STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157495	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME SERVICES UNLIMITED INC	7750 N MICHIGAN RD INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	This visit was for a home health federal recertification survey. This visit resulted in a partial extended survey. Survey date: December 12 - 15, 2011 Facility #: 9865 Medicaid Vendor #: 200122510A Surveyor: Ingrid Miller, PHNS, RN Skilled unduplicated census: 667 patients	G0000		
G0101	The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. Based on home visit observation, policy review, and interview, the agency failed to ensure the patient's rights including respect and confidentiality, were honored for 3 of 7 home visit observations (Files #1, #3, and #7). Findings 1. On 12/12/11 at 3:15 PM, Employee F, a registered nurse (RN), was observed to perform a wound vac dressing change at	G0101	G 0101 Clinical and paraprofessional staff re educated on 12/30 11on informing patients of their right, protecting and promoting the exercise of those rights particularly in areas of patient rights to include respect and confidentiality.Director of Clinical Services completed on site visit to assess competency in on 12/28/11.To ensure compliance Director of clinical services will monitor compliance through on site visits and cometency testing	12/30/2011

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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	a home visit with patient #1. During the wound vac dressing change, the patient was undressed with all parts of the patient's perineal and buttocks area exposed. No attempt was made to cover the patient for privacy during the wound care treatment. This visit evidenced a lack of respect for the patient's privacy and dignity. 2. On 12/14/11 at 10:10 AM, Employee J, a home health aide, was observed to give patient #7 a partial bed bath. The aide did not cover the patient's "private" areas after washing occurred. This visit evidenced a lack of respect for the patient's privacy and dignity. 3. On 12/13/11 at 10:15 AM, Employee D, RN, was observed to take a photo of patient #3's left leg wound with a personal cell phone with photo capability. No signed permission form was found in patient #3's clinical record. 4. On 12/15/11 at 8:40 AM, the administrator indicated the above home visits evidenced a lack of respect for the patient's rights for dignity, privacy, and confidentiality. 5. The agency policy titled "Patient Bill of Rights" states, "As a home care		on ongoing basis.	

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	patient/client you have the right to be informed of your rights and responsibilities and to exercise them before the initiation of care/service ... respect and confidentiality, you have the right to be treated with consideration, respect, dignity, including the provision of privacy during care." 6. The agency policy titled "Home Services Unlimited, Inc. Employee Handbook for Exempt Employee," with an effective date March 1, 2010 states, "Employees may not use any function of a personal cellular telephone (including recording images such as photographs and video) for any reason ... Employees may not use a camera or video recorder of any kind for any reason in work areas or during work hours, including in patient's homes without the prior written consent of the employee supervisor."			

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G0111	The patient has the right to confidentiality of the clinical records maintained by the HHA. Based on home visit observation, policy review, and interview, the agency failed to ensure the patient's rights for confidentiality of medical information was maintained for 1 of 7 home visits observed (clinical record #3). Findings 1. On 12/13/11 at 10:15 AM, Employee D, RN, was observed to take a photo of patient #3's left leg wound with a personal cell phone with photo capability. No signed permission form was found in patient #3's clinical record. 2. On 12/15/11 at 8:40 AM, the administrator indicated the above home visits evidenced a lack of respect for the patient's rights for dignity, privacy, and confidentiality. 3. The agency policy titled "Patient Bill of Rights" states, "As a home care patient/client you have the right to be informed of your rights and responsibilities and to exercise them before the initiation of care/service ... respect and confidentiality, you have the	G0111	G 111 Clinical and paraprofessional staff re trained on 12/30 /11 in area of confidentiality of clinical records. Staff has been informed that they are prohibited using their personal telephone to take pictures of wounds. In the event that physicain gives an order to take pictures of wound only HSU provided camera may be used and picture donloaded in the office providing privacy and confidentility.Director of clinical services will monitor for compliance through site visits and competency evaluations on ongoing basis to ensure compliance.	12/30/2011

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	right to be treated with consideration, respect, dignity, including the provision of privacy during care." 4. The agency policy titled "Home Services Unlimited, Inc. Employee Handbook for Exempt Employee," with an effective date March 1, 2010 states, "Employees may not use any function of a personal cellular telephone (including recording images such as photographs and video) for any reason ... Employees may not use a camera or video recorder of any kind for any reason in work areas or during work hours, including in patient's homes without the prior written consent of the employee supervisor."			
G0121	The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on home visit observation, clinical record review, interview, and policy review, the agency failed to ensure that 4 of 7 clinical staff (Employee F, G, H, and J) observed at 4 of 7 home visits (clinical records #1, #2, #6, and #7) followed infection control agency policies with the potential to affect all the agency's patients. Findings 1. At a home visit on 12/12/11 at 3:15	G0121	G 0121 Clinical and paraprofessional staff re trined on 12/30/11 on Infection control Policy. Post test completed by staff to demonstrate level of undrestanding.Director of Clinical Services completed on site visits to assess competency in area of infection control particular attention given in areas of wound care and provision of personal care to patients.Director of clinical srviuces will monitor compliance.	12/30/2011

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	PM, Employee F, a registered nurse (RN), was observed to perform a physical assessment including taking vital signs and to perform a wound vac dressing change with patient #1. Employee F assessed the patient's oral temperature using an electronic oral thermometer by first applying a protective sleeve as a barrier around the stem and bulb area. After the temperature was assessed, Employee F took the used sleeve off the thermometer with ungloved hands. Employee F used the patient's personal towel to dry hands after Employee F had finished washing with liquid soap and water. Employee F placed wound vac dressing supplies on the patient's bed without using a barrier between the supplies and bedding. Employee F did not wash hands after removing gloves and donning clean gloves between removing soiled vac dressing and cleansing the wound area. To measure the wound, Employee F first placed gloved finger into the decubitus wound with a depth that could not be visualized and then used a cotton-tipped applicator which was removed from an already opened sterile package to measure the depth of the wound. Employee F used 4 by 4 gauze dressings to remove soiled black foam and discard. At this time, Employee F removed gloves and then threw away the used wound vac tubing into trash with			

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	ungloved hands. 2. On 12/13/11 at 8 AM, Employee H, RN, was observed with patient #2 to perform a dressing change on a wound by removing a soiled dressing and soiled gloves and then donning new gloves without washing hands with soap and water or antibacterial hand gel between glove changes. 3. On 12/13/11 at 2:30 PM, Employee G, a licensed practical nurse (LPN) was observed to perform two wound dressing changes on patient #6. Employee G was observed to place the wound dressing supplies on the bed without a barrier. Employee G did not place a barrier under the patient's right leg after the dressing was removed and the leg was readied for the new dressing application. 4. On 12/14/11 at 10:10 AM, Employee J, a home health aide, was observed to give patient #7 a partial bed bath. After washing patient's anal area with a wash cloth and soapy water from a basin, the aide was observed to use the same washcloth without rinsing to wash the patient's back. Employee J started the bath procedure by washing the feet, the legs, the peri area, the anal and buttocks area and back in that order.			

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	5. On 12/15/11 at 8:40 AM, the administrator indicated the infection control policy, handwashing policy, assisting with a bed bath policy, universal precautions and patient's rights policy were not followed at the above home visits with the assigned clinical staff. 6. The agency policy titled "Infection Control" with an effective date of 6/09 states, "The employee utilizes standard precautions and expanded precautions appropriately, practices hand hygiene appropriately, follows proper work practices and procedures (including care of supplies/equipment, following aseptic principles, isolation techniques as appropriate, etc) ... Procedures: Work Practice Controls 1. Hand Hygiene is to be done following the CDC Guidelines for Hand Hygiene in Health Care setting ... Hand hygiene should be done before and after patient contact, when hands visibly dirty contaminated, after contact with bodily fluid, wound dressing, excretion, contaminate, before and after gloving ... Personal Protective Equipment (PPE) ... Gloves are to be worn for any anticipated exposure to blood, body fluids, excretions, secretions (except sweat), mucous membranes or non-intact skin is anticipated. This includes handling or touching contaminated items or surfaces ... "			

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	7. The agency policy titled "Handwashing" from page 11 of Infection Control Practices with a copyright date from 2000 from Mosby states, "Take equipment to wash the hands (liquid soap, paper towels, lotion) to the sink area ... Avoid using cloth towels or bars of soap because these are a haven for bacteria." 8. The agency procedure titled "Providing Home Care: A Textbook for Home Health Aides" by William Leahy, MD, second edition, states, "Assisting with a bed bath ... Wash your hands, explain the procedure to the client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible. Provide privacy for the client. Be sure the room is a comfortable temperature and there are no drafts ... Place a soft cotton blanket or towel over client and ask him to hold onto it as you remove the top sheet and blanket ... Uncover only one part of the body at a time. Place a towel under the body part being washed ... Start at the head and work down ... If the client is unable to provide perineal care, you must do so ... Cleanse the anal area without contaminating the perineal area. Wash, rinse, dry buttocks and anal area ... Cover the client with the cotton blanket. Place soiled washcloths and towels in the hamper or laundry basket. Dispose of the			

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	dirty bath water in the toilet ... " 9. The agency policy titled "Universal Precautions and Patient's rights," and no effective date states, "Disposable coverings may be used on some surfaces to prevent contamination."			

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G0141	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 file review and interview, the agency failed to ensure they followed their policy regarding a physical examination that evidenced the employee was free of communicable disease for 1 of 18 personnel files reviewed (file M). The finding 1. Personnel file M, date of hire 10/31/11 and first patient contact 11/4/11, a home health aide, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease. 2. On 12/15/11 at 4 PM, the administrator indicated Employee M lacked a physical examination that included the statement "free of communicable disease." 3. The agency policy titled "Required Employee Health Screening" states, "Physical examination: all employees providing patient care are required to submit evidence of a physical	G0141	G 141Administaror re educated Director of Human Resources and HR support staff that upon hire they must carefully review each physical to insure that the physical has a statement regarding communcable disease. Employee may not be assighned to see patients if Physical does not indicate that he/she is free of communcable disease.Administrator will monitor for compliance by periodically reviewing files.	01/05/2012

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	examination by a physician or nurse practitioner no more than 180 days before the date that the employee has direct patient contact. Documentation from the exam should minimally indicate that the employee will not spread communicable or infectious diseases to patients."			
G0158	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on document review and interview, the agency failed to ensure the aide only performed tasks identified on the plan of care for 1 of 1 home health aide visit observations (clinical record #7). Findings 1. At a home visit on 12/13/11 at 10:30 AM, patient #7 indicated Employee J, home health aide, assisted her/him by emptying the medications from the medication reminder box into a bowl in order that the patient could take the medicine. 2. Clinical record #7, start of care 8/19/08, evidenced a plan of care with a certification period of 12/2/11 - 1/30/12 with no orders for medication assist by the	G0158	G158 Clinical and paraprofessional staff re-educated on 10/01/12 on following Plan of Care for each patient that they are providing care to. RN Case managers are to review, update, and monitor plan of care for each patient as needed, upon supervisory visits Case managers are to review patient home folders to ensure that it contains a plan of care and it ais accurate.Post test given to each participant to ensure competency.To ensure compliance:Quality Imrovement Coordinator will review 10% of patient charts quterly.Director of Clinical Services will perform home visits with nurses and HHA's on ongoing basis to assess cometency.	01/05/2012

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	home health aide.			
G0173	The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review, policy review, and interview, the agency failed to ensure the skilled nurse updated the plan of care for 1 of 12 records reviewed (Clinical record #2). Findings 1. Clinical record #2, start of care 3/14/10, evidenced a skilled nursing visit note on 10/18/11 time in 1:00 PM time out 2:00 PM signed by Employee G, a licensed practical nurse. The second page of this clinical document states, "Contacted Director of Nursing to obtain order for wound treatment to open area from patient's MD." No order was present in the record. However, an order was found and presented. This order was not present on the updated plan of care (POC). a. On 12/15/11 at 2:50 PM, the director of nursing indicated the order had been obtained.	G0173	G 0173 On 01/05/2012 Clinical Staff re educated on Plan of Care Policy.RN Case managers are to update Plan of Care as patient condition dictates, review and update no less than every 60 days .Post test taken by each employee verified competency.To ensure compliance: QI coordinator will review 10 % of patient charts quaterly.Director of Clinical Services will monitor by performing competency evaluations with clinical staff on ongoing basis.	01/05/2012

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	b. On 12/15/11 at 4 PM, the director of nursing updated the missing order and a communication note had been found and presented two documents as follows: 1.) One document absent from Clinical Record #2 and signed by the director of nursing on 10/18/11 at 1:16 PM states, "Received call from [Employee G], patient has wound on RLE [right lower extremity] calf area and states they are putting a dry dressing on it. I will call RN [Employee H] to find out more. At 1:30 PM spoke with [Employee H] RN who stated [he/she] received order from MD for abd [abdominal pad] and secure with tape." 2.) The second document also absent from Clinical Record #2 and signed by the DON states, "Physician-please sign and return immediately, Agency HSU, [Patient #2], Physician's name, date ordered 10/18/11, cleanse right calf wound with normal saline or wound cleanser. Apply abd and secure with tape. Cleanse daily until healed." This was signed by the DON. On 12/15/11, no physician signature was present. c. The updated plan of care with a certification period from 11/4/11 - 1/2/11 failed to show the above order for wound			

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	care on the right lower extremity. 2. On 12/15/11 at 11 AM, the director of nursing indicated the plan of care had failed to be updated with the new order obtained on 10/18/11. 3. The agency policy titled "Plan of Care" with an effective date of 5/10 states, "Each patient has an individualized plan of care (POC) based on assessments and/or physician's orders. The POC is not a static document. It includes but is not limited to the CMS 485 or equivalent, supplemental orders, discipline specific interventions ... Procedure: the written POC is developed following a comprehensive assessment and collaboration with the physician for orders at admission at refortification, when applicable. The patient is involved with the process ... Updates to the POC are done with supplemental orders when required by law and regulation and/or documentation of discipline specific interventions linked to problems/needs." 4. The agency policy titled "Policy on the Provision of Nursing Services" with an effective date of 8/06 states, "The registered nurse duties providing SN (Skilled nursing) services include: ... Initiates the plan of care and necessary revisions."			

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G0212	The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. Based on personnel file review and interview, the agency failed to ensure the home health aide had been competency tested for medication assistance for 1 of 1 home health aide visit observations (employee J). Findings 1. At a home visit on 12/13/11 at 10:30 AM, patient #7 indicated Employee J, home health aide, employee J, assisted her/him by emptying the medications from the medication reminder box into a bowl in order that the patient could take the medicine. 2. Employee J's personnel file evidenced a document signed by this employee and the director of nursing titled "Indiana Association for Home Care Home Health Aide Skills Check List," which did not list medication assist as a skill the aide had been checked off on. This document was signed on 9/24/11. 4. On 12/14/11 at 3:30 PM, the administrator indicated the aide was not	G0212	G212 Clinical and paraprofessional staff re educated on following Plan of Care policy.Paraprofessional staff retrained to ensure that they perform duties in accordance with Plan of Care and if patient requiers assistance in areas not specified on Plan of Care they muyst inform RN Case manager or Directior of Clinical Services. Paraprofessional staff also re educated to only perform tasks that they completed competency training and successfully passed their skills check.This specific clients plan of care updated to include medication assist and employee J succesfully completed skills check off in area of medication assist for this patient.Director of Clinical Services will monitor on ongoing basis compliance to ensure that HHA's perform tasks only after successfully completing competency tesing. QI coordinator will review 10% of patient files quaterly and employee files to ensure that competency evaluation us completed and skills are documented prior to employees performing tasks with patients.	01/05/2012

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	skill-checked on medication assist.			
G0224	Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.	G0224	G 224 On 12/30/ 2011 Clinical Staff re educated to ensure that written patient care instructions for Home Health Aides are prepared by clinical staff i.e registered nurses, therapists that are responsible for supervisory visits of Home Health aides. Paraprofessional Staff re educated to check patient folder and review POC on every visit prior to performing patient care tasks; notify case manager or Director of Clinical Services if POC missing.To ensure compliance: RN case managers and therapists that are responsible for supervisory visits will review patient folder periodically but not less than every 60 days to ensure that an up to date POC is in the home folder.Director of Clinical Services will periodically perform home visits, review patient folder to ensure that Plan of Care is in folder and it is up to date. .	12/30/2011
	Based on document review, clinical record review, home visit observation, and interview, the agency failed to ensure the home health aide had written patient care instructions for 1 of 4 home visit observations of patients with home health aide services (Clinical record #1). Findings 1. On 12/12/11 at 3:15 PM, Patient #1's home folder evidenced no written patient care instructions. 2. On 12/12/11 at 3:30 PM at 9:10 AM, Employee F indicated there were no written instructions for the home health aide in the patient's home. 3. An agency policy titled "Job Description Certified Home Health Aide," states "A Certified Home Health Aide is a non-licensed member of the home health care team who assists the client with the tasks of daily living as outlined in a			

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	written care plan that is established by a Registered Nurse Supervisor and is kept in the client's home."			
N0462	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 file review and interview, the agency failed to ensure a physical examination that evidenced the employee was free of communicable disease for 1 of 18 personnel files reviewed (file M). The finding 1. Personnel file M, date of hire 10/31/11 and first patient contact 11/4/11, a home health aide, failed to evidence a pre-employment physical examination that identified the patient was free of communicable disease. 2. On 12/15/11 at 4 PM, the administrator indicated Employee M lacked a physical	N0462	N 462 Director of HR and Support staff re educating that each employee must have a physical by a physician or nurse practitioner no more that one hundred (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 communcable duisease. No employee may start providing care to paitents if a statement free of communicable disease is not in employee file.To ensure compliance Administrator will monitor all new hire physicals on ongoing basis.	01/05/2012

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	examination that included the statement "free of communicable disease." 3. The agency policy titled "Required Employee Health Screening" states, "Physical examination: all employees providing patient care are required to submit evidence of a physical examination by a physician or nurse practitioner no more than 180 days before the date that the employee has direct patient contact. Documentation from the exam should minimally indicate that the employee will not spread communicable or infectious diseases to patients."			
N0470	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 home visit observation, clinical record review, interview, and policy review, the agency failed to ensure that 4 of 7 clinical staff (Employee F, G, H, and J) observed at 4 of 7 home visits (clinical records #1, #2, #6, and #7) followed infection control agency policies with the potential to affect all the agency's patients. Findings 1. At a home visit on 12/12/11 at 3:15	N0470	N 470 Clinical and paraprofessional staff re educated on infection control policy. Post test taken by each employee to assess competency.Director of Clinical Services completed on site visits to assess competency in areas of infection control to invlude hand washing technique, adhearence to infection control policy during wound care and provision of personal care to patient.To ensure compliance:Competency based education regarding	12/30/2011

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	PM, Employee F, a registered nurse (RN), was observed to perform a physical assessment including taking vital signs and to perform a wound vac dressing change with patient #1. Employee F assessed the patient's oral temperature using an electronic oral thermometer by first applying a protective sleeve as a barrier around the stem and bulb area. After the temperature was assessed, Employee F took the used sleeve off the thermometer with ungloved hands. Employee F used the patient's personal towel to dry hands after Employee F had finished washing with liquid soap and water. Employee F placed wound vac dressing supplies on the patient's bed without using a barrier between the supplies and bedding. Employee F did not wash hands after removing gloves and donning clean gloves between removing soiled vac dressing and cleansing the wound area. To measure the wound, Employee F first placed gloved finger into the decubitus wound with a depth that could not be visualized and then used a cotton-tipped applicator which was removed from an already opened sterile package to measure the depth of the wound. Employee F used 4 by 4 gauze dressings to remove soiled black foam and discard. At this time, Employee F removed gloves and then threw away the used wound vac tubing into trash with		control of communicable disease, good infection control techniques, hand washing will be offered twice a year.Director of Clinical Services will be responsible to ensure compliance by proividing joint visits with clinical staff and Home health aides to assess compliance.	

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	ungloved hands. 2. On 12/13/11 at 8 AM, Employee H, RN, was observed with patient #2 to perform a dressing change on a wound by removing a soiled dressing and soiled gloves and then donning new gloves without washing hands with soap and water or antibacterial hand gel between glove changes. 3. On 12/13/11 at 2:30 PM, Employee G, a licensed practical nurse (LPN) was observed to perform two wound dressing changes on patient #6. Employee G was observed to place the wound dressing supplies on the bed without a barrier. Employee G did not place a barrier under the patient's right leg after the dressing was removed and the leg was readied for the new dressing application. 4. On 12/14/11 at 10:10 AM, Employee J, a home health aide, was observed to give patient #7 a partial bed bath. After washing patient's anal area with a wash cloth and soapy water from a basin, the aide was observed to use the same washcloth without rinsing to wash the patient's back. Employee J started the bath procedure by washing the feet, the legs, the peri area, the anal and buttocks area and back in that order.			

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	5. On 12/15/11 at 8:40 AM, the administrator indicated the infection control policy, handwashing policy, assisting with a bed bath policy, universal precautions and patient's rights policy were not followed at the above home visits with the assigned clinical staff. 6. The agency policy titled "Infection Control" with an effective date of 6/09 states, "The employee utilizes standard precautions and expanded precautions appropriately, practices hand hygiene appropriately, follows proper work practices and procedures (including care of supplies/equipment, following aseptic principles, isolation techniques as appropriate, etc) ... Procedures: Work Practice Controls 1. Hand Hygiene is to be done following the CDC Guidelines for Hand Hygiene in Health Care setting ... Hand hygiene should be done before and after patient contact, when hands visibly dirty contaminated, after contact with bodily fluid, wound dressing, excretion, contaminate, before and after gloving ... Personal Protective Equipment (PPE) ... Gloves are to be worn for any anticipated exposure to blood, body fluids, excretions, secretions (except sweat), mucous membranes or non-intact skin is anticipated. This includes handling or touching contaminated items or surfaces ... "			

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	7. The agency policy titled "Handwashing" from page 11 of Infection Control Practices with a copyright date from 2000 from Mosby states, "Take equipment to wash the hands (liquid soap, paper towels, lotion) to the sink area ... Avoid using cloth towels or bars of soap because these are a haven for bacteria." 8. The agency procedure titled "Providing Home Care: A Textbook for Home Health Aides" by William Leahy, MD, second edition, states, "Assisting with a bed bath ... Wash your hands, explain the procedure to the client, speaking clearly, slowly, and directly, maintaining face-to-face contact whenever possible. Provide privacy for the client. Be sure the room is a comfortable temperature and there are no drafts ... Place a soft cotton blanket or towel over client and ask him to hold onto it as you remove the top sheet and blanket ... Uncover only one part of the body at a time. Place a towel under the body part being washed ... Start at the head and work down ... If the client is unable to provide perineal care, you must do so ... Cleanse the anal area without contaminating the perineal area. Wash, rinse, dry buttocks and anal area ... Cover the client with the cotton blanket. Place soiled washcloths and towels in the hamper or laundry basket. Dispose of the			

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	dirty bath water in the toilet ... " 9. The agency policy titled "Universal Precautions and Patient's rights," and no effective date states, "Disposable coverings may be used on some surfaces to prevent contamination."			
N0494	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. Based on home visit observation, clinical record review, policy review and interview, the agency failed to ensure the patient's rights including respect and confidentiality, were honored for 3 of 7 home visit observations (Files #1, #3, and #7). Findings 1. On 12/12/11 at 3:15 PM, Employee F, a registered nurse (RN), was observed to perform a wound vac dressing change at a home visit with patient #1. During the	N0494	N 494 On 12/30 11 Clinical and paraprofessional staff re educated to ensure that patient or legal guardian be informed of patients rights through effective means of communication. That each agency employee must protect and promote the exercise of these rights:Provide the patient with written notice of patient rights, in advance of furnishing care to patient or during the initial evaluation visit before the initiation of treatment. Maintain documentation showing compliance in this area. That each patient has the right to	12/30/2011

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	wound vac dressing change, the patient was undressed with all parts of the patient's perineal and buttocks area exposed. No attempt was made to cover the patient for privacy during the wound care treatment. This visit evidenced a lack of respect for the patient's privacy and dignity. 2. On 12/14/11 at 10:10 AM, Employee J, a home health aide, was observed to give patient #7 a partial bed bath. The aide did not cover the patient's "private" areas after washing occurred. This visit evidenced a lack of respect for the patient's privacy and dignity. 3. On 12/13/11 at 10:15 AM, Employee D, RN, was observed to take a photo of patient #3's left leg wound with a personal cell phone with photo capability. No signed permission form was found in patient #3's clinical record. 4. On 12/15/11 at 8:40 AM, the administrator indicated the above home visits evidenced a lack of respect for the patient's rights for dignity, privacy, and confidentiality. 5. The agency policy titled "Patient Bill of Rights" states, "As a home care patient/client you have the right to be		respect and confidentiality during each visit.Clinical staff received re education on propor draping of patient during wound care to ensure patient dignity and on use of personal self phone while in the home. Use of personal self phone in the home for any reason to include taking pictures of wounds is prohibited by agency policy. In an event that a physcian orders picutures of wounds only agency camera may be used to take a picture, picture will be downloaded in the office. Paraprofessional staff re educated in area of bathing and personal care to ensure proper coverage of patient to ensure dignity of the patient and use of personal cell phone in the patient home.Each employees understanding tested through a post test.To ensure compliance:All new staff receives training in area of Patient Rights upon hire and annualy therafter.Director of Clinical Services will be responsible for monitoring comliance on ongoing basis through home visits, evaluation during visits of adhearance to policy on Patient Rights and employee handbook policy on using personal cell phones while in patient homes.	

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	informed of your rights and responsibilities and to exercise them before the initiation of care/service ... respect and confidentiality, you have the right to be treated with consideration, respect, dignity, including the provision of privacy during care." 6. The agency policy titled "Home Services Unlimited, Inc. Employee Handbook for Exempt Employee," with an effective date March 1, 2010 states, "Employees may not use any function of a personal cellular telephone (including recording images such as photographs and video) for any reason ... Employees may not use a camera or video recorder of any kind for any reason in work areas or during work hours, including in patient's homes without the prior written consent of the employee supervisor."			
N0508	Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.			

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	Based on home visit observation, policy review, and interview, the agency failed to ensure the patient's rights for confidentiality of medical information was maintained for 1 of 7 home visits observed (clinical record #3). Findings 1. On 12/13/11 at 10:15 AM, Employee D, RN, was observed to take a photo of patient #3's left leg wound with a personal cell phone with photo capability. No signed permission form was found in patient #3's clinical record. 2. On 12/15/11 at 8:40 AM, the administrator indicated the above home visits evidenced a lack of respect for the patient's rights for dignity, privacy, and confidentiality. 3. The agency policy titled "Patient Bill of Rights" states, "As a home care patient/client you have the right to be informed of your rights and responsibilities and to exercise them before the initiation of care/service ... respect and confidentiality, you have the right to be treated with consideration, respect, dignity, including the provision of privacy during care."	N0508	N 508 On 12/30/11 Clinical and paraprofessional staff re eductaed that the patient has the right to :Confidentiality of clinical records amintained by our agency, that clinical staff is responsible to advice patient on confidentiality of clinical records . Re - educated on agency policy on use of personal cell phone in patient homes to include prohibition of taking pictures with personal cell phone and informed that failure of comliance with this policy will result in progressive discipline.Post test taken by each employee to demonstarte understanding.To ensure compliance:Director of Clinical Services will monitor compliance during home visits on ongoing basis.	12/30/2011

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	4. The agency policy titled "Home Services Unlimited, Inc. Employee Handbook for Exempt Employee," with an effective date March 1, 2010 states, "Employees may not use any function of a personal cellular telephone (including recording images such as photographs and video) for any reason ... Employees may not use a camera or video recorder of any kind for any reason in work areas or during work hours, including in patient's homes without the prior written consent of the employee supervisor."			
N0522	Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on document review and interview, the agency failed to ensure the aide only performed tasks identified on the plan of care for 1 of 1 home health aide visit observations (clinical record #7). Findings 1. At a home visit on 12/13/11 at 10:30	N0522	N 0522 Clinical and paraprofessional staff re-educated that they must follow a wtitten medical care of plan established and periodically reviewed by physician, dentist, chiropractor, optometrist, or podiatrist. The aide may only perform tesks identefied on the care of plan. RN Case managers re educated to update care plan as dictated by patient needs and every 60 days.Home Health Aides	01/05/2012

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	AM, patient #7 indicated Employee J, home health aide, assisted her/him by emptying the medications from the medication reminder box into a bowl in order that the patient could take the medicine. 2. Clinical record #7, start of care 8/19/08, evidenced a plan of care with a certification period of 12/2/11 - 1/30/12 with no orders for medication assist by the home health aide.		re educated that they must review Plan of Care on each vusit pruor to providing care to patien and to notify RN Case manager or Director of clinical services if patient has additional needs that are not on the plan of Care.Post test taken by each participant to ensure understanding .Director of Clinical Services is responsible to Monitor compliance on ongoing basis during home visits.	
N0542	Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on clinical record review, policy review, and interview, the agency failed to ensure the skilled nurse updated the plan of care for 1 of 12 records reviewed (Clinical record #2). Findings 1. Clinical record #2, start of care 3/14/10, evidenced a skilled nursing visit note on 10/18/11 time in 1:00 PM time out 2:00 PM signed by Employee G, a licensed practical nurse. The second page of this clinical document states, "Contacted Director of Nursing to obtain order for wound treatment to open area	N0542	On 01/05/12 All clincal staff re educated on policy regarding of plan of care, that it must be intiated by Registered Nurse (exception therapy only cases) and necessary revisions. Plan of Care must be updated to include all new orders received from physician. QI Cordinator will be responsible for reviewing 10 % of clinical records to ensure compliance.	01/05/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	from patient's MD." No order was present in the record. However, an order was found and presented. This order was not present on the updated plan of care (POC). a. On 12/15/11 at 2:50 PM, the director of nursing indicated the order had been obtained. b. On 12/15/11 at 4 PM, the director of nursing updated the missing order and a communication note had been found and presented two documents as follows: 1.) One document absent from Clinical Record #2 and signed by the director of nursing on 10/18/11 at 1:16 PM states, "Received call from [Employee G], patient has wound on RLE [right lower extremity] calf area and states they are putting a dry dressing on it. I will call RN [Employee H] to find out more. At 1:30 PM spoke with [Employee H] RN who stated [he/she] received order from MD for abd [abdominal pad] and secure with tape." 2.) The second document also absent from Clinical Record #2 and signed by the DON states, "Physician-please sign and return immediately, Agency HSU, [Patient #2], Physician's name, date ordered 10/18/11,			

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	cleanse right calf wound with normal saline or wound cleanser. Apply abd and secure with tape. Cleanse daily until healed." This was signed by the DON. On 12/15/11, no physician signature was present. c. The updated plan of care with a certification period from 11/4/11 - 1/2/11 failed to show the above order for wound care on the right lower extremity. 2. On 12/15/11 at 11 AM, the director of nursing indicated the plan of care had failed to be updated with the new order obtained on 10/18/11. 3. The agency policy titled "Plan of Care" with an effective date of 5/10 states, "Each patient has an individualized plan of care (POC) based on assessments and/or physician's orders. The POC is not a static document. It includes but is not limited to the CMS 485 or equivalent, supplemental orders, discipline specific interventions ... Procedure: the written POC is developed following a comprehensive assessment and collaboration with the physician for orders at admission at refortification, when applicable. The patient is involved with the process ... Updates to the POC are done with supplemental orders when required by law and regulation and/or			

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	documentation of discipline specific interventions linked to problems/needs." 4. The agency policy titled "Policy on the Provision of Nursing Services" with an effective date of 8/06 states, "The registered nurse duties providing SN (Skilled nursing) services include: ... Initiates the plan of care and necessary revisions."			
N0596	Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file review and interview, the agency failed to ensure the home health aide had been competency tested for medication assistance for 1 of 1 home health aide visit observations (employee J). Findings	N0596	N 596 Clinical and paraprofessional staff re - educated that the agency is responsible for ensuring that prior to patient contact, the individuals who furnish home health aide services meet the requierments:The Home Health aide shell have sucessfully completed a competency evaluation prior to performing task with patient. Employee J has	01/05/2012

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	1. At a home visit on 12/13/11 at 10:30 AM, patient #7 indicated Employee J, home health aide, employee J, assisted her/him by emptying the medications from the medication reminder box into a bowl in order that the patient could take the medicine. 2. Employee J's personnel file evidenced a document signed by this employee and the director of nursing titled "Indiana Association for Home Care Home Health Aide Skills Check List," which did not list medication assist as a skill the aide had been checked off on. This document was signed on 9/24/11. 4. On 12/14/11 at 3:30 PM, the administrator indicated the aide was not skill-checked on medication assist.		succesfully passed her competency evaluation in area of mediaction assist.To ensure compliance: Quality Improvement specialist will review 10 % of clinical records quaterly.Director of Clinical Services will monitor compliance of skills check on ongoing basis to ensure that employees do not perform tasks that they are not competency tested for.	