We had to wait for prior approval from Medicaid."</p> <p>3. Clinical record number 10 included a plan of care established by the physician for the certification period 7-9-12 to 9-6-12 that identified the physician had</p>				

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	<p>ordered the SN to "assess . . . Endocrine [system] . . . S/S [signs and symptoms] of hypo/hyperglycemia."</p> <p>A. SN visit notes, dated 7-13-12, 7-20-12, 8-8-12, 8-9-12, 8-10-12, 8-13-12, 8-14-12, 8-15-12, and 8-16-12, failed to evidence the SN had assessed the patient's endocrine system or for signs and symptoms of low and/or high blood sugars.</p> <p>B. The supervising nurse, employee G, indicated, on 8-29-12 at 11:10 AM, the SN visit notes did not evidence the nurse had completed the assessments as ordered.</p> <p>4. The agency's 03/09 "Client Plan of Care" policy number 3011 states, "Better Living services are furnished to clients: A. Under the general supervision of a physician, B. Following a written plan of care established and reviewed every 60 days by a doctor of medicine, osteopathy, podiatry, chiropractic, ophthalmology or dentistry."</p>				