

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 10/24/2012
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NAME OF PROVIDER OR SUPPLIER CM SUNSHINE HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8300 BROADWAY SUITE H2 MERRILLVILLE, IN 46410
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N0000	<p>This was an initial home health state licensure survey.</p> <p>Survey dates: October 23 and 24, 2012</p> <p>Facility: #012985</p> <p>Medicaid Vendor: N/A</p> <p>Surveyor: Bridget Boston, RN, PHNS</p> <p>Census: 11 Skilled: 11 Aide only: 0 Homemaker only: 0</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 29, 2012</p>	N0000		

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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N0451	<p>410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence.</p> <p>Based on personnel file, 410 IAC Article 17, and policy review and interview, the administrator failed to ensure a qualified person was employed as alternate administrator to act in the absence of the administrator with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 410 IAC 17 - 9 - 2 defines an Administer and states, "Administrator means any health care professional who has at least one (1) year of supervisory or administrative experience in health service, or any individual who has at least one (1) year of experience in health service administration or health service finance." On 10/24/12 at 11 AM (central time), employee C, the alternate administrator, indicated her experience with previous home health providers, facility 1 and 2, was to assist other individuals with agency tasks, input data into computers, 	N0451	The Administrator reviewed the state/federal regulation for Administrator qualifications and will submit a new qualified Alternate Administrator candidate for state approval to act in the absence of the Administrator. The Administrator will interview the candidate, review job qualifications, job description, and candidate's work history. Detailed work history will be verified to ensure candidate meets/exceeds state and company requirements. The candidate information will then be submitted to State for approval. The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	11/26/2012			

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	<p>track physician signatures on physician orders, filing, and supervise one clerical staff.</p> <p>3. On 10/24/12 at 3:40 PM (eastern time), an administrative employee of facility 2 was interviewed by telephone and indicated employee C was employed from February 1 through August 3, 2012, and did not work in an administrative capacity. The individual indicated employee C was not responsible for scheduling, management, hiring, policies and procedures development, plans of care development or auditing.</p> <p>4. On 10/24/12 at 3:45 PM (eastern time), an administrative employee of facility 1 was interviewed by telephone and indicated employee C was employed from June 11, 2011, through January 31, 2012, and did not work in an administrative capacity. The individual indicated employee C input data into a computer and supervised one other clerical staff to ensure proper filing.</p> <p>5. The policy titled "Position: Administrator" dated 07/2012 stated, "Minimum of one year experience in supervisory or administrative positions. ... Knowledge of the regulatory requirements at the state, federal, and local level. ... Plans, organizes, and</p>			

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	directs the agency's ongoing functions."				

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N0464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on</p>						

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	<p>a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel record review, policy review, and interview, the agency failed to ensure home health aide files included a screening for tuberculosis for 1 of 2 home health aide files reviewed (I) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. Personnel record I, date of hire 9/7/12, first patient contact 9/25/12, failed to evidence documentation of a negative tuberculosis screening completed within the previous twelve months, a negative chest x ray report, or a two step tuberculosis screening completed at hire. The file evidenced a Mantoux was administered on 1/1/11, an unsigned and incomplete Mantoux documentation dated 1/4/12 from another provider, and documentation of a Mantoux placed on 9/7/12 and read 9/11/12 at hire.</p>	N0464	<p>Personnel I, date of hire 09/07/2012 is no longer employed at CM Sunshine Home Healthcare, Inc. as of 10/25/2012. No further action needed with regard to this record. The Administrator/Director of Nursing reviewed the applicable policy, in-serviced staff responsible for assisting with hiring/orientation on ensuring all employees, staff members, persons providing direct patient contact are evaluated for Tuberculosis and documentation is properly completed with: dates/time of administration/reading, site, lot number and expiration date, signature of individual who placed and read the test. The Administrator/Director of Nursing will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	10/30/2012			

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	<p>2. On 10/24/12 at 1:20 PM, the administrator / director of nursing indicated she did not realize the Mantoux dated 1/4/12 was incomplete and did not have the signature of the individual who placed and read the test.</p> <p>3. The policy dated 08/2012 and titled "Health Screening" number D - 240 states, "On any employee or contracted personnel providing direct patient contact, there shall be documentation of completion of a tuberculin (TB) skin test, Mantoux method. ... If there is documented evidence of a negative skin test within the twelve months prior to employment, testing completed at the time of hire will fulfill the two-step requirement. If the employee does not have documented evidence of a negative Mantoux skin test within the past 12 months, a Mantoux skin test will be given at the time of hire and repeated within one to two weeks of the first test. (Verify time frames with state requirements.)"</p>			

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N0522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on interview and review of clinical records and policy, the agency failed to ensure the medical care provided to the patient followed the medical plan of care as established by the physician and orders were obtained for all services and treatments provided in 5 of 6 (# 1, 2, 3, 5, and 6) clinical records reviewed with the potential to affect all the agency's patients.</p> <p>The findings include:</p> <p>1. Clinical record # 1, start of care 10/3/12, included a plan of care dated 10/3/12 through 12/1/12 with orders that stated, "Pt [patient] / family to administer flush(es) saline 10 milliliters normal saline, pre and post IV [intravenous]. 5 mL [milliliters] Heparin 100 units / mL post med IV." The clinical record failed to evidence a written physician order was obtained for the flush order written on the plan of care.</p> <p>A. The record evidenced a comprehensive assessment and skilled nurse visit note dated 10/3/12 completed</p>	N0522	<p>Instructed professional clinicians to document all verbal orders received in detail upon receipt of order. Admitting clinicians have been instructed to include any requests by family/caregiver for delay in any initial services provided by other disciplines during their admission report with the Director of Nursing. Therapists have been instructed to include a verbal order stating treatment, frequency, and duration with their evaluation/re-evaluation. A new SOC/Admission Order template has been created which encompasses/summarizes information documented on the SOC OASIS by the admitting clinician, which serves as the verbal order for initial evaluation, treatments, and services to be provided. A new Therapy Evaluation/Re-evaluation order template has been created which encompasses/summarizes Therapy treatment orders and frequency/duration of services. Modified the clinical record review form to include: · All services, treatments, and labs have correlating verbal orders. · All discontinuation of services, treatments, and labs have</p>	11/07/2012			

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	<p>by employee D. The skilled nurse visit noted stated, "PICC line crimped under dressing. Double lumen would flush, but not draw. ... Both lumen flush." The record failed to evidence a physician order was received and written to be counter signed by the physician that specified the medication and dosage to be administered for the flush completed on 10/3/12 and taught to the patient.</p> <p>B. The record evidenced a verbal order dated 10/3/12 that stated, "Q [every] Monday, CBC, CMP, CRP, SED rate, [lab tests] ... Q Thursday CMP." The record failed to evidence weekly lab draws were completed. The record evidenced lab results from 10/3/12 and 10/8/12 only.</p> <p>C. On 10/24/12 at 3:09 PM, employee B indicated the record did not evidence a written verbal order for the PICC line flushes was obtained prior to employee D completing the treatment with the patient on 10/3/12 and the verbal order written for weekly labs was an error and should have been a one time order. She indicated there was not an order to discontinue the weekly lab orders dated 10/3/12.</p> <p>2. Clinical record 2 evidenced start of care dated 9/13/12 and a comprehensive</p>		<p>correlating verbal orders. The Administrator/Director of Nursing will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>assessment dated 9/13/12 and completed by employee A, that stated, "Labs drawn." The clinical record failed to evidence a physician order was obtained prior to employee A performing the venipuncture and obtaining the blood sample.</p> <p>On 10/24/12 at 2:59 PM, employee B indicated no verbal order was written to obtain a blood sample via venipuncture on 9/13/12 during the initial visit to the patient's home.</p> <p>3. Clinical record # 3 evidenced a start of care 9/20/12 and a comprehensive assessment dated 9/20/12 which included documentation a blood sample was drawn during the visit. The clinical record failed to evidence a physician order for the blood sample drawn by the registered nurse.</p> <p>A. The record evidenced skilled nurse visit notes dated 9/26/12 and 10/5/12 completed by employee B. Both notes included documentation a blood sample was drawn during the visits. The record failed to evidence a physician order for the blood samples collected on 9/26/12 and 10/5/12 by employee B.</p> <p>B. The record evidenced employee G, a contracted physical therapist, evaluated the patient and completed a treatment on</p>						

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	<p>9/21/12 and employee F, a contracted physical therapist assistant, completed visits on 9/24/12 and 9/27/12. The record failed to evidence physician orders for the treatment provided.</p> <p>On 10/24/12 at 2:47 PM, employee B indicated the record did not include a written verbal order for the physical therapy treatment to be provided to the patient and indicated there was no written physician order for the blood samples drawn.</p> <p>4. Clinical record # 5 included a plan of care dated 9/18/12 through 11/16/12 with orders for aide services 2 times a week for 9 weeks. The record failed to evidence aide services were provided until 9/25/12.</p> <p>On 10/24/12 at 2:22 PM, employee B indicated the plan of care contained an error and should have read the aide was to begin the week of 9/23/12.</p> <p>5. Clinical record # 6 evidenced a plan of care dated 9/15/12 through 11/13/12 with orders for Physical Therapy to evaluate. The record evidenced employee G evaluated the patient and provided physical therapy treatment on 9/21/12. The record evidenced employee F provided services on 9/24/12, 9/27/12, 10/1/12, 10/11/12, 10/15/12, and</p>						

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	<p>10/17/12. The record failed to evidence a physician order for the physical therapy treatment and services provided.</p> <p>On 10/24/12 at 3:02 PM, employee B indicated the record did not contain written physician orders for the physical therapy services provided.</p> <p>6. The policy dated 07/2012 and titled "Physician Orders" numbered C - 635 stated, "All medications, treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician."</p>			

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N0565	<p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on clinical record and policy review and interview, the agency failed to ensure the plan of care was developed that included orders for treatment to be provided by the physical therapist in 2 (# 3 and 6) of 2 clinical records reviewed of patients receiving physical therapy services with the potential to affect all patients receiving therapy services.</p> <p>The findings include:</p> <p>1. Clinical record # 3, start of care 9/20/12, evidenced employee G, a contracted physical therapist, evaluated the patient and completed a treatment on 9/21/12 and employee F, a contracted physical therapist assistant, completed visits on 9/24/12 and 9/27/12. The record failed to evidence physician orders for the treatment provided.</p> <p>On 10/24/12 at 2:47 PM, employee B indicated the record did not include a written verbal order for the physical therapy treatment to be provided to the patient.</p> <p>2. Clinical record # 6 evidenced a plan of</p>	N0565	<p>Instructed professional clinicians to document all verbal orders received in detail upon receipt of order. Admitting clinicians have been instructed to include any requests by family/caregiver for delay in any initial services provided by other disciplines during their admission report with the Director of Nursing. Therapists have been instructed to include a verbal order stating treatment, frequency, and duration with their evaluation/re-evaluation. A new SOC/Admission Order template has been created which encompasses/summarizes information documented on the SOC OASIS by the admitting clinician, which serves as the verbal order for initial evaluation, treatments, and services to be provided. A new Therapy Evaluation/Re-evaluation order template has been created which encompasses/summarizes Therapy treatment orders and frequency/duration of services. Modified the clinical record review form to include: · All services, treatments, and labs have correlating verbal orders. · All discontinuation of services, treatments, and labs have correlating verbal orders. The</p>	11/07/2012			

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	<p>care dated 9/15/12 through 11/13/12 with orders for Physical Therapy to evaluate. The record evidenced employee G evaluated the patient and provided physical therapy treatment on 9/21/12. The record evidenced employee F provided services on 9/24/12, 9/27/12, 10/1/12, 10/11/12, 10/15/12, and 10/17/12. The record failed to evidence a physician order for the physical therapy treatment and services provided.</p> <p>On 10/24/12 at 3:02 PM, employee B indicated the record did not contain written physician orders for the physical therapy services provided.</p> <p>3. The policy dated 07/2012 and titled "Physician Orders" numbered C - 635 and stated, "All medications, treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. ... All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician."</p>		Administrator/Director of Nursing will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.				

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N0597	<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. Based on personnel record and clinical review and interview, the agency failed to ensure home health aides were entered on and in good standing on the state aide registry within 3 business days of employment for 1 of 2 home health aide files reviewed (H) with the potential to affect all the agency's patients who receive home health aide services.</p> <p>Findings include:</p> <p>1. Personnel record H, date of hire 9/25/12, failed to evidence the agency had checked the registry to ensure the employee was entered on and in good standing on the state aide registry within 3 business days of employment. The file evidenced the individual was placed on the state aide registry on 10/18/12.</p> <p>A. Clinical record 3 evidenced employee H provided care on October 2, 5, 9, and 11, 2012.</p> <p>B. Clinical record 5 evidenced employee H provided care on October 2, 5, 11, 16, and 19, 2012.</p>	N0597	<p>The Administrator/Director of Nursing reviewed the state rule and associated company policies. The Home Health Aide Job Description – "Employment qualifications" has been revised to include: "Be entered on and be in good standing on the IN State Aide Registry prior to first patient contact and within three business days of hire." Personnel Record H has been updated to reflect documentation of the Home Health Aide Registry effective 10/02/2012. Staff responsible for assisting with hiring/orientation have been in-serviced on ensuring verification of Home Health Aide Licensure/Registry within three days of hire/prior to first patient contact. Documentation verification will be maintained in the personnel files. The Administrator/Director of Nursing will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	10/30/2012			

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 10/24/2012	
NAME OF PROVIDER OR SUPPLIER CM SUNSHINE HOME HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8300 BROADWAY SUITE H2 MERRILLVILLE, IN 46410			
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	<p>C. Clinical record 6 evidenced employee H provided care on October 2, 5, 11, 16, and 19, 2012.</p> <p>2. On 10/24/12 at 1:14 PM, the administrator / director of nursing indicated she misunderstood the rule and confirmed the aide was not placed on the registry until 10/18/12.</p>						

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N0598	<p>410 IAC 17-14-1(l)(2) Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met.</p> <p>Based on personnel record and clinical review and interview, the agency failed to ensure documentation evidenced home health aides were entered on and in good standing on the state aide registry within 3 business days of employment for 1 of 2 home health aide files reviewed (H) with the potential to affect all the agency's patients who receive home health aide services.</p> <p>Findings include:</p> <p>1. Personnel record H, date of hire 9/25/12, failed to evidence the agency had checked the registry to ensure the employee was entered on and in good standing on the state aide registry within 3 business days of employment. The file evidenced the individual was placed on the state aide registry on 10/18/12.</p> <p>A. Clinical record 3 evidenced employee H provided care on October 2, 5, 9, and 11, 2012.</p> <p>B. Clinical record 5 evidenced employee H provided care on October 2,</p>	N0598	<p>The Administrator/Director of Nursing reviewed the state rule and associated company policies. The Home Health Aide Job Description – "Employment qualifications" has been revised to include: "Be entered on and be in good standing on the IN State Aide Registry prior to first patient contact and within three business days of hire." Personnel Record H has been updated to reflect documentation of the Home Health Aide Registry effective 10/02/2012. Staff responsible for assisting with hiring/orientation have been in-serviced on ensuring verification of Home Health Aide Licensure/Registry within three days of hire/prior to first patient contact. Documentation verification will be maintained in the personnel files. The Administrator/Director of Nursing will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.</p>	10/30/2012			

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	<p>5, 11, 16, and 19, 2012.</p> <p>C. Clinical record 6 evidenced employee H provided care on October 2, 5, 11, 16, and 19, 2012.</p> <p>2. On 10/24/12 at 1:14 PM, the administrator / director of nursing indicated she misunderstood the rule and confirmed the aide was not placed on the registry until 10/18/12.</p>			