

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
--------------------	--	---------------	---	----------------------

G 0000  Bldg. 00	<p>This was a federal home health recertification survey. This was an extended survey.</p> <p>Survey Dates: July 19, 20, 21, 22, 25, and 26, 2016 Partial Extended Dates: July 22, 25, 2016 Extended Dates: July 26, 2016</p> <p>Facility Number: 011316</p> <p>Medicaid Number: 200853200</p> <p>Census Service Type: Skilled: 35 Home Health Aide Only: 46 Personal Care Only: 2 Total: 83</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 HV w/o RR: 1 Total: 11</p> <p>Able Hands is precluded from providing its own home health aide training and competency evaluation program for a</p>	G 0000		
------------------------	--	--------	--	--

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:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
G 0110 Bldg. 00	<p>period of 2 years beginning July 26, 2016 for being found out of compliance with the Conditions of Participation 42 CFR 484.48: Clinical Records.</p> <p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on observation and document review, the agency failed to ensure patients were provided the most recent revision of the State of Indiana Advanced Directives dated July 2013, for 5 of 5 home visit observations. (# 1, 2, 3, 4, and 11)</p> <p>Findings include</p> <p>1. The agency's admission packet</p>	G 0110	G110 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY FOR 484.10(C)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE. THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED/EDUCATED AND PROVIDED COPIES OF THE DDRS POLICY ON ADVANCED DIRECTIVES, THE REVISED INDIANA STATE DEPARTMENT	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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>evidenced the State of Indiana Advanced Directives dated May 2004. The admission packet failed to evidence the most recent revision (July 2013) of the State of Indiana Advanced Directives document.</p> <p>2. On 7/20/16 at 1:30 PM, the home admission folder was observed during a home visit for patient # 1. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</p> <p>3. On 7/21/16 at 10:00 AM, the home admission folder was observed during a home visit for patient # 2. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</p> <p>4. On 7/21/16 at 12:15 PM, the home admission folder was observed during a home visit for patient # 3. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</p> <p>5. On 7/21/16 at 1:00 PM, the home admission folder was observed during a home visit for patient # 4. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</p>		<p>OF HEALTH ADVANCED DIRECTIVE (JULY 2013), ABLE HANDS HOMECARE POLICY AND PROCEDURE ON ADVANCED DIRECTIVES AND ABLE HANDS HOMECARE BILL OF RIGHTS WITH ALL NURSING STAFF. A CURRENT REVISED COPY (JULY 2013) OF THE INDIANA STATE DEPARTMENT OF HEALTH ADVANCED DIRECTIVES HAS BEEN RECEIVED AND WILL BE GIVEN TO EVERY CLIENT UPON ADMISSION. STARTING JULY 26, 2016 ALL CURRENT CLIENTS OF ABLE HANDS HOMECARE WILL BE PROVIDED THE REVISED, JULY 1,2013, ADVANCED DIRECTIVE BROCHURE. THE ADMINISTRATOR WILL CHECK THE ISDH WEBSITE QUARTERLY FOR UPDATES/REVISIONS TO THE INDIANA STATE DEPARTMENT OF HEALTH ADVANCED DIRECTIVES IN ORDER TO PREVENT THE DEFICIENCY FROM RECURRING THE ADMINISTRATOR WILL BE RESPONSIBLE FOR ENSURING THE DEFICIENCY HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED BY REVIEWING ADVANCED DIRECTIVES AT EACH QUARTERLY QUALITY ASSURANCE MEETING THRU 08/2017</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
G 0121 Bldg. 00	<p>6. On 7/22/16 at 10:30 AM, the home admission folder was observed during a home visit for patient # 11. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</p> <p>7. The agency's un-dated policy titled "Home Care/Bill of Rights/Grievance Procedure," # C-380, stated "Purpose ... to consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care."</p> <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. Based on observation, document review, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 1 of 5 home visit observations. (# 2)</p>	G 0121	G121 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY FOR 484.12(C) COMPLIANCE WITH ACCEPTED PROFESSIONAL STANDARDS. THE ADMINISTRATOR AND	08/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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>Findings include</p> <ol style="list-style-type: none"> <li>1. During home visit on 7/21/16 at 10:00 AM, employee D (Home Health Aide) was observed providing homemaker services for patient # 2. Employee D prepared floor mopping water, placed the mop into the water, and then proceeded to handle clean dishes from strainer to put them away. Employee D failed to wash her hands or use hand sanitizer prior to touching the clean dishes.</li> <li>2. During interview on 7/23/16 at 12:20 PM, employee B (Nursing Supervisor) stated she usually sings the happy birthday song twice to ensure proper hand washing length of time.</li> <li>3. The agency's un-dated policy titled "Hand Washing Demonstration," # N130, stated "Note: The need for hand washing depends on the type, intensity, duration, and sequence of activities. The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: ... After handling contaminated equipment."</li> </ol>		<p>DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL STAFF ON FEDERAL, STATE AND COMPANY POLICY FOR 484.12(C) THE DIRECTOR OF NURSING WILL ENSURE ALL CURRENT ABLE HANDS HOMECARE STAFF ARE GIVEN A COPY OF ABLE HANDS HOMECARE POLICY N130 ON HANDWASHING AND A SIGNATURE OBTAINED TO AFFIRM UNDERSTANDING OF THE POLICY BY 8/12/2016. THE HUMAN RESOURCE COORDINATOR WILL REVIEW THE POLICY ANNUALLY AS PART OF ABLE HANDS HOMECARE'S INSERVICE PROGRAM. STARTING 8/1/2016, ABLE HANDS WILL HAVE THE HANDWASHING POLICY N130 REVIEWED DURING EMPLOYEE ORIENTATION AND A SIGNATURE OBTAINED TO AFFIRM UNDERSTANDING OF THE POLICY IN ORDER TO PREVENT THE DEFICIENCY FROM RECURRING STARTING 08/01/2016 THE HUMAN RESOURCE COODINATOR WILL AUDIT ALL NEW EMPLOYEE FILES AND REPORT ANY FINDINGS DURING THE QUARTERLY QUALITY ASSURANCE MEETINGS THRU 08/2017. THIS PROCESS OF REVIEW WILL BE DONE ON ALL NEW HIRES QUARTERLY TO MONITOR CORRECTIVE ACTIONS AND</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
G 0141 Bldg. 00	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on document review and interview, the agency failed to ensure employee criminal background checks were completed within 3 days of providing patient care for 1 of 11 employee files reviewed. (G)</p> <p>Findings include</p> <p>1. Employee file G, Certified Occupational Therapy Assistant (COTA), was reviewed on 7/26/16. Employee G date of hire 7/5/13, first patient contact date 2/26/15. The file failed to evidence the criminal background check was completed within 3 days of providing patient care.</p> <p>A. The Indiana State Police Limited Criminal History for employee G was dated 3/10/2014.</p>	G 0141	<p>ENSURE THE DEFICIENCY IS CORRECTED. THE ADMINISTRATOR WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS</p> <p>G141 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY FOR 484.14(E) PERSONNEL POLICIES. THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED THE HUMAN RESOURCE COORDINATOR ON FEDERAL, STATE AND COMPANY POLICY 484.14(E) HUMAN RESOURCE COORDINATOR ALSO INSERVICED ON ALL CRIMINAL BACKGROUND CHECKS BEING COMPLETED BEFORE FIRST PATIENT CONTACT (AS PER HUMAN RESOURCE JOB SPECIFIC DESCRIPTION) HUMAN RESOURCE COORDINATOR WILL COMPLETE APPROPRIATE BACK GROUND CHECKS ON ALL EMPLOYEES PRIOR TO FIRST PATIENT CONTACT. HUMAN RESOURCE</p>	08/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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			
G 0158 Bldg. 00	<p>2. During interview on 7/26/16 at 1:10 PM, employee M, Human Resources (HR), stated employee G was an office employee first until she obtained her COTA in February, and the agency should have ran a criminal check closer to the first patient contact date. Employee M stated she was not the HR person prior and that criminal check was probably ran because there was not one at date of hire.</p> <p>3. The agency's un-dated job description titled "Human Resources Coordinator Job Specific Orientation," no date, stated "Personnel Records Personnel record to include: Before First Patient Contact ... 3. Copy of Limited Criminal History."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on document review and interview, the agency failed to ensure home health aide (HHA) visits were provided as ordered on the plan of care for 1 of 10 clinical records reviewed. (# 6)</p> <p>Findings include</p>	G 0158	<p>COORDINATOR WILL AUDIT 10% OF ALL EMPLOYEE FILES QUARTERLY FOR COMPLIANCE TO PREVENT THE DEFICIENCY FROM RECURRING. ANY FINDINGS WILL BE REVIEWED IN EACH QUARTERLY QUALITY ASSURANCE MEETING THRU 08/2017 THE ADMINISTRATOR WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THE DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED</p> <p>G158 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.18 ACCEPTANCE OF PATIENTS PLAN OF CARE AND MEDICAL SUPERVISION THE ADMINISTRATOR AND DIRECTOR OF NURSING INSERVICED ALL LICENSED PERSONNEL DESIGNATED BY THE AGENCY TO RECEIVE</p>	08/19/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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>1. Clinical record # 6 was reviewed on 7/25/16. Start of care date 5/15/14. The plan of care dated 7/3-8/31/16 contained orders for HHA effective 7/4/16 3-4 hours a day, 4-5 days a week for 8 weeks, then 3-4 hours a day, 2-3 days a week for 1 week. The record evidenced the agency provided more hours than ordered for the weeks of 7/4-7/10, and 7/11-7/17/16.</p> <p>A. The Homecare Weekly Visit Note dated 7/4/16-7/10/16 evidenced the HHA provided 5 hours of care on 7/5/16 from 8 AM-1 PM; 7 hours on 7/6/16 from 8 AM-3 PM; and 5 hours on 7/8/16 from 8 AM-1 PM. The record failed to evidence a physician order for the extra hours of care provided.</p> <p>B. During interview on 7/25/16 at 11:15 AM, employee B (Nursing Supervisor) stated the Quality Assurance person probably had not yet reviewed the HHA visit notes, and when she does if she sees HHA hours over or under what is ordered, she will write a clarification order to cover the hours.</p> <p>C. During interview on 7/25/16 at 12:30 PM, employee B stated they were over hours for patient # 6 the week of 7/4-7/10/16 due to Monday was a holiday and the agency does not cover holidays unless the patient has orders for 7 days a</p>		<p>ORDERS FROM THE PHYSICIAN ON FEDERAL, STATE AND COMPANY POLICY 484.18</p> <p>ALL DESIGNATED STAFF SHALL PROMPTLY NOTIFY THE PHYSICIAN OF ANY CHANGES THAT SUGGEST A NEED TO ALTER THE PLAN OF CARE. ANY ORDER MY BE INITIATED VIA TELEPHONE OR IN WRITING AND WILL BE OBTAINED FROM THE PHYSICIAN FOR CHANGES TO THE PLAN OF CARE PRIOR TO SERVICES BEING PROVIDED. ALL ORDERS ARE TO BE REVIEWED BY THE DIRECTOR OF NURSING TO VERIFY THAT ORDERS FOR SERVICES HAVE BEEN OBTAINED FROM THE PHYSICIAN PRIOR TO PROVIDING SERVICES</p> <p>THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED THRU 08/2017</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>week, so they make up the hours throughout the week so that patients do not lose Medicaid hours.</p> <p>D. During interview on 7/25/16 at 12:30 PM employee B presented a written order dated 7/25/16 that stated "Clarification; 7 hours on 7/6/16 for already scheduled hours." Employee B stated this order was just written up.</p> <p>-The order dated 7/25/16 failed to include extra hours for 7/5 and 7/6 and was created after issue was found, and failed to contain a signature of the creator (employee Q, compliance).</p> <p>E. The Homecare Weekly Visit Note dated 7/11/16-7/17/16 evidenced the HHA provided 6 hours of care on 7/13/16 from 9 AM-2 PM. The record failed to evidence a clarification order for the 2 extra hours of care provided.</p> <p>2. The agency's un-dated policy titled "Physician Orders," # 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 ... If patient records are maintained electronically, the agency may use electronic signatures. However, all entries must be appropriately authenticated and dated.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
G 0166 Bldg. 00	<p>Authentication must include signatures, written initials, or computer secure entry by a unique identifier."</p> <p>3. The agency's un-dated policy titled "Plan of Care," # C-580, stated "Special Instructions ... 10. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on document review and interview, the agency failed to ensure physician orders were obtained for an increase in Home Health Aide (HHA) hours for 1 of 10 clinical records reviewed. (# 6)</p> <p>Findings include</p> <p>1. Clinical record # 6 was reviewed on 7/25/16. Start of care date 5/15/14. The plan of care dated 7/3-8/31/16 contained</p>	G 0166	G166 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.18(c)ACCEPTANCE OF PATIENTS PLAN OF CARE AND MEDICAL SUPERVISION THE ADMINISTRATOR AND DIRECTOR OF NURSING INSERVICED ALL LICENSED PERSONNEL DESIGNATED BY THE AGENCY TO RECEIVE ORDERS FROM THE PHYSICIAN ON FEDERAL, STATE AND COMPANY POLICY	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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>orders for HHA effective 7/4/16 3-4 hours a day, 4-5 days a wee for 8 weeks, then 3-4 hours a day, 2-3 days a week for 1 week. The record evidenced the agency provided more hours than ordered for the weeks of 7/4-7/10, and 7/11-7/17/16.</p> <p>A. The Homecare Weekly Visit Note dated 7/4/16-7/10/16 evidenced the HHA provided 5 hours of care on 7/5/16 from 8 AM-1 PM; 7 hours on 7/6/16 from 8 AM-3 PM; and 5 hours on 7/8/16 from 8 AM-1 PM. The record failed to evidence a physician order for the extra hours of care provided.</p> <p>B. During interview on 7/25/16 at 11:15 AM, employee B (Nursing Supervisor) stated the Quality Assurance person probably had not yet reviewed the HHA visit notes, and when she does if she sees HHA hours over or under what is ordered, she will write a clarification order to cover the hours.</p> <p>C. During interview on 7/25/16 at 12:30 PM, employee B stated they were over hours for patient # 6 the week of 7/4-7/10/16 due to Monday was a holiday and the agency does not cover holidays unless the patient has orders for 7 days a week, so they make up the hours throughout the week so that patients do not lose Medicaid hours.</p>		484.18(c) ALL DESIGNATED STAFF SHALL PROMPTLY NOTIFY THE PHYSICIAN OF ANY CHANGES THAT SUGGEST A NEED TO ALTER THE PLAN OF CARE. ANY ORDER MY BE INITIATED VIA TELEPHONE OR IN WRITING AND WILL BE OBTAINED FROM THE PHYSICIAN FOR CHANGES TO THE PLAN OF CARE PRIOR TO SERVICES BEING PROVIDED. ALL ORDERS ARE TO BE REVIEWED BY THE DIRECTOR OF NURSING TO VERIFY THAT ORDERS FOR SERVICES HAVE BEEN OBTAINED FROM THE PHYSICIAN PRIOR TO PROVIDING SERVICES THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED THRU 08/2017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>D. During interview on 7/25/16 at 12:30 PM employee B presented a written order dated 7/25/16 that stated "Clarification; 7 hours on 7/6/16 for already scheduled hours." Employee B stated this order was just written up.</p> <p>-The order dated 7/25/16 failed to include extra hours for 7/5 and 7/6, was not signed by the creator (employee Q) and was created after issue was found.</p> <p>E. The Homecare Weekly Visit Note dated 7/11/16-7/17/16 evidenced the HHA provided 6 hours of care on 7/13/16 from 9 AM-2 PM. The record failed to evidence a clarification order for the 2 extra hours of care provided.</p> <p>2. The agency's un-dated policy titled "Physician Orders," # 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 ... If patient records are maintained electronically, the agency may use electronic signatures. However, all entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier."</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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
G 0171 Bldg. 00	<p>3. The agency's un-dated policy titled "Plan of Care," # C-580, stated "Special Instructions ... 10. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit. Based on document review, and interview, the agency failed to ensure the Registered Nurse (RN) performed an initial Skilled Nurse add-on evaluation visit and wound assessment for 1 of 2 clinical records with orders for wound care. (# 7)</p> <p>Findings include</p> <p>1. Clinical record # 7 was reviewed on 7/21 and 7/22/16. Start of care date 5/26/16. The plan of care dated 5/26-7/24/16 contained orders for Home Health Aide (HHA) services of Attendant Care effective 6/2/16 for 2-3 hours 1-2 days a week for 8 weeks; and Homemaker 1-2 hours a day 1-2 days a week for 8 weeks.</p>			G 0171	<p>G171 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.30(a) DUTIES OF A REGISTERED NURSE THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL REGISTERED NURSES ON FEDERAL, STATE AND COMPANY POLICY 484.30(a) A REGISTERED NURSE WILL MAKE THE INITIAL ASSESSMENT VISIT FOR ALL WOUND CARE CLIENTS AND WILL REGULARLY RE-EVALUATE THE PATIENT'S NEEDS A REGISTERED NURSE WILL REVIEW ALL ORDERS AND/OR DOCUMENTS RECEIVED FROM OTHER PROFESSIONAL SOURCES INVOLVED IN THE</p>		08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>A. The Comprehensive Adult Assessment dated 5/26/16 on start of care evidenced the patient did not have a wound on admission.</p> <p>B. A physician order dated 7/16/2016 stated "Begin Date: 7/16/2016 1 D [day] 30 ... Skilled nurse to complete daily wound care as follows: 1) Cleanse wound to left shin with wound cleanser or normal saline, pat dry. 2) Swab area lightly with Betadine, let dry. 3) Apply thin layer of Santyl ointment 4) Cover with ABD [abdominal] pad 5) Secure with roll gauze 6) Cover with Coban." The record failed to evidence the RN conducted the initial SN add on visit, and failed to evidence a comprehensive assessment had been completed.</p> <p>C. The Skilled Nurse Clinical Progress Note dated 7/16/16 failed to evidence an RN conducted this initial visit. The note was signed by employee J (Licensed Practical Nurse), and failed to evidence the wound had been measured.</p> <p>D. The Skilled Nurse Clinical Progress Note dated 7/17/16 evidenced this visit was conducted by the LPN also, so wound was not measured.</p> <p>E. The Skilled Nurse Clinical</p>		<p>PATIENT'S CARE AND WILL INITIAL A REGISTERED NURSE ASSESSMENT VISIT FOR THOSE CLIENTS WITH NEW WOUNDS/TREATMENTS. THIS VISIT IS TO INCLUDE BASELINE MEASUREMENTS AS APPROPRIATE THE REGISTERED NURSE WILL INFORM THE PHYSICIAN, NECESSARY PERSONNEL AND CAREGIVER OF ANY CHANGE IN CONDITION AS WELL AS INITIATE ANY NEEDED REVISIONS TO THE PLAN OF CARE THE DIRECTOR OF NURSING WILL AUDIT ALL CLINICAL RECORDS FOR THOSE CLIENTS WITH WOUNDS BEING MONITORED BY THE RESGISTERED NURSE FROM INITIATION OF TREATMENT UNTIL THE WOUND CARE IS DISCONTINUED THE DIRECTOR OF NURSING IS TO MONITOR THE CORRECTIVE ACTIONS TO ENSURE THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED IN ORDER TO PREVENT THE DEFICIENCY FROM RE-CURRING</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>Progress Note dated 7/18/16 evidenced this was the first visit by a RN, employee B. The wound measured Length 8.6, Width 6.2, and Depth 0.1.</p> <p>F. During interview on 7/26/16 at 12:40 PM, employee B stated wounds should be measured weekly by the RNs and include length, width and depth. Employee B stated patient # 7's wound was cellulitis related so it was not necessary to give it a stage since not a pressure ulcer. Employee B stated they did not have to measure the wound on the first visit because they had wound measurements from the physician.</p> <p>G. The document titled "Hospitalization/Major Diagnostic Procedure" dated 7/14/2016 stated "Examination General Exam: ... EXTREMITIES: open wound on [patient's] left lower leg 8 cm [centimeters] long and 6 cm in width with purulent drainage."</p> <p>H. During interview on 7/20/16 at 11:45 AM, employee B (Nursing Supervisor) stated only RN's measure wounds.</p> <p>I. During interview on 7/22/16 at 1:20 PM, employee B stated this patient only had a small scabbed spot prior.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
G 0176  Bldg. 00	<p>J. During interview on 7/25/16 at 12:00 PM, employee B stated a RN does not always conduct the first visit for adding of SN services mid certification period, it just depends; stated she was present at visit and could co-sign the LPN notes.</p> <p>2. The agency's un-dated policy titled "Case Management Guide to Basic Homeopathic Regulations," no number, stated "When patient needs to be seen by RN vs. LPN: ... 2. RN should measure wounds(S) 1 x [time] per week."</p> <p>3. The agency's un-dated policy titled "Patient Reassessment/Update of Comprehensive Assessment," # AC-155 stated "12. Reassessments are conducted every visit based on physician orders, patient conditions, and/or professional staff judgment."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>Based on document review, and interview, the agency failed to ensure the Registered Nurse (RN) performed and documented an initial Skilled Nurse add-on wound assessment for 1 of 2 clinical records reviewed with orders for wound care. (# 7)</p> <p>Findings include</p> <p>1. Clinical record # 7 was reviewed on 7/21 and 7/22/16. Start of care date 5/26/16. The plan of care dated 5/26-7/24/16 contained orders for Home Health Aide (HHA) services of Attendant Care effective 6/2/16 for 2-3 hours 1-2 days a week for 8 weeks; and Homemaker 1-2 hours a day 1-2 days a week for 8 weeks.</p> <p>A. The Comprehensive Adult Assessment dated 5/26/16 evidenced the patient did not have a wound on admission.</p> <p>B. A physician order dated 7/16/2016 stated "Begin Date: 7/16/2016 1 D [day] 30 ... Skilled nurse to complete daily wound care as follows: 1) Cleanse wound to left shin with wound cleanser or normal saline, pat dry. 2) Swab area lightly with Betadine, let dry. 3) Apply thin layer of Santyl ointment 4) Cover with ABD [abdominal] pad 5) Secure</p>	G 0176	<p>G176 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.30(a) DUTIES OF A REGISTERED NURSE THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL REGISTERED NURSES ON FEDERAL, STATE AND COMPANY POLICY 484.30(a) A REGISTERED NURSE WILL MAKE THE INITIAL ASSESSMENT VISIT FOR ALL WOUND CARE CLIENTS AND WILL REGULARLY RE-EVALUATE THE PATIENT'S NEEDS A REGISTERED NURSE WILL REVIEW ALL ORDERS AND/OR DOCUMENTS RECEIVED FROM OTHER PROFESSIONAL SOURCES INVOLVED IN THE PATIENT'S CARE AND WILL INITIAL A REGISTERED NURSE ASSESSMENT VISIT FOR THOSE CLIENTS WITH NEW WOUNDS/TREATMENTS. THIS VISIT IS TO INCLUDE BASELINE MEASUREMENTS AS APPROPRIATE THE REGISTERED NURSE WILL INFORM THE PHYSICIAN, NECESSARY PERSONNEL AND CAREGIVER OF ANY CHANGE IN CONDITION AS WELL AS INITIATE ANY NEEDED REVISIONS TO THE PLAN OF CARE THE DIRECTOR OF NURSING WILL AUDIT ALL CLINICAL RECORDS FOR</p>	08/19/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>with roll gauze 6) Cover with Coban." The record failed to evidence the RN conducted the initial SN add on visit.</p> <p>C. The Skilled Nurse Clinical Progress Note dated 7/16/16 failed to evidence an RN conducted this initial visit. The note was signed by employee J (Licensed Practical Nurse), and failed to evidence the wound had been measured.</p> <p>D. The Skilled Nurse Clinical Progress Note dated 7/17/16 evidenced this visit was conducted by the LPN also, so wound was not measured.</p> <p>E. The Skilled Nurse Clinical Progress Note dated 7/18/16 evidenced this was the first visit by a RN, employee B. The wound measured Length 8.6, Width 6.2, and Depth 0.1.</p> <p>F. During interview on 7/26/16 at 12:40 PM, employee B stated wounds should be measured weekly by the RNs and include length, width and depth. Employee B stated patient # 7's wound was cellulitis related so it was not necessary to give it a stage since not a pressure ulcer. Employee B stated they did not have to measure the wound on the first visit because they had wound measurements from the physician.</p>		<p>THOSE CLIENTS WITH WOUNDS BEING MONITORED BY THE RESGISTERED NURSE FROM INITIATION OF TREATMENT UNTIL THE WOUND CARE IS DISCONTINUED THE DIRECTOR OF NURSING IS TO MONITOR THE CORRECTIVE ACTIONS TO ENSURE THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED IN ORDER TO PREVENT THE DEFICIENCY FROM RE-CURRING</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>G. The document titled "Hospitalization/Major Diagnostic Procedure" dated 7/14/2016 stated "Examination General Exam: ... EXTREMITIES: open wound on [patient's] left lower leg 8 cm [centimeters] long and 6 cm in width with purulent drainage."</p> <p>H. During interview on 7/20/16 at 11:45 AM, employee B (Nursing Supervisor) stated only RN's measure wounds.</p> <p>I. During interview on 7/22/16 at 1:20 PM, employee B stated this patient only had a small scabbed spot prior.</p> <p>J. During interview on 7/25/16 at 12:00 PM, employee B stated a RN does not always conduct the first visit for adding of SN services mid certification period, it just depends; stated she was present at visit and could co-sign the LPN notes.</p> <p>2. The agency's un-dated policy titled "Case Management Guide to Basic Homeopathic Regulations," no number, stated "When patient needs to be seen by RN vs. LPN: ... 2. RN should measure wounds(S) 1 x [time] per week."</p> <p>3. The agency's un-dated policy titled</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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	
G 0235 Bldg. 00	<p>"Patient Reassessment/Update of Comprehensive Assessment," # AC-155 stated "12. Reassessments are conducted every visit based on physician orders, patient conditions, and/or professional staff judgment."</p> <p>4. The agency's un-dated procedure titled "Wound Measurement," not numbered, stated "The Amedisys wound measurement policy is MANDATORY and is as follows: ... It is recommended that you measure and document your measurements on the first visit of the week."</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on document review, and interview, the agency failed to ensure clinical records contained appropriate and necessary documentation for 2 of 10 clinical records reviewed. (See G 236)</p> <p>The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.</p>	G 0235	G235 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.48 ACCEPTANCE OF PATIENTS PLAN OF CARE AND MEDICAL SUPERVISION THE ADMINISTRATOR AND DIRECTOR OF NURSING INSERVICED ALL LICENSED PERSONNEL DESIGNATED BY THE AGENCY TO RECEIVE ORDERS FROM THE PHYSICIAN ON FEDERAL, STATE AND COMPANY POLICY 484.48 ALL DESIGNATED STAFF SHALL PROMPTLY NOTIFY THE PHYSICIAN OF ANY CHANGES THAT	08/19/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
			SUGGEST A NEED TO ALTER THE PLAN OF CARE. ANY ORDER MY BE INITIATED VIA TELEPHONE OR IN WRITING AND WILL BE OBTAINED FROM THE PHYSICIAN FOR CHANGES TO THE PLAN OF CARE PRIOR TO SERVICES BEING PROVIDED. ALL ORDERS ARE TO BE REVIEWED BY THE DIRECTOR OF NURSING TO VERIFY THAT ORDERS FOR SERVICES HAVE BEEN OBTAINED FROM THE PHYSICIAN PRIOR TO PROVIDING SERVICES THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED THRU 08/2017 G235 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.30(a) DUTIES OF A REGISTERED NURSE THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL REGISTERED NURSES ON FEDERAL, STATE AND COMPANY POLICY 484.30(a) A REGISTERED NURSE WILL MAKE THE INITIAL ASSESSMENT VISIT FOR ALL WOUND CARE CLIENTS AND WILL REGULARLY RE-EVALUATE THE PATIENT'S	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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	
G 0236	484.48 CLINICAL RECORDS		NEEDS A REGISTERED NURSE WILL REVIEW ALL ORDERS AND/OR DOCUMENTS RECEIVED FROM OTHER PROFESSIONAL SOURCES INVOLVED IN THE PATIENT'S CARE AND WILL INITIAL A REGISTERED NURSE ASSESSMENT VISIT FOR THOSE CLIENTS WITH NEW WOUNDS/TREATMENTS. THIS VISIT IS TO INCLUDE BASELINE MEASUREMENTS AS APPROPRIATE THE REGISTERED NURSE WILL INFORM THE PHYSICIAN, NECESSARY PERSONNEL AND CAREGIVER OF ANY CHANGE IN CONDITION AS WELL AS INITIATE ANY NEEDED REVISIONS TO THE PLAN OF CARE THE DIRECTOR OF NURSING WILL AUDIT ALL CLINICAL RECORDS FOR THOSE CLIENTS WITH WOUNDS BEING MONITORED BY THE RESGISTERED NURSE FROM INITIATION OF TREATMENT UNTIL THE WOUND CARE IS DISCONTINUED THE DIRECTOR OF NURSING IS TO MONITOR THE CORRECTIVE ACTIONS TO ENSURE THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED IN ORDER TO PREVENT THE DEFICIENCY FROM RE-CURRING		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
Bldg. 00	<p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on document review and interview, the agency failed to ensure clinical records contained appropriate and necessary documentation for 2 of 10 clinical records reviewed. (# 6 and 7)</p> <p>Findings include</p> <p>1. Clinical record # 6 was reviewed on 7/25/16. Start of care date 5/15/14. The plan of care dated 7/3-8/31/16 contained orders for HHA effective 7/4/16 3-4 hours a day, 4-5 days a wee for 8 weeks, then 3-4 hours a day, 2-3 days a week for 1 week. The record evidenced the agency provided more hours than ordered for the weeks of 7/4-7/10, and 7/11-7/17/16.</p> <p>A. The Homecare Weekly Visit Note dated 7/4/16-7/10/16 evidenced the HHA provided 5 hours of care on 7/5/16 from 8 AM-1 PM; 7 hours on 7/6/16 from 8 AM-3 PM; and 5 hours on 7/8/16 from 8 AM-1 PM. The record failed to evidence</p>	G 0236	G236 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.48 ACCEPTANCE OF PATIENTS PLAN OF CARE AND MEDICAL SUPERVISION THE ADMINISTRATOR AND DIRECTOR OF NURSING INSERVICED ALL LICENSED PERSONNEL DESIGNATED BY THE AGENCY TO RECEIVE ORDERS FROM THE PHYSICIAN ON FEDERAL, STATE AND COMPANY POLICY 484.48 ALL DESIGNATED STAFF SHALL PROMPTLY NOTIFY THE PHYSICIAN OF ANY CHANGES THAT SUGGEST A NEED TO ALTER THE PLAN OF CARE. ANY ORDER MY BE INITIATED VIA TELEPHONE OR IN WRITING AND WILL BE OBTAINED FROM THE PHYSICIAN FOR CHANGES TO THE PLAN OF CARE PRIOR TO SERVICES BEING PROVIDED. ALL ORDERS ARE TO BE REVIEWED BY THE DIRECTOR	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>a physician order for the extra hours of care provided.</p> <p>B. During interview on 7/25/16 at 11:15 AM, employee B (Nursing Supervisor) stated the Quality Assurance person probably had not yet reviewed the HHA visit notes, and when she does if she sees HHA hours over or under what is ordered, she will write a clarification order to cover the hours.</p> <p>C. During interview on 7/25/16 at 12:30 PM employee B presented a written order dated 7/25/16 that stated "Clarification; 7 hours on 7/6/16 for already scheduled hours." Employee B stated this order was just written up. This order failed to include extra hours for 7/5 and 7/6, was not signed by the creator (employee Q) and was created after issue was found.</p> <p>E. The Homecare Weekly Visit Note dated 7/11/16-7/17/16 evidenced the HHA provided 6 hours of care on 7/13/16 from 9 AM-2 PM. The record failed to evidence a clarification order for the 2 extra hours of care provided.</p> <p>2. The agency's un-dated policy titled "Physician Orders," # C-635, stated "All medications, treatments and services provided to patients must be ordered by a</p>		<p>OF NURSING TO VERIFY THAT ORDERS FOR SERVICES HAVE BEEN OBTAINED FROM THE PHYSICIAN PRIOR TO PROVIDING SERVICES THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED THRU 08/2017 G236 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.30(a) DUTIES OF A REGISTERED NURSE THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL REGISTERED NURSES ON FEDERAL, STATE AND COMPANY POLICY 484.30(a) A REGISTERED NURSE WILL MAKE THE INITIAL ASSESSMENT VISIT FOR ALL WOUND CARE CLIENTS AND WILL REGULARLY RE-EVALUATE THE PATIENT'S NEEDS A REGISTERED NURSE WILL REVIEW ALL ORDERS AND/OR DOCUMENTS RECEIVED FROM OTHER PROFESSIONAL SOURCES INVOLVED IN THE PATIENT'S CARE AND WILL INITIAL A REGISTERED NURSE ASSESSMENT VISIT FOR THOSE CLIENTS WITH NEW WOUNDS/TREATMENTS. THIS</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>physician. The orders may be initiated via telephone or in writing ... If patient records are maintained electronically, the agency may use electronic signatures. However, all entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier."</p> <p>3. The agency's un-dated policy titled "Plan of Care," # C-580, stated "Special Instructions ... 10. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>4. Clinical record # 7 was reviewed on 7/21 and 7/22/16. Start of care date 5/26/16. The plan of care dated 5/26-7/24/16 contained orders for Home Health Aide (HHA) services of Attendant Care effective 6/2/16 for 2-3 hours 1-2 days a week for 8 weeks; and Homemaker 1-2 hours a day 1-2 days a week for 8 weeks.</p> <p>A. A physician order dated 7/16/2016 stated "Begin Date: 7/16/2016 1 D [day] 30 ... Skilled nurse to complete daily wound care as follows: 1) Cleanse wound to left shin with wound cleanser or normal saline, pat dry. 2) Swab area lightly with Betadine, let dry. 3) Apply</p>		<p>VISIT IS TO INCLUDE BASELINE MEASUREMENTS AS APPROPRIATE THE REGISTERED NURSE WILL INFORM THE PHYSICIAN, NECESSARY PERSONNEL AND CAREGIVER OF ANY CHANGE IN CONDITION AS WELL AS INITIATE ANY NEEDED REVISIONS TO THE PLAN OF CARE THE DIRECTOR OF NURSING WILL AUDIT ALL CLINICAL RECORDS FOR THOSE CLIENTS WITH WOUNDS BEING MONITORED BY THE RESGISTERED NURSE FROM INITIATION OF TREATMENT UNTIL THE WOUND CARE IS DISCONTINUED THE DIRECTOR OF NURSING IS TO MONITOR THE CORRECTIVE ACTIONS TO ENSURE THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED IN ORDER TO PREVENT THE DEFICIENCY FROM RE-CURRING</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>thin layer of Santyl ointment 4) Cover with ABD [abdominal] pad 5) Secure with roll gauze 6) Cover with Coban." The record failed to evidence the RN conducted the comprehensive assessment for the SN add on visit.</p> <p>B. The Skilled Nurse Clinical Progress Note dated 7/16/16 failed to evidence an RN conducted this initial visit. The note was signed by employee J (Licensed Practical Nurse), and failed to evidence the wound had been measured.</p> <p>C. The Skilled Nurse Clinical Progress Note dated 7/17/16 evidenced this visit was conducted by the LPN also, so wound was not measured.</p> <p>D. The Skilled Nurse Clinical Progress Note dated 7/18/16 evidenced this was the first visit by a RN, employee B. The wound measured Length 8.6, Width 6.2, and Depth 0.1.</p> <p>E. During interview on 7/26/16 at 12:40 PM, employee B stated wounds should be measured weekly by the RNs and include length, width and depth. Employee B stated patient # 7's wound was cellulitis related so it was not necessary to give it a stage since not a pressure ulcer. Employee B stated they did not have to measure the wound on the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>first visit because they had wound measurements from the physician.</p> <p>F. The document titled "Hospitalization/Major Diagnostic Procedure" dated 7/14/2016 stated "Examination General Exam: ... EXTREMITIES: open wound on [patient's] left lower leg 8 cm [centimeters] long and 6 cm in width with purulent drainage."</p> <p>G. During interview on 7/20/16 at 11:45 AM, employee B (Nursing Supervisor) stated only RN's measure wounds.</p> <p>H. During interview on 7/22/16 at 1:20 PM, employee B stated this patient only had a small scabbed spot prior.</p> <p>I. During interview on 7/25/16 at 12:00 PM, employee B stated a RN does not always conduct the first visit for adding of SN services mid certification period, it just depends; stated she was present at visit and could co-sign the LPN notes.</p> <p>J. The comprehensive assessment for recertification with Outcome Assessment Information Set data dated 7/21/16 evidenced the RN (employee I) staged the wound at stage 2.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>K. During interview on 7/26/16 at 12:40 PM, employee B stated it was not necessary to stage this wound since it was not a pressure ulcer.</p> <p>5. The agency's un-dated policy titled "Case Management Guide to Basic Homeopathic Regulations," no number, stated "When patient needs to be seen by RN vs. LPN: ... 2. RN should measure wound(s) 1 x [time] per week."</p> <p>6. The agency's un-dated policy titled "Patient Reassessment/Update of Comprehensive Assessment," # AC-155 stated "12. Reassessments are conducted every visit based on physician orders, patient conditions, and/or professional staff judgment."</p> <p>7. The agency's un-dated procedure titled "Wound Measurement," not numbered, stated "The Amedisys wound measurement policy is MANDATORY and is as follows: ... It is recommended that you measure and document your measurements on the first visit of the week."</p> <p>8. The agency's un-dated job description titled "Registered Nurse," no number, stated "The RN will: ... 9. Perform initial and ongoing patient assessments.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
N 0000  Bldg. 00	<p>10. Update patient's plan of care as needed. ... 19. Document legibly, and follow state, federal, and agency standards for documentation."</p> <p>9. The agency's un-dated policy titled "Clinical Documentation," # C-680, stated "Purpose ... To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement. Special Instructions ... 3. Additional information that is pertinent to the patient's care or condition may be documented on the Progress Note or Flow Sheet."</p> <p>This was a home health state licensure survey.</p> <p>Survey Dates: July 19, 20, 21, 22, 25, and 26, 2016</p> <p>Facility Number: 011316</p> <p>Medicaid Number: 200853200</p> <p>Census Service Type: Skilled: 35 Home Health Aide Only: 46 Personal Care Only: 2 Total: 83</p>	N 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
N 0458 Bldg. 00	<p>Sample: RR w/HV: 5 RR w/o HV: 5 HV w/o RR: 1 Total: 11</p> <p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on document review and interview, the agency failed to ensure employee criminal background checks were completed within 3 days of providing patient care for 1 of 11 employee files reviewed. (G)</p> <p>Findings include</p>	N 0458	N458 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY FOR 484.14(E) PERSONNEL POLICIES. THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED THE HUMAN RESOURCE COORDINATOR ON FEDERAL, STATE AND COMPANY POLICY	08/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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			
N 0470	<p>1. Employee file G, Certified Occupational Therapy Assistant (COTA), was reviewed on 7/26/16. Employee G date of hire 7/5/13, first patient contact date 2/26/15. The file failed to evidence the criminal background check was completed within 3 days of providing patient care.</p> <p>A. The Indiana State Police Limited Criminal History for employee G was dated 3/10/2014.</p> <p>2. During interview on 7/26/16 at 1:10 PM, employee M, Human Resources (HR), stated employee G was an office employee first until she obtained her COTA in February, and the agency should have ran a criminal check closer to the first patient contact date. Employee M stated she was not the HR person prior and that criminal check was probably ran because there was not one at date of hire.</p> <p>3. The agency's un-dated job description titled "Human Resources Coordinator Job Specific Orientation," no date, stated "Personnel Records Personnel record to include: Before First Patient Contact ...</p> <p>3. Copy of Limited Criminal History."</p> <p>410 IAC 17-12-1(m) Home health agency</p>		<p>484.14(E) HUMAN RESOURCE COORDINATOR ALSO INSERVICED ON ALL CRIMINAL BACKGROUND CHECKS BEING COMPLETED BEFORE FIRST PATIENT CONTACT (AS PER HUMAN RESOURCE JOB SPECIFIC DESCRIPTION) HUMAN RESOURCE COORDINATOR WILL COMPLETE APPROPRIATE BACK GROUND CHECKS ON ALL EMPLOYEES PRIOR TO FIRST PATIENT CONTACT. HUMAN RESOURCE COORDINATOR WILL AUDIT 10% OF ALL EMPLOYEE FILES QUARTERLY FOR COMPLIANCE TO PREVENT THE DEFICIENCY FROM RECURRING. ANY FINDINGS WILL BE REVIEWED IN EACH QUARTERLY QUALITY ASSURANCE MEETING THRU 08/2017 THE ADMINISTRATOR WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THE DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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			
Bldg. 00	<p>administration/management</p> <p>Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, document review, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 1 of 5 home visit observations. (# 2)</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. During home visit on 7/21/16 at 10:00 AM, employee D (Home Health Aide) was observed providing homemaker services for patient # 2. Employee D prepared floor mopping water, placed the mop into the water, and then proceeded to handle clean dishes from strainer to put them away. Employee D failed to wash her hands or use hand sanitizer prior to touching the clean dishes.</li> <li>2. During interview on 7/23/16 at 12:20 PM, employee B (Nursing Supervisor) stated she usually sings the happy birthday song twice to ensure proper hand washing length of time.</li> <li>3. The agency's un-dated policy titled "Hand Washing Demonstration," # N130, stated "Note: The need for hand washing depends on the type, intensity, duration,</li> </ol>	N 0470	<p>N470 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY FOR 484.12(C) COMPLIANCE WITH ACCEPTED PROFESSIONAL STANDARDS. THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL STAFF ON FEDERAL, STATE AND COMPANY POLICY FOR 484.12(C) THE DIRECTOR OF NURSING WILL ENSURE ALL CURRENT ABLE HANDS HOMECARE STAFF ARE GIVEN A COPY OF ABLE HANDS HOMECARE POLICY N130 ON HANDWASHING AND A SIGNATURE OBTAINED TO AFFIRM UNDERSTANDING OF THE POLICY BY 8/12/2016. THE HUMAN RESOURCE COORDINATOR WILL REVIEW THE POLICY ANNUALLY AS PART OF ABLE HANDS HOMECARE'S INSERVICE PROGRAM. STARTING 8/1/2016, ABLE HANDS WILL HAVE THE HANDWASHING POLICY N130 REVIEWED DURING EMPLOYEE ORIENTATION AND A SIGNATURE OBTAINED TO AFFIRM UNDERSTANDING OF THE POLICY IN ORDER TO</p>	08/12/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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	
N 0518 Bldg. 00	and sequence of activities. The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: ... After handling contaminated equipment."  410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.  Based on observation and document review, the agency failed to ensure patients were provided the most recent revision of the State of Indiana Advanced Directives dated July 2013, for 5 of 5 home visit observations. (# 1, 2, 3, 4, and 11)	N 0518	PREVENT THE DEFICIENCY FROM RECURRING STARTING 08/01/2016 THE HUMAN RESOURCE COODINATOR WILL AUDIT ALL NEW EMPLOYEE FILES AND REPORT ANY FINDINGS DURING THE QUARTERLY QUALITY ASSURANCE MEETINGS THRU 08/2017. THIS PROCESS OF REVIEW WILL BE DONE ON ALL NEW HIRES QUARTERLY TO MONITOR CORRECTIVE ACTIONS AND ENSURE THE DEFICIENCY IS CORRECTED. THE ADMINISTRATOR WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS  N518 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY FOR 484.10(C)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE. THE ADMINISTRATOR AND	08/19/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>Findings include</p> <ol style="list-style-type: none"> <li>1. The agency's admission packet evidenced the State of Indiana Advanced Directives dated May 2004. The admission packet failed to evidence the most recent revision (July 2013) of the State of Indiana Advanced Directives document.</li> <li>2. On 7/20/16 at 1:30 PM, the home admission folder was observed during a home visit for patient # 1. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</li> <li>3. On 7/21/16 at 10:00 AM, the home admission folder was observed during a home visit for patient # 2. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</li> <li>4. On 7/21/16 at 12:15 PM, the home admission folder was observed during a home visit for patient # 3. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</li> <li>5. On 7/21/16 at 1:00 PM, the home admission folder was observed during a</li> </ol>		<p>DIRECTOR OF NURSING HAVE INSERVICED/EDUCATED AND PROVIDED COPIES OF THE DDRS POLICY ON ADVANCED DIRECTIVES, THE REVISED INDIANA STATE DEPARTMENT OF HEALTH ADVANCED DIRECTIVE (JULY 2013), ABLE HANDS HOMECARE POLICY AND PROCEDURE ON ADVANCED DIRECTIVES AND ABLE HANDS HOMECARE BILL OF RIGHTS WITH ALL NURSING STAFF. A CURRENT REVISED COPY (JULY 2013) OF THE INDIANA STATE DEPARTMENT OF HEALTH ADVANCED DIRECTIVES HAS BEEN RECEIVED AND WILL BE GIVEN TO EVERY CLIENT UPON ADMISSION. STARTING JULY 26, 2016 ALL CURRENT CLIENTS OF ABLE HANDS HOMECARE WILL BE PROVIDED THE REVISED, JULY 1,2013, ADVANCED DIRECTIVE BROCHURE. THE ADMINISTRATOR WILL CHECK THE ISDH WEBSITE QUARTERLY FOR UPDATES/REVISIONS TO THE INDIANA STATE DEPARTMENT OF HEALTH ADVANCED DIRECTIVES IN ORDER TO PREVENT THE DEFICIENCY FROM RECURRING THE ADMINISTRATOR WILL BE RESPONSIBLE FOR ENSURING THE DEFICIENCY HAS BEEN CORRECTED AND COMPLIANCE MAINTAINED BY REVIEWING ADVANCED</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
N 0522 Bldg. 00	<p>home visit for patient # 4. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</p> <p>6. On 7/22/16 at 10:30 AM, the home admission folder was observed during a home visit for patient # 11. The folder failed to evidence the State of Indiana Advanced Directives document revised July 1, 2013.</p> <p>7. The agency's un-dated policy titled "Home Care/Bill of Rights/Grievance Procedure," # C-380, stated "Purpose ... to consistently inform patients verbally and in writing, or by other means understood by the patients, of their right to make informed decisions regarding their care."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on document review and interview, the agency failed to ensure</p>	N 0522	<p>DIRECTIVES AT EACH QUARTERLY QUALITY ASSURANCE MEETING THRU 08/2017</p> <p>N522 THE ADMINISTRATOR AND DIRECTOR OF NURSING</p>	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>home health aide (HHA) visits were provided as ordered on the plan of care for 1 of 10 clinical records reviewed. (# 6)</p> <p>Findings include</p> <p>1. Clinical record # 6 was reviewed on 7/25/16. Start of care date 5/15/14. The plan of care dated 7/3-8/31/16 contained orders for HHA effective 7/4/16 3-4 hours a day, 4-5 days a week for 8 weeks, then 3-4 hours a day, 2-3 days a week for 1 week. The record evidenced the agency provided more hours than ordered for the weeks of 7/4-7/10, and 7/11-7/17/16.</p> <p>A. The Homecare Weekly Visit Note dated 7/4/16-7/10/16 evidenced the HHA provided 5 hours of care on 7/5/16 from 8 AM-1 PM; 7 hours on 7/6/16 from 8 AM-3 PM; and 5 hours on 7/8/16 from 8 AM-1 PM. The record failed to evidence a physician order for the extra hours of care provided.</p> <p>B. During interview on 7/25/16 at 11:15 AM, employee B (Nursing Supervisor) stated the Quality Assurance person probably had not yet reviewed the HHA visit notes, and when she does if she sees HHA hours over or under what is ordered, she will write a clarification order to cover the hours.</p>		<p>HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.18 ACCEPTANCE OF PATIENTS PLAN OF CARE AND MEDICAL SUPERVISION THE ADMINISTRATOR AND DIRECTOR OF NURSING INSERVICED ALL LICENSED PERSONNEL DESIGNATED BY THE AGENCY TO RECEIVE ORDERS FROM THE PHYSICIAN ON FEDERAL, STATE AND COMPANY POLICY 484.18 ALL DESIGNATED STAFF SHALL PROMPTLY NOTIFY THE PHYSICIAN OF ANY CHANGES THAT SUGGEST A NEED TO ALTER THE PLAN OF CARE. ANY ORDER MY BE INITIATED VIA TELEPHONE OR IN WRITING AND WILL BE OBTAINED FROM THE PHYSICIAN FOR CHANGES TO THE PLAN OF CARE PRIOR TO SERVICES BEING PROVIDED. ALL ORDERS ARE TO BE REVIEWED BY THE DIRECTOR OF NURSING TO VERIFY THAT ORDERS FOR SERVICES HAVE BEEN OBTAINED FROM THE PHYSICIAN PRIOR TO PROVIDING SERVICES THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED THRU 08/2017</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>C. During interview on 7/25/16 at 12:30 PM, employee B stated they were over hours for patient # 6 the week of 7/4-7/10/16 due to Monday was a holiday and the agency does not cover holidays unless the patient has orders for 7 days a week, so they make up the hours throughout the week so that patients do not lose Medicaid hours.</p> <p>D. During interview on 7/25/16 at 12:30 PM employee B presented a written order dated 7/25/16 that stated "Clarification; 7 hours on 7/6/16 for already scheduled hours." Employee B stated this order was just written up.</p> <p>-The order dated 7/25/16 failed to include extra hours for 7/5 and 7/6 and was created after issue was found, and failed to contain a signature of the creator (employee Q, compliance).</p> <p>E. The Homecare Weekly Visit Note dated 7/11/16-7/17/16 evidenced the HHA provided 6 hours of care on 7/13/16 from 9 AM-2 PM. The record failed to evidence a clarification order for the 2 extra hours of care provided.</p> <p>2. The agency's un-dated policy titled "Physician Orders," # C-635, stated "All medications, treatments and services</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
N 0540 Bldg. 00	<p>provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing ... If patient records are maintained electronically, the agency may use electronic signatures. However, all entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier."</p> <p>3. The agency's un-dated policy titled "Plan of Care," # C-580, stated "Special Instructions ... 10. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on document review, and interview, the agency failed to ensure the Registered Nurse (RN) performed an initial Skilled Nurse add-on evaluation visit and wound assessment for 1 of 2</p>	N 0540	N540 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.30(a) DUTIES OF A REGISTERED NURSE THE	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>clinical records with orders for wound care. (# 7)</p> <p>Findings include</p> <p>1. Clinical record # 7 was reviewed on 7/21 and 7/22/16. Start of care date 5/26/16. The plan of care dated 5/26-7/24/16 contained orders for Home Health Aide (HHA) services of Attendant Care effective 6/2/16 for 2-3 hours 1-2 days a week for 8 weeks; and Homemaker 1-2 hours a day 1-2 days a week for 8 weeks.</p> <p>A. The Comprehensive Adult Assessment dated 5/26/16 on start of care evidenced the patient did not have a wound on admission.</p> <p>B. A physician order dated 7/16/2016 stated "Begin Date: 7/16/2016 1 D [day] 30 ... Skilled nurse to complete daily wound care as follows: 1) Cleanse wound to left shin with wound cleanser or normal saline, pat dry. 2) Swab area lightly with Betadine, let dry. 3) Apply thin layer of Santyl ointment 4) Cover with ABD [abdominal] pad 5) Secure with roll gauze 6) Cover with Coban." The record failed to evidence the RN conducted the initial SN add on visit, and failed to evidence a comprehensive assessment had been completed.</p>		<p>ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL REGISTERED NURSES ON FEDERAL, STATE AND COMPANY POLICY 484.30(a) A REGISTERED NURSE WILL MAKE THE INITIAL ASSESSMENT VISIT FOR ALL WOUND CARE CLIENTS AND WILL REGULARLY RE-EVALUATE THE PATIENT'S NEEDS A REGISTERED NURSE WILL REVIEW ALL ORDERS AND/OR DOCUMENTS RECEIVED FROM OTHER PROFESSIONAL SOURCES INVOLVED IN THE PATIENT'S CARE AND WILL INITIAL A REGISTERED NURSE ASSESSMENT VISIT FOR THOSE CLIENTS WITH NEW WOUNDS/TREATMENTS. THIS VISIT IS TO INCLUDE BASELINE MEASUREMENTS AS APPROPRIATE THE REGISTERED NURSE WILL INFORM THE PHYSICIAN, NECESSARY PERSONNEL AND CAREGIVER OF ANY CHANGE IN CONDITION AS WELL AS INITIATE ANY NEEDED REVISIONS TO THE PLAN OF CARE THE DIRECTOR OF NURSING WILL AUDIT ALL CLINICAL RECORDS FOR THOSE CLIENTS WITH WOUNDS BEING MONITORED BY THE RESGISTERED NURSE FROM INITIATION OF TREATMENT UNTIL THE WOUND CARE IS</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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>C. The Skilled Nurse Clinical Progress Note dated 7/16/16 failed to evidence an RN conducted this initial visit. The note was signed by employee J (Licensed Practical Nurse), and failed to evidence the wound had been measured.</p> <p>D. The Skilled Nurse Clinical Progress Note dated 7/17/16 evidenced this visit was conducted by the LPN also, so wound was not measured.</p> <p>E. The Skilled Nurse Clinical Progress Note dated 7/18/16 evidenced this was the first visit by a RN, employee B. The wound measured Length 8.6, Width 6.2, and Depth 0.1.</p> <p>F. During interview on 7/26/16 at 12:40 PM, employee B stated wounds should be measured weekly by the RNs and include length, width and depth. Employee B stated patient # 7's wound was cellulitis related so it was not necessary to give it a stage since not a pressure ulcer. Employee B stated they did not have to measure the wound on the first visit because they had wound measurements from the physician.</p> <p>G. The document titled "Hospitalization/Major Diagnostic Procedure" dated 7/14/2016 stated</p>		DISCONTINUED THE DIRECTOR OF NURSING IS TO MONITOR THE CORRECTIVE ACTIONS TO ENSURE THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED IN ORDER TO PREVENT THE DEFICIENCY FROM RE-CURRING		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>"Examination General Exam: ... EXTREMITIES: open wound on [patient's] left lower leg 8 cm [centimeters] long and 6 cm in width with purulent drainage."</p> <p>H. During interview on 7/20/16 at 11:45 AM, employee B (Nursing Supervisor) stated only RN's measure wounds.</p> <p>I. During interview on 7/22/16 at 1:20 PM, employee B stated this patient only had a small scabbed spot prior.</p> <p>J. During interview on 7/25/16 at 12:00 PM, employee B stated a RN does not always conduct the first visit for adding of SN services mid certification period, it just depends; stated she was present at visit and could co-sign the LPN notes.</p> <p>2. The agency's un-dated policy titled "Case Management Guide to Basic Homeopathic Regulations," no number, stated "When patient needs to be seen by RN vs. LPN: ... 2. RN should measure wounds(S) 1 x [time] per week."</p> <p>3. The agency's un-dated policy titled "Patient Reassessment/Update of Comprehensive Assessment," # AC-155 stated "12. Reassessments are conducted</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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
N 0544  Bldg. 00	<p>every visit based on physician orders, patient conditions, and/or professional staff judgment."</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on document review, and interview, the agency failed to ensure the Registered Nurse (RN) performed and documented an initial Skilled Nurse add-on wound assessment for 1 of 2 clinical records reviewed with orders for wound care. (# 7)</p> <p>Findings include</p> <p>1. Clinical record # 7 was reviewed on 7/21 and 7/22/16. Start of care date 5/26/16. The plan of care dated 5/26-7/24/16 contained orders for Home Health Aide (HHA) services of Attendant Care effective 6/2/16 for 2-3 hours 1-2 days a week for 8 weeks; and Homemaker 1-2 hours a day 1-2 days a week for 8 weeks.</p>			N 0544	<p>N544 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.30(a) DUTIES OF A REGISTERED NURSE THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE INSERVICED AND EDUCATED ALL REGISTERED NURSES ON FEDERAL, STATE AND COMPANY POLICY 484.30(a) A REGISTERED NURSE WILL MAKE THE INITIAL ASSESSMENT VISIT FOR ALL WOUND CARE CLIENTS AND WILL REGULARLY RE-EVALUATE THE PATIENT'S NEEDS A REGISTERED NURSE WILL REVIEW ALL ORDERS AND/OR DOCUMENTS RECEIVED FROM OTHER PROFESSIONAL SOURCES INVOLVED IN THE</p>		08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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>A. The Comprehensive Adult Assessment dated 5/26/16 evidenced the patient did not have a wound on admission.</p> <p>B. A physician order dated 7/16/2016 stated "Begin Date: 7/16/2016 1 D [day] 30 ... Skilled nurse to complete daily wound care as follows: 1) Cleanse wound to left shin with wound cleanser or normal saline, pat dry. 2) Swab area lightly with Betadine, let dry. 3) Apply thin layer of Santyl ointment 4) Cover with ABD [abdominal] pad 5) Secure with roll gauze 6) Cover with Coban." The record failed to evidence the RN conducted the initial SN add on visit.</p> <p>C. The Skilled Nurse Clinical Progress Note dated 7/16/16 failed to evidence an RN conducted this initial visit. The note was signed by employee J (Licensed Practical Nurse), and failed to evidence the wound had been measured.</p> <p>D. The Skilled Nurse Clinical Progress Note dated 7/17/16 evidenced this visit was conducted by the LPN also, so wound was not measured.</p> <p>E. The Skilled Nurse Clinical Progress Note dated 7/18/16 evidenced this was the first visit by a RN, employee</p>		<p>PATIENT'S CARE AND WILL INITIAL A REGISTERED NURSE ASSESSMENT VISIT FOR THOSE CLIENTS WITH NEW WOUNDS/TREATMENTS. THIS VISIT IS TO INCLUDE BASELINE MEASUREMENTS AS APPROPRIATE THE REGISTERED NURSE WILL INFORM THE PHYSICIAN, NECESSARY PERSONNEL AND CAREGIVER OF ANY CHANGE IN CONDITION AS WELL AS INITIATE ANY NEEDED REVISIONS TO THE PLAN OF CARE THE DIRECTOR OF NURSING WILL AUDIT ALL CLINICAL RECORDS FOR THOSE CLIENTS WITH WOUNDS BEING MONITORED BY THE REGISTERED NURSE FROM INITIATION OF TREATMENT UNTIL THE WOUND CARE IS DISCONTINUED THE DIRECTOR OF NURSING IS TO MONITOR THE CORRECTIVE ACTIONS TO ENSURE THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED IN ORDER TO PREVENT THE DEFICIENCY FROM RE-CURRING</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>B. The wound measured Length 8.6, Width 6.2, and Depth 0.1.</p> <p>F. During interview on 7/26/16 at 12:40 PM, employee B stated wounds should be measured weekly by the RNs and include length, width and depth. Employee B stated patient # 7's wound was cellulitis related so it was not necessary to give it a stage since not a pressure ulcer. Employee B stated they did not have to measure the wound on the first visit because they had wound measurements from the physician.</p> <p>G. The document titled "Hospitalization/Major Diagnostic Procedure" dated 7/14/2016 stated "Examination General Exam: ... EXTREMITIES: open wound on [patient's] left lower leg 8 cm [centimeters] long and 6 cm in width with purulent drainage."</p> <p>H. During interview on 7/20/16 at 11:45 AM, employee B (Nursing Supervisor) stated only RN's measure wounds.</p> <p>I. During interview on 7/22/16 at 1:20 PM, employee B stated this patient only had a small scabbed spot prior.</p> <p>J. During interview on 7/25/16 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
N 0547 Bldg. 00	<p>12:00 PM, employee B stated a RN does not always conduct the first visit for adding of SN services mid certification period, it just depends; stated she was present at visit and could co-sign the LPN notes.</p> <p>2. The agency's un-dated policy titled "Case Management Guide to Basic Homeopathic Regulations," no number, stated "When patient needs to be seen by RN vs. LPN: ... 2. RN should measure wounds(S) 1 x [time] per week."</p> <p>3. The agency's un-dated policy titled "Patient Reassessment/Update of Comprehensive Assessment," # AC-155 stated "12. Reassessments are conducted every visit based on physician orders, patient conditions, and/or professional staff judgment."</p> <p>4. The agency's un-dated procedure titled "Wound Measurement," not numbered, stated "The Amedisys wound measurement policy is MANDATORY and is as follows: ... It is recommended that you measure and document your measurements on the first visit of the week."</p> <p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:</p> <p>(H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on document review and interview, the agency failed to ensure physician orders were obtained for an increase in Home Health Aide (HHA) hours for 1 of 10 clinical records reviewed. (# 6)</p> <p>Findings include</p> <p>1. Clinical record # 6 was reviewed on 7/25/16. Start of care date 5/15/14. The plan of care dated 7/3-8/31/16 contained orders for HHA effective 7/4/16 3-4 hours a day, 4-5 days a wee for 8 weeks, then 3-4 hours a day, 2-3 days a week for 1 week. The record evidenced the agency provided more hours than ordered for the weeks of 7/4-7/10, and 7/11-7/17/16.</p> <p>A. The Homecare Weekly Visit Note dated 7/4/16-7/10/16 evidenced the HHA provided 5 hours of care on 7/5/16 from 8 AM-1 PM; 7 hours on 7/6/16 from 8 AM-3 PM; and 5 hours on 7/8/16 from 8 AM-1 PM. The record failed to evidence a physician order for the extra hours of care provided.</p>	N 0547	<p>N547 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.18 ACCEPTANCE OF PATIENTS PLAN OF CARE AND MEDICAL SUPERVISION THE ADMINISTRATOR AND DIRECTOR OF NURSING INSERVICED ALL LICENSED PERSONNEL DESIGNATED BY THE AGENCY TO RECEIVE ORDERS FROM THE PHYSICIAN ON FEDERAL, STATE AND COMPANY POLICY 484.18 ALL DESIGNATED STAFF SHALL PROMPTLY NOTIFY THE PHYSICIAN OF ANY CHANGES THAT SUGGEST A NEED TO ALTER THE PLAN OF CARE. ANY ORDER MY BE INITIATED VIA TELEPHONE OR IN WRITING AND WILL BE OBTAINED FROM THE PHYSICIAN FOR CHANGES TO THE PLAN OF CARE PRIOR TO SERVICES BEING PROVIDED. ALL ORDERS ARE TO BE REVIEWED BY THE DIRECTOR OF NURSING TO VERIFY THAT ORDERS FOR SERVICES HAVE BEEN OBTAINED FROM THE PHYSICIAN PRIOR TO PROVIDING SERVICES THE</p>	08/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>B. During interview on 7/25/16 at 11:15 AM, employee B (Nursing Supervisor) stated the Quality Assurance person probably had not yet reviewed the HHA visit notes, and when she does if she sees HHA hours over or under what is ordered, she will write a clarification order to cover the hours.</p> <p>C. During interview on 7/25/16 at 12:30 PM, employee B stated they were over hours for patient # 6 the week of 7/4-7/10/16 due to Monday was a holiday and the agency does not cover holidays unless the patient has orders for 7 days a week, so they make up the hours throughout the week so that patients do not lose Medicaid hours.</p> <p>D. During interview on 7/25/16 at 12:30 PM employee B presented a written order dated 7/25/16 that stated "Clarification; 7 hours on 7/6/16 for already scheduled hours." Employee B stated this order was just written up.</p> <p>-The order dated 7/25/16 failed to include extra hours for 7/5 and 7/6, was not signed by the creator (employee Q) and was created after issue was found.</p> <p>E. The Homecare Weekly Visit Note dated 7/11/16-7/17/16 evidenced the HHA provided 6 hours of care on 7/13/16</p>		DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED THRU 08/2017				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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
N 0608 Bldg. 00	<p>from 9 AM-2 PM. The record failed to evidence a clarification order for the 2 extra hours of care provided.</p> <p>2. The agency's un-dated policy titled "Physician Orders," # 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 ... If patient records are maintained electronically, the agency may use electronic signatures. However, all entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier."</p> <p>3. The agency's un-dated policy titled "Plan of Care," # C-580, stated "Special Instructions ... 10. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953		
(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>findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information.</p> <p>(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist.</p> <p>(3) Drug, dietary, treatment, and activity orders.</p> <p>(4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on document review and interview, the agency failed to ensure clinical records contained appropriate and necessary documentation for 2 of 10 clinical records reviewed. (# 6 and 7)</p> <p>Findings include</p> <p>1. Clinical record # 6 was reviewed on 7/25/16. Start of care date 5/15/14. The plan of care dated 7/3-8/31/16 contained orders for HHA effective 7/4/16 3-4 hours a day, 4-5 days a wee for 8 weeks, then 3-4 hours a day, 2-3 days a week for 1 week. The record evidenced the agency provided more hours than ordered for the weeks of 7/4-7/10, and 7/11-7/17/16.</p> <p>A. The Homecare Weekly Visit Note</p>	N 0608	N608 THE ADMINISTRATOR AND DIRECTOR OF NURSING HAVE REVIEWED FEDERAL, STATE AND COMPANY POLICY 484.18 ACCEPTANCE OF PATIENTS PLAN OF CARE AND MEDICAL SUPERVISION THE ADMINISTRATOR AND DIRECTOR OF NURSING INSERVICED ALL LICENSED PERSONNEL DESIGNATED BY THE AGENCY TO RECEIVE ORDERS FROM THE PHYSICIAN ON FEDERAL, STATE AND COMPANY POLICY 484.18 ALL DESIGNATED STAFF SHALL PROMPTLY NOTIFY THE PHYSICIAN OF ANY CHANGES THAT SUGGEST A NEED TO ALTER THE PLAN OF CARE. ANY ORDER MY BE INITIATED VIA TELEPHONE OR IN WRITING AND WILL BE OBTAINED FROM	08/19/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>dated 7/4/16-7/10/16 evidenced the HHA provided 5 hours of care on 7/5/16 from 8 AM-1 PM; 7 hours on 7/6/16 from 8 AM-3 PM; and 5 hours on 7/8/16 from 8 AM-1 PM. The record failed to evidence a physician order for the extra hours of care provided.</p> <p>B. During interview on 7/25/16 at 11:15 AM, employee B (Nursing Supervisor) stated the Quality Assurance person probably had not yet reviewed the HHA visit notes, and when she does if she sees HHA hours over or under what is ordered, she will write a clarification order to cover the hours.</p> <p>C. During interview on 7/25/16 at 12:30 PM employee B presented a written order dated 7/25/16 that stated "Clarification; 7 hours on 7/6/16 for already scheduled hours." Employee B stated this order was just written up. This order failed to include extra hours for 7/5 and 7/6, was not signed by the creator (employee Q) and was created after issue was found.</p> <p>E. The Homecare Weekly Visit Note dated 7/11/16-7/17/16 evidenced the HHA provided 6 hours of care on 7/13/16 from 9 AM-2 PM. The record failed to evidence a clarification order for the 2 extra hours of care provided.</p>		<p>THE PHYSICIAN FOR CHANGES TO THE PLAN OF CARE PRIOR TO SERVICES BEING PROVIDED. ALL ORDERS ARE TO BE REVIEWED BY THE DIRECTOR OF NURSING TO VERIFY THAT ORDERS FOR SERVICES HAVE BEEN OBTAINED FROM THE PHYSICIAN PRIOR TO PROVIDING SERVICES THE DIRECTOR OF NURSING WILL BE RESPONSIBLE FOR MONITORING THESE CORRECTIVE ACTIONS TO ENSURE THAT THIS DEFICIENCY IS CORRECTED AND COMPLIANCE MAINTAINED THRU 08/2017</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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. The agency's un-dated policy titled "Physician Orders," # 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 ... If patient records are maintained electronically, the agency may use electronic signatures. However, all entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier."</p> <p>3. The agency's un-dated policy titled "Plan of Care," # C-580, stated "Special Instructions ... 10. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>4. Clinical record # 7 was reviewed on 7/21 and 7/22/16. Start of care date 5/26/16. The plan of care dated 5/26-7/24/16 contained orders for Home Health Aide (HHA) services of Attendant Care effective 6/2/16 for 2-3 hours 1-2 days a week for 8 weeks; and Homemaker 1-2 hours a day 1-2 days a week for 8 weeks.</p> <p>A. A physician order dated 7/16/2016 stated "Begin Date: 7/16/2016 1 D [day]"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2016	
NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953			
(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>30 ... Skilled nurse to complete daily wound care as follows: 1) Cleanse wound to left shin with wound cleanser or normal saline, pat dry. 2) Swab area lightly with Betadine, let dry. 3) Apply thin layer of Santyl ointment 4) Cover with ABD [abdominal] pad 5) Secure with roll gauze 6) Cover with Coban." The record failed to evidence the RN conducted the comprehensive assessment for the SN add on visit.</p> <p>B. The Skilled Nurse Clinical Progress Note dated 7/16/16 failed to evidence an RN conducted this initial visit. The note was signed by employee J (Licensed Practical Nurse), and failed to evidence the wound had been measured.</p> <p>C. The Skilled Nurse Clinical Progress Note dated 7/17/16 evidenced this visit was conducted by the LPN also, so wound was not measured.</p> <p>D. The Skilled Nurse Clinical Progress Note dated 7/18/16 evidenced this was the first visit by a RN, employee B. The wound measured Length 8.6, Width 6.2, and Depth 0.1.</p> <p>E. During interview on 7/26/16 at 12:40 PM, employee B stated wounds should be measured weekly by the RNs and include length, width and depth.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>Employee B stated patient # 7's wound was cellulitis related so it was not necessary to give it a stage since not a pressure ulcer. Employee B stated they did not have to measure the wound on the first visit because they had wound measurements from the physician.</p> <p>F. The document titled "Hospitalization/Major Diagnostic Procedure" dated 7/14/2016 stated "Examination General Exam: ... EXTREMITIES: open wound on [patient's] left lower leg 8 cm [centimeters] long and 6 cm in width with purulent drainage."</p> <p>G. During interview on 7/20/16 at 11:45 AM, employee B (Nursing Supervisor) stated only RN's measure wounds.</p> <p>H. During interview on 7/22/16 at 1:20 PM, employee B stated this patient only had a small scabbed spot prior.</p> <p>I. During interview on 7/25/16 at 12:00 PM, employee B stated a RN does not always conduct the first visit for adding of SN services mid certification period, it just depends; stated she was present at visit and could co-sign the LPN notes.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>J. The comprehensive assessment for recertification with Outcome Assessment Information Set data dated 7/21/16 evidenced the RN (employee I) staged the wound at stage 2.</p> <p>K. During interview on 7/26/16 at 12:40 PM, employee B stated it was not necessary to stage this wound since it was not a pressure ulcer.</p> <p>5. The agency's un-dated policy titled "Case Management Guide to Basic Homeopathic Regulations," no number, stated "When patient needs to be seen by RN vs. LPN: ... 2. RN should measure wound(s) 1 x [time] per week."</p> <p>6. The agency's un-dated policy titled "Patient Reassessment/Update of Comprehensive Assessment," # AC-155 stated "12. Reassessments are conducted every visit based on physician orders, patient conditions, and/or professional staff judgment."</p> <p>7. The agency's un-dated procedure titled "Wound Measurement," not numbered, stated "The Amedisys wound measurement policy is MANDATORY and is as follows: ... It is recommended that you measure and document your measurements on the first visit of the week."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157588	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ABLE HANDS HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 504 S BALDWIN AVE MARION, IN 46953
---	--

(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>8. The agency's un-dated job description titled "Registered Nurse," no number, stated "The RN will: ... 9. Perform initial and ongoing patient assessments. 10. Update patient's plan of care as needed. ... 19. Document legibly, and follow state, federal, and agency standards for documentation."</p> <p>9. The agency's un-dated policy titled "Clinical Documentation," # C-680, stated "Purpose ... To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement. Special Instructions ... 3. Additional information that is pertinent to the patient's care or condition may be documented on the Progress Note or Flow Sheet."</p>			