STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCROGGINS NURSING AND HOME SERVICES INC	8550 W CR 700 S COMMISKEY, IN 47227

(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
G000000	This was a Home Health Medicaid recertification survey. This was a partially extended survey. Survey dates: 10/29/13 - 11/1/13 Facility #: 10088 Medicaid #: 200081930A Surveyor: Ingrid Miller, RN, PHNS Census service type: Skilled nursing: 11 patients in last year Home Health Aide only patients: 11 patients in past year Personal Service only patients: 5 patients in past year Total: 27 patients in past year Quality Review: Joyce Elder, MSN, BSN, RN November 7, 2013	G000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, interview, and review of policy and procedure, the agency failed to ensure all employees followed agency policy and procedure related to infection control for 1 of 5 home visit observations (Employee A, Registered Nurse) resulting in the potential to spread infectious diseases to the other 12 skilled nurse patients, family, and staff. Findings 1. On 10/30/13 at 7:20 AM - 8:05 AM, Employee A, Registered Nurse, was observed at the bedside of patient #1. Employee A cleansed her hands, donned gloves, and removed a soiled dressing from a wound on the patient's left buttocks area. She discarded the dressing, washed hands, and donned new gloves. Then she cleansed the wound and discarded the used gloves and applied new gloves without washing hands. She then prepped the skin with skin prep, measured the wound, packed the wound with alginate rope, covered with alginate	G000121	Correction: existing agency policy on hand washing reviewed and updated which is attached and / or available upon request.Staff educated and provided a copy of the updated policy titled :hand washing".Verification of the staffs understanding /education on topic present in his / her personnel file indicated by their signature / date of inservice on hand washing. In addition the agency is in process of incorporating new infection control program / policies and procedures using BRIGGS Home Care Infection Control policies as a reference.The entire process of this incorporation will be completed by 12.31.2013 which includes presentation and approval by the board of directors as well as PAB. Prevention : quarterly agency will perform a home visit with 10% of active employees to observe their hand washing in accordance with the agency updated "Hand washing Policy".Agency personnel will have inservice related to new / updated infection control program / policy and procedures. Annual employee evaluations will include at least one home visit with specific attention to the employees infection control	12/02/2013

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	pad and gauze with abdominal pad, and covered with transparent dressing. She then took gloves off and put the supplies at the bedside away into the patient's supply drawer. She did not wash her hands at this time. She applied new gloves before administering an injection. Employee A took these gloves off and did not wash hands prior to putting the injection supplies away before administering the morning medications. 2. On 10/31/13 at 11 AM, the director of nursing indicated handwashing should occur after gloves are removed. 3. The agency policy titled "Handwashing" with no effective date stated, "Handwashing should be done by client care staff ... after removal of gloves."		measures.Responsible Person : Director of Nursing / Administrator .Updated “Hand Washing “ policy completed on 11.07.2013.Scheduled for policy / procedure to be reviewed at called BOD and PAB meetings scheduled for 12.02.2013 at 12:00 pm . Agency will incorporate the updated Infection Control Program with board of directors approval as well as Profession Advisory Board review / approval by 12.31.2013 . 30 day increments for the incorporation of Infection Control Program will begin on 12.02.2013 and end no later than 12.31.2013 by the board of directors / professional advisory board reviewing /approval of the new / updated Infection Control Program. HAND WASHING POLICY : SCROGGINS NURSING & HOME SERVICES, INC. POLICY & PROCEDURE MANUAL POLICY TOPIC : Hand Washing EFFECTIVE DATE: 11.07.2013 REVIEW DATE / UPDATED : POLICY: Direct client care staff will perform hand washing and / or use of hand sanitizer as deemed appropriate and available during client care visits. PROCEDURE: Hand washing will be performed when possible/ available with either antimicrobial /antibacterial liquid soap , rinsed then dried with disposable towels.At such time it is not convenient or possible to perform hand washing as stated in # 1,	

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			the direct client care staff will cleanse their hands with either liquid hand sanitizer or hand sanitizer wipes.At such time the direct client care staff uses hand sanitizer , he / she will perform hand washing with specific stated soap / water / disposable towels when available. Hand washing is encouraged upon entering the clients home or before entering their client care bag or supplies left in the home to provide care to the client.If hand washing with soap /water is not possible /available, the staff can use the hand sanitizer. Hand washing is encouraged after removing gloves however use of hand sanitizer either liquid /wipes is allowed. At the completion of client care visit the staff is encouraged to perform hand washing as stated in item # 1	

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G000141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. Based on personnel record review, policy review, and interview, the agency failed to ensure the personnel policies were followed in 3 of 13 personnel files reviewed (I, L, and M) with the potential to affect all the agency's patients. Findings 1. The agency policy titled "Personnel Requirements / Files" with no effective date stated, "Personnel records of employees who perform direct patient care will be kept current and will include documentation of the following ... signed job description specific to the employees' job title ... Employees who have direct patient contact will have a physical examination by a physician or nurse practitioner no more than 180 days before the date the employee has direct patient contact. The physical examination will be of sufficient scope to ensure that the employee will not spread infectious or communicable disease to patients." 2. Personnel file I, date of hire 2/1/13 and	G000141	1. Correction: Personnel Requirements/files policy was reviewed /updated on 11.07.2013. Employee I had job description give to him / her , reviewed and signed by employee and DON then placed in his / her personnel file on 11.07.2013. Employee L & M pre-employment physicals cannot be corrected prior to patient contact however, they were removed from staffing on 11.04.2013 with employee physical completed by MD and verified to be free of communicable disease. The 2 employees we reassigned for client care on 11.07.2013. 2. Prevention: quarterly agency will audit all new employee /new hires to verify they meet the employee requirements . 3. Director of Nursing / Administrator 4. Completion Date: 11.07.2013	11/07/2013

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	first patient contact 2/20/13, Registered Nurse, failed to evidence a signed job description. 3. Personnel file L, date of hire 4/16/13 and first patient contact 4/30/13, Licensed Practical Nurse, failed to evidence a pre-employment physical examination. 4. Personnel file M, date of hire 1/2/10 and first patient contact 1/23/10, home health aide, failed to evidence a pre-employment physical examination. 5. On 11/1/13 at 2:40 PM, the director of nursing indicated the above personnel files were not complete.			

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G000159	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. Based on agency policy review, clinical record review, and interview, the agency failed to ensure the plan of care included a timely physician signature, included accurate medications, and specified how medications were to be given for 5 of 10 records reviewed (clinical record #2, #3, #8, #9, and #10) with the potential to affect all the active patients of the agency. Findings 1. Clinical record #2, start of care (SOC) 1/28/13, included a plan of care with a certification period of 9/24/13 - 11/22/13 that failed to evidence a timely physician's signature and accurate medications. This was evidenced by the following: a. A clinical document titled	G000159	Correction: Agency reviewed /updated policy & procedure for MD signature to be “timely” within 30 days from the date of the MD order / Plan of Care .Clinical Record # 2 agency is unable to correct with the 30 day time frame lapsed prior to survey however, on 11.04.2013 the agency contacted the MD requesting he sign / return the signed POC.Agency received the POC signed on 11.07.2013.Clinical record # 2 inaccurate medications listed in item # 10 on the POC.Discussed with MD / nurse on 11.04.13 via phone with the corrections made in form of single order which was faxed to MD for signature and received signed on 11.07 .2013.Clinical record # 8 unable to correct with 30 day time frame lapsed prior to end of survey.Clinical record # 9 unable to correct with 30 day time frame lapsed prior to end of survey.Clinical record # 10 unable to correct as client was transferred to long term care	11/12/2013

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	"Certification and Plan of Treatment Home Health" with a certification period of 9/24/13 - 11/22/13 was not signed by the physician and included the medications Lexapro and Effexor. b. On 10/30/13 at 9:12 AM, Patient #2 indicated Lexapro and Effexor had been removed from his / her medication list several months ago. c. On 10/31/13 at 1:55 PM, the director of nursing indicated the physician had not signed the plan of care at this time. d. On 10/31/13 at 2:05 PM, the director of nursing indicated the patient medications Lexapro and Effexor had been discontinued and should not be included on the current plan of care. 2. On 10/30/13 at 11 AM, Employee J, RN, was observed to administer via patient #3's peg tube approximately 100 milliliters of cloudy water containing medications the caregiver mixed prior to administering. The medications were followed by a feeding of 275 milliliters of fibersource. This method of medication administration was not on the plan of care for the certification period 9/10/13 -11/8/13.		facility with discharge from agency on 10.04.13.Clinical record # 3 corrected on POC dated 11.09.2013to 01.07.2014 with MD order stating, all medications unless otherwise indicated are to be given by GT after being crushed / mixed with 50 to 100 ml water and given within 30 minutes of time dissolved.Prevention : agency has developed a form “Tracking MD order Signature” which has been assigned to an office personnel member.Each MD order to include plan of care, will be logged on this form the date of the order, which will include the date order sent either fax /mail.Weekly on Monday , the office staff member will review MD orders / POC to determine which do not have MD signature . Those that are not returned signed by MD on week # 2will be refaxed /re-sent to MD with a phone call to MD office requesting the order be signed and returned.Those orders /POC not signed on week # 3 will be hand delivered for signature at the time of delivery.Quarterly agency will audit 10% of active clients to determineis this tracking sheet is effective and insure that MD orders /POC are returned to the agency signed by the MD within 30 days from the date of the order. Responsible Person: Director of Nursing Completion Date: 11.12.2013	

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	3. Clinical record #8, SOC 9/2/13, included a plan of care for the certification period of 9/2/13 - 10/31/13 that failed to evidence a timely physician's signature. a. A clinical document titled "Certification and Plan of Treatment Home Health" with a certification period of 9/2/13 - 10/31/13 was signed by the physician on 10/23/13. b. On 11/1/13 at 9:55 AM, the director of nursing indicated the plan of care was not signed until 10/23/13. 4. Clinical record #9, SOC 4/13/13, included a plan of care for the certification period of 6/12/13 - 8/10/13 that failed to evidence a timely physician's signature. a. A clinical document titled "Certification and Plan of Treatment Home Health" with a certification period of 6/12/13 - 8/10/13 was signed by the physician on 7/30/13. b. On 11/1/13 at 1:40 PM, the director of nursing indicated the plan of care was not signed until 7/30/13. 5. Clinical record #10, SOC 10/30/12, included a plan of care for the			

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	certification period of 8/26/13 - 10/24/13 that failed to evidence a timely physician signatures. a. A clinical document titled "Certification and Plan of Treatment" with a certification period of 8/26/13 - 10/24/13 was not signed by the physician. b. On 11/1/13 at 2 PM, the director of nursing indicated the plan of care was not yet signed. 6. The agency policy titled "Completion of a Plan of Care /485" with no effective date stated, "27. The physician will sign the plan of care."			

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G000171	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit. Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit in 2 of 10 records reviewed (5 and 10) creating the potential to affect all of the agency's new patients. The findings include 1. Clinical record #5, start of care 10/30/12, failed to evidence an initial assessment had been completed. 2. Clinical record #10, start of care 3/27/12, failed to evidence an initial assessment had been completed. 3. On 11/1/13 at 2 PM, the director of nursing indicated the initial assessment had been completed but had been thinned from the record and was in storage. 4. The agency policy titled "Admission" and no effective date stated, "The registered nurse or physical therapist shall make the initial visit to the patient's residence completing a detailed physical assessment to determine the client's medical needs."	G000171	Correction: Clinical record 5 and10 initial assessments were located in storage after survey process was completed.The initial assessment / oasis start o fcare data sets were returned to the current clinical record for this client on 11.07.2013 Previous to survey process agency thinned charts back to the current POC and one prior to the current one.Agency has adopted policy indicating that the initial assessment / oasis data set for SOC , will remain in the active clinical record and not be included in the thinned chart process. Prevention : agency will not thin the clinical record to include the initial assessments /oasis data set SOC.Agency will audit all new admissions quarterly to assess and insure the initial assessments / SOC data collection set, remain in the current active clinical record. Responsible Person:Director of Nursing Completion Date:11.07.2013	11/07/2013

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G000236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Based on observation, clinical record review, policy review, and interview, the agency failed to ensure medications that were administered were documented in the medical record in 2 of 3 home visit observations with a registered nurse (#2 and 3) creating the potential to affect all 12 patients receiving skilled nurse services. Findings 1. Clinical record #2 included a plan of care established by the physician for the certification period of 9/24/13 - 11/22/13 that states, "Orders for discipline: SN (skilled nurse) 3 times a day - 7 days a week X 60 days ... to perform the following ... dispense and administer meds as ordered by MD at appropriate visit of am." The record failed to evidence which medications were administered or at what time the	G000236	Correction:agency has incorporated new policy titles " medication administration ".This policy outlines nursing staff administering medications during a home care visit / care, will document so on either the medication administration record or in the clinical note for the date of care.The documentation whether in MAR form or in clinical note must include : Name of each medicationDose of each medication Route of each medicationTime medication administeredNurses signature /initials indicating who administered the medication Policy was written on 11.07.2013 and will be presented /reviewed and approved at called board of directors meetins / PAB meetings on 12.02.2013. Prevention:agency will audit 10% of active clients quaerterly to determine clients with medication administration is given and recorded according to agency	11/25/2013

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	medications were given. a. On 10/30/13 at 9:10 AM, Employee I, Registered Nurse (RN), indicated giving Vitamin D 2000 IU (international units) po (by mouth) qd (every day), Ditropan XL 10 mg (milligrams) po q (every) day, 1 multi vitamin tab, and Macrobid 100 mg one po qd this am. She indicated she gave the medications without documenting which medications had been given. b. On 10/31/13 at 1:55 PM, the director of nursing indicated the medications were to be given as written on the plan of care. However, there was no medication administration log or other means to record that the medications had been given or which medications were given. c. Nursing visit documentation dated 10/19/13, 10/20/13, 10/21/13, 10/22/13, 10/23/13, 10/24/13, and 10/25/13, all from 8 AM - 10 AM, indicated the skilled nurse (SN) had given oral medications. There was no documentation which specific medications had been given. Instead each nurse visit stated, "PO Meds" with a check by it. d. On 10/31/13 at 1:55 PM, the		policy. Responsible Person:Director of Nursing / administrator Completion Date:11.25.2013	

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	director of nursing indicated the SN failed to document what medications were given in the am. 2. Clinical record #3 included a plan of care established by the physician for the certification period of 9/10/13 - 11/8/13 that failed to evidence what medications were to be given at 11 AM by the SN. The plan of care states, "Assess medication regimen [therapeutic effects and side effects]." On 10/30/13 at 11 AM, the SN gave medications mixed and dissolved in water by the caregiver at 8 AM. This method of medication administration was not on the plan of care. a. On 10/30/13 at 11 AM, Employee J, RN, was observed to administer via patient #3's peg tube approximately 100 milliliters of cloudy water containing medications that the caregiver mixed prior to administering. The medications were followed by a feeding of 275 milliliters of fibersource. b. On 10/30/13 at 11 AM, Employee J indicated the medications given in the cloudy water were Prilosec, Atenolol, Lisinopril, Claritin, and Lexapro that the caregiver had dissolved them in the water at 8 AM. However, Employee J had not seen the medications			

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	added to the water. There was no record of what medications had been placed in the water. 3. The agency policy titled "Medical Plan of Care" with no effective date stated, "Medical plan of care means written instructions signed by the physician ... for the provision of care to given by a registered or practical nurse to a patient in the patient's place of residence."			

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G000243	484.52 EVALUATION OF THE AGENCY'S PROGRAM The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. Based on agency policy and document review and interview, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency. Findings 1. Review of agency documents failed to evidence the agency had completed a Quality Assurance program. 2. On November 1, 2013, at 3 PM, the director of nursing indicated there was no completed quality assurance program for 2012 or 2013 and the program had not been maintained or evaluated annually. 3. The agency policy titled "Quality Assurance Program" with no effective date stated, "SNHS [Scroggins Nursing and Home Services] will have an ongoing Quality Assurance Program which will be the responsibility of the Administrator and / or Administrator of Nursing. The	G000243	Correction :unable to correct year 2012.On 11.12.13, agency staff had quarterly chart audit for period of July to September of 2013.Included was the independent audit of hospital admissions during this period of 2013.The audit paperwork is available upon request.Below / attached is the QA plan for 2014. SCROGGINS NURSING & HOME SERVICES, INC. QUALITY REVIEW PROGRAMYEAR 2014 (Below are the independent audit topics that will be performed in addition to the quarterly chart audits)Jan – March 2014 quarterly chart audit Specific Audit Topic : Pain and Pain Control April – June 2014 quarterly chart audit Specific Audit Topic : On-Call Response July – Sept. 2014 quarterly chart audit Specific Audit Topic: Medication Records compared to POC item # 10 Oct. - Dec. 2014 quarterly chart audit Specific Audit Topic: Pressure Ulcers / Treatment Prevention:administrator will	11/12/2013

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	Quality Assurance Program is designed to objectively and systematically monitoring and evaluate the quality and appropriateness of client care, resolve identified problems, and improve client care and agency operation. Procedure: 1. It will be the direct responsibility of the administrator to assure that Quality Assurance Program is in effect and active for the agency."		monitor quarterly the QA program which must be completed with a report and presented to the administrator by the end of the following months.April 30,2014 - - July 31, 2014 - - Oct. 31, 2014 - - Jan. 31, 2015 - - Responsible Person :administrator/Director of Nursing Date of Completion :11.12.2013	

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G000331	484.55(a)(1) INITIAL ASSESSMENT VISIT 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. Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit in 2 of 10 records reviewed (5 and 10) creating the potential to affect all of the agency's new patients. The findings include 1. Clinical record #5, start of care 10/30/12, failed to evidence an initial assessment had been completed. 2. Clinical record #10, start of care 3/27/12, failed to evidence an initial assessment had been completed. 3. On 11/1/13 at 2 PM, the director of nursing indicated the initial assessment had been completed but had been thinned from the record and was in storage. 4. The agency policy titled "Admission" and no effective date stated, "The registered nurse or physical therapist shall make the initial visit to the patient's residence completing a detailed physical	G000331	Correction:Clinical record 5 and10 initial assessments were located in storage after survey process was completed.The initial assessment / oasis start o fcare data sets were returned to the current clinical record for this client on 11.07.2013Previous to survey process agency thinned charts back to the current POC and one prior to the current one.Agency has adopted policy indicating that the initial assessment / oasis data set for SOC , will remain in the active clinical record and not be included in the thinned chart process. Prevention : agency will not thin the clinical record to include the initial assessments /oasis data set SOC.Agency will audit all new admissions quarterly to assess and insure the initial assessments / SOC data collection set, remain in the current active clinical record. Responsible Person:Director of Nursing Completion Date:11.07.2013	11/07/2013

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	assessment to determine the client's medical needs."			
N000000		N000000		
	This visit was for a home health state licensure survey. Facility #: 10088 Medicaid Vendor #: 200081930 Dates of Survey: 10/29/13 - 11/1/13 Unduplicated Admissions: 11 skilled, unduplicated patients in past year Surveyor: Ingrid Miller, RN, PHNS Quality Review: Joyce Elder, MSN, BSN, RN November 7, 2013			

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N000456	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. Based on agency policy and document review and interview, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency. Findings 1. Review of agency documents failed to evidence the agency had completed a Quality Assurance program. 2. On November 1, 2013, at 3 PM, the director of nursing indicated there was no completed quality assurance program for 2012 or 2013 and the program had not been maintained or evaluated annually. 3. The agency policy titled "Quality Assurance Program" with no effective date stated, "SNHS [Scroggins Nursing and Home Services] will have an ongoing Quality Assurance Program which will be	N000456	Correction :unable to correct year 2012.On 11.12.13, agency staff had quarterly chart audit for period of July to September of 2013.Included was the independent audit of hospital admissions during this period of 2013.The audit paperwork is available upon request.Below / attached is the QA plan for 2014. SCROGGINS NURSING & HOME SERVICES, INC. QUALITY REVIEW PROGRAM YEAR 2014 (Below are the independent audit topics that will be performed in addition to the quarterly chart audits)Jan – March 2014 quarterly chart audit Specific Audit Topic : Pain and Pain Control April – June 2014 quarterly chart audit Specific Audit Topic : On-Call Response July – Sept. 2014 quarterly chart audit Specific Audit Topic: Medication Records compared to POC item # 10 Oct. - Dec. 2014 quarterly chart audit Specific Audit Topic: Pressure Ulcers /	11/12/2013

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	the responsibility of the Administrator and / or Administrator of Nursing. The Quality Assurance Program is designed to objectively and systematically monitoring and evaluate the quality and appropriateness of client care, resolve identified problems, and improve client care and agency operation. Procedure: 1. It will be the direct responsibility of the administrator to assure that Quality Assurance Program is in effect and active for the agency."		Treatment Prevention:administrator will monitor quarterly the QA program which must be completed with a report and presented to the administrator by the end of the following months.April 30,2014 - - July 31, 2014 - - Oct. 31, 2014 - - Jan. 31, 2015 - - Responsible Person :administrator/Director of Nursing Date of Completion :11.12.2013	

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N000458	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on personnel record review, policy review, and interview, the agency failed to ensure the personnel file had a signed job description for 1 of 13 personnel files reviewed (I) with the potential to affect all the agency's patients. Findings 1. Personnel file I, date of hire 2/1/13 and first patient contact 2/20/13, Registered Nurse, failed to evidence a signed job description. 2. On 11/1/13 at 2:40 PM, the director of nursing indicated the above personnel file was not complete.	N000458	1. Correction : Employee I was given /reviewed her job description on11.07.2013 with him / her signing the job description with DON as witness. This signed job description was incorporated into this employees personnel file on 11.07.2013. 2. Prevention : quarterly agency will audit all new hire employees to verify their employee personnel files meet the requirements set forth in the regulation . 3. Responsible Person : Director of Nursing / Administrator 4. Date of Completion: 11.07.2013	11/07/2013

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	3. The agency policy titled "Personnel Requirements / Files" with no effective date stated, "Personnel records of employees who perform direct patient care will be kept current and will include documentation of the following ... signed job description specific to the employees' job title."			

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N000462	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on personnel record review, policy review, and interview, the agency failed to ensure employees with direct patient contact had a physical examination no more than 180 days before patient contact for 2 of 13 personnel files reviewed (L and M) with the potential to affect all the agency's patients. Findings 1. Personnel file L, date of hire 4/16/13 and first patient contact 4/30/13, Licensed Practical Nurse, failed to evidence a pre-employment physical examination. 2. Personnel file M, date of hire 1/2/10 and first patient contact 1/23/10, home health aide, failed to evidence a pre-employment physical examination. 3. On 11/1/13 at 2:40 PM, the director of	N000462	1. Correction : Employees L & M initial physical exam prior to first client contact cannot be corrected as the regulation requires. However, on 11.04.13 the 2 employees (L & M) were removed from client care and obtained a physical exam that rendered them free from communicable disease on 11.07.2013. The employees L & M were reassigned to client care on 11.08.2013. 2. Prevention : Quarterly agency will audit all new hired employees in that quarter to verify their employee personnel files have documentation as identified in the regulation completed. 3. Responsible Person : Director of Nursing / Administrator 4. Date of Completion 11.07.2013	11/07/2013

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	nursing indicated the above personnel files were not complete. 4. The agency policy titled "Personnel Requirements / Files" with no effective date stated, "Personnel records of employees who perform direct patient care will be kept current and will include documentation of the following ... Employees who have direct patient contact will have a physical examination by a physician or nurse practitioner no more than 180 days before the date the employee has direct patient contact. The physical examination will be of sufficient scope to ensure that the employee will not spread infectious or communicable disease to patients."			

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N000470	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. Based on observation, interview, and review of policy and procedure, the agency failed to ensure all employees followed agency policy and procedure related to infection control for 1 of 5 home visit observations (Employee A, Registered Nurse) resulting in the potential to spread infectious diseases to the other 12 skilled nurse patients, family, and staff. Findings 1. On 10/30/13 at 7:20 AM - 8:05 AM, Employee A, Registered Nurse, was observed at the bedside of patient #1. Employee A cleansed her hands, donned gloves, and removed a soiled dressing from a wound on the patient's left buttocks area. She discarded the dressing, washed hands, and donned new gloves. Then she cleansed the wound and discarded the used gloves and applied new gloves without washing hands. She then prepped the skin with skin prep, measured the wound, packed the wound with alginate rope, covered with alginate	N000470	Correction:existing agency policy on hand washing reviewed and updated which is attached and / or available upon request.Staff educated and provided a copy of the updated policy titled :hand washing".Verification of the staffs understanding /education on topic present in his / her personnel file indicated by their signature / date of inservice on hand washing. In addition the agency is in process of incorporating new infection control program / policies and procedures using BRIGGS Home Care Infection Control policies as a reference.The entire process of this incorporation will be completed by 12.31.2013 which includes presentation and approval by the board of directors as well as PAB. Prevention :quarterly agency will perform a home visit with 10% of active employees to observe their hand washing in accordance with the agency updated "Hand washing Policy".Agency personnel will have inservice related to new / updated infection control program / policy and procedures. Annual employee evaluations will include at least one home visit with specific attention to the	12/02/2013

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	pad and gauze with abdominal pad, and covered with transparent dressing. She then took gloves off and put the supplies at the bedside away into the patient's supply drawer. She did not wash her hands at this time. She applied new gloves before administering an injection. Employee A took these gloves off and did not wash hands prior to putting the injection supplies away before administering the morning medications. 2. On 10/31/13 at 11 AM, the director of nursing indicated handwashing should occur after gloves are removed. 3. The agency policy titled "Handwashing" with no effective date stated, "Handwashing should be done by client care staff ... after removal of gloves."		employees infection control measures.Responsible Person :Director of Nursing / Administrator .Updated “Hand Washing “ policy completed on 11.07.2013.Scheduled for policy / procedure to be reviewed at called BOD and PAB meetings scheduled for 12.02.2013 at 12:00 pm. Agency will incorporate the updated /new Infection Control Program with board of directors approval as well as professional advisory board review / approval by 12.31.2013. 30 day increments for the incorporation of Infection Control Program will begin on 12.02.13 and end no later than 12.31.2013 by the board of director /professional advisory board reviewing / approving the new / updated Infection Control Program	

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N000472	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on agency policy and document review and interview, the agency failed to have a quality assessment and performance improvement program for 1 of 1 agency with the potential to affect all the patients of the agency. Findings 1. Review of agency documents failed to evidence the agency had completed a Quality Assurance program. 2. On November 1, 2013, at 3 PM, the director of nursing indicated there was no completed quality assurance program for 2012 or 2013 and the program had not been maintained or evaluated annually. 3. The agency policy titled "Quality Assurance Program" with no effective	N000472	Correction :unable to correct year 2012.On 11.12.13, agency staff had quarterly chart audit for period of July to September of 2013.Included was the independent audit of hospital admissions during this period of 2013.The audit paperwork is available upon request.Below / attached is the QA plan for 2014. SCROGGINS NURSING & HOME SERVICES, INC. QUALITY REVIEW PROGRAM YEAR 2014 (Below are the independent audit topics that will be performed in addition to the quarterly chart audits)Jan – March 2014 quarterly chart audit Specific Audit Topic : Pain and Pain Control April – June 2014 quarterly chart audit Specific Audit Topic : On-Call Response July – Sept. 2014 quarterly chart audit Specific Audit Topic: Medication Records	11/12/2013

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	date stated, "SNHS [Scroggins Nursing and Home Services] will have an ongoing Quality Assurance Program which will be the responsibility of the Administrator and / or Administrator of Nursing. The Quality Assurance Program is designed to objectively and systematically monitoring and evaluate the quality and appropriateness of client care, resolve identified problems, and improve client care and agency operation. Procedure: 1. It will be the direct responsibility of the administrator to assure that Quality Assurance Program is in effect and active for the agency."		compared to POC item # 10 Oct. - Dec. 2014 quarterly chart audit Specific Audit Topic: Pressure Ulcers / Treatment Prevention:administrator will monitor quarterly the QA program which must be completed with a report and presented to the administrator by the end of the following months.April 30,2014 - - July 31, 2014 - - Oct. 31, 2014 - - Jan. 31, 2015 - - Responsible Person :administrator/Director of Nursing Date of Completion :11.12.2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/01/2013

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N000524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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. Based on agency policy review, clinical record review, and interview, the agency failed to ensure the plan of care included a timely physician signature, included accurate medications, and specified how medications were to be given for 5 of 10 records reviewed (clinical record #2, #3, #8, #9, and #10) with the potential to affect all the active patients of the agency.	N000524	Correction:Agency reviewed /updated policy & procedure for MD signature to be “timely” within 30 days from the date of the MD order / Plan of Care .Clinical Record # 2agency is unable to correct with the 30 day time frame lapsed prior to survey however, on 11.04.2013 the agency contacted the MD requesting he sign / return the signed POC.Agency received the POC signed on 11.07.2013.Clinical record # 2 inaccurate medications listed in item # 10 on the	11/12/2013

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	Findings 1. Clinical record #2, start of care (SOC) 1/28/13, included a plan of care with a certification period of 9/24/13 - 11/22/13 that failed to evidence a timely physician's signature and accurate medications. This was evidenced by the following: a. A clinical document titled "Certification and Plan of Treatment Home Health" with a certification period of 9/24/13 - 11/22/13 was not signed by the physician and included the medications Lexapro and Effexor. b. On 10/30/13 at 9:12 AM, Patient #2 indicated Lexapro and Effexor had been removed from his / her medication list several months ago. c. On 10/31/13 at 1:55 PM, the director of nursing indicated the physician had not signed the plan of care at this time. d. On 10/31/13 at 2:05 PM, the director of nursing indicated the patient medications Lexapro and Effexor had been discontinued and should not be included on the current plan of care. 2. On 10/30/13 at 11 AM, Employee J, RN, was observed to administer via		POC.Discussed with MD / nurse on 11.04.13 via phone with the corrections made in form of single order which was faxed to MD for signature and received signed on 11.07 .2013.Clinical record # 8 unable to correct with 30 day time frame lapsed prior to end of survey.Clinical record # 9 unable to correct with 30 day time frame lapsed prior to end of survey.Clinical record # 10 unable to correct as client was transferred to long term care facility with discharge from agency on 10.04.13.Clinical record # 3 corrected on POC dated 11.09.2013to 01.07.2014 with MD order stating, all medications unless otherwise indicated are to be given by GT after being crushed / mixed with 50 to 100 ml water and given within 30 minutes of time dissolved.Prevention :agency has developed a form “Tracking MD order Signature” which has been assigned to an office personnel member.Each MD order to include plan of care, will be logged on this form the date of the order, which will include the date order sent either fax /mail.Weekly on Monday , the office staff member will review MD orders / POC to determine which do not have MD signature .Those that are not returned signed by MD on week # 2will be refaxed /re-sent to MD with a phone call to MD office requesting the order be signed	

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	patient #3's peg tube approximately 100 milliliters of cloudy water containing medications the caregiver mixed prior to administering. The medications were followed by a feeding of 275 milliliters of fibersource. This method of medication administration was not on the plan of care for the certification period 9/10/13 -11/8/13. 3. Clinical record #8, SOC 9/2/13, included a plan of care for the certification period of 9/2/13 - 10/31/13 that failed to evidence a timely physician's signature. a. A clinical document titled "Certification and Plan of Treatment Home Health" with a certification period of 9/2/13 - 10/31/13 was signed by the physician on 10/23/13. b. On 11/1/13 at 9:55 AM, the director of nursing indicated the plan of care was not signed until 10/23/13. 4. Clinical record #9, SOC 4/13/13, included a plan of care for the certification period of 6/12/13 - 8/10/13 that failed to evidence a timely physician's signature. a. A clinical document titled "Certification and Plan of Treatment		and returned.Those orders /POC not signed on week # 3 will be hand delivered for signature at the time of delivery.Quarterly agency will audit 10% of active clients to determine is this tracking sheet is effective and insure that MD orders /POC are returned to the agency signed by the MD within 30 days from the date of the order. Responsible Person:Director of Nursing Completion Date:11.12.2013	

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	Home Health" with a certification period of 6/12/13 - 8/10/13 was signed by the physician on 7/30/13. b. On 11/1/13 at 1:40 PM, the director of nursing indicated the plan of care was not signed until 7/30/13. 5. Clinical record #10, SOC 10/30/12, included a plan of care for the certification period of 8/26/13 - 10/24/13 that failed to evidence a timely physician signatures. a. A clinical document titled "Certification and Plan of Treatment" with a certification period of 8/26/13 - 10/24/13 was not signed by the physician. b. On 11/1/13 at 2 PM, the director of nursing indicated the plan of care was not yet signed. 6. The agency policy titled "Completion of a Plan of Care /485" with no effective date stated, "27. The physician will sign the plan of care."			

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N000540	410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse (RN) had made an initial assessment visit in 2 of 10 records reviewed (5 and 10) creating the potential to affect all of the agency's new patients. The findings include 1. Clinical record #5, start of care 10/30/12, failed to evidence an initial assessment had been completed. 2. Clinical record #10, start of care 3/27/12, failed to evidence an initial assessment had been completed. 3. On 11/1/13 at 2 PM, the director of nursing indicated the initial assessment had been completed but had been thinned from the record and was in storage. 4. The agency policy titled "Admission" and no effective date stated, "The registered nurse or physical therapist shall make the initial visit to the patient's residence completing a detailed physical	N000540	Correction:Clinical record 5 and10 initial assessments were located in storage after survey process was completed.The initial assessment / oasis start o fcare data sets were returned to the current clinical record for this client on 11.07.2013Previous to survey process agency thinned charts back to the current POC and one prior to the current one.Agency has adopted policy indicating that the initial assessment / oasis data set for SOC , will remain in the active clinical record and not be included in the thinned chart process. Prevention : agency will not thin the clinical record to include the initial assessments /oasis data set SOC.Agency will audit all new admissions quarterly to assess and insure the initial assessments / SOC data collection set, remain in the current active clinical record. Responsible Person:Director of Nursing Completion Date:11.07.2013	11/07/2013

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	assessment to determine the client's medical needs."			

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N000608	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: (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. Based on observation, clinical record review, policy review, and interview, the agency failed to ensure medications that were administered were documented in the medical record in 2 of 3 home visit observations with a registered nurse (#2 and 3) creating the potential to affect all 12 patients receiving skilled nurse services. Findings 1. Clinical record #2 included a plan of care established by the physician for the certification period of 9/24/13 - 11/22/13 that states, "Orders for discipline: SN	N000608	Correction:agency has incorporated new policy titles " medication administration ".This policy outlines nursing staff administering medications during a home care visit / care, will document so on either the medication administration record or in the clinical note for the date of care.The documentation whether in MAR form or in clinical note must include : Name of each medicationDose of each medication Route of each medicationTime medication administeredNurses signature /initials indicating who administered the medication Policy was written on 11.07.2013 and will be presented /reviewed	11/07/2013

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	(skilled nurse) 3 times a day - 7 days a week X 60 days ... to perform the following ... dispense and administer meds as ordered by MD at appropriate visit of am." The record failed to evidence which medications were administered or at what time the medications were given. a. On 10/30/13 at 9:10 AM, Employee I, Registered Nurse (RN), indicated giving Vitamin D 2000 IU (international units) po (by mouth) qd (every day), Ditropan XL 10 mg (milligrams) po q (every) day, 1 multi vitamin tab, and Macrobid 100 mg one po qd this am. She indicated she gave the medications without documenting which medications had been given. b. On 10/31/13 at 1:55 PM, the director of nursing indicated the medications were to be given as written on the plan of care. However, there was no medication administration log or other means to record that the medications had been given or which medications were given. c. Nursing visit documentation dated 10/19/13, 10/20/13, 10/21/13, 10/22/13, 10/23/13, 10/24/13, and 10/25/13, all from 8 AM - 10 AM, indicated the skilled nurse (SN) had given		and approved at called board of directors meeting / PAB meetings on 12.02.2013. Client # 3 mother demands that she dispense the meds / crush / dissolve prior at or about 7:45 am daily. These meds are not given till 11 am . The mother was informed in writing / verbally that MD order now states meds will be crushed / dissolved and given by PEG tube within 30 minutes of being dissolved. . Agency reviewed / updated policy dates 11.07.2013 indicates that nursing staff administering medications during their time of care to a client must compare the medications to the prescribed bottle or dispense them themselves verifying the medication is the correct med /dose.Prevention:agency will audit 10% of active clients quarterly to determine clients with medication administration is given and recorded according to agency policy. Responsible Person:Director of Nursing / administrator Completion Date:11.25.2013	

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	oral medications. There was no documentation which specific medications had been given. Instead each nurse visit stated, "PO Meds" with a check by it. d. On 10/31/13 at 1:55 PM, the director of nursing indicated the SN failed to document what medications were given in the am. 2. Clinical record #3 included a plan of care established by the physician for the certification period of 9/10/13 - 11/8/13 that failed to evidence what medications were to be given at 11 AM by the SN. The plan of care states, "Assess medication regimen [therapeutic effects and side effects]." On 10/30/13 at 11 AM, the SN gave medications mixed and dissolved in water by the caregiver at 8 AM. This method of medication administration was not on the plan of care. a. On 10/30/13 at 11 AM, Employee J, RN, was observed to administer via patient #3's peg tube approximately 100 milliliters of cloudy water containing medications that the caregiver mixed prior to administering. The medications were followed by a feeding of 275 milliliters of fibersource.			

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	b. On 10/30/13 at 11 AM, Employee J indicated the medications given in the cloudy water were Prilosec, Atenolol, Lisinopril, Claritin, and Lexapro that the caregiver had dissolved them in the water at 8 AM. However, Employee J had not seen the medications added to the water. There was no record of what medications had been placed in the water. 3. The agency policy titled "Medical Plan of Care" with no effective date stated, "Medical plan of care means written instructions signed by the physician ... for the provision of care to given by a registered or practical nurse to a patient in the patient's place of residence."			