

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157141	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/22/2013
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NAME OF PROVIDER OR SUPPLIER KING'S DAUGHTERS' HOSPITAL HOME CARE SERVICES, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2670 MICHIGAN RD MADISON, IN 47250
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G000000	<p>This was a federal home health recertification survey. This was a partial extended survey.</p> <p>Survey dates: 11/18/13 - 11/22/13</p> <p>Facility #: IN005318</p> <p>Medicaid #: 200010440A</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Census service type: 402 skilled unduplicated patients in past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 27, 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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G000101	<p>484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p> <p>Based on home visit observation, clinical record review, interview, and review of agency documents, the agency failed to protect the right of dignity and personal privacy for 1 of 1 home visit observations (patient #4) with a home health aide with the potential to affect all the patients receiving care from Employee I.</p> <p>Findings</p> <ol style="list-style-type: none"> On 11/20/13 at 10:30 AM, Employee I, Home health Aide, was observed to give a bed bath to patient #4. While Employee I washed the patient's genital area, the patient was not draped for privacy. The patient indicated being cold during the bath. Clinical record #4, start of care 9/6/13, contained a document titled "Treatment and financial authorizations, assignments, acknowledgements" signed by the patient's caregiver on 9/6/13 evidenced the patient had received and had the the patient rights explained. The agency document titled "You [the patient] have the right" with no date 	G000101	<p>On 12/3/13, all deficiencies were reviewed and discussed with all Home Health staff. On 12/4/13, the DON made a supervisory visit with Employee I, Home Health aide. DON observed and instructed on maintaining patient privacy during personal care. DON will perform similar supervisory visits with other two Home Health aides prior to 12/25/13. Also on 12/4/13, the Administrator provided written education on Privacy & Dignity to all Home Health aides with a written test to be completed by 12/10/13. The DON or ADON will make quarterly supervisory visits for one year with the Home Health aides to monitor compliance with privacy. Additional education will be provided as needed to the Aides based on observation of practice.</p>	12/10/2013			

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	<p>stated, "You [the patient] have the right ... to personal privacy."</p> <p>4. The agency document titled "Patient Rights and Responsibilities" with no effective date stated, "As a patient of King's Daughters Home Care & Hospice Services, you have the specific rights and responsibilities ... They include ... the right ... to be treated with dignity."</p> <p>4. On 11/21/13 at 2:40 PM, the director of nursing indicated the patient's personal privacy and dignity is part of the patient's rights.</p>			

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G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on agency document review, home visit observation, interview, clinical record review, and policy and procedure review, the agency failed to ensure all employees (Employee G and H) followed agency policies related to infection control at 3 of 6 home visit observations (patient #1, #2, #3) and patients were entered on the infection control log when they acquired an infection as required by agency policy in 2 of 12 records reviewed (#1, #8) resulting in the potential to spread infectious diseases to other patients, family, and staff.</p> <p>Findings</p> <p>Regarding infection control policies</p> <p>1. On 11/19/13 at 9:55 AM, Employee H, Registered Nurse (RN) was observed to wash hands and then don gloves to assess the upper leg area of patient #1, who had a wound on the inner thigh. Employee H removed the dressing and removed gloves and discarded the gloves and dressing and did not wash her hands. Employee H</p>	G000121	<p>On 11/21/13, the Administrator discussed proper Infection Control procedures specific to wound care and hand hygiene with all RN's and OT including Employees G, H and O. On 12/3/13, the Administrator discussed and reviewed all deficiencies with all Home Care Staff. On 12/4/13, the DON made a Home Health Aide supervisory visit to monitor Infection Control practice during the provision of personal care. She also instructed the Aide on Infection Control at this time. The DON will make similar visits with the other two Home Health Aides to monitor Infection Control practice prior to 12/25/13. On 12/5/13, the Infection Prevention RN for the organization provided mandatory Infection Control inservice training to clinical staff on hand hygiene; aseptic technique; specific IC issues encountered in the home setting; and IC specific to wound care. All RN's, Aides and Therapy staff completed this training. The DON or ADON will perform aide supervisory visits quarterly for one year to monitor Infection Control compliance. The DON or ADON will perform</p>	12/05/2013			

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	<p>touched the supplies for the wound vac dressing change and placed these supplies on the patient's bed without a barrier under these supplies. The patient's bed was soiled. She donned gloves. She measured the wound and cleansed the wound with normal saline and then opened the sterile packages and placed these supplies by the patient's leg on the bed. She then changed the canister of the wound vac device and discarded the canister filled with wound drainage. She removed gloves and washed hands and proceeded to apply the wound vac dressing including black foam and adhesive covering. After completing the wound vac procedure, she turned the wound vac on and removed her gloves and discarded the outer packaging of the wound vac dressing supplies that had been on the soiled bedding. She did not wash her hands. She then picked up a sterile 4 by 4 gauze package and normal saline squirt and washed the patient's other wound: a great toe amputation wound before applying the dressing and silk tape.</p> <p>On 11/19/13 at 2:15 PM, Employee D, RN, indicated infection control was not followed at the above visit.</p> <p>2. On 11/19/13 at 1:20 PM, Employee G, RN, was observed to measure a wound on</p>		<p>random visits 2 times per month for 6 months to monitor IC compliance by Therapy staff and RN staff. Additional education will be provided as needed to staff based on observation of practice. Employee D, RN will add to her daily chart audits to check the Infection Control log when she notes documentation of a newly ordered antibiotic. This will be to ensure a corresponding infection is logged if and as necessary. The DON will remind RN's weekly for one month to complete the Infection Control log. This reminder will then change to monthly and will be ongoing. The Infection Control log will be placed in a visible location in nursing documentation office area.</p>		

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	<p>patient #2's buttock area with gloved hands and a measuring stick. She then discarded the stick and removed her gloves and did not wash hands. She then opened the wound vac kit.</p> <p>On 11/19/13 at 2:25 PM, the director of nursing indicated infection control was not followed at the above visit.</p> <p>3. On 11/20/13 at 9:10 AM, Employee O, Occupational Therapist, was observed to apply neosporin ointment to patient #3's surgical incision on the left hand. Employee O squeezed the tube of medication and applied a strip of medication onto a sterile gauze pad and then applied this dressing to the patient's wound.</p> <p>On 11/20/13 at 3:45 PM, the director of nursing indicated the neosporin was applied without a tongue depressor.</p> <p>4. The agency policy titled "Hand hygiene - recommendations" with an effective date of 11/02 and reviewed / revised date of 2/13 stated, "Indications for handwashing and hand antisepsis ... If hands are not visibly soiled use an alcohol - based hand rub for routinely decontaminating hands in all other clinical conditions listed below ... before clean / aseptic procedure 3. after body</p>				

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	<p>fluid exposure risk and removing gloves 4. after touching a patient 5. after touching patient surroundings."</p> <p>5. The agency policy titled "Asepsis" with an effective date of 9/02 and reviewed / revised dated 2/13 stated, "Illness caused by microorganisms can be prevented by interrupting the transmission of microorganisms from reservoir to susceptible host."</p> <p>6. The agency procedure titled "Medication administration" with an effective date of 7/78 and revised / reviewed date of 3/04 stated, "Apply the ointment with long, smooth strokes that follow the direction of hair growth ... use a tongue depressor each time you remove additional ointment from the container to prevent contamination."</p> <p>Regarding the infection surveillance log</p> <p>7. Clinical record #1, start of care 10/16/13, included a plan of care for the certification period from 10/16/13 - 12/14/13 and a medication profile which evidenced the patient had started keflex on 11/14/13 for treatment of an infection. This was evidenced by the following: a. A clinical document titled "Medication Profile" with a date of</p>			

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	<p>11/18/13 evidenced the patient had started the antibiotic, Keflex, on 11/14/13 for treatment of infection.</p> <p>b. A agency document titled "Infection log patient" with a date of 2012 documented infections from 11/17/11 - 10/25/13. This log failed to evidence patient #1 had an order for keflex.</p> <p>c. On 11/20/13 at 4 PM, the director of nursing indicated the infection control log failed to document clinical record #1's use of keflex.</p> <p>8. Clinical record #8, SOC 6/18/13, included a plan of care for the certification period from 6/18/13 - 8/16/13 and a skilled nurse visit document on 6/28/13 by Employee H which evidenced the patient had started diflucan for treatment of an infection. This infection was not entered into the infection surveillance log.</p> <p>On 11/21/13 at 3:35 PM, the director of nursing indicated the patient #8's infection was not documented in the infection control log.</p> <p>9. The agency policy titled "Infection Prevention Log" with a date of 9/13 stated, "The home care staff maintain an infection control log of patient acquired infections. The infections are to be documented as they occur and / or are</p>			

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	discovered."			

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G000131	<p>484.14(b) GOVERNING BODY The governing body adopts and periodically reviews written bylaws or an acceptable equivalent.</p> <p>Based on document review and interview, the agency failed to ensure the governing body had reviewed the bylaws for 1 of 1 agency with the potential to affect all the agency's 75 active patients.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. A review of agency documents failed to evidence the bylaws had been approved by the governing body. 2. On 11/22/23 at 10:45 AM, the administrator indicated the bylaws had not been approved by the governing body in 2012 or 2013. 	G000131	On 12/3/13, all deficiencies were discussed and reviewed with all Home Health staff. On 12/4/13, after consulting with the VP of Patient Services, the Administrator revised the agency policy on Program Evaluation to include approval of the bylaws by the King's Daughters' Health Board of Managers/Governing Body on an annual basis. The Administrator will monitor that this approval is completed annually.	12/05/2013	

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G000159	<p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Plan of Care included all Durable Medical Equipment used by patients for 1 of 12 records reviewed (#10) with the potential to affect all the agency's 75 active patients.</p> <p>Findings</p> <p>1. Clinical record #10, start of care 11/4/13, contained a plan of care for the certification period 11/4/13 - 1/2/14 that failed to list all of the durable medical equipment for this patient This was evidenced by the following:</p> <p>a. A clinical record document titled "Occupational Therapy Evaluation Visit Note" with a date of 11/6/13 and signature of Employee O, occupational therapist, stated, "Patient has shower</p>	G000159	On 11/22/13, the DON discussed the then potential deficiency with the Admitting Physical Therapist and the Occupational Therapist, Employee O. The DON added the need to check and verify DME on Therapy patients to her Plan of Care checklist. She also instructed Employee O to consult with the Admitting PT after every OT evaluation to advise the PT on any DME for the patient. The DON will keep this item on her checklist long term to verify proper DME documentation on the Plan of Care. Additional education will be provided as needed to the Therapists based on results of chart audits.	12/05/2013			

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	<p>chair, rolling walker, reacher, sock aid, cane."</p> <p>b. The plan of care for the certification period 11/4/13 - 1/2/14 listed rolator walker under durable medical equipment and supplies. No other equipment was listed.</p> <p>b. On 11/21/13 at 10:47 AM, the director of nursing indicated the plan of care did not list any of patient #10's durable medical equipment.</p> <p>2. The agency policy titled "Care Planning" with an effective date of 12/89 and reviewed / revised date of 10/13 stated, "The medical plan of care is developed in consultation with the agency staff and includes the following ... types of services and equipment required."</p>				

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G000337	<p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>Based on interview, clinical record review, and policy review, the agency failed to ensure the medication profile included all the patient's medications for 1 of 12 records (6) reviewed with the potential to affect all the agency patients.</p> <p>Findings include:</p> <p>1. Clinical record #6, start of care 5/8/13, failed to evidence a medication profile had been updated with a complete list of the patient's current medications. This was evidenced by the following:</p> <p style="padding-left: 40px;">a. A clinical record document titled "Medical history ... Current medications 10/2/13" was identified as a list that the patient has prepared and is given to the agency staff. This list identified that the patient was on Phenergan 25 mg 1 - 2 tablets for nausea and Voltaren tablets 75 milligrams 1 - 2 times a day.</p> <p style="padding-left: 40px;">b. A clinical document titled</p>	G000337	<p>On 12/3/13, the Administrator discussed and reviewed all deficiencies with all Home Health staff. On 12/5/13 at a mandatory meeting, the Administrator and DON reviewed with all RN's the agency policy on patient medications and the patient medication profile. The DON will check all patient new admissions and patient recertifications to verify all medications are accurately documented. The ADON will monitor patient resumptions of care to verify all medications are accurately documented. These will be added to a checklist. Employee D, RN will add to her daily chart audit checklist to verify medications are accurately documented. The DON or ADON will perform random patient visits 2 times per month for 6 months on RN and Therapy visits to verify accuracy of medication documentation. Further education to RN and Therapy staff will be provided as necessary based on results of audits.</p>	12/05/2013			

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	<p>"Medication Profile for 11/4/13 failed to evidence Phenergan or Voltaren were listed on the medication profile.</p> <p>c. A clinical record document titled "Medication Profile for 11/19/13" failed to evidence Phenergan or Voltaren on the medication profile.</p> <p>d. On 11/21/13 at 10:28 AM, the director of nursing indicated the medications in the above findings were not on the medication profile.</p> <p>2. The agency policy titled "Patient Assessment" with an effective date of 3/91 and a reviewed / revised date of 11/13 stated, "The initial assessment for home health services included the following ... all medications ... Medication assessment ... at the time of the comprehensive assessment, the RN will review all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects ... Meditech Home Care performs a drug regimen review each time the clinician is in that patient's chart. This is completed upon finishing their task."</p>						

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N000000	<p>This visit was for a home health state licensure survey.</p> <p>Survey dates: 11/18/13 - 11/22/13</p> <p>Facility #: IN005318</p> <p>Medicaid #: 200010440A</p> <p>Surveyor: Ingrid Miller, RN, PHNS</p> <p>Census service type: 402 skilled unduplicated patients in past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 27, 2013</p>	N000000			

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N000442	<p>410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency.</p> <p>Based on document review and interview, the agency failed to ensure the governing body had reviewed the bylaws for 1 of 1 agency with the potential to affect all the agency's 75 patients.</p> <p>Findings</p> <p>1. A review of agency documents failed to evidence the bylaws had been approved by the governing body.</p> <p>2. On 11/22/23 at 10:45 AM, the administrator indicated the bylaws had not been approved by the governing body in 2012 or 2013.</p>	N000442	On 12/3/13, all deficiencies were discussed and reviewed with all Home Health staff. On 12/4/13, after consulting with the Vice President of Patient Services, the Administrator revised the agency policy on Program Evaluation to include approval of the bylaws by the King's Daughters' Health Board of Managers/Governing Body on an annual basis. The Administrator will monitor that this approval is completed annually.	12/05/2013	

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N000458	<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.</p> <p>Based on personnel file and interview, the agency failed to ensure a limited criminal history was applied for within 3 business days of first patient contact for 1 of 18 files reviewed (file H) of employees that required a limited criminal history with the potential to affect all the 75 active patients of the agency.</p> <p>Findings</p> <p>1. Personnel file H, date of hire 11/7/11 and first patient contact 11/10/11, failed to evidence a limited criminal history had been obtained.</p> <p>2. On 11/21/13 at 4 PM, the</p>	N000458	On 11/20/13, Human Resources completed the limited criminal history on Employee H, RN. The Administrator and Vice President of Patient Services discussed the potential deficiency with the Director of Human Resources. On 12/3/13, the Administrator reviewed the deficiency with the HR Director and with all Home Health staff. The HR Director revised the new employee hire checklist to verify the criminal history is completed prior to any new employee attending the first day of orientation. The HR Director also implemented a required 2nd check by the Human Resources Chief Specialist to verify all items on the new employee hire checklist are completed prior to employment.	12/04/2013			

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	administrator indicated the limited criminal history was not in Employee H's file.		This includes the criminal history check and will be ongoing.		

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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 agency document review, home visit observation, interview, clinical record review, and policy and procedure review, the agency failed to ensure all employees (Employee G and H) followed agency policies related to infection control at 3 of 6 home visit observations (patient #1, #2, #3) resulting in the potential to spread infectious diseases to other patients, family, and staff.</p> <p>Findings</p> <p>1. On 11/19/13 at 9:55 AM, Employee H, Registered Nurse (RN) was observed to wash hands and then don gloves to assess the upper leg area of patient #1, who had a wound on the inner thigh. Employee H removed the dressing and removed gloves and discarded the gloves and dressing and did not wash her hands. Employee H touched the supplies for the wound vac dressing change and placed these supplies on the patient's bed without a barrier under these supplies. The patient's bed was soiled. She donned gloves. She measured the wound and cleansed the</p>	N000470	<p>On 11/21/13, the Administrator discussed proper Infection Control procedures specific to wound care and hand hygiene with all RN's and OT including Employees G, H and O. On 12/3/13, the Administrator discussed and reviewed all deficiencies with all Home Care Staff. On 12/4/13, the DON made a Home Health Aide supervisory visit to monitor Infection Control practice during the provision of personal care. She also instructed on Infection Control at this time. The DON will make similar visits with the other two Home Health Aides to monitor Infection Control practice prior to 12/25/13. On 12/5/13, the Infection Prevention RN for the organization provided mandatory Infection Control inservice training to clinical staff on hand hygiene; aseptic technique; specific IC issues encountered in the home setting; and IC specific to wound care. All RN's, Aides and Therapy staff completed this training. The DON or ADON will perform aide supervisory visits quarterly for one year to monitor Infection Control compliance.</p>	12/05/2013			

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	<p>wound with normal saline and then opened the sterile packages and placed these supplies by the patient's leg on the bed. She then changed the canister of the wound vac device and discarded the canister filled with wound drainage. She removed gloves and washed hands and proceeded to apply the wound vac dressing including black foam and adhesive covering. After completing the wound vac procedure, she turned the wound vac on and removed her gloves and discarded the outer packaging of the wound vac dressing supplies that had been on the soiled bedding. She did not wash her hands. She then picked up a sterile 4 by 4 gauze package and normal saline squirt and washed the patient's other wound: a great toe amputation wound before applying the dressing and silk tape.</p> <p>On 11/19/13 at 2:15 PM, Employee D, RN, indicated infection control was not followed at the above visit.</p> <p>2. On 11/19/13 at 1:20 PM, Employee G, RN, was observed to measure a wound on patient #2's buttock area with gloved hands and a measuring stick. She then discarded the stick and removed her gloves and did not wash hands. She then opened the wound vac kit.</p>		<p>The DON or ADON will perform random visits 2 times per month for 6 months to monitor IC compliance by Therapy staff and RN staff. Additional education will be provided as needed to staff based on observation of practice. Employee D, RN will add to her daily chart audits to check the Infection Control log when she notes documentation of a newly ordered antibiotic. This will be to ensure a corresponding infection is logged if and as necessary. The DON will remind RN's weekly for one month to complete the Infection Control log. This reminder will then change to monthly and will be ongoing. The Infection Control log will be placed in a visible location in nursing documentation office area.</p>		

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	<p>On 11/19/13 at 2:25 PM, the director of nursing indicated infection control was not followed at the above visit.</p> <p>3. On 11/20/13 at 9:10 AM, Employee O, Occupational Therapist, was observed to apply neosporin ointment to patient #3's surgical incision on the left hand. Employee O squeezed the tube of medication and applied a strip of medication onto a sterile gauze pad and then applied this dressing to the patient's wound.</p> <p>On 11/20/13 at 3:45 PM, the director of nursing indicated the neosporin was applied without a tongue depressor.</p> <p>4. The agency policy titled "Hand hygiene - recommendations" with an effective date of 11/02 and reviewed / revised date of 2/13 stated, "Indications for handwashing and hand antiseptis ... If hands are not visibly soiled use an alcohol - based hand rub for routinely decontaminating hands in all other clinical conditions listed below ... before clean / aseptic procedure 3. after body fluid exposure risk and removing gloves 4. after touching a patient 5. after touching patient surroundings."</p> <p>5. The agency policy titled "Asepsis" with an effective date of 9/02 and</p>						

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	<p>reviewed / revised dated 2/13 stated, "Illness caused by microorganisms can be prevented by interrupting the transmission of microorganisms from reservoir to susceptible host."</p> <p>6. The agency procedure titled "Medication administration" with an effective date of 7/78 and revised / reviewed date of 3/04 stated, "Apply the ointment with long, smooth strokes that follow the direction of hair growth ... use a tongue depressor each time you remove additional ointment from the container to prevent contamination."</p>				

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N000494	<p>410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.</p> <p>Based on home visit observation, clinical record review, interview, and review of agency documents, the agency failed to protect the right of dignity and personal privacy for 1 of 1 home visit observations (patient #4) with a home health aide with the potential to affect all the patients receiving care from Employee I.</p> <p>Findings</p> <p>1. On 11/20/13 at 10:30 AM, Employee I, Home health Aide, was observed to give a bed bath to patient #4. While Employee I washed the patient's genital area, the patient was not draped for privacy. The patient indicated being cold during the bath.</p>	N000494	<p>On 12/3/13, all deficiencies were reviewed and discussed with all Home Health staff. On 12/4/13, the DON made a supervisory visit with Employee I, Home Health aide. The DON observed and instructed on maintaining patient privacy during personal care. The DON will perform similar supervisory visits with the other two Home Health aides prior to 12/25/13. Also on 12/4/13, the Administrator provided written education on Privacy & Dignity to all Home Health aides with a written test to be completed by 12/10/13. The DON or ADON will make quarterly supervisory visits for one year with Home Health aides to monitor compliance with privacy. Additional education will be provided as needed to the Aides based on observation of practice.</p>	12/10/2013			

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	<p>2. Clinical record #4, start of care 9/6/13, contained a document titled "Treatment and financial authorizations, assignments, acknowledgements" signed by the patient's caregiver on 9/6/13 evidenced the patient had received and had the the patient rights explained.</p> <p>3. The agency document titled "You [the patient] have the right" with no date stated, "You [the patient] have the right ... to personal privacy."</p> <p>4. The agency document titled "Patient Rights and Responsibilities" with no effective date stated, "As a patient of King's Daughters Home Care & Hospice Services, you have the specific rights and responsibilities ... They include ... the right ... to be treated with dignity."</p> <p>4. On 11/21/13 at 2:40 PM, the director of nursing indicated the patient's personal privacy and dignity is part of the patient's rights.</p>			

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: <ul style="list-style-type: none"> (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Plan of Care included all Durable Medical Equipment used by patients for 1 of 12 records reviewed (#10) with the potential to affect all the agency's 75 active patients.</p> <p>Findings</p> <p>1. Clinical record #10, start of care</p>	N000524	On 11/22/13, the DON discussed the then potential deficiency with the Admitting Physical Therapist and the Occupational Therapist, Employee O. The DON added the need to check and verify DME on Therapy patients to her Plan of Care checklist. She also instructed Employee O to consult with the Admitting PT after every OT evaluation to advise on any DME for the patient. The DON will keep this item on her checklist long term to verify proper DME documentation on	12/05/2013			

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	<p>11/4/13, contained a plan of care for the certification period 11/4/13 - 1/2/14 that failed to list all of the durable medical equipment for this patient This was evidenced by the following:</p> <p>a. A clinical record document titled "Occupational Therapy Evaluation Visit Note" with a date of 11/6/13 and signature of Employee O, occupational therapist, stated, "Patient has shower chair, rolling walker, reacher, sock aid, cane."</p> <p>b. The plan of care for the certification period 11/4/13 - 1/2/14 listed rolator walker under durable medical equipment and supplies. No other equipment was listed.</p> <p>b. On 11/21/13 at 10:47 AM, the director of nursing indicated the plan of care did not list any of patient #10's durable medical equipment.</p> <p>2. The agency policy titled "Care Planning" with an effective date of 12/89 and reviewed / revised date of 10/13 stated, "The medical plan of care is developed in consultation with the agency staff and includes the following ... types of services and equipment required."</p>		the Plan of Care. Additional education will be provided to the Therapists as needed based on results of chart audits.		

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