

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157231	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/17/2014
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NAME OF PROVIDER OR SUPPLIER REID-ANC HOME CARE SERVICES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4180 S A ST RICHMOND, IN 47374
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G000000	<p>This visit was a home health federal recertification survey.</p> <p>Survey dates: January 13, 14, 15, 16, and 17, 2014</p> <p>Facility #005952</p> <p>Medicaid Vendor: # 200416620</p> <p>Surveyors: Shannon Pietraszewski RN, PH Nurse Surveyor</p> <p>Census: 185 Home Visits: 8</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 28, 2014</p>	G000000	Concur	
G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, agency policy</p>	G000121	G121 The Director of Clinical Services in-serviced field staff on	02/16/2014

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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	<p>review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 8 (patients 9, 10, 11, 12, 13, 14, 15, and 16) of 8 home visit observations completed creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <p>1. The agency's policy titled "Standard (Universal) Precautions" dated 03/26/12 stated, "Standard precautions are designed for care of all patients regardless of their diagnosis or presumed infection status. ... All healthcare workers should routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact is anticipated with blood or other potentially infectious materials ... Wear gloves when expecting contact with blood and other potentially infectious materials, mucous membranes or non-intact skin. Wear gloves when handling items or surfaces soiled with blood and body fluids ... "</p> <p>2. The agency's policy titled "Bag Technique" dated 08/05/11 stated, "Once in a patient's home, select a hard clean, dry surface to place the bag. If needed a barrier may be used underneath</p>		<p>2/6/2014 re: infection control measures using the following Policies: #33.39 Standard (Universal) Precautions, #33.83 Bag Technique, #33.900 Hand Hygiene. To ensure compliance with the above policies 4 shared home visits/month will be performed for 3 months by the Director of Clinical Services or designee to assess for evidence that Infection Control practices are being maintained. Ongoing shared visits will occur quarterly and be the responsibility of the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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	<p>the bag ... Hand hygiene should be performed before re-entering the bag ... Entire stethoscopes will be wiped with alcohol after each use before returning to the bag ... "</p> <p>3. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or 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</p>			

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	<p>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>3. A home visit was made to patient number 9 on 01/14/14 at 10:05 AM with employee C, an Occupational Therapist (OT). The OT was observed to assess and examine the patient. The employee was observed to place her nursing bag and her computer on the patient's table without a barrier beneath the items. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the entire stethoscope after obtaining the patients blood pressure.</p> <p>4. A home visit was made to patient number 10 on 01/14/14 at 10:45 PM with employee D, a Physical Therapist (PT). The PT was observed to assess</p>				

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	<p>and examine the patient. The employee was observed to place his bag on the patient's foot stool and his computer on the arm of the couch without a barrier beneath the items. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the entire stethoscope after obtaining the patient's blood pressure. The employee failed to clean his hands between checking the patient's radial pulse and typing on his computer. The employee failed to clean the gait belt between patient use and placing in his bag.</p> <p>5. A home visit was made to patient number 11 on 01/14/14 at 1:15 PM with employee E, a Registered Nurse (RN). The RN failed to clean her hands after removing her gloves between applying the wound dressing and gauze wrap. The employee failed to clean the entire stethoscope after obtaining the patient's blood pressure.</p> <p>6. A home visit was made to patient number 12 on 01/15/13 at 10:00 AM with employee F, a Licensed Practical Nurse (LPN). The LPN was observed to assess and examine the patient. The employee was observed to place her</p>				

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	<p>nursing bag and clipboard on the patient's table without a barrier. The LPN was observed to remove her computer and place it on the chair without a barrier. The LPN failed to cleanse each wound with a new gauze on the patient's leg and coccyx individually. The LPN failed to cut the patient's wound product at a level to prevent contamination. The LPN cut the wound product above the trash bag that was setting on the floor.</p> <p>7. A home visit was made to patient number 13 on 01/15/13 at 11:30 AM with employee G, a Physical Therapist Assistant (PTA). The PTA was observed to place his computer on the patient's table without a barrier. The PTA failed to clean his hands in between touching the patient and reaching into his work bag. The PTA failed to clean his entire stethoscope after obtaining the patient's blood pressure.</p> <p>8. A home visit was made to patient number 14 on 01/15/13 at 1:00 PM with employee H, an Occupational Therapist Assistant (OTA). The OTA was observed to placed the work bag and computer on the table without a barrier. The employee failed to don gloves prior to removing the thermometer from the</p>				

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	<p>patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the entire stethoscope after obtaining the patients blood pressure.</p> <p>9. A home visit was made to patient number 15 on 01/15/13 at 1:45 PM with employee I, a Registered Nurse (RN). The RN was observed to place wound care supplies, computer, thermometer, stethoscope, and pulse oximeter on the patients coffee table without a barrier. The employee was observed to use the same gauze to clean the patient's two wounds on her right lower extremity. The employee failed to clean hands after removing gloves and obtaining gloves from her bag. The employee placed the gloves on the coffee table without a barrier. The employee failed to change the wound vac canister after the exposed tubing was observed on the floor under the patient's left foot. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the thermometer prior to replacing it in the thermometer container and failed to clean the pulse oximeter prior to replacing it in the nursing bag.</p>			

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G000143	<p>10. A home visit was made to patient number 16 on 01/16/13 at 10:30 a.m with employee J, home health aide. The aide failed to change her gloves between giving the patient a shower and drying him off.</p> <p>11. The above-stated observations were discussed with the Director of Nursing, Employee B, on 11/16/13 at 11:30 AM. The Director of Nursing indicated the employees had not followed standard precautions and the agency's infection control procedures.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure it had maintained communication with other service providers in 1 (# 1) of 8 closed records reviewed of patients that received services from other care providers creating the potential to affect all of the</p>	G000143	G 143 The Director of Clinical Services in-serviced field staff on 2/6/2014 re: Policy #33.20 Case Conferences-Interdisciplinary Group Meeting/Coordination of Services. Education included importance of coordination of care with all service providers. Clinical record number 1 - Patient was discharged	02/16/2014	

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	<p>agency's patients that receive services from another provider.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a comprehensive admission assessment dated 10/06/13 that identified the patient had an "implanted device [port]" and listed "end stage renal disease" as a diagnosis. The clinical record failed to evidenced any communication and/or coordination with the dialysis facility that provided the patient's in-center hemodialysis treatments. 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM. 3. A policy titled "Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" dated 09/26/12, stated "Care will be coordinated with other involved external organizations (i.e. home medical equipment providers, infusion therapy/pharmacy companies and community agencies). Staff will ... Communicate with other individuals or organizations involved in the patients 		<p>10-14-2013. To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure coordination of care occurred. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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G000144	<p>care when significant changes occur in the patients overall care, no later than one (1) business day. Share relevant information to facilitate appropriate continuity and care coordination."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record and agency policy review and interview, the agency failed to ensure it had maintained communication with other service providers in 1 (# 1) of 8 closed records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a comprehensive admission assessment dated 10/06/13 that identified the patient had an "implanted device [port]" and listed "end stage renal disease as a diagnosis."</p>	G000144	G 144The Director of Clinical Services in-serviced field staff on 2/6/2014 re: Policy #33.20 Case Conferences-Interdisciplinary Group Meeting/Coordination of Services. Clinical record number 1 - Patient was discharged 10-14-2013.To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure coordination of care occurred. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.	02/16/2014	

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	<p>The clinical record failed to evidenced any communication and/or coordination with the dialysis facility that provided the patient's in-center hemodialysis treatments.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p> <p>3. A policy titled "Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" dated 09/26/12, stated "Care will be coordinated with other involved external organizations (i.e. home medical equipment providers, infusion therapy/pharmacy companies and community agencies). Staff will ... Communicate with other individuals or organizations involved in the patients care when significant changes occur in the patients overall care, no later than one (1) business day. Share relevant information to facilitate appropriate continuity and care coordination."</p>				

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered by the physician in 1 (# 1) of 16 records reviewed creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a plan of care dated 10/06/13 to 12/06/13 that identified skilled nursing visits were to be 1 visit a week for 3 weeks the 2 visits a week for 2 weeks. The clinical record evidenced skilled nursing visits had been provided 3 times during the first week of services and 2 times the second week of services. 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM. 3. A policy titled "Nursing Service" dated 04/30/07, indicated "The 	G000158	G158 The Director of Clinical Services in-serviced nursing staff on 2/6/2014 re:Policy #33.08 Nursing Service. Education included following a written plan of care. Clinical record number 1 - Patient was discharged 10-14-2013. To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that plan of care was followed. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.	02/16/2014

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G000159	<p>Registered Nurse ... Follows a written plan of care established and periodically reviewed by the physician. Provides care only in conformance with the physician orders ... "</p> <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 and agency policy review and interview, the agency failed to ensure plans of care included all treatment orders and supplies for 2 (#s 12 and 15) of 2 records reviewed for patients with wound care, creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 12 included a plan of care established by the physician for the certification period 12/04/13 to 02/01/14. The record failed to evidence the plan of care had been updated to include treatment orders for wound care</p>	G000159	G 159 The Director of Clinical Services will in-serviced clinical staff on 2/6/2014 re: Policy #33.24 Plan of Care and Physician Orders. Education included accurate development of plan of care. Clinical record number 12-The Director of Clinical Services received orders from the physician to clarify wound care on 2/3/2014. Clinical record number 15-The Director of Clinical Services received orders from the physician to clarify wound care on 2/3/2014. To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that accurate plan of care was created and followed. On going monitoring will be part of	02/16/2014			

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G000170	<p>to the patient's right lower extremity and posterior thigh areas.</p> <p>2. Clinical record number 15 included a plan of care established by the physician for the certification period 08/29/13 to 10/27/13. The record failed to evidence the plan of care had been updated to include treatment orders for wound care to right lower extremity.</p> <p>3. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p> <p>4. A policy titled "Plan of Care and Physician Orders" dated 04/28/08, indicated "The plan of care should be based upon a current assessment of the client's needs for care. the plan of care must include ... All treatments ... "</p> <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 agency failed to ensure skilled nurse visits had been provided as ordered by the physician in 1 (# 1) of 16 records reviewed creating the potential to affect</p>	G000170	<p>quarterly record review performed by the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p> <p>G170 The Director of Clinical Services in-serviced nursing staff on 2/6/2014 re:Policy #33.08 Nursing Service. Education included following a written plan of care.Clinical record number 1 - Patient was discharged 10-14-2013.To ensure</p>	02/16/2014	

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	<p>all of the agency's 185 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a plan of care dated 10/06/13 to 12/06/13 that identified skilled nursing visits were to be 1 visit a week for 3 weeks the 2 visits a week for 2 weeks. The clinical record evidenced skilled nursing visits had been provided 3 times during the first week of services and 2 times the second week of services. 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM. 3. A policy titled "Nursing Service" dated 04/30/07, indicated "The Registered Nurse ... Follows a written plan of care established and periodically reviewed by the physician. Provides care only in conformance with the physician orders ... " 		<p>compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that plan of care was followed. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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G000176	<p>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.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse informed the physician of a patient's non-compliance (# 1) and early discharges (# 3, 5, 7, 8, and 13) and for 6 of 16 records reviewed and maintained communication with other service providers in 1 (# 1) of 8 closed records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a skilled nurse visit note dated 10/06/13 that stated, "Ask about medications d/t [due to] none being in the home." A skilled nurse visit note dated 10/07/13 stated, "Non-compliant ... awaiting meds from family ... Spoke with pt [patient] about medications being in home [sic]. Pt said [family member] will be able to help [patient] with meds tonight et [and] set them up for tomorrow." A skilled nurse visit note dated 10/09/13 stated,</p>	G000176	G176The Director of Clinical Services in-serviced field staff on 2/6/2014 re: Policies: #33.08 Nursing Service and #33.20 Case Conferences- Interdisciplinary Group Meeting/ Coordination of Services. Education included physician notification of change in condition or alteration in plan of care. Clinical record number 1- Patient discharged 10-24-2013 Patient chart number 3- Patient discharged 12-27-2013 Clinical record number 5- Patient discharged from the agency 10-3-2013 Clinical record number 7- Patient discharged from the agency 11-18-13 Clinical record number 8- Patient discharged from the agency 11-1-2013 Clinical record number 13- Patient discharged from agency 1-31-2014 To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that physician was notified of change in condition and/or alteration in plan of care. On going monitoring will be part of quarterly record review performed by the Director of Clinical	02/16/2014

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	<p>"No med box available to set up meds ... Pts. [another family member] is to come over today with medbox and set up meds for pt." A skilled nurse visit note dated 10/11/13 stated, "Awaiting for family member to bring pill holder over. Still waiting on insulins." A skilled nurse visit note dated 10/17/13 stated, "Spoke with pt. about takling [sic] with social worker to help with possible home delivery for medications et pt. refused [sic]. Spoke with [family member] et she was not concerned about pt. not having medication." The record failed to evidence the nurse had informed the physician of the patient's non compliance with medications.</p> <p>The record also included a comprehensive admission assessment dated 10/06/13 that identified the patient had an "implanted device [port]" and listed "end stage renal disease as a diagnosis." The clinical record failed to evidenced any communication and/or coordination with the dialysis facility that provided the patient's in-center hemodialysis treatments.</p> <p>2. Clinical record number 3 included a plan of care dated 11/26/13 to 01/24/14 with physical therapy to see the patient 2 times a week for 1 week and 3 times a week for 2 weeks. The clinical record</p>		Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.		

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	<p>evidenced the physical therapist saw the patient 2 times during week 3 and the patient was discharged.</p> <p>The record failed to evidence the physician had been informed of the patient's early discharge.</p> <p>3. Clinical record number 5 included a plan of care dated 09/09/13 to 11/07/13 that included skilled nursing to see the patient "2W1 [2 times a week for 1 week], 3W1 [3 times a week for 1 week], then 1W5 [1 time a week for 5 weeks]." The clinical record evidenced the patient was seen by nursing for 4 weeks and was discharged.</p> <p>The record failed to evidence the registered nurse had informed the physician prior to the patient's early discharge.</p> <p>4. Clinical record number 7 included a referral from a physician for Physical Therapy on 11/15/13. The Physical Therapist evaluated the patient on 11/18/13. The patient declined home health services.</p> <p>The record failed to evidence the physician had been informed of the patient's early discharge.</p>				

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	<p>5. Clinical record number 8 included a physical therapy discharge summary dated 10/15/13 that included physical therapy frequency of "2W1, 3W2 then 1W1. The clinical record evidenced physical therapy saw the patient for 2 weeks and the patient was discharged.</p> <p>A. Clinical record number 8 included a home health aide frequency of "2W8 starting the week of 10/04/13". The home health aide was canceled by the patient/family on 10/7/13, 10/10/13, and 10/17/13.</p> <p>B. The record failed to evidence the physician was informed of the patient/family canceling of home health aide services and the physician had been informed of the patient's early discharge.</p> <p>7. Clinical record number 13 included a plan of care indicating a occupational therapy frequency of "2W4 starting the week of 12/30/13." The clinical record evidenced occupational therapy saw the patient for 2 weeks and the patient was discharged.</p> <p>The record failed to evidence the physician had been informed of the patient's early discharge.</p> <p>8. The Director of Nursing, employee</p>						

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G000186	<p>B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p> <p>9. A policy titled "Nursing Service" dated 04/30/07, indicated "The Registered Nurse ... Promptly alerts the physician to any changes that would suggest a need to alter the plan of care."</p> <p>10. A policy titled "Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" dated 09/26/12, stated "Care will be coordinated with other involved external organizations (i.e. home medical equipment providers, infusion therapy/pharmacy companies and community agencies). Staff will ... Communicate with other individuals or organizations involved in the patients care when significant changes occur in the patients overall care, no later than one (1) business day. Share relevant information to facilitate appropriate continuity and care coordination."</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)</p>			

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	<p>Based on clinical record record and interview, the agency failed to ensure the physical therapist and occupational therapist evaluated a patient timely for 1 (# 4) of 10 records reviewed and the occupational therapist evaluated a patient as ordered for 1 of 10 (# 10) records reviewed of patients who were receiving therapy services. This had the potential to affect all patients who currently receive therapy services.</p> <p>Finding include:</p> <ol style="list-style-type: none"> 1. Clinical record number 4 included physician orders dated 07/29/13 that identified physical and occupational therapy were to evaluate and treat the patient with an end date of 08/02/13. <p>The clinical record failed to evidence that physical and occupational therapy evaluated the patient between 07/29/13 to 08/02/13.</p> <ol style="list-style-type: none"> 2. Clinical record number 10 included a plan of care with orders for occupational therapy to evaluate the patient starting the week of 01/06/14. The clinical record included a transfer assessment dated 01/05/14 and resumption of care assessment dated 01/07/14. <p>The record failed to evidence the</p>	G000186	G 186 The Director of Clinical Services in-serviced clinical field staff on 1/23/2014 re: Policy # 33.24 Plan of Care and Physician Orders. Education included following a written plan of care.Clinical record number 4- Patient discharged 8-28-2013Clinical record number 10- Physician was contacted on 2-6-14 regarding alteration in plan of careTo ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that plan of care was followed. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.	02/16/2014			

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G000321	<p>occupational therapist evaluated the patient after the resumption the of care visit by the registered nurse.</p> <p>3. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p> <p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. Based on Indiana State Department of Health (ISDH) document review, agency policy review, and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completion in 55 of 1340 transmissions reviewed creating the potential to affect all of the agency's current 185 skilled patients. (Patients # 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54,</p>	G000321	G321 The Director of Clinical Services has in-serviced clinical staff on 1-23-2014 re: Policy #33.106 OASIS Management. Education included completion and submission requirements. To ensure compliance with the above policy the Director of Clinical Services or designee will review 20 completed Oasis data sets monthly for 3 months to ensure timely submission requirement was met. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or	02/16/2014

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	<p>55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, and 71)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 10/10/13 for patient number 17. The document evidenced the OASIS data had not been transmitted until 12/16/13. 2. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/22/13 for patient number 18. The document evidenced the OASIS data had not been transmitted until 10/30/13. 3. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 09/04/13 for patient number 19. The document evidenced the OASIS data had not been transmitted until 11/05/13. 4. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 10/25/13 for patient number 20. The document evidenced the OASIS data had not been transmitted until 12/09/13. 5. An ISDH document dated 01/09/14 		<p>designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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	<p>evidenced a discharge assessment had been completed on 11/07/13 for patient number 21. The document evidenced the OASIS data had not been transmitted until 12/09/13.</p> <p>6. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/17/13 for patient number 22. The document evidenced the OASIS data had not been transmitted until 08/23/13.</p> <p>7. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/30/13 for patient number 23. The document evidenced the OASIS data had not been transmitted until 10/14/13.</p> <p>8. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/17/13 for patient number 24. The document evidenced the OASIS data had not been transmitted until 08/23/13.</p> <p>9. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 11/03/13 for patient number 25. The document evidenced the OASIS data had not been transmitted until 12/16/13.</p>			

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	<p>10. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 09/25/13 for patient number 26. The document evidenced the OASIS data had not been transmitted until 11/18/13.</p> <p>11. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/25/13 for patient number 27. The document evidenced the OASIS data had not been transmitted until 09/17/13.</p> <p>12. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 09/30/13 for patient number 28. The document evidenced the OASIS data had not been transmitted until 11/06/13.</p> <p>13. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/19/13 for patient number 29. The document evidenced the OASIS data had not been transmitted until 11/25/13.</p> <p>14. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 08/23/13 for patient number 30. The document evidenced the OASIS data had not been transmitted until 10/03/13.</p>						

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	<p>15. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 08/24/13 for patient number 31. The document evidenced the OASIS data had not been transmitted until 10/03/13.</p> <p>16. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 10/07/13 for patient number 32. The document evidenced the OASIS data had not been transmitted until 11/18/13.</p> <p>17. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 10/04/13 for patient number 33. The document evidenced the OASIS data had not been transmitted until 11/18/13.</p> <p>18. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 08/27/13 for patient number 34. The document evidenced the OASIS data had not been transmitted until 10/03/13.</p> <p>19. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 10/14/13 for patient number 35. The document evidenced the OASIS data had not been transmitted</p>						

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	<p>until 12/16/13.</p> <p>20. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 08/16/13 for patient number 36. The document evidenced the OASIS data had not been transmitted until 09/25/13.</p> <p>21. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 08/21/13 for patient number 37. The document evidenced the OASIS data had not been transmitted until 09/25/13.</p> <p>22. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 11/07/13 for patient number 38. The document evidenced the OASIS data had not been transmitted until 12/11/13.</p> <p>23. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 09/19/13 for patient number 39. The document evidenced the OASIS data had not been transmitted until 11/06/13. The document also evidenced the discharge assessment had been completed on 10/31/13 for patient number 38. The document evidenced the OASIS data had not been transmitted until 12/03/13.</p>				

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	24. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 10/22/13 for patient number 40. The document evidenced the OASIS data had not been transmitted until 12/02/13.			
	25. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/06/13 for patient number 41. The document evidenced the OASIS data had not been transmitted until 09/17/13.			
	25. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/02/13 for patient number 42. The document evidenced the OASIS data had not been transmitted until 09/10/13.			
	26. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/09/13 for patient number 43. The document evidenced the OASIS data had not been transmitted until 09/11/13.			
	27. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 09/22/13 for patient number 44. The document evidenced the OASIS data had not been transmitted			

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	<p>until 11/06/13.</p> <p>28. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/07/13 for patient number 45. The document evidenced the OASIS data had not been transmitted until 09/10/13.</p> <p>29. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 07/28/13 for patient number 46. The document evidenced the OASIS data had not been transmitted until 09/10/13.</p> <p>30. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/02/13 for patient number 47. The document evidenced the OASIS data had not been transmitted until 08/05/13.</p> <p>31. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/02/13 for patient number 48. The document evidenced the OASIS data had not been transmitted until 09/25/13.</p> <p>32. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/06/13 for patient number 49. The document evidenced</p>						

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	<p>the OASIS data had not been transmitted until 09/17/13.</p> <p>33. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/02/13 for patient number 49. The document evidenced the OASIS data had not been transmitted until 08/12/13.</p> <p>34. An ISDH document dated 01/09/13 evidenced a transfer assessment had been completed on 07/12/13 for patient number 50. The document evidenced the OASIS data had not been transmitted until 08/28/13.</p> <p>35. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 07/12/13 for patient number 51. The document evidenced the OASIS data had not been transmitted until 08/28/13.</p> <p>36. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 08/12/13 for patient number 52. The document evidenced the OASIS data had not been transmitted until 09/25/13.</p> <p>37. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 10/02/13 for patient</p>			

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	<p>number 53. The document evidenced the OASIS data had not been transmitted until 12/09/13.</p> <p>38. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 08/22/13 for patient number 54. The document evidenced the OASIS data had not been transmitted until 09/25/13.</p> <p>39. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 11/15/13 for patient number 55. The document evidenced the OASIS data had not been transmitted until 01/06/14. The document also evidenced a discharge assessment had been completed on 11/26/13. The OASIS data had not been transmitted until 01/06/14.</p> <p>40. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 08/14/13 for patient number 56. The document evidenced the OASIS data had not been transmitted until 09/17/13.</p> <p>41. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 08/08/13 for patient number 57. The document evidenced the OASIS data had not been transmitted</p>				

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	<p>until 09/10/13.</p> <p>42. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 10/18/13 for patient number 58. The document evidenced the OASIS data had not been transmitted until 11/25/13.</p> <p>43. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 10/18/13 for patient number 59. The document evidenced the OASIS data had not been transmitted until 12/16/13.</p> <p>44. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/23/13 for patient number 60. The document evidenced the OASIS data had not been transmitted until 09/03/13.</p> <p>45. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 08/28/13 for patient number 61. The document evidenced the OASIS data had not been transmitted until 10/03/13.</p> <p>46. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 11/10/13 for patient number 62. The document evidenced</p>			

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	<p>the OASIS data had not been transmitted until 12/16/13.</p> <p>47. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 07/05/13, resumption of care completed on 07/10/13, and discharge completed on 07/25/13 for patient number 63. The document evidenced all the OASIS data had not been transmitted until 10/03/13.</p> <p>48. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 07/03/13 for patient number 64. The document evidenced the OASIS data had not been transmitted until 08/05/13. The document also evidenced the discharge assessment had been completed on 09/05/13. The document evidenced the OASIS data had not been transmitted until 10/30/13.</p> <p>49. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 09/23/13 for patient number 65. The document evidenced the OASIS data had not been transmitted until 11/18/13.</p> <p>50. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 11/09/13 for patient number 66. The document evidenced</p>						

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	<p>the OASIS data had not been transmitted until 12/16/13.</p> <p>51. An ISDH document dated 01/09/14 evidenced a discharge assessment had been completed on 07/18/13 for patient number 67. The document evidenced the OASIS data had not been transmitted until 08/28/13.</p> <p>52. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 07/10/13 and a discharge assessment completed on 08/07/13 for patient number 68. The document evidenced the OASIS data had not been transmitted until 09/10/13.</p> <p>53. An ISDH document dated 01/09/14 evidenced a transfer assessment had been completed on 07/20/13 for patient number 69. The document evidenced the OASIS data had not been transmitted until 09/17/13.</p> <p>54. An ISDH document dated 01/09/14 evidenced a start of care assessment had been completed on 10/20/13 for patient number 70. The document evidenced the OASIS data had not been transmitted until 12/16/13.</p> <p>55. An ISDH document dated 01/09/14 evidenced a transfer assessment had</p>				

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N000000	<p>been completed on 11/08/13 for patient number 71. The document evidenced the OASIS data had not been transmitted until 12/16/13.</p> <p>56. The Director of Nursing, employee B, indicated the corporate office handles the OASIS transmissions when asked on 01/16/13 at 9:30 PM.</p> <p>57. A policy titled "Comprehensive Assessment and OASIS Management" dated 08/30/12, indicated "OASIS data on MCR/MCD patients must be submitted/transmitted to the state no later than 30 days following when the assessment is completed. OASIS transmissions are done centrally by Revenue Cycle at CHS ensuring data is submitted timely and correctly ... "</p> <p>This visit was a home health state relicensure survey.</p> <p>Survey dates: January 13, 14, 15, 16, and 17, 2014</p> <p>Facility #005952</p> <p>Medicaid Vendor: # 200416620</p>	N000000	Concur				

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N000470	<p>Surveyors: Shannon Pietraszewski RN, PH Nurse Surveyor</p> <p>Census: 185 Home Visits: 8</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 28, 2014</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, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 8 (patients 9, 10, 11, 12, 13, 14, 15, and 16) of 8 home visit observations completed creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <p>1. The agency's policy titled "Standard (Universal) Precautions" dated 03/26/12 stated, "Standard precautions are designed for care of all patients regardless of their diagnosis or</p>	N000470	N 470 The Director of Clinical Services in-serviced field staff on 2/6/2014 re: infection control measures using the following Policies: #33.39 Standard (Universal) Precautions, #33.83 Bag Technique, #33.900 Hand Hygiene. To ensure compliance with the above policies 4 shared home visits/month will be performed for 3 months by the Director of Clinical Services or designee to assess for evidence that Infection Control practices are being maintained. Ongoing shared visits will occur quarterly and be the responsibility of the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the	02/16/2014

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	<p>presumed infection status. ... All healthcare workers should routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact is anticipated with blood or other potentially infectious materials ... Wear gloves when expecting contact with blood and other potentially infectious materials, mucous membranes or non-intact skin. Wear gloves when handling items or surfaces soiled with blood and body fluids ... "</p> <p>2. The agency's policy titled "Bag Technique" dated 08/05/11 stated, "Once in a patient's home, select a hard clean, dry surface to place the bag. If needed a barrier may be used underneath the bag ... Hand hygiene should be performed before re-entering the bag ... Entire stethoscopes will be wiped with alcohol after each use before returning to the bag ... "</p> <p>3. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands</p>		Regional Clinical Manager and Regional Vice President.				

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	<p>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>3. A home visit was made to patient number 9 on 01/14/14 at 10:05 AM with</p>			

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	<p>employee C, an Occupational Therapist (OT). The OT was observed to assess and examine the patient. The employee was observed to place her nursing bag and her computer on the patient's table without a barrier beneath the items. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the entire stethoscope after obtaining the patients blood pressure.</p> <p>4. A home visit was made to patient number 10 on 01/14/14 at 10:45 PM with employee D, a Physical Therapist (PT). The PT was observed to assess and examine the patient. The employee was observed to place his bag on the patient's foot stool and his computer on the arm of the couch without a barrier beneath the items. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the entire stethoscope after obtaining the patient's blood pressure. The employee failed to clean his hands between checking the patient's radial pulse and typing on his computer. The employee failed to clean the gait belt between patient use and placing in his</p>				

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	<p>bag.</p> <p>5. A home visit was made to patient number 11 on 01/14/14 at 1:15 PM with employee E, a Registered Nurse (RN). The RN failed to clean her hands after removing her gloves between applying the wound dressing and gauze wrap. The employee failed to clean the entire stethoscope after obtaining the patient's blood pressure.</p> <p>6. A home visit was made to patient number 12 on 01/15/13 at 10:00 AM with employee F, a Licensed Practical Nurse (LPN). The LPN was observed to assess and examine the patient. The employee was observed to place her nursing bag and clipboard on the patient's table without a barrier. The LPN was observed to remove her computer and place it on the chair without a barrier. The LPN failed to cleanse each wound with a new gauze on the patient's leg and coccyx individually. The LPN failed to cut the patient's wound product at a level to prevent contamination. The LPN cut the wound product above the trash bag that was setting on the floor.</p> <p>7. A home visit was made to patient number 13 on 01/15/13 at 11:30 AM with employee G, a Physical Therapist</p>				

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	<p>Assistant (PTA). The PTA was observed to place his computer on the patient's table without a barrier. The PTA failed to clean his hands in between touching the patient and reaching into his work bag. The PTA failed to clean his entire stethoscope after obtaining the patient's blood pressure.</p> <p>8. A home visit was made to patient number 14 on 01/15/13 at 1:00 PM with employee H, an Occupational Therapist Assistant (OTA). The OTA was observed to placed the work bag and computer on the table without a barrier. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the entire stethoscope after obtaining the patients blood pressure.</p> <p>9. A home visit was made to patient number 15 on 01/15/13 at 1:45 PM with employee I, a Registered Nurse (RN). The RN was observed to place wound care supplies, computer, thermometer, stethoscope, and pulse oximeter on the patients coffee table without a barrier. The employee was observed to use the same gauze to clean the patient's two wounds on her right lower extremity.</p>			

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	<p>The employee failed to clean hands after removing gloves and obtaining gloves from her bag. The employee placed the gloves on the coffee table without a barrier. The employee failed to change the wound vac canister after the exposed tubing was observed on the floor under the patient's left foot. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer. The employee failed to clean the thermometer prior to replacing it in the thermometer container and failed to clean the pulse oximeter prior to replacing it in the nursing bag.</p> <p>10. A home visit was made to patient number 16 on 01/16/13 at 10:30 a.m with employee J, home health aide. The aide failed to change her gloves between giving the patient a shower and drying him off.</p> <p>11. The above-stated observations were discussed with the Director of Nursing, Employee B, on 11/16/13 at 11:30 AM. The Director of Nursing indicated the employees had not followed standard precautions and the agency's infection control procedures.</p>				

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N000486	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure it had maintained communication with other service providers in 1 (# 1) of 8 closed records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a comprehensive admission assessment dated 10/06/13 that identified the patient had an "implanted device [port]" and listed "end stage renal disease as a diagnosis."</p> <p>The clinical record failed to evidenced any communication and/or coordination with the dialysis facility that provided the patient's in-center hemodialysis treatments.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when</p>	N000486	<p>N 486 The Director of Clinical Services in-serviced field staff on 2/6/2014 re: Policy #33.20 Case Conferences-Interdisciplinary Group Meeting/Coordination of Services. Education included importance of coordination of care with all service providers.1. Clinical record number 1- Patient was discharged 10-14-2013.To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure coordination of care occurred.On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	02/16/2014	

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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			
N000522	<p>asked on 01/14/13 at 3:30 PM.</p> <p>3. A policy titled "Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" dated 09/26/12, stated "Care will be coordinated with other involved external organizations (i.e. home medical equipment providers, infusion therapy/pharmacy companies and community agencies). Staff will ... Communicate with other individuals or organizations involved in the patients care when significant changes occur in the patients overall care, no later than one (1) business day. Share relevant information to facilitate appropriate continuity and care coordination."appropriate continuity and care coordination."</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:</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure visits had been provided as ordered by the physician in 1 (# 1) of 16 records reviewed creating the</p>	N000522	N 522 The Director of Clinical Services in-serviced nursing staff on 2/6/2014 re:Policy #33.08 Nursing Service. Education included following a written plan of care.Clinical record number 1 - Patient was discharged	02/16/2014			

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	<p>potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a plan of care dated 10/06/13 to 12/06/13 that identified skilled nursing visits were to be 1 visit a week for 3 weeks the 2 visits a week for 2 weeks. The clinical record evidenced skilled nursing visits had been provided 3 times during the first week of services and 2 times the second week of services. 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM. 3. A policy titled "Nursing Service" dated 04/30/07, indicated "The Registered Nurse ... Follows a written plan of care established and periodically reviewed by the physician. Provides care only in conformance with the physician orders ... " 		<p>10-14-2013.To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that plan of care was followed. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>		

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all treatment orders and supplies for 2 (#s 12 and 15) of 2 records reviewed for patients with wound care, creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p>	N000524	N524The Director of Clinical Services will in-serviced clinical staff on 2/6/2014 re: Policy #33.24 Plan of Care and Physician Orders. Education included accurate development of plan of care.In order to show compliance 6 clinical records will be audited by the Director of Clinical Services or designee to ensure clinical staff are writing physician orders correctly. Clinical record number 12-The Director of Clinical Services received orders from the physician to clarify	02/16/2014			

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N000537	<p>1. Clinical record number 12 included a plan of care established by the physician for the certification period 12/04/13 to 02/01/14. The record failed to evidence the plan of care had been updated to include treatment orders for wound care to the patient's right lower extremity and posterior thigh areas.</p> <p>2. Clinical record number 15 included a plan of care established by the physician for the certification period 08/29/13 to 10/27/13. The record failed to evidence the plan of care had been updated to include treatment orders for wound care to right lower extremity.</p> <p>3. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p> <p>4. A policy titled "Plan of Care and Physician Orders" dated 04/28/08, indicated "The plan of care should be based upon a current assessment of the client's needs for care. the plan of care must include ... All treatments ... "</p> <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:</p>		wound care on 2/3/2014. Clinical record number 15-The Director of Clinical Services received orders from the physician to clarify wound care on 2/3/2014.To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that accurate plan of care was created and followed. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.	

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	<p>Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nurse visits had been provided as ordered by the physician in 1 (# 1) of 16 records reviewed creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included a plan of care dated 10/06/13 to 12/06/13 that identified skilled nursing visits were to be 1 week 3, 2 week 2. The clinical record evidenced skilled nursing visits had been provided 3 times during the first week of services and 2 times the second week of services. 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM. 3. A policy titled "Nursing Service" dated 04/30/07, indicated "The Registered Nurse ... Promptly alerts the physician to any changes that would suggest a need to alter the plan of care, Follows a written plan of care established and periodically reviewed by the physician. Provides care only in conformance with the physician orders ... " 	N000537	<p>N 537 The Director of Clinical Services in-serviced nursing staff on 2/6/2014 re:Policy #33.08 Nursing Service. Education included following a written plan of care.Clinical record number 1 - Patient was discharged 10-14-2013.To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that plan of care was followed. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	02/16/2014	

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N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had maintained communication with other service providers in 1 (# 1) of 8 closed records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's patients that receive services from another provider.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a comprehensive admission assessment dated 10/06/13 that identified the patient had an "implanted device [port]" and listed "end stage renal disease as a diagnosis."</p> <p>The clinical record failed to evidenced any communication and/or coordination with the dialysis facility that provided the patient's in-center</p>	N000545	<p>N 545 The Director of Clinical Services in-serviced field staff on 2/6/2014 re: Policies: #33.08 Nursing Service and #33.20 Case Conferences- Interdisciplinary Group Meeting/ Coordination of Services. Education included physician notification of change in condition or alteration in plan of care.Clinical record number 1- Patient discharged 10-24-2013To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that plan of care was followed.On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee.This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>	02/16/2014			

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	<p>hemodialysis treatments.</p> <p>2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p> <p>3. A policy titled "Case Conferences - Interdisciplinary Group Meeting/Coordination of Services" dated 09/26/12, stated "Care will be coordinated with other involved external organizations (i.e. home medical equipment providers, infusion therapy/pharmacy companies and community agencies). Staff will ... Communicate with other individuals or organizations involved in the patients care when significant changes occur in the patients overall care, no later than one (1) business day. Share relevant information to facilitate appropriate continuity and care coordination."</p>			

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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse informed the physician of a patient's non-compliance (# 1) and early discharges (# 3, 5, 7, 8, and 13) and for 6 of 16 records reviewed creating the potential to affect all of the agency's 185 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a skilled nurse visit note dated 10/06/13 that stated,"Ask about medications d/t [due to] none being in the home." A skilled nurse visit note dated 10/07/13 stated, "Non-compliant ... awaiting meds from family ... Spoke with pt [patient] about medications being in home [sic]. Pt said [family member] will be able to help [patient] with meds tonight et [and]</p>	N000546	N546The Director of Clinical Services in-serviced field staff on 2/6/2014 re: Policies: #33.08 Nursing Service and #33.20 Case Conferences- Interdisciplinary Group Meeting/ Coordination of Services. Education included physician notification of change in condition or alteration in plan of care.Clinical record number 1- Patient discharged 10-24-2013.Patient chart number 3- Patient discharged 12-27-2013Clinical record number 5- Patient discharged from the agency 10-3-2013Clinical record number 7- Patient discharged from the agency 11-18-13Clinical record number 8- Patient discharged from the agency 11-1-2013Clinical record number 13- Patient discharged from agency 1-31-2014To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical	02/16/2014			

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	<p>set them up for tomorrow." A skilled nurse visit note dated 10/09/13 stated, "No med box available to set up meds ... Pts. [another family member] is to come over today with medbox and set up meds for pt." A skilled nurse visit note dated 10/11/13 stated, "Awaiting for family member to bring pill holder over. Still waiting on insulins." A skilled nurse visit note dated 10/17/13 stated, "Spoke with pt. about takling [sic] with social worker to help with possible home delivery for medications et pt. refused [sic]. Spoke with [family member] et she was not concerned about pt. not having medication."</p> <p>The record failed to evidence the nurse had informed the physician of the patient's non compliance with medications.</p> <p>2. Clinical record number 3 included a plan of care dated 11/26/13 to 01/24/14 with physical therapy to see the patient 2 times a week for 1 week and 3 times a week for 2 weeks. The clinical record evidenced the physical therapist saw the patient 2 times during week 3 and the patient was discharged.</p> <p>The record failed to evidence the physician had been informed of the patient's early discharge.</p>		<p>Services or designee to ensure that physician was notified of change in condition and/or alteration in plan of care. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.</p>				

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	<p>3. Clinical record number 5 included a plan of care dated 09/09/13 to 11/07/13 that included skilled nursing to see the patient "2W1 [2 times a week for 1 week], 3W1 [3 times a week for 1 week], then 1W5 [1 time a week for 5 weeks]." The clinical record evidenced the patient was seen by nursing for 4 weeks and was discharged.</p> <p>The record failed to evidence the registered nurse had informed the physician prior to the patient's early discharge.</p> <p>4. Clinical record number 7 included a referral from a physician for Physical Therapy on 11/15/13. The Physical Therapist evaluated the patient on 11/18/13. The patient declined home health services.</p> <p>The record failed to evidence the physician had been informed of the patient's early discharge.</p> <p>5. Clinical record number 8 included a physical therapy discharge summary dated 10/15/13 that included physical therapy frequency of "2W1, 3W2 then 1W1. The clinical record evidenced physical therapy saw the patient for 2 weeks and the patient was discharged.</p>						

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	<p>A. Clinical record number 8 included a home health aide frequency of "2W8 starting the week of 10/04/13". The home health aide was canceled by the patient/family on 10/7/13, 10/10/13, and 10/17/13.</p> <p>B. The record failed to evidence the physician was informed of the patient/family canceling of home health aide services and the physician had been informed of the patient's early discharge.</p> <p>7. Clinical record number 13 included a plan of care indicating a occupational therapy frequency of "2W4 starting the week of 12/30/13." The clinical record evidenced occupational therapy saw the patient for 2 weeks and the patient was discharged.</p> <p>The record failed to evidence the physician had been informed of the patient's early discharge.</p> <p>8. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p> <p>9. A policy titled "Nursing Service" dated 04/30/07, indicated "The Registered Nurse ... Promptly alerts the</p>				

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N000564	<p>physician to any changes that would suggest a need to alter the plan of care." 410 IAC 17-14-1(c)(3) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (3) assist the physician, chiropractor, podiatrist, dentist, or optometrist in evaluating level of function; Based on clinical record record and interview, the agency failed to ensure the physical therapist and occupational therapist evaluated a patient timely for 1 (# 4) of 10 records reviewed and the occupational therapist evaluated a patient as ordered for 1 of 10 (# 10) records reviewed of patients who were receiving therapy services. This had the potential to affect all patients who currently receive therapy services.</p> <p>Finding include:</p> <ol style="list-style-type: none"> 1. Clinical record number 4 included physician orders dated 07/29/13 that identified physical and occupational therapy were to evaluate and treat the patient with an end date of 08/02/13. <p>The clinical record failed to evidence that physical and occupational therapy evaluated the patient between 07/29/13 to 08/02/13.</p> <ol style="list-style-type: none"> 2. Clinical record number 10 included a 	N000564	The Director of Clinical Services in-serviced clinical field staff on 1/23/2014 re: Policy # 33.24 Plan of Care and Physician Orders. Education included following a written plan of care. Clinical record number 4- Patient discharged 8-28-2013 Clinical record number 10- Physician was contacted on 2-6-14 regarding alteration in plan of care To ensure compliance with the above policy 6 random clinical records will be monitored monthly for 3 months by the Director of Clinical Services or designee to ensure that plan of care was followed. On going monitoring will be part of quarterly record review performed by the Director of Clinical Services or designee. This compliance process will be under the direct supervision of the Director of Operations with oversight by the Regional Clinical Manager and Regional Vice President.	02/16/2014			

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	<p>plan of care with orders for occupational therapy to evaluate the patient starting the week of 01/06/14. The clinical record included a transfer assessment dated 01/05/14 and resumption of care assessment dated 01/07/14.</p> <p>The record failed to evidence the occupational therapist evaluated the patient after the resumption the of care visit by the registered nurse.</p> <p>3. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 01/14/13 at 3:30 PM.</p>				