

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	<p>This visit was a Home Health federal recertification survey. This was a partially extended survey.</p> <p>Survey Dates: October 22 -24, 2012 Partially Extended Survey Dates: October 22-24, 2012</p> <p>Facility Number: IN005375</p> <p>Medicaid Number: 100265410A</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 47 Home Health Aide Only: 16 Personal Care Only: 4 Total: 67</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  October 25, 2012</p>	G0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0121	<p><b>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on policy review, job description review, document review, observation, and interview, the agency failed to ensure the home health agency's infection control policies were followed during 3 of 5 home visits with the potential to affect all the patients seen by employees B and C. (#1, 2, and 3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "Standard Infection Control Procedures for Home Care" policy number N-100 dated 8/2002 states, "Gloves should be worn for any known or anticipated contact with patient blood, body fluids, tissue, mucous membranes and non-intact skin. Change gloves and wash hands between client contacts."</li> <li>2. Facility policy titled "Hand Washing" policy number N-130 dated 8/2002 states, "The need for hand washing depends on the type, intensity, duration and sequence of activities. The Center</li> </ol>	G0121	All Nursefinders' employees will be inserviced on infection control and handwashing techniques/policies. Gloves should be worn when handling any patient blood, body fluids, tissue or mucous membranes and non-intact skin. Nursefinders will be providing hand sanitizer to each employee. Employee will be instructed to keep the hand sanitizer on their person at all time. They will be instructed to use it before patient contact, in between procedures and when visit is complete. They will be instructed to apply enough hand sanitizer to cover the entire surface of their hands and fingers. They will be instructed to rub hands vigorously causing friction to degerm between fingers, around and under the fingernails, back of hands, palms and wrist for at least 20 seconds. Once hands are washed and gloves are put on and a task is performed such as assessment of vital signs or skin assessment, gloves should be removed, hands washed again with hand sanitizer for 20 seconds and new gloves put on before an invasive procedure is done such as; venipuncture for blood specimen,	11/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>for Disease Control (CDC) recommends routinely washing hands in the following situations: ... after caring for a client ... before performing invasive procedures such as catheterization and suctioning, before and after handling dressings or touching open wounds, after handling contaminated equipment."</p> <p>3. Facility policy titled "Venipuncture for Blood Specimen Collection" policy number I-140 dated 8/2002 states, "To obtain a blood specimen by venipuncture for laboratory analysis using aseptic technique ... Procedure: ... 3. Thoroughly wash hands ... Don clean gloves ... 4. use aseptic technique and observe standard precautions throughout the procedure."</p> <p>4. Job description titled "Registered Nurse (RN) - Home Care" document number 5/98 dated 1998 states, "Each Registered Nurse is responsible for complying with Nursefinders' policies and the Nurse Practice Act of the state in which he or she practices."</p> <p>5. Document review from the Centers for Disease Control (CDC) titled "Guideline for Hand Hygiene in Health Care Settings" volume number 51, document number RR-16 dated 10/25/02 states, "Indications for</p>		<p>giving an IM or subcutaneous injection or changing a dressing. All employees will be re-inserviced on infection control policies and the initiation of using hand sanitizer when they come into the office to get their personal hand sanitizer that is to be kept on their person. They will also be instructed to wash their hands with soap and water, after 10-12 uses of hand sanitizer. This inservice will be documented and signed by all employees. The quality assurance nurse will be responsible for the inservice. The clinical supervisors and clinical staff will be responsible during home visits to ensure employees are following the infection control policy.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>handwashing and hand antisepsis: ... F. Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care. I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... 6. Other Aspects of Hand Hygiene ... C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur. D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients. E. Change gloves during patient care if moving from a contaminated body site to a clean body site. "</p> <p>6. During a home visit on 10/22/12 at 2:30 PM, employee B, Registered Nurse (RN), washed hands upon entering the patient ' s home. Then RN then proceeded to perform her nursing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>assessment including blood pressure, temperature, pulse and respirations. The RN then applied gloves and performed a blood draw on the patient with no hand sanitation prior to applying gloves.</p> <p>During an interview on 10/23/12 at 5:00 PM, employee A, Administrator, indicated the RN should have washed her hands again prior to performing the blood draw.</p> <p>7. During a home visit on 10/22/12 at 3:30 PM, employee C, RN, washed hands upon entering the patient ' s home. The RN then proceeded to perform her nursing assessment including blood pressure, temperature, pulse, and respirations. The RN then proceeded to administer the patient ' s Betaserone injection. No gloves were worn and no hand hygiene was performed prior to administering the injection.</p> <p>During an interview on 10/23/12 at 5:05 PM, employee A, Administrator, indicated the RN should have washed her hands again and applied gloves prior to giving injection.</p> <p>8. During a home visit on 10/23/12 at 10:30 AM, employee B, RN, washed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>hands upon entering the patient's home. Then RN then set up supplies to provide wound care. The RN applied gloves and cleansed wound with normal saline and gauze. The remaining unused supplies remained on chux that was below the patient's leg. The RN then removed her gloves and washed her hands. Then RN then returned to the patient's bedroom, picked up the gauze and wrappers with bare hands, and threw into trash. The RN then applied new gloves, with no hand hygiene prior, and began to perform dressing change on patient.</p> <p>During an interview on 10/23/12 at 5:10 PM, employee A, Administrator, indicated the RN should have washed her hands again prior to performing the dressing change.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0158	<p><b>484.18</b> <b>ACCEPTANCE OF PATIENTS, POC, MED SUPER</b> Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on record and job description review and interview, the home health agency failed to provide home health aide visits in accordance with the plan of care in 1 of 6 records reviewed of those receiving home health aide services with the potential to affect all patient's of the agency who receive home health aide services and skilled nurse services for 1 of 8 records reviewed of patients receiving skilled nurse services with the potential to affect all patients receiving skilled nurse services. (#2)</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care 8/1/2007, contained a plan of care for the certification period dated 9/4/12-11/2/12 with orders for Home Health Aide (HHA) two times per day for 60 days. The record failed to evidence the HHA saw the patient two times per day on 10/7/2012.</p> <p>During an interview on 10/24/12 at</p>	G0158	<p>The administrator will review the policy and procedure with the clinical supervisors, quality assurance nurse and clinical staff. All orders on the plan of care will be followed. When there is a change in the patient's condition, a new order will be written. Upon recertification, the new order will be revised into the new plan of care. If a visit is missed, a missed visit report will be completed and faxed to the physician and then filed in the patient's chart to reflect why there was no visit. Notes will be checked with the care plan upon receipt by the quality assurance nurse or clinical supervisors. .Chart audits will be performed to review the plan of care to ensure all orders are being followed. If a discrepancy is found between the plan of care and the employee's note, they will be notified to review the plan of care and follow it. The quality assurance nurse and clinical supervisors will be responsible for reviewing the notes against the plan of care. If there is a discrepancy, the quality assurance nurse will notify the employee of the discrepancy and to follow the care plan in the</p>	11/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>5:00 PM, employee A, Administrator, indicated the record failed to evidence a HHA visit was made two times per day on 10/7/2012.</p> <p>2. The plan of care also contained orders for skilled nursing to monitor and record vital signs weekly and as needed. The patient had a diagnosis of hypertension. Review of the nursing skilled care notes evidenced the following:</p> <p>A. During the week of 9/24/12, employee C, RN, failed to take the patient's blood pressure.</p> <p>B. During the week of 10/1/12, employee C, RN, failed to take the patient's blood pressure.</p> <p>C. Job description titled "Registered Nurse (RN) - Home Care" document number 3-95 dated 5/98 states, "The RN also implements and evaluates client care by : ... Observing and recording all pertinent information and reporting to the appropriate supervisor ... Follows the physician's orders and implements the nursing care plan, documents all pertinent information on the client's clinical record and keeps Nursefinders' office and physician informed of any changes in the client's condition."</p>		future.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012	
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G0170	<p><b>484.30 SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on job description review and record review, the home health agency failed to ensure skilled nursing services were provided in accordance with the plan of care in 1 of 8 records reviewed of those receiving skilled nursing services with the potential to affect all patients of the agency who receive skilled nursing services. (#2)</p> <p>Findings include:</p> <p>1. Job description titled "Registered Nurse (RN) - Home Care" document number 3-95 dated 5/98 states, "The RN also implements and evaluates client care by : ... Observing and recording all pertinent information and reporting to the appropriate supervisor ... Follows the physician's orders and implements the nursing care plan, documents all pertinent information on the client's clinical record and keeps Nursefinders' office and physician informed of any changes in the client's condition."</p> <p>2. Clinical Record #2, start of care 8/1/2007, contained a plan of care for the certification period dated</p>			G0170	<p>The administrator will review the policy and procedure with the clinical supervisors, quality assurance nurse and clinical staff. All orders on the plan of care will be followed. When there is a change in the patient's condition, a new order will be written. Upon recertification, the new order will be revised into the new plan of care. If a visit is missed, a missed visit report will be completed and faxed to the physician and then filed in the patient's chart to reflect why there was no visit. Notes will be checked with the care plan upon receipt by the quality assurance nurse or clinical supervisors. Chart audits will be performed to review the plan of care to ensure all orders are being followed. If a discrepancy is found between the plan of care and the employee's note, they will be notified to review the plan of care and follow it. The quality assurance nurse and the clinical supervisors will be responsible for reviewing the notes against the plan of care. If there is a discrepancy, the quality assurance nurse will notify the employee of the discrepancy and to follow the care plan in the future.</p>		11/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>9/4/12-11/2/12 with orders for skilled nursing to monitor and record vital signs weekly and as needed. The patient had a diagnosis of hypertension. Review of the nursing skilled care notes evidenced the following:</p> <p>A. During the week of 9/24/12, employee C, RN, failed to take the patient's blood pressure.</p> <p>B. During the week of 10/1/12, employee C, RN, failed to take the patient's blood pressure.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0324	<p><b>484.20(c)(2)</b> <b>TRANSMITTAL OF OASIS DATA</b> The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section.</p> <p>Based on document review and interview, the home health agency failed to ensure OASIS data was transmitted in an acceptable format for 1 of 1 home health agencies reviewed with the potential to affect all patients who require OASIS data to be transmitted.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Document titled "CMS State Report Submission Statistics by Agency" with submission dates from 4/1/12-9/30/12 evidenced Nursefinder's had a 45.03% rejection rate of records submitted for this period.</li> <li>2. Review of 3 patient's OASIS final validation reports evidenced the following: <ol style="list-style-type: none"> <li>A. The final validation report for patient #6 evidenced the assessment was received by state.</li> <li>B. The final validation report for patient</li> </ol> </li> </ol>	G0324	<p>Nursefinders uses Sandata, a software company, to transmit our OASIS assessments to the state. We were unaware that the assessments were being rejected as it showed "transmitted" in our system. In speaking with Sandata, it was discovered that the patient tracking sheet, which includes the patient's demographics, was not linking up with the assessment. Working with Sandata, we have gone back through the rejected assessments from October to current and they have been successfully transmitted to state as of 11-1-12. The issue has been resolved. The administrator will run a validation report after each assessment shows that it has been transmitted in the system. The validation report shows whether the assessment was accepted or rejected. All assessments have been accepted as of 11-1-12. The administrator will be responsible for running the validation reports and following up with Sandata if there are any further discrepancies.</p>	11/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#7 failed to evidence the assessment was received by state. The final validation report states "Fatal Record Inconsistent M0016 value: The M0016 (Branch ID) submitted in this assessment does not match the State database."</p> <p>C. The final validation report for patient #9 evidenced the assessment was received by state.</p> <p>3. During an interview on 10/24/12 at 4:45 PM, employee A, administrator indicated that when they closed the Lafayette branch, the branch ID changed from "P" to "N." The administrator indicated the tracking sheet never got changed when the branch shut down and still indicated "P," instead of "N." She indicated the branch closed in January 2012 and they received final notice of its closure from CMS in March 2012. She indicated the problems began in March 2012. The Administrator indicated the software company they use to transmit OASIS data is "Sandata." The administrator indicated Sandata was not providing them with feedback reports so she was not aware the problem was still occurring. The administrator indicated she has now changed all of the tracking sheets for each patient from "P" to "N" and she hopes this will fix the problem.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0000	<p>This visit was a Home Health state licensure survey.</p> <p>Survey Dates: October 22 -24, 2012</p> <p>Facility Number: IN005375</p> <p>Surveyor: Kelly Ennis, BSN, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 47 Home Health Aide Only: 16 Personal Care Only: 4 Total: 67</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 25, 2012</p>	N0000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012	
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on policy review, job description review, document review, observation, and interview, the agency failed to ensure the home health agency's infection control policies were followed during 3 of 5 home visits with the potential to affect all the patients seen by employees B and C. (#1, 2, and 3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "Standard Infection Control Procedures for Home Care" policy number N-100 dated 8/2002 states, "Gloves should be worn for any known or anticipated contact with patient blood, body fluids, tissue, mucous membranes and non-intact skin. Change gloves and wash hands between client contacts."</li> <li>2. Facility policy titled "Hand Washing" policy number N-130 dated 8/2002 states, "The need for hand washing depends on the type, intensity, duration and sequence of activities. The Center for Disease Control (CDC) recommends</li> </ol>	N0470	<p>All Nursefinders' employees will be inservices on infection control and hadwashing techniques/policies. Gloves should be worn when handling any patient blood, body fluids, tissue prmucous membranes and non-intact skin. Nursefinders will be providing hand sanitizer to each employee. Employees will be instructed to keep the hand sanitizer on their person at all times. They will be instucted to use it before patient contact, in between procedures and when visit is complete. They will be instructed to apply enough hand sanitizer to cover the entire surface of thier hands and fingers. They will be instructed to rub hands vigorously causing friction to degerm between fingers, aroung and under the fingernails, back of hands, palms and wrist for at least 20 seconds. Once hands are washed and gloves are put on and a task is performed such as; vital signs, or skin assessment, gloves should be removed, hands washed with hand sanitizer for 20 seconds and new gloves put on before an invasive procedure such as; venipuncture for blood specient,</p>	11/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>routinely washing hands in the following situations: ... after caring for a client ... before performing invasive procedures such as catheterization and suctioning, before and after handling dressings or touching open wounds, after handling contaminated equipment."</p> <p>3. Facility policy titled "Venipuncture for Blood Specimen Collection" policy number I-140 dated 8/2002 states, "To obtain a blood specimen by venipuncture for laboratory analysis using aseptic technique ... Procedure: ... 3. Thoroughly wash hands ... Don clean gloves ... 4. use aseptic technique and observe standard precautions throughout the procedure."</p> <p>4. Job description titled "Registered Nurse (RN) - Home Care" document number 5/98 dated 1998 states, "Each Registered Nurse is responsible for complying with Nursefinders' policies and the Nurse Practice Act of the state in which he or she practices."</p> <p>5. Document review from the Centers for Disease Control (CDC) titled "Guideline for Hand Hygiene in Health Care Settings" volume number 51, document number RR-16 dated 10/25/02 states, "Indications for handwashing and hand antiseptics: ... F.</p>		<p>giving an IM or subcutaneous injection or changing a dressing. All employees will be re-inserviced on infection control policies and procedures and the initiation of using hand sanitizer when they come into the office to get their personal hand sanitizer that is to be kept on their person. They will also be instructed to wash their hands with soap and water after 10-12 uses of hand sanitizer. This inservice will be documented and signed by all employees. The quality assurance nurse will be responsible for the inservice and the clinical supervisors and clinical staff will be responsible during home visits to ensure the employees are following the infection control policy.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Decontaminate hands after contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care. I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... 6. Other Aspects of Hand Hygiene ... C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur. D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients. E. Change gloves during patient care if moving from a contaminated body site to a clean body site. "</p> <p>6. During a home visit on 10/22/12 at 2:30 PM, employee B, Registered Nurse (RN), washed hands upon entering the patient ' s home. Then RN then proceeded to perform her nursing assessment including blood pressure,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>temperature, pulse and respirations.</p> <p>The RN then applied gloves and performed a blood draw on the patient with no hand sanitation prior to applying gloves.</p> <p>During an interview on 10/23/12 at 5:00 PM, employee A, Administrator, indicated the RN should have washed her hands again prior to performing the blood draw.</p> <p>7. During a home visit on 10/22/12 at 3:30 PM, employee C, RN, washed hands upon entering the patient ' s home. The RN then proceeded to perform her nursing assessment including blood pressure, temperature, pulse, and respirations. The RN then proceeded to administer the patient ' s Betaserone injection. No gloves were worn and no hand hygiene was performed prior to administering the injection.</p> <p>During an interview on 10/23/12 at 5:05 PM, employee A, Administrator, indicated the RN should have washed her hands again and applied gloves prior to giving injection.</p> <p>8. During a home visit on 10/23/12 at 10:30 AM, employee B, RN, washed hands upon entering the patient's home.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Then RN then set up supplies to provide wound care. The RN applied gloves and cleansed wound with normal saline and gauze. The remaining unused supplies remained on chux that was below the patient's leg. The RN then removed her gloves and washed her hands. Then RN then returned to the patient's bedroom, picked up the gauze and wrappers with bare hands, and threw into trash. The RN then applied new gloves, with no hand hygiene prior, and began to perform dressing change on patient.</p> <p>During an interview on 10/23/12 at 5:10 PM, employee A, Administrator, indicated the RN should have washed her hands again prior to performing the dressing change.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012	
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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:</p> <p>Based on record review and interview, the home health agency failed to provide home health aide visits in accordance with the plan of care in 1 of 6 records reviewed of those receiving home health aide services with the potential to affect all patient's of the agency who receive home health aide services. (#2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #2, start of care 8/1/2007, contained a plan of care for the certification period dated 9/4/12-11/2/12 with orders for Home Health Aide (HHA) two times per day for 60 days. The record failed to evidence the HHA saw the patient two times per day on 10/7/2012.</li> <li>2. During an interview on 10/24/12 at 5:00 PM, employee A, Administrator, indicated the record failed to evidence a HHA visit was made two times per day on 10/7/2012.</li> </ol>	N0522	<p>The Administrator will review the policy and procedure with the clinical supervisors, quality assurance nurse and clinical staff. All orders on the plan of care will be followed. When there is a change in the patient's condition, a new order will be written. Upon recertification, the new order will be revised into the new plan of care. If a visit is missed, a missed visit report will be completed and faxed to the physician and then filed in the patient's chart to reflect why there was no visit. Notes will be checked with the care plan upon receipt by the quality assurance nurse or clinical supervisors. Chart audit will be performed to review the plan of care to ensure all orders are being followed. If a discrepancy is found between the plan of care and the employee's note, they will be notified to review the plan of care and follow it. The quality assurance nurse and clinical supervisors will be responsible for reviewing the notes against the plan of care. If there is a discrepancy, the quality assurance nurse will notify the employee of the discrepancy and to follow the care plan in the</p>	11/30/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
N0537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on record and job description review and interview, the home health agency failed to provide home health aide visits in accordance with the plan of care in 1 of 6 records reviewed of those receiving home health aide services with the potential to affect all patient's of the agency who receive home health aide services and skilled nurse services for 1 of 8 records reviewed of patients receiving skilled nurse services with the potential to affect all patients receiving skilled nurse services. (#2)</p> <p>The findings include:</p> <p>1. Clinical record #2, start of care 8/1/2007, contained a plan of care for the certification period dated 9/4/12-11/2/12 with orders for Home Health Aide (HHA) two times per day for 60 days. The record failed to evidence the HHA saw the patient two times per day on 10/7/2012.</p> <p>During an interview on 10/24/12 at</p>	N0537	<p>The administrator will review the policy and procedure with the clinical supervisors, quality assurance nurse and the clinical staff. All orders on the plan of care will be followed. When there is a change in the patient's condition, a new order will be written. Upon recertification, the new order will be revised into the new plan of care. If a visit is missed, a missed visit report will be completed and faxed to the physician and then filed in the patient's chart to reflect why there was no visit. Notes will be checked with the care plan upon receipt by the quality assurance nurse or clinical supervisors. Chart audits will be performed to review the plan of care to ensure all orders are being followed. If a discrepancy is found between the plan of care and the employee's note, they will be notified to review the plan of care and follow it. The quality assurance nurse and clinical supervisors will be responsible for reviewing the notes against the plan of care. If there is a discrepancy, the quality assurance nurse will notify th employee of the discrepancy and to follow the care plan in the</p>	11/30/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2012
NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>5:00 PM, employee A, Administrator, indicated the record failed to evidence a HHA visit was made two times per day on 10/7/2012.</p> <p>2. The plan of care also contained orders for skilled nursing to monitor and record vital signs weekly and as needed. The patient had a diagnosis of hypertension. Review of the nursing skilled care notes evidenced the following:</p> <p>A. During the week of 9/24/12, employee C, RN, failed to take the patient's blood pressure.</p> <p>B. During the week of 10/1/12, employee C, RN, failed to take the patient's blood pressure.</p> <p>C. Job description titled "Registered Nurse (RN) - Home Care" document number 3-95 dated 5/98 states, "The RN also implements and evaluates client care by : ... Observing and recording all pertinent information and reporting to the appropriate supervisor ... Follows the physician's orders and implements the nursing care plan, documents all pertinent information on the client's clinical record and keeps Nursefinders' office and physician informed of any changes in the client's condition."</p>		future.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NURSEFINDERS OF INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8925 N MERIDIAN ST STE 105 INDIANAPOLIS, IN 46260
--	---

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