

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157004	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/21/2013
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NAME OF PROVIDER OR SUPPLIER  VISITING NURSE ASSOCIATION OF SOUTHWESTERN INDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 610 E WALNUT ST PO BOX 3487 EVANSVILLE, IN 47734
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G000000	<p>This was a Federal home health agency recertification survey.</p> <p>Survey Dates: 11-18-13, 11-19-13, 11-20-13, &amp; 11-21-13</p> <p>Facility #: 005247</p> <p>Medicaid Vendor #: 100272010A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency current census: 178 skilled patients 1 home health aide only patient 118 personal services patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  November 26, 2013</p>	G000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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G000121	<p><b>484.12(c)</b> <b>COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</b> The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 4 (patients 3, 4, 9, and 10) of 6 home visit observations completed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Infection Control Precautions" policy states, "The staff will apply 'Standard Precautions' in the care of all patients regardless of their diagnosis or presumed infection status . . . Standard Precautions will be applied to all patients, non-intact skin, mucous membranes, and all body fluids except sweat."</p> <p>The agency's undated "Standard Precautions Procedure" states, "Handwashing. Hands must be washed before and after contact with each patient; after any contact with blood or body fluids; immediately after removing gloves</p>	G000121	<p>The Operations Managers will re-educate the Agency staff that they must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Re-Education will also include the need to ensure that services are provided according to VNA Plus policies and procedures, specifically:1. Infection Control Precautions (including Standard Precautions)2. Handwashing3. Hand HygieneTo keep this deficiency from recurring, Operations Managers will initiate periodic on-site observation of caregiving staff. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013

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	<p>to avoid transfer of microorganisms to the environment; before eating and after toileting. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites . . . Gloves must be worn when it can be reasonably anticipated to have direct contact with blood, body fluids, mucous membranes, or non-intact skin, when handling items soiled with blood or body fluids; or when touching equipment or surfaces contaminated with blood or body fluids . . . Gloves are to be removed promptly after use and hands washed before touching non-contaminated items and environmental surfaces and before going to another patient."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p>			

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	<p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves.</p> <p>IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. A home visit was made to patient number 3 on 11-19-13 at 11:25 AM with employee F, a registered nurse (RN). The RN was observed to assess and examine the patient. The employee was observed to place her nursing bag and her computer on the patient's table without a barrier beneath the items. The employee failed to</p>			

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	<p>cleanse her hands after removing her gloves after assessing the patient's back for shingles and prior to obtaining the scale from the bathroom. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer.</p> <p>After removing the thermometer from the patient's mouth without wearing gloves, the employee obtained a blood pressure cuff from her nursing bag. The employee failed to clean the stethoscope after assessing the patient's back and chest prior to replacing it into her nursing bag. The employee's nursing bag did not have a specific area for clean supplies nor a specific area for her used, dirty supplies.</p> <p>4. A home visit was made to patient number 4 on 11-19-13 at 1:25 PM with employee I, a home health aide. The aide was observed to wash the patient's face, hair, back, chest, legs, and feet. The aide then changed her gloves without cleansing her hands. The aide assisted the patient to stand and washed the front perineal area. The aide changed her gloves without cleansing her hands. The aide washed the patient's buttocks and rectal area. The aide changed her gloves without cleansing her hands and assisted the patient to dry and applied lotion to the</p>			

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	<p>patient's arms and legs.</p> <p>5. A home visit was made to patient number 9 on 11-20-13 at 11:30 AM with employee G, an RN. The RN place her nursing bag on a chair without a barrier. The RN was observed to remove a thermometer from the patient's mouth and remove the protective sheath from the thermometer for disposal without wearing gloves.</p> <p>A. Observation noted a wound vacuum connected to a wound on the patient's right inner groin. The RN was observed to change the canister that held the drainage from the wound without wearing gloves. The RN then then removed a new canister from its package and applied the new canister. The RN opened a package of gauze, soaked it with normal saline and then cleansed her hands.</p> <p>B. After cleansing her hands and donning clean gloves, the RN disposed of the dirty canister that was observed to have drainage from the wound. The RN then removed the old dressing from the wound and changed her gloves without cleansing her hands. The RN probed the wound with a long cotton swab and removed the glove from her left hand. The RN held a flashlight in her left hand</p>			
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	<p>that had been retrieved from the patient's home by the patient's spouse. The RN then donned a clean glove to the left hand without cleansing her hands.</p> <p>C. The RN then cleansed the wound with the normal saline soaked gauze and removed her gloves and cleansed her hands. The RN then opened the wound vac dressing black foam and tubing obtained from a supply in the patient's home. The RN then donned clean gloves without cleansing her hands. After applying the black foam, tubing, and drape to the wound, the RN removed her gloves and, without cleansing her hands, touched the machine to turn it on. The RN then applied more pieces of the drape to the wound dressing.</p> <p>6. A home visit was made to patient number 10 on 11-20-13 at 10:05 AM with employee H, an RN. The RN was observed to place her nursing bag on the patient's couch without a barrier. The RN cleansed her hands and donned clean gloves. She removed the old dressing to the wound on the patient's left foot and removed her gloves. Without cleansing her hands, the RN obtained 2 washcloths from the patient's bathroom and then donned clean gloves. The RN applied soap and water to the washcloths and washed and dried the wound. The RN</p>			

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	<p>then measured the wound and without changing her gloves or cleansing her hands, obtained the prescribed topical medication and a Band-Aid from the patient's supply. The RN applied the medication and Band-Aid to the wound, reapplied the patient's sock and replaced the medication into its package.</p> <p>After replacing the medication into the package, and without changing her gloves or cleansing her hands, the RN then removed the sock from the patient's right foot and touched the right foot to examine. The RN replaced the patient's sock on the right foot, turned the sock on the left foot inside out, gathered the trash and placed the used washcloths in the patient's bathroom. The RN then removed her gloves and cleansed her hands.</p> <p>7. The above-stated observations were discussed with the supervising nurse, employee K, and the branch manager, employee L, on 11-20-13 at 1:10 PM. The employees indicated the employees had not followed standard precautions and the agency's infection control procedures.</p>			

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 5 included a plan of care established by the physician for the certification period 10-9-13 to 12-7-13. The plan of care identifies the skilled nurse (SN) is to provide a visit 1 time every 2 weeks and that the SN is to obtain the patient's weight every SN visit. <ul style="list-style-type: none"> <li>A. The record evidenced a SN visit had been provided on 10-21-13. The record failed to include an order for the 10-21-13 SN visit.</li> <li>B. SN visit notes, dated 10-21-13, 10-24-13, and 11-4-13, failed to evidence the SN had obtained the patient's weight.</li> </ul> </li> <li>The supervising nurse, employee K,</li> </ol>	G000158	The Operations Managers will re-educate the Agency staff that the patient's care follows a written plan of care established and periodically reviewed by the patient's physician. Re-education will include the regulatory requirement that skilled nursing services must be provided in accordance with physician's orders. To keep this deficiency from recurring, Operations managers will initiate a review of a sample of patient records to ensure that skilled services are provided in accordance with physician's orders. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013			

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	<p>was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p> <p>3. The agency's March 2003 "Care Planning Policy" states, "Each patient is provided care as identified by an individualized care plan initiated upon admission and revised as the patient's needs change. All care plans are to be in accordance with the plan of treatment, as developed by the patient's physician."</p>			

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G000164	<p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse informed the physician of a change in the patient's condition in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a skilled nurse visit note dated 11-4-13 that states, "Patient is having an increased cough and is getting up a thick tan colored sputum. [The patient] has increased shortness of breath. [The patient's] lungs are course and dimminished [sic]. [The patient] is on 3L of oxygen at all times. [The patient] has not been running a temp but is not felling [sic] well. Advised caregiver to have patient increase [the patient's] fluids and to have a humidify [sic] running at all times. Advised to call in [if] has increased temp or shortness of breath."</p> <p>The record failed to evidence the nurse had informed the physician of the patient's increased, productive cough and the increased shortness of breath.</p>	G000164	<p>The Operations Managers will re-educate the Agency staff to promptly alert the physician to any changes that suggest a need to alter the plan of care. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that staff are promptly alerting the physician to any changes that suggest a need to alter the plan of care. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013
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	2. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.			

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G000170	<p><b>484.30</b> <b>SKILLED NURSING SERVICES</b> The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 5 included a plan of care established by the physician for the certification period 10-9-13 to 12-7-13. The plan of care identifies the skilled nurse (SN) is to provide a visit 1 time every 2 weeks and that the SN is to obtain the patient's weight every SN visit. <ul style="list-style-type: none"> <li>A. The record evidenced a SN visit had been provided on 10-21-13. The record failed to include an order for the 10-21-13 SN visit.</li> <li>B. SN visit notes, dated 10-21-13, 10-24-13, and 11-4-13, failed to evidence the SN had obtained the patient's weight.</li> </ul> </li> <li>The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</li> </ol>	G000170	Operations Managers will re-educate the Agency staff that skilled nursing services are to be furnished in accordance with the plan of care. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure services are furnished in accordance with the plan of care. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013			

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	3. The agency's March 2003 "Care Planning Policy" states, "Each patient is provided care as identified by an individualized care plan initiated upon admission and revised as the patient's needs change. All care plans are to be in accordance with the plan of treatment, as developed by the patient's physician."			

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G000175	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) initiated appropriate nursing interventions related to the patient's receipt of incenter dialysis treatments and the presence of a hemodialysis access in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During a home visit to patient number 9, on 11-20-13 at 11:30 AM, the patient indicated the patient receives incenter dialysis treatments 3 times per week and has a fistula in the left arm.</li> <li>2. Clinical record number 9 included an initial assessment completed by the registered nurse (RN), employee N, on 11-10-13. The assessment failed to identify that the patient received incenter dialysis treatments 3 times per week and has a fistula in the left arm. The record failed to evidence the RN had initiated appropriate nursing interventions related to the patient's receipt of incenter hemodialysis treatment 3 times per week</li> </ol>	G000175	Operations Managers will re-educate the Agency nursing staff that the registered nurse initiates appropriate preventative and rehabilitative nursing procedures. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that the RN initiates appropriate preventative and rehabilitative nursing procedures. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013

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	and the presence of a fistula in the patient's left arm.  3. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.			

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G000176	<p><b>484.30(a)</b> <b>DUTIES OF THE REGISTERED NURSE</b> The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse informed the physician of a change in the patient's condition in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a skilled nurse visit note dated 11-4-13 that states, "Patient is having an increased cough and is getting up a thick tan colored sputum. [The patient] has increased shortness of breath. [The patient's] lungs are course and diminished [sic]. [The patient] is on 3L of oxygen at all times. [The patient] has not been running a temp but is not felling [sic] well. Advised caregiver to have patient increase [the patient's] fluids and to have a humidify [sic] running at all times. Advised to call in [if] has increased temp or shortness of breath."</li> </ol> <p>The record failed to evidence the nurse had informed the physician of the</p>	G000176	The Operations Managers will re-educate staff about requirements for preparation of clinical and progress notes, coordination of services and informing the physician and other personnel of changes in the patient's condition and needs. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that clinical documentation indicates coordination of services and communication to the physician and other personnel of changes in the patient's condition and needs. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013

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	<p>patient's increased, productive cough and the increased shortness of breath.</p> <p>2. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p>			

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G000229	<p><b>484.36(d)(2) SUPERVISION</b></p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) completed supervisory visits every 2 weeks in 1(#5) of 3 records reviewed of patients that received home health aide and skilled services creating the potential to affect all of the agency's 23 current patients that receive home health aide and skilled services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 evidenced home health aide services had been provided 2 times per week during the certification period 10-9-13 to 12-7-13. The record evidenced supervisory visits had been completed on 9-23-13 and not again until 10-24-13. No further supervisory visits were documented after 10-24-13.</li> <li>2. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</li> </ol>	G000229	<p>The Operations Managers will re-educate RN staff that an on-site supervisory visit must be made to the patient's home no less frequently than every 2 weeks. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that these supervisory visits are made no less frequently than every 2 weeks. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013			

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	3. The agency's undated "Supervision" policy states, "Skilled Care - Case Managers make the initial evaluation visit to the patient's residence and make a re-evaluation visit at least every 14 days to assess relationships and determine whether goals are being met."			

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G000303	<p><b>484.48</b> <b>CLINICAL RECORDS</b> The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.</p> <p>Based on clinical record review and interview, the agency failed to ensure it had informed the physician of the availability of a discharge summary in 1 (# 12) of 1 closed records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 12 evidenced the patient had been discharged from the agency on 10-29-13. The record failed to evidence the physician had been made aware of the availability of a discharge summary.</li> <li>2. The supervising nurse, employee K, indicated, on 11-21-13 at 8:35 AM, the record did not evidence the physician had been made aware of the availability of a discharge summary. The supervising nurse indicated the record did not include a discharge summary.</li> </ol>	G000303	<p>Operations Managers and the Health Information Manager will re-educate Agency staff that the attending physician must be informed of the availability of a discharge summary. This re-education will include that the discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. To keep this deficiency from recurring, Operations Managers and the Health Information Manager will initiate a review of a sample of patient records to ensure that the attending physician is informed of the availability of the discharge summary; that summaries are sent to the physician upon request and that the summaries contain the patient's medical and health status at discharge. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013	

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G000331	<p><b>484.55(a)(1)</b> <b>INITIAL ASSESSMENT VISIT</b> A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse completed an initial assessment that included all of the patient's care and support needs in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During a home visit to patient number 9, on 11-20-13 at 11:30 AM, the patient indicated the patient receives incenter dialysis treatments 3 times per week and has a fistula in the left arm.</li> <li>2. Clinical record number 9 included an initial assessment completed by the registered nurse (RN), employee N, on 11-10-13. The assessment failed to identify the patient received incenter dialysis treatments 3 times per week and has a fistula in the left arm. The assessment failed to identify patient care needs related to the patient's dialysis treatments and access care needs.</li> </ol>	G000331	<p>Operations Managers will re-educate Agency staff that an RN must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and for Medicare patients, to determine the eligibility for the Medicare home health benefit, including homebound status. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that the initial assessment includes the immediate care and support needs of the patient; and for Medicare patients, the documentation of determination of the eligibility for the Medicare home health benefit, including homebound status. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013

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N000000	<p>3. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p> <p>This was a State home health agency re-licensure survey.</p> <p>Survey Dates: 11-18-13, 11-19-13, 11-20-13, &amp; 11-21-13</p> <p>Facility #: 005247</p> <p>Medicaid Vendor #: 100272010A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Agency current census: 178 skilled patients 1 home health aide only patient 118 personal services patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 26, 2013</p>	N000000		

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N000456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on quality assurance and performance improvement (QAPI) document review, agency policy review, and interview, the agency failed to ensure its QAPI program included the monitoring and evaluation of the agency's infection control practices in 4 (3rd and 4th quarter 2012 and 1st and 2nd quarter 2013) of 4 quarters reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The agency's July 2002 "Performance Improvement Policy" states, "The scope of PI activities will include . . . infection control."</li> <li>The agency's QAPI documents for the 3rd and 4th quarter of 2012 and the 1st and 2nd quarter of 2013 failed to evidence the infection control practices of the agency's staff had been monitored and</li> </ol>	N000456	<p>In order to correct this deficiency and keep it from recurring, Operations Managers will develop a plan for monitoring and evaluation of the Agency's infection control practices. The Health Information Manager will revise the quarterly Performance Improvement Committee (PIC) meeting agenda to include reporting of Infection Control monitoring and evaluation. Operations Managers will re-educate Agency staff on Infection Control practices. (Cross refer to plan of correction for G121) The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013

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	<p>evaluated.</p> <p>3. Deficient practices were noted during observations of agency staff during home visits in 4 of 6 home visit observations completed. Cross refer to N 470.</p> <p>4. The supervising nurse, employee K, indicated, on 11-21-13 at 11:00 AM, the agency did not include infection control monitoring and evaluation in its QAPI activities.</p>			

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N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, agency policy review, and interview, the agency failed to ensure employees provided care in accordance with the agency's own infection control policies and procedures in 4 (patients 3, 4, 9, and 10) of 6 home visit observations completed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <p>1. The agency's undated "Infection Control Precautions" policy states, "The staff will apply 'Standard Precautions' in the care of all patients regardless of their diagnosis or presumed infection status . . . Standard Precautions will be applied to all patients, non-intact skin, mucous membranes, and all body fluids except sweat."</p> <p>The agency's undated "Standard Precautions Procedure" states, "Handwashing. Hands must be washed before and after contact with each patient; after any contact with blood or body</p>	N000470	<p>The Operations Managers will re-educate the Agency staff that they must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Re-Education will also include the need to ensure that services are provided according to VNA Plus policies and procedures, specifically:1. Infection Control Precautions (including Standard Precautions)2. Handwashing3. Hand HygieneTo keep this deficiency from recurring, Operations Managers will initiate periodic on-site observation of caregiving staff.The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013

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	<p>fluids; immediately after removing gloves to avoid transfer of microorganisms to the environment; before eating and after toileting. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites . . . Gloves must be worn when it can be reasonably anticipated to have direct contact with blood, body fluids, mucous membranes, or non-intact skin, when handling items soiled with blood or body fluids; or when touching equipment or surfaces contaminated with blood or body fluids . . . Gloves are to be removed promptly after use and hands washed before touching non-contaminated items and environmental surfaces and before going to another patient."</p> <p>2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes,</p>			

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	<p>nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care.</p> <p>IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.</p> <p>IV.A.3.f. After removing gloves . . .</p> <p>IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . .</p> <p>IV.B. Personal protective equipment (PPE) . . .</p> <p>IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. A home visit was made to patient number 3 on 11-19-13 at 11:25 AM with employee F, a registered nurse (RN). The RN was observed to assess and examine the patient. The employee was observed to place her nursing bag and her computer on the patient's table without a barrier</p>			

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	<p>beneath the items. The employee failed to cleanse her hands after removing her gloves after assessing the patient's back for shingles and prior to obtaining the scale from the bathroom. The employee failed to don gloves prior to removing the thermometer from the patient's mouth and removing the protective sheath from the thermometer.</p> <p>After removing the thermometer from the patient's mouth without wearing gloves, the employee obtained a blood pressure cuff from her nursing bag. The employee failed to clean the stethoscope after assessing the patient's back and chest prior to replacing it into her nursing bag. The employee's nursing bag did not have a specific area for clean supplies nor a specific area for her used, dirty supplies.</p> <p>4. A home visit was made to patient number 4 on 11-19-13 at 1:25 PM with employee I, a home health aide. The aide was observed to wash the patient's face, hair, back, chest, legs, and feet. The aide then changed her gloves without cleansing her hands. The aide assisted the patient to stand and washed the front perineal area. The aide changed her gloves without cleansing her hands. The aide washed the patient's buttocks and rectal area. The aide changed her gloves without cleansing her hands and assisted</p>			

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	<p>the patient to dry and applied lotion to the patient's arms and legs.</p> <p>5. A home visit was made to patient number 9 on 11-20-13 at 11:30 AM with employee G, an RN. The RN place her nursing bag on a chair without a barrier. The RN was observed to remove a thermometer from the patient's mouth and remove the protective sheath from the thermometer for disposal without wearing gloves.</p> <p>A. Observation noted a wound vacuum connected to a wound on the patient's right inner groin. The RN was observed to change the canister that held the drainage from the wound without wearing gloves. The RN then then removed a new canister from its package and applied the new canister. The RN opened a package of gauze, soaked it with normal saline and then cleansed her hands.</p> <p>B. After cleansing her hands and donning clean gloves, the RN disposed of the dirty canister that was observed to have drainage from the wound. The RN then removed the old dressing from the wound and changed her gloves without cleansing her hands. The RN probed the wound with a long cotton swab and removed the glove from her left hand.</p>			

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	<p>The RN held a flashlight in her left hand that had been retrieved from the patient's home by the patient's spouse. The RN then donned a clean glove to the left hand without cleansing her hands.</p> <p>C. The RN then cleansed the wound with the normal saline soaked gauze and removed her gloves and cleansed her hands. The RN then opened the wound vac dressing black foam and tubing obtained from a supply in the patient's home. The RN then donned clean gloves without cleansing her hands. After applying the black foam, tubing, and drape to the wound, the RN removed her gloves and, without cleansing her hands, touched the machine to turn it on. The RN then applied more pieces of the drape to the wound dressing.</p> <p>6. A home visit was made to patient number 10 on 11-20-13 at 10:05 AM with employee H, an RN. The RN was observed to place her nursing bag on the patient's couch without a barrier. The RN cleansed her hands and donned clean gloves. She removed the old dressing to the wound on the patient's left foot and removed her gloves. Without cleansing her hands, the RN obtained 2 washcloths from the patient's bathroom and then donned clean gloves. The RN applied soap and water to the washcloths and</p>			

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	<p>washed and dried the wound. The RN then measured the wound and without changing her gloves or cleansing her hands, obtained the prescribed topical medication and a Band-Aid from the patient's supply. The RN applied the medication and Band-Aid to the wound, reapplied the patient's sock and replaced the medication into its package.</p> <p>After replacing the medication into the package, and without changing her gloves or cleansing her hands, the RN then removed the sock from the patient's right foot and touched the right foot to examine. The RN replaced the patient's sock on the right foot, turned the sock on the left foot inside out, gathered the trash and placed the used washcloths in the patient's bathroom. The RN then removed her gloves and cleansed her hands.</p> <p>7. The above-stated observations were discussed with the supervising nurse, employee K, and the branch manager, employee L, on 11-20-13 at 1:10 PM. The employees indicated the employees had not followed standard precautions and the agency's infection control procedures.</p>			

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N000488	<p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on clinical record review and interview, the agency failed to ensure it had implemented its own discharge policy in 1 (# 12) of 1 closed records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p>	N000488	Operations Managers will re-educate staff to provide a notice of discharge of service to the patient, patient's legal representative, or other individual responsible for the patient's care at least (5) calendar days before the services are stopped - according to state regulations and VNA Plus policies and	12/21/2013			

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	<p>1. The agency's undated "Discharge Policy" states, "The patient is to be notified in writing at least five (5) calendar days in advance of the date of termination unless an exception to this practice is approved by the Executive Director."</p> <p>2. Clinical record number 12 evidenced the patient had been discharged from the agency on 10-29-13. The record failed to evidence the patient had been provided with a 5 day notice of discharge from the agency.</p> <p>2. The supervising nurse, employee K, indicated, on 11-21-13 at 8:35 AM, the record did not evidence the patient had been provided with a 5 day notice of discharge from the agency. The supervising nurse indicated no exceptions had been noted.</p>		<p>procedures. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that the notice of discharge is provided to the patient, patient's legal representative or other individual responsible for the patient's care according to state regulations and VNA Plus policies and procedures. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N000522	<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 clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 5 included a plan of care established by the physician for the certification period 10-9-13 to 12-7-13. The plan of care identifies the skilled nurse (SN) is to provide a visit 1 time every 2 weeks and that the SN is to obtain the patient's weight every SN visit. <ul style="list-style-type: none"> <li>A. The record evidenced a SN visit had been provided on 10-21-13. The record failed to include an order for the 10-21-13 SN visit.</li> <li>B. SN visit notes, dated 10-21-13, 10-24-13, and 11-4-13, failed to evidence the SN had obtained the patient's weight.</li> </ul> </li> <li>The supervising nurse, employee K,</li> </ol>	N000522	The Operations Managers will re-educate the Agency staff that the patient's care follows a written plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. Re-education will include the regulatory requirement that skilled nursing services must be provided in accordance with physician's orders. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that skilled services are provided in accordance with physician's orders. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013

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	<p>was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p> <p>3. The agency's March 2003 "Care Planning Policy" states, "Each patient is provided care as identified by an individualized care plan initiated upon admission and revised as the patient's needs change. All care plans are to be in accordance with the plan of treatment, as developed by the patient's physician."</p>			

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N000527	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse informed the physician of a change in the patient's condition in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 included a skilled nurse visit note dated 11-4-13 that states,"Patient is having an increased cough and is getting up a thick tan colored sputum. [The patient] has increased shortness of breath. [The patient's] lungs are course and diminished [sic]. [The patient] is on 3L of oxygen at all times. [The patient] has not been running a temp but is not felling [sic] well. Advised caregiver to have patient increase [the patient's] fluids and to have a humidify [sic] running at all times. Advised to call in [if] has increased temp or shortness of breath."</li> </ol> <p>The record failed to evidence the nurse</p>	N000527	The Operations Managers will re-educate the Agency staff to promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that staff are promptly alerting the appropriate person to any changes that suggest a need to alter the plan of care. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013

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	<p>had informed the physician of the patient's increased, productive cough and the increased shortness of breath.</p> <p>2. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p>			

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N000537	<p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services had been provided in accordance with physician orders in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Clinical record number 5 included a plan of care established by the physician for the certification period 10-9-13 to 12-7-13. The plan of care identifies the skilled nurse (SN) is to provide a visit 1 time every 2 weeks and that the SN is to obtain the patient's weight every SN visit. <ul style="list-style-type: none"> <li>A. The record evidenced a SN visit had been provided on 10-21-13. The record failed to include an order for the 10-21-13 SN visit.</li> <li>B. SN visit notes, dated 10-21-13, 10-24-13, and 11-4-13, failed to evidence the SN had obtained the patient's weight.</li> </ul> </li> <li>The supervising nurse, employee K,</li> </ol>	N000537	Operations Managers will re-educate the Agency staff that skilled nursing services are to be furnished in accordance with the plan of care. To keep this deficiency from recurring, the Operations Managers will initiate a review of a sample of patient records to ensure services are furnished in accordance with the plan of care. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013	

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	<p>was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p> <p>3. The agency's March 2003 "Care Planning Policy" states, "Each patient is provided care as identified by an individualized care plan initiated upon admission and revised as the patient's needs change. All care plans are to be in accordance with the plan of treatment, as developed by the patient's physician."</p>			

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N000543	<p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on clinical record review and interview, the agency failed to ensure the registered nurse (RN) initiated appropriate nursing interventions related to the patient's receipt of incenter dialysis treatments and the presence of a hemodialysis access in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. During a home visit to patient number 9, on 11-20-13 at 11:30 AM, the patient indicated the patient receives incenter dialysis treatments 3 times per week and has a fistula in the left arm.</li> <li>2. Clinical record number 9 included an initial assessment completed by the registered nurse (RN), employee N, on 11-10-13. The assessment failed to identify that the patient received incenter dialysis treatments 3 times per week and has a fistula in the left arm. The record failed to evidence the RN had initiated</li> </ol>	N000543	<p>Operations Managers will re-educate the Agency nursing staff that the registered nurse initiates appropriate preventative and rehabilitative nursing procedures. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that the RN initiates appropriate preventative and rehabilitative nursing procedures. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	12/21/2013			

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	<p>appropriate nursing interventions related to the patient's receipt of incenter hemodialysis treatment 3 times per week and the presence of a fistula in the patient's left arm.</p> <p>3. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p>			

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N000546	<p>410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.</p> <p>Based on clinical record review and interview, the agency failed to ensure the registered nurse informed the physician of a change in the patient's condition in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a skilled nurse visit note dated 11-4-13 that states, "Patient is having an increased cough and is getting up a thick tan colored sputum. [The patient] has increased shortness of breath. [The patient's] lungs are course and dimminished [sic]. [The patient] is on 3L of oxygen at all times. [The patient] has not been running a temp but is not felling [sic] well. Advised caregiver to have patient increase [the patient's] fluids and to have a humidify [sic] running at all</p>	N000546	The Operations Managers will re-educate staff about requirements for preparation of clinical and progress notes, coordination of services and informing the physician and other personnel of changes in the patient's condition and needs. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that clinical documentation indicates coordination of services and communication to the physician and other personnel of changes in the patient's condition and needs. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013			

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NAME OF PROVIDER OR SUPPLIER  VISITING NURSE ASSOCIATION OF SOUTHWESTERN INDIAN	STREET ADDRESS, CITY, STATE, ZIP CODE 610 E WALNUT ST PO BOX 3487 EVANSVILLE, IN 47734
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>times. Advised to call in [if] has increased temp or shortness of breath."</p> <p>The record failed to evidence the nurse had informed the physician of the patient's increased, productive cough and the increased shortness of breath.</p> <p>2. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when asked on 11-21-13 at 11:30 AM.</p>			

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) completed supervisory visits every 2 weeks in 1(#5) of 3 records reviewed of patients that received home health aide and skilled services creating the potential to affect all of the agency's 23 current patients that receive home health aide and skilled services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 5 evidenced home health aide services had been provided 2 times per week during the certification period 10-9-13 to 12-7-13. The record evidenced supervisory visits had been completed on 9-23-13 and not again until 10-24-13. No further supervisory visits were documented after 10-24-13.</li> <li>2. The supervising nurse, employee K, was unable to provide any additional documentation and/or information when</li> </ol>	N000606	The Operations Managers will re-educate RN staff that an on-site supervisory visit must be made to the patient's home no less frequently than every 2 weeks. To keep this deficiency from recurring, Operations Managers will initiate a review of a sample of patient records to ensure that these supervisory visits are made no less frequently than every 2 weeks. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	12/21/2013			

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	asked on 11-21-13 at 11:30 AM.  3. The agency's undated "Supervision" policy states, "Skilled Care - Case Managers make the initial evaluation visit to the patient's residence and make a re-evaluation visit at least every 14 days to assess relationships and determine whether goals are being met."			

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N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current 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. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (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. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure records of patients that had been discharged from the agency included a discharge summary in 1 (# 12) of 1 closed record reviewed creating the potential to affect all of the agency's 179 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 12 evidenced the patient had been discharged from the agency on 10-29-13. The record failed to evidence a discharge summary.</p>	N000608	Operations Managers and the Health Information Manager will re-educate Agency staff that the attending physician must be informed of the availability of a discharge summary. This re-education will include that the discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. To keep this deficiency from recurring, Operations Managers and the Health Information Manager will initiate a review of a sample of patient records to ensure that the attending physician is informed of the availability of the discharge summary; that summaries are	12/21/2013			

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	2. The supervising nurse, employee K, indicated, on 11-21-13 at 8:35 AM, the record did not evidence a discharge summary.		sent to the physician upon request and that the summaries contain the patient's medical and health status at discharge. The Executive Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		