PRINTED: 05/07/2015					
FORM AP	PROVED				
OMB NO.	0938-0391				

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING <u>00</u>			LETED
		15K079	B. W.	ING		04/02	/2015
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			EAST STREET SUITE A9		
ATTENT	IVE HOME HEALT	HCARE LLC			APOLIS, IN 46227		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
G 000							
Dida 00							
Bldg. 00			G 0	00			
				00			
	This visit was fo	or a home health agency					
		recertification survey.					
	partial extended	recertification survey.					
	Dates of survey	: 3-30, 3-31, 4-1, and					
	4-2-2015	. 5-50, 5-51, <del>4</del> -1, and					
	4-2-2013						
	Facility #: IN0	12723					
	Facility #. INU.	12725					
	Medicaid Vende	or #: 201060380A					
	Census:	11 Skilled unduplicated					
	admissions, pas	t twelve months					
		15 Skilled active patients					
		50 Home health aide only					
	active patients	so frome nearth arecomy					
	active patients						
	Quality Review	· IF 4/7/15					
		. 31. 7/7/13					
G 121	484.12(c)						
	COMPLIANCE W						
Bldg. 00	PROFESSIONAL						
		staff must comply with					
		ional standards and					
		ply to professionals					
I	furnishing service		I		l		I

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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15K079	B. WING	<u></u>	04/02/2015
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	R		EAST STREET SUITE A9	
ATTENT	IVE HOME HEALT	HCARELLC		NAPOLIS, IN 46227	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	, -	(V5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRIATE DATE
_			G 121	Attentive home healthcare will	05/06/201
	Based on observ	vation, policy review, and	0 121	continue to in-service newclinic	
				staff on how to properly follow	
		gency failed to ensure the		policy and procedure on the	
		le had provided services		donning ofgloves and hand was	hing
		with infection control		procedures to be in compliance	with
		ocedures in 1 of 3 home		all infectioncontrol policy and	
	visit observation	ns (3) with a home health		procedures.	
	aide (HHA), En	nployee H.		Attentive Home Healthcare as a	
				result of the state surveyfinding	
	Findings includ	e:		in-service all clinical staff on pro	
	e			procedure and policy of donning	í l
	1 During home	visit observation for		gloves and proper hand washin techniques to be in compliance	-
	-	1-15 at 10:30 AM,		agencypolicy and procedures of	
	· ·			infection control during our	
		HA, was observed		mandatory staff meetingon Apr	il
		ces. When Employee H		28th and April 30th. All clinical s	
		leting and shower/bath of		will becompleted by May 6th 20	15.
	· ·	as observed to don 2 pair		The agency decided the best	
	of non-sterile g	loves. After assisting		practice to in-service allclinical	staff
	client to remove	e clothing, including a		would be during the mandatory	staff
	soiled (wet) adu	It diaper, HHA placed the		meetings and any staff thatcoul	d not
	. ,	a plastic bag, removed her		attend would be in-serviced by	May
	-	d closed the bag. She		6th 2015.	.
	<b>.</b> .	served to remove inner		The steps that the agency will ta	
		orm hand hygiene.		to ensure this does not recur will	
	-			to in-service clinical staff quarter mandatory monthly staffmeetir	
		sisted client with bathing		with proper procedure and poli	
		gloves she had donned		donning of gloves and proper	-, -:
	earlier.			handwashing techniques.	
				The corrective actions will be	
	2. Agency poli	cy "Handwashing/Hand		monitored by the director ofnu	rsing
	Hygiene", last r	eviewed/revised 2014,		quarterly during the mandatory	staff
	states, "Indicati	ons for hand washing and		meetings and will be document	ed
		between tasks on the		inthe monthly meeting minutes	and
		after removing gloves		sign-in log of who attended. The	e
	-	bjects that are potentially		skilled nurseswill also monitor	
		bjeets that are potentially		proper donning of gloves and p	roper

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZD4X11 Facility ID: 012723

If continuation sheet Page 2 of 6

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	NOF CORRECTION	IDENTIFICATION NUMBER: 15K079	A. BUILDING <u>00</u> B. WING		COMPLETED 04/02/2015	
NAME OF	PROVIDER OR SUPPLIE	UR		ET ADDRESS, CITY, STATE, ZIP CODE		
	TIVE HOME HEALT			3 S EAST STREET SUITE A9 ANAPOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) BE COMPLETION RIATE DATE	
1 000 Bidg. 00	<ul> <li>contaminated</li> <li>to use the bathr hands after rem</li> <li>3. On 4-2-15 at the nursing sup Employee H ha control principl instructed during</li> </ul>	. after assisting the client oom decontaminate oving gloves " t 11:55 AM, Employee B, ervisor, indicated d not followed infection es and agency policy as ag orientation, during ney, and agency continuing	N 000	hand washing techniquesduring supervisory visits and will be listed on supervisory visit form underuniversal precautions. The agency will also add the procedu of donning ofgloves and proper hand washing techniques by our designated home health aidefield auditor during random audits that are performed weekly. The action of the procedure will be document on the auditor's form that is completed by theauditor and will filed in our home health aide quat assurance log. Themonitoring of donning of gloves and proper hat washing techniques will beon-goo indefinitely, monthly meeting minutes will reflect quarterlyin-services on infection control policies such as donning gloves and properhand washing techniques. Quality assurance lo will reflect weekly random homehealth aide audit forms that document the proper procedure donning of glovesand hand wash techniques.	ed re d d t ns nted l be ality nd ing of g ut of	
	This visit was f state re-licensu	or a home health agency re survey.				
	Dates of survey 4-2-2015	r: 3-30, 3-31, 4-1, and				

State Form

Event ID:

ZD4X11

Facility ID: 012723

If continuation sheet

Page 3 of 6

PRINTED: 05/07/2015

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 05/07/2015

 FORM APPROVED

 OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	ATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         D PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       00         15K079       B. WING		<u>00</u>	(X3) DATE SURVEY COMPLETED 04/02/2015	
	PROVIDER OR SUPPLIE		5226	ET ADDRESS, CITY, STATE, ZIP CODE S EAST STREET SUITE A9 ANAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Facility #: IN0 Medicaid Vend	12723 lor #: 201060380A			
	Census: admissions, pas active patients Quality Review	<ul> <li>11 Skilled unduplicated</li> <li>st twelve months</li> <li>15 Skilled active patients</li> <li>50 Home health aide only</li> <li>7: JE 4/7/15</li> </ul>			
N 470 Bldg. 00	shall be written a control of commu	ency	N 470		05/06/201
	interview, the a home health aid in accordance v policies and pro	vation, policy review, and agency failed to ensure the de had provided services with infection control occdures in 1 of 3 home ns (3) with a home health mployee H.	N 470	Attentive home healthcare will continue to in-service newclinical staff on how to properly follow policy and procedure on the donning ofgloves and hand washing procedures to be in compliance with all infectioncontrol policy and procedures. Attentive Home Healthcare as a result of the state surveyfindings wi	1
	Findings includ	le:		in-service all clinical staff on proper procedure and policy ofdonning gloves and proper hand washing	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MED	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S	NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLE	
	of conduction	15K079	B. WING	00	04/02/2	
		151(07.5			04/02/2	010
AME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP CODE		
				S EAST STREET SUITE A9		
TTENT	TIVE HOME HEAL	THCARE LLC	INDIA	NAPOLIS, IN 46227		
(4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICII	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	COMPLETION
TAG	REGULATORY (	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	1. During hom	e visit observation for		techniques to be in compliance of		
	patient 3, on 4-	-1-15 at 10:30 AM,		agencypolicy and procedures of		
	Employee H, H	IHA, was observed		infection control during our		
		ices. When Employee H		mandatory staff meetingon April		
		ileting and shower/bath of		28th and April 30th. All clinical stat		
		vas observed to don 2 pair		will becompleted by May 6th 2015	o.	
	-	-		The agency decided the best practice to in-service allclinical sta	ft	
	-	loves. After assisting		would be during the mandatory st		
		e clothing, including a		meetings and any staff thatcould		
		ult diaper, HHA placed the		attend would be in-serviced by M		
	adult diaper in	a plastic bag, removed her		6th 2015.	.,	
	outer gloves, a	nd closed the bag. She		The steps that the agency will take	e	
	then was not of	bserved to remove inner		to ensure this does notrecur will b		
	gloves and per	form hand hygiene.		to in-service clinical staff quarterly	y at	
		ssisted client with bathing		mandatory monthly staffmeetings	5	
		gloves she had donned		with proper procedure and policy	of	
	earlier.	gioves she had donned		donning of gloves and proper		
	earner.			handwashing techniques.		
				The corrective actions will be		
		icy "Handwashing/Hand		monitored by the director ofnursi	-	
		reviewed/revised 2014,		quarterly during the mandatory st		
	states, "Indicat	ions for hand washing and		meetings and will be documented		
	hand antisepsis	s: between tasks on the		in the monthly meeting minutes and size in los of who extended. The	na	
	same patient	after removing gloves		sign-in log of who attended. The skilled nurseswill also monitor		
	-	objects that are potentially		proper donning of gloves and pro	ner	
		after assisting the client		hand washing techniquesduring		
		room decontaminate		supervisory visits and will be listed	l 1	
		noving gloves "		on supervisory visit form		
	nanus arter ren	ioving gioves		underuniversal precautions. The		
				agency will also add the procedur	e	
		tt 11:55 AM, Employee B,		of donning ofgloves and proper		
	• •	pervisor, indicated		hand washing techniques by our		
	Employee H ha	ad not followed infection		designated home health aidefield		
		les and agency policy as		auditor during random audits that	t I	
		ng orientation, during		are performed weekly. The action	s	
		ncy, and agency continuing		ofthe procedure will be document	ted	
	education offer			on the auditor's form that is		
		шдэ.		completed by theauditor and will	be	

Event ID: ZD4X11 Facility ID: 012723

If continuation sheet Page 5 of 6

PRINTED: 05/07/2015

FORM APPROVED

	f OF HEALTH AND HU R MEDICARE & MEDIC				PRINTED: 05/07/2 FORM APPROVEI OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K079	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/02/2015
	PROVIDER OR SUPPLIE		5226 S	ADDRESS, CITY, STATE, ZIP CODE EAST STREET SUITE A9 APOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				filed in our home health aide qualit assurance log. Themonitoring of donning of gloves and proper hand washing techniques will beon-going indefinitely, monthly meeting minutes will reflect quarterlyin-services on infection control policies such as donning of gloves and properhand washing techniques. Quality assurance log will reflect weekly random homehealth aide audit forms that document the proper procedure of donning of glovesand hand washing techniques.	g