

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

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

G000000	<p>This visit was a Home Health Initial Medicaid Certification survey. This was a partial extended survey.</p> <p>Survey Dates: November 6-8, 2013 Partial Extended Survey Dates: November 7 - November 8, 2013</p> <p>Facility Number: 013308</p> <p>Medicaid Number: N/A</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 10 Home Health Aide Only: 0 Personal Care Only: 0 Total: 10</p> <p>Sample: RR w/HV: 3 RR w/o HV: 7 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">November 14, 2013</p>	G000000		
---------	---	---------	--	--

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
G000116	<p>484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p> <p>Based on admission packet review, clinical record review, and interview, the agency failed to ensure patients were given the correct Indiana State Department of Health (ISDH) complaint hotline number for 10 of 10 records reviewed (#1-#10) with the potential to affect all 10 patients receiving services.</p> <p>The findings include:</p> <p>1. The undated admission packet states,"Complaint Report Line: 1-800-246-8909. [Long Term Care number]." The document provided to patients failed to evidence the ISDH Home Health Hotline number, 1-800-227-6334.</p>	G000116	<p>The admission packet was updated to reflect the correct ISDH home health hotline complaint number on 11/6/2013. The corrected admission packet forms were delivered to all active patients on 11/8/2013. The corrected admission packet forms were mailed to all discharged patients on 11/6/2013. All policies and procedures were reviewed, including complaint procedure, to verify correct ISDH home health hotline complaint number. Two policies and procedures included the number and both had the correct number – no changes necessary. Recurrence is prevented through replacing admission packet forms with the corrected form reflecting the correct ISDH home health complaint number on 11/6/2013. The administrator,</p>	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Clinical records 1-10 evidenced the patient had received the admission packet with the incorrect hotline number.</p> <p>3. During an interview on 11/6/13 at 3:40 PM, employee P, Administrator, indicated they were unaware of the Home Health Agency hotline.</p>		Irene Danielsen, is responsible for correction and recurrence prevention.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on policy review, document review, clinical record review, observation, and interview, the agency failed to ensure staff followed infection control standards during 2 of 3 home visits (#1 and #3) and failed to ensure supervisory visits of the Licensed Practical Nurse were made as required by agency policy for 1 of 10 records (#5) reviewed with the potential to affect all patients receiving services from the Home Health Aide (HHA) and the Licensed Practical Nurse (LPN).</p> <p>The findings include:</p> <p>1. Related to infection control 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 contaminated hands to surfaces . . .</p>	G000121	<p>Correction and Prevention of Recurrence: Retraining memo provided to applicable staff on infection control and proper procedures on 11/8/2013.</p> <p>Correction and Prevention of Recurrence: Retraining of home health aides via inservice on proper glove technique and infection control to be conducted at November monthly HHA inservice. To be completed on 11/25/2013. Prevention of Recurrence: Employee F, home health aide, and Employee A, LPN, will be checked off on glove technique by RN to ensure full understanding of the proper procedure and full compliance. To be completed on 11/20/2013 and 11/26/2013, respectively.</p> <p>Correction and Prevention of Recurrence: Develop a process and checklist for scheduler to assign all supervisory visit to RNs. Retrain RN/LPN and applicable staff on respective scope of practice and policy requirements for the supervisory visit at least once every 30 days. Completed 11/14/2013.</p> <p>Prevention and Recurrence: Audit LPN supervisory visits for the three next occurrences for compliance.</p>	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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>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. B. During the home visit to patient #1 on 11/6/13 at 4:42 PM, employee F, HHA, washed her hands with soap and water, donned clean gloves, and helped the</p>		To be completed on 11/26/2013, 12/2/2013, and 12/5/2013. The DON, Julie Sykes Hutslar, is responsible for correction and prevention of recurrence.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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>patient take off their socks. Then the HHA picked up the patient's underwear and pants off the floor, guided the patient to the shower, assisted with the shower, squeezed shampoo onto her gloves, and lathered the shampoo in the patient's hair. The HHA rinsed the patient's hair with water, handed the patient a towel to dry their eyes, and placed the towel on the sink countertop. Then the HHA scrubbed the patient's back, chest, skin folds, and legs with a scrubbie and proceeded to rinse the patient with water. The HHA got a new scrubbie, added body wash, and the patient scrubbed their peri-area and buttocks. The HHA then rinsed the scrubbie and sprayed the peri-area and buttocks with water. The HHA dried the patient's body with a towel. The HHA then applied lotion to the patient's body. The HHA then changed gloves without sanitizing her hands before donning the new gloves. Then the HHA applied powder to the patient's buttocks, back of legs, belly, and under skin folds. The HHA helped the patient put on a new diaper, underwear, and shorts. The patient pulled their diaper, underwear, and shorts up by themselves. The HHA handed the patient their shirt to put on. Then the HHA brushed the patient's hair and took off her gloves. The HHA then washed her hands with soap and water. The HHA donned clean gloves, took the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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>patient's blood pressure, reached in her pants pocket for her keys, unlocked the secure portion of her work bag, pulled out the visit note, and documented the blood pressure. Then the HHA put the thermometer in a sleeve, put the thermometer in the patient's mouth, and listened to heart and lung sounds.</p> <p>During an interview on 11/7/13 at 11:56 AM, employee P, Administrator, indicated that employee F, HHA, should have sanitized her hands between glove changes.</p> <p>C. During the home visit to patient #3 on 11/7/13 at 10:00 AM, employee A, LPN, washed his hands with soap and water, donned clean gloves, took the patient's temperature, blood pressure, and typed the vital signs on his laptop with the same gloves on. Then he listened to the patient's heart, lungs, and bowel sounds. The LPN then cleaned his stethoscope with a sanitizing wipe, dropped the wipe on the floor, got a new wipe to clean the thermometer and blood pressure cuff. Then he took off his gloves, washed his hands with soap and water, donned new gloves, assessed the ostomy site, and assessed the buttocks lesion while touching the patient's upper buttocks area. Then the LPN assessed and touched the G-tube site, G-tube cap, and lifted the dressing to assess the G-tube insertion site. Then the LPN drew up water in a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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>large syringe for the G-tube and handed it to the caregiver to evaluate the caregiver's demonstration and understanding of the process. The caregiver pushed the water through the G-tube. The LPN then took off his gloves and washed hands with soap and water.</p> <p>During an interview on 11/7/13 at 12:10 PM, employee Q, Alternate Administrator, indicated that employee A, LPN, should have changed gloves when going back to the G-tube site.</p> <p>2. Related to LPN Supervisory Visits</p> <p>A. The policy titled "Medical Supervision" with an effective date of 8/2/13 states,"12. LPN supervision is done at least every 30 days and documented in Kinnser under the LPN supervision task."</p> <p>B. Clinical record #5 contained a plan of care for the certification period 9/12/13 - 11/10/13 with orders for Skilled Nursing services. The LPN initially started seeing the patient on 9/13/13. The RN made a supervisory visit on 10/16/13. The record failed to evidence a LPN supervisory visit for 10/13/13.</p> <p>C. During an interview on 11/8/13 at 11:33 AM, employee Q, Alternate Administrator, indicated the RN made the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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
	LPN supervisory visit three days late. Employee Q further indicated the agency's policy requires the RN to make a LPN visit every 30 days.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on clinical record review and interview, the home health agency failed to ensure the License Practical Nurse (LPN) was reporting out-of-range temperatures to the physician or registered nurse in 1 of 10 clinical records reviewed (#3) with the potential to affect all patients of the agency who receive skilled nursing services from employee A, LPN.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #3, start of care 9/11/13, contained a home health certification and plan of care dated 9/11/13-11/9/13 with orders for Skilled Nursing to notify the physician of a temperature greater than 101 or less than 97. The record failed to evidence the physician or registered nurse was notified of out-of-range temperatures for 9/19/13, 9/27/13, 10/21/13, 10/23/13, 10/25/13, and 11/6/13. During an interview on 11/7/13 at 6:30 PM, employee Q, Alternate Administrator, acknowledged that employee A, LPN, did not report the out-of-range temperatures to the physician 	G000170	<p>Correction: The physician was notified that the patient's temperature was below the stated parameter on 11/11/2013. Because the patient's temperature is historically low, the physician changed the parameters on the plan of care on 11/11/2013. Prevention: Applicable staff educated about the use of parameters on the plan of care and how to document, use, and QA this within the EMR. To be completed by 11/30/2013. Audit 100% of patient records with parameters for compliance with reporting procedures from 11/30/2013 through 12/30/2013. To be completed by 12/30/2013. The DON, Julie Sykes Hutslar, is responsible for correction and prevention of recurrence.</p>	12/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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
	or registered nurse.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
G000178	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel.</p> <p>Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse supervised the licensed practical nurse (LPN) as required by agency policy in 1 of 10 records reviewed (#5) with the potential to affect all patients receiving services from the LPN.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Medical Supervision" with an effective date of 8/2/13 states, "12. LPN supervision is done at least every 30 days and documented in Kinnser under the LPN supervision task." Clinical record #5 contained a plan of care for the certification period 9/12/13 - 11/10/13 with orders for Skilled Nursing services. The LPN initially started seeing the patient on 9/13/13. The RN made a supervisory visit on 10/16/13. The record failed to evidence a LPN supervisory visit for 10/13/13. During an interview on 11/8/13 at 11:33 AM, employee Q, Alternate 	G000178	<p>Correction and Prevention of Recurrence: Develop a process and checklist for scheduler to assign all supervisory visits to RNs. Retrain RN/LPN and applicable staff on respective scope of practice and policy requirements for the supervisory visit at least once every 30 days. Completed on 11/14/2013.</p> <p>Prevention of Recurrence: Audit LPN supervisory visits for the three next occurrences for compliance. To be completed on 11/26/2013, 12/2/2013, and 12/5/2013. The DON, Julie Sykes Hutslar, is responsible for correction and prevention of recurrence.</p>	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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>Administrator, indicated the RN made the LPN supervisory visit three days late. Employee Q further indicated the agency's policy requires the RN to make a LPN visit every 30 days.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
G000337	<p>484.55(c) DRUG REGIMEN REVIEW</p> <p>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on clinical record review and interview, the agency failed to ensure the medication profile was updated as part of the comprehensive assessment and included start dates for medications in 2 of 10 clinical records reviewed with the potential to affect all patients at this agency. (#7 and #10)</p> <p>Findings include:</p> <p>1. Clinical record #7, Start of Care (SOC) 8/8/13, included plans of care for the home health certification periods from 8/8/13 to 10/6/13 and from 10/7/13 to 12/5/13. The record also included a patient medication record signed off by the RN on 9/11/13 and another patient medication record signed off by the RN on 10/28/13. The record failed to evidence signature dates were close to the SOC and recertification assessment dates.</p> <p>During an interview on 11/8/13 at 1:38 PM, employee Q, Alternate</p>	G000337	<p>Correction and Prevention of Recurrence: Train and educate all RNs on use of EMR Kinnser three step Medication Reconciliation process. Completed on 11/15/2013. Prevention of Recurrence: Add Kinnser medication reconciliation process to RN orientation. Completed on 11/13/2013. Develop and train staff on quick reference tool on Kinnser process for medication reconciliation. Completed on 11/15/2013. Audit 100% of new admissions through 12/8/2013 for compliance with medication reconciliation requirements. To be completed 12/9/2013. The Administrator, Irene Danielsen, is responsible for correction and prevention of recurrence.</p>	12/09/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401		
(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>Administrator, acknowledged the RN signature dates were not close to the SOC and recertification assessment dates. Employee P, Administrator, indicated the agency has since educated the RN about the computer more since this was a software issue.</p> <p>2. Clinical record #10, SOC 8/26/13, included a plan of care for the home health certification period from 8/26/13 to 10/20/13. The record also included a medication record that failed to include the medication start dates or any reason the start dates were not available.</p> <p>During an interview on 11/8/13 at 5:00 PM, employee Q, Alternate Administrator, acknowledged the start dates were not on the patient medication record. Employee Q further indicated that the patient has been on the medications for many years and locating the start dates was not possible.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N000000	<p>This visit was for an Initial Home Health state licensure survey.</p> <p>Survey Dates: November 6-8, 2013</p> <p>Facility Number: 13308</p> <p>Medicaid Number: N/A</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 10 Home Health Aide Only: 0 Personal Care Only: 0 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 14, 2013</p>	N000000					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
N000460	<p>410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall:</p> <p>(1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.</p> <p>Based on personnel file review and interview, the agency failed to ensure the limited criminal background check was completed within 3 business days after the employee began providing services for 1 of 5 personnel files reviewed (A) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Personnel file A, date of hire 9/14/13 and first patient contact 9/11/13, evidenced a document titled "Limited Criminal History" dated 9/18/13.</p> <p>2. During an interview on 11/8/13 at 3:06 PM, employee P, Administrator, acknowledged the limited criminal</p>	N000460	<p>Correction and Prevention of Recurrence: Employee A's criminal background was completed on 09/06/2013, which this HHA holds a receipt log as evidence and dated before Employee A had patient contact on 09/11/2013. The Administrator, Irene Danielsen, discovered four lost/shredded employee limited criminal history checks by office staff error on 09/15/2013.</p> <p>Employee A's criminal record was completed for a second time on 09/18/2013 and filed by the Administrator. Prevention of Recurrence: The hiring process flowchart was examined and found to contain the requirements set forth in N-460 for employees to have a limited criminal background check completed within 3 business days of the employee beginning providing services; The hiring process was</p>	11/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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
	background check needed to be done sooner.		revised to include guidelines for office staff for a process to file employee records timely and correctly. This process will be audited for compliance for 100% of new direct patient care hires for the next two such hires. The administrator, Irene Danielson, is responsible for prevention of recurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
N000462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review and interview, the agency failed to ensure all employees had a physical exam within 180 days prior to first patient contact for 1 of 5 personnel files reviewed (A) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A, date of hire 9/14/13 and first patient contact 9/11/13, evidenced a document titled "Confidential Employee Medical Information" that was not completed until 9/23/13, after first patient contact. 2. During an interview on 11/8/13 at 3:05 PM, employee P, Administrator, acknowledged the physical exam was not completed in accordance with the 180 day requirement. 	N000462	<p>Correction and Prevention of Recurrence: Employee A completed the required physical on 9/23/2013. Prevention of Recurrence: The hiring process was revised to require direct care employees have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. The revised hiring process includes a verification of the required physical prior to the employee being assigned to a patient. This process will be audited for compliance for 100% of new direct patient care hires for the next two such hires. The administrator, Irene Danielsen, is responsible for prevention and recurrence.</p>	11/11/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on policy review, document review, clinical record review, observation, and interview, the agency failed to ensure staff followed infection control standards during 2 of 3 home visits (Employees F and A) with the potential to affect all patients receiving services from the Home Health Aide (HHA) and the Licensed Practical Nurse (LPN).</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes,</p>	N000470	<p>Correction and Prevention of Recurrence: Retraining memo provided to applicable staff on infection control and proper procedures on 11/8/2013.</p> <p>Correction and Prevention of Recurrence: Retraining of home health aides via inservice on proper glove technique and infection control to be conducted at November monthly HHA inservice. To be completed on 11/25/2013. Prevention of Recurrence: Employee F, home health aide, and Employee A, LPN, will be checked off on glove technique by RN to ensure full understanding of the proper procedure and full compliance. To be completed on 11/20/2013 and 11/26/2013, respectively.</p> <p>Correction and Prevention of Recurrence: Develop a process and checklist for scheduler to assign all supervisory visit to RNs. Retrain RN/LPN and applicable staff on respective scope of practice and policy requirements for the supervisory visit at least once every 30 days. Completed 11/14/2013.</p> <p>Prevention and Recurrence: Audit LPN supervisory visits for the three next occurrences for</p>	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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>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.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>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 . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>2. During the home visit to patient #1 on 11/6/13 at 4:42 PM, employee F, HHA, washed her hands with soap and water, donned clean gloves, and helped the patient take off their socks. Then the HHA picked up the patient's underwear and pants off the floor, guided the patient to the shower, assisted with the shower,</p>		<p>compliance. To be completed on 11/26/2013, 12/2/2013, and 12/5/2013. The DON, Julie Sykes Hutslar, is responsible for correction and prevention of recurrence.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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>squeezed shampoo onto her gloves, and lathered the shampoo in the patient's hair. The HHA rinsed the patient's hair with water, handed the patient a towel to dry their eyes, and placed the towel on the sink countertop. Then the HHA scrubbed the patient's back, chest, skin folds, and legs with a scrubbie and proceeded to rinse the patient with water. The HHA got a new scrubbie, added body wash, and the patient scrubbed their peri-area and buttocks. The HHA then rinsed the scrubbie and sprayed the peri-area and buttocks with water. The HHA dried the patient's body with a towel. The HHA then applied lotion to the patient's body. The HHA then changed gloves without sanitizing her hands before donning the new gloves. Then the HHA applied powder to the patient's buttocks, back of legs, belly, and under skin folds. The HHA helped the patient put on a new diaper, underwear, and shorts. The patient pulled their diaper, underwear, and shorts up by themselves. The HHA handed the patient their shirt to put on. Then the HHA brushed the patient's hair and took off her gloves. The HHA then washed her hands with soap and water. The HHA donned clean gloves, took the patient's blood pressure, reached in her pants pocket for her keys, unlocked the secure portion of her work bag, pulled out the visit note, and documented the blood</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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>pressure. Then the HHA put the thermometer in a sleeve, put the thermometer in the patient's mouth, and listened to heart and lung sounds.</p> <p>During an interview on 11/7/13 at 11:56 AM, employee P, Administrator, indicated that employee F, HHA, should have sanitized her hands between glove changes.</p> <p>3. During the home visit to patient #3 on 11/7/13 at 10:00 AM, employee A, LPN, washed his hands with soap and water, donned clean gloves, took the patient's temperature, blood pressure, and typed the vital signs on his laptop with the same gloves on. Then he listened to the patient's heart, lungs, and bowel sounds. The LPN then cleaned his stethoscope with a sanitizing wipe, dropped the wipe on the floor, got a new wipe to clean the thermometer and blood pressure cuff. Then he took off his gloves, washed his hands with soap and water, donned new gloves, assessed the ostomy site, and assessed the buttocks lesion while touching the patient's upper buttocks area. Then the LPN assessed and touched the G-tube site, G-tube cap, and lifted the dressing to assess the G-tube insertion site. Then the LPN drew up water in a large syringe for the G-tube and handed it to the caregiver to evaluate the caregiver's demonstration and understanding of the process. The caregiver pushed the water</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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>through the G-tube. The LPN then took off his gloves and washed hands with soap and water.</p> <p>During an interview on 11/7/13 at 12:10 PM, employee Q, Alternate Administrator, indicated that employee A, LPN, should have changed gloves when going back to the G-tube site.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
N000502	<p>410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency.</p> <p>Based on admission packet review, clinical record review, and interview, the agency failed to ensure patients were given the correct Indiana State Department of Health (ISDH) complaint hotline number for 10 of 10 records reviewed (#1-#10) with the potential to affect all 10 patients receiving services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The undated admission packet states,"Complaint Report Line: 1-800-246-8909. [Long Term Care number]." The document provided to patients failed to evidence the ISDH Home Health Hotline number, 1-800-227-6334. Clinical records 1-10 evidenced the patient had received the admission packet with the incorrect hotline number. During an interview on 11/6/13 at 3:40 PM, employee P, Administrator, indicated 	N000502	The admission packet was updated to reflect the correct ISDH home health hotline complaint number on 11/6/2013. The corrected admission packet forms were delivered to all active patients on 11/8/2013. The corrected admission packet forms were mailed to all discharged patients on 11/6/2013. All policies and procedures were reviewed, including complaint procedure, to verify correct ISDH home health hotline complaint number. Two policies and procedures included the number and both had the correct number – no changes necessary. Recurrence is prevented through replacing admission packet forms with the corrected form reflecting the correct ISDH home health complaint number on 11/6/2013. The administrator, Irene Danielsen, is responsible for correction and recurrence prevention.	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(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
	they were unaware of the Home Health Agency hotline.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
N000537	<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> <p>Based on clinical record review and interview, the home health agency failed to ensure the License Practical Nurse (LPN) was reporting out-of-range temperatures to the physician or registered nurse in 1 of 10 clinical records reviewed (#3) with the potential to affect all patients of the agency who receive skilled nursing services from employee A, LPN.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #3, start of care 9/11/13, contained a home health certification and plan of care dated 9/11/13-11/9/13 with orders for Skilled Nursing to notify the physician of a temperature greater than 101 or less than 97. The record failed to evidence the physician or registered nurse was notified of out-of-range temperatures for 9/19/13, 9/27/13, 10/21/13, 10/23/13, 10/25/13, and 11/6/13. During an interview on 11/7/13 at 6:30 PM, employee Q, Alternate 	N000537	<p>Correction: The physician was notified that the patient's temperature was below the stated parameter. Because the patient's temperature is historically low, the physician changed the parameters on the plan of care on 11/11/2013. Prevention: Applicable staff educated about the use of parameters on the plan of care and how to document, use, and QA this within the EMR. To be completed by 11/30/2013. Audit 100% of patient records with parameters for compliance with reporting procedures from 11/30/2013 through 12/30/2013. To be completed by 12/30/2013. The DON, Julie Sykes Hutslar, is responsible for correction and prevention of recurrence.</p>	12/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401		
(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	
	Administrator, acknowledged that employee A, LPN, did not report the out-of-range temperatures to the physician or registered nurse.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
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 policy review, clinical record review, and interview, the agency failed to ensure the registered nurse supervised the licensed practical nurse (LPN) as required by agency policy in 1 of 10 records reviewed (#5) with the potential to affect all patients receiving services from the LPN.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The policy titled "Medical Supervision" with an effective date of 8/2/13 states, "12. LPN supervision is done at least every 30 days and documented in Kinnser under the LPN supervision task." Clinical record #5 contained a plan of care for the certification period 9/12/13 - 11/10/13 with orders for Skilled Nursing services. The LPN initially started seeing 	N000546	<p>Correction and Prevention of Recurrence: Develop a process and checklist for scheduler to assign all supervisory visits to RNs. Retrain RN/LPN and applicable staff on respective scope of practice and policy requirements for the supervisory visit at least once every 30 days. Completed on 11/14/2013. Prevention of Recurrence: Audit LPN supervisory visits for the three next occurrences for compliance. To be completed on 11/26/2013, 12/2/2013, and 12/5/2013. The DON, Julie Sykes Hutslar, is responsible for correction and prevention of recurrence.</p>	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the patient on 9/13/13. The RN made a supervisory visit on 10/16/13. The record failed to evidence a LPN supervisory visit for 10/13/13.</p> <p>3. During an interview on 11/8/13 at 11:33 AM, employee Q, Alternate Administrator, indicated the RN made the LPN supervisory visit three days late. Employee Q further indicated the agency's policy requires the RN to make a LPN visit every 30 days.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/08/2013	
NAME OF PROVIDER OR SUPPLIER HOOSIER HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 7110 S LEISURE LANE BLOOMINGTON, IN 47401			
(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			
N000597	<p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry.</p> <p>Based on personnel file review and interview, the agency failed to ensure home health aides (HHA) were entered on and in good standing on the state aide registry for 1 of 3 HHA files reviewed (F) with the potential to affect all patients receiving HHA services.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Personnel file F, date of hire 9/14/13 with a first patient contact date of 9/12/13, failed to evidence the aide was entered on and in good standing on the state aide registry. During an interview on 11/8/13 at 3:20 PM, Employee P, Administrator, acknowledged the HHA was not on the state aide registry. 	N000597	<p>Correction and Prevention of Recurrence: Aide was pulled from patient care until on the home health aide registry in good standing as a home health aide on 11/8/2013. Aide's competency evaluation program was complete on 09/06/2013, but RN educator was on unanticipated bereavement leave prior to signing the Aide Registry Paperwork. Another RN was assigned to re-evaluate the aide's competency on 11/11/2013 and submit the paperwork to the Aide Registry. Completed on 11/15/2013. The supervising RN, Julie Sykes Hutslar, RN, DON, is responsible for the competency evaluation and aide registry paperwork submission. Hiring process was revised to require documentation of individual being on the state aide registry in good standing prior to being assigned to patient. Completed on 11/11/2013. The DON, Julie Sykes Hutslar, is responsible for prevention and recurrence.</p>	11/13/2013			