

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130
--	---

(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	<p>This visit was a home health federal recertification survey.</p> <p>Survey dates: March 10, 11, 12, 13, and 14, 2014</p> <p>Facility #: 006000</p> <p>Medicaid #: 100265560</p> <p>Surveyors: Susan E. Sparks, RN PHNS</p> <p>Agency Census</p> <p>Skilled Patients 968 Home Health Aide Only Patients 0 Personal Service Only Patients 0 Total 968</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 17, 2014</p>	G000000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014	
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130			
(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			
G000121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on document review, observation, and interview, the agency failed to ensure their registered nurse followed infection control practices in 1 of 3 skilled nurse home visits (7) with the potential to affect all 968 patients.</p> <p>Findings:</p> <p>1. On 3/12/14 at 10:55 AM, Employee B, a registered nurse (RN), was observed performing wound care for patient #7. The RN removed the bandage on the right heel. The RN did not change her gloves and continued to cleanse the wound with warm water. The RN went to the living room and retrieved home wash cloths to dry the open wound. The RN removed her gloves but did not sanitize her hands before regloving. The RN used Clens AF Denal Wound Cleanser to clean the scissors instead of an alcohol based cleaner. She needed more supplies and got into the supply box, while the open duo derm patch was tucked under her arm, without changing her gloves. She applied the duo derm patch. She changed her gloves but did not sanitize her hands.</p>	G000121	<p>Mandatory education for all nursing staff will be provided using policies PCP-001 (hand Hygiene) and WC-001(wound Care/Reference/Resources/Documentation) from the Home Health Administrative Manual. This will also include instructing clinicians on infection control measures related to hand washing requirements when changing gloves performing wound care, and use of equipment. The Director Of Operations will ensure this education is completed no later than 4-11-2014. clinicians will adhere to al infection control policies while preforming care as outlined above. Director Of Operations, Clinical Manager or designee will perform joint visits with clinicians to assess infection control practices in the home. this will be done at a minimum of monthly for 2 months until 100 percent compliance is achieved. one compliance is achieved, home visits will be incorporated into agency quartely performance improvement activities.</p>	04/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014	
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>A. Wound care on left outer calf was completed. She changed her gloves but did not sanitize her hands. She cleansed the wound with Aloe Vesta Cleaning Foam on a regular household wash cloth. Then she used the Cleansing Spray into the open wound and wiped it out with a different household wash cloth. She changed her gloves but did not sanitize her hands.</p> <p>B. Wound care was performed on the coccyx wound. When removing the old bandage it was approximately 4 inches above the wound and the aquacel was not present. The RN used the Aloe Vest Cleaning Foam on a regular household wash cloth directly into the open wound. Then she used the Cleansing Spray in the open wound and wiped it off with a different household wash cloth. She changed her gloves without sanitizing her hands. She then took two different tubes of medicated creams and used her index finger against the end of one tube to get the medicine, and then moved to the next tube to get the second medicine with the same index finger, rubbed them together and applied them to the coccyx wound. She inserted the Aquacel and covered the wound.</p> <p>2. The Centers for Disease Control</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>"Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. On 3/14/14 at 10:25 PM, Employee A, Clinical Manager, indicated the RN was not using appropriate technique in performing the wound care.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130
--	---

(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
--------------------	--	---------------	---	----------------------

G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review and interview, the agency failed to ensure visits and treatments were performed as ordered on the plan of care in 4 of 16 clinical records reviewed with the potential to affect all 968 patients. (6, 7, 14, and 16)</p> <p>Findings:</p> <p>1. Clinical record 6, start of care (SOC) 2/15/14, included a plan of care for the certification period 2/15/14 through 4/15/14 with physician orders for "SN [skilled nurse] to perform wound care: Cleanse coccyx with SAF CLENS and apply SENSICARE daily." The clinical record failed to evidence wound care was provided 2/28, 3/4, and 3/12/14 and failed to evidence physician notification of wound care not being provided.</p> <p>2. Clinical record 7, SOC 11/4/13, included a plan of care for the certification period 1/3/14 through 3/3/14 with physician orders for the skilled nurse 1 time a week for 1 week, 3 times a week for 8 weeks, and 1 time a week for 1</p>	G000158	<p>The Director of Operation or Designee will</p> <p>1. Complete education for all clinicians regarding Amedisys Policy TX-001 (Physician Orders/Medical Supervision of Plan of Care). The Director of Operations will ensure this education is completed no later than April 11, 2014.</p> <p>2. Assign responsibility to the Clinical Manger for ongoing monitoring.</p> <p>ACCOUNTABILITY PROCESS:</p> <p>1. Each professional clinician will have access to their daily assignments with current orders prior to making visits for patients. Staff may contact the office by telephone speaking directly with a clinical manager for follow up if unsure about current orders or changes.</p> <p>2. The professional making the visit is to document any/all changes on the flow sheet in the home for the next clinician and discuss each/all changes with the patient/caregiver in order to facilitate continuity of care among all disciplines & the patient/caregiver.</p> <p>MONITORING PROCESS: 100% - concurrent / ongoing</p> <p>1.Each Clinical Manager will</p>	04/03/2014
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>week. The clinical record failed to evidence 1 visit in week 1, 3 visits in week 2, and 1 visit in week 10.</p> <p>3. Clinical record 14, SOC 5/1/13, included a plan of care for the certification period 5/1/13 through 6/29/13 with physician orders for the physical therapist 1 time a week for 1 week, 2 times a week for 4 weeks, starting week 7. The clinical record failed to evidence two visits week 9.</p> <p>4. Clinical record 16, SOC 8/21/13, included a plan of care for the certification period 10/20/13 through 2/18/13 that failed to evidence an order for telemonitoring. The record evidenced telemonitoring was completed daily.</p> <p>5. On 3/14/14 at 10:25 AM, Employee A, Clinical Manager, indicated the plan of care was not followed in the above records.</p>		<p>completed concurrent review daily on all Plans of Care generated by the professional staff to ensure that a clinically valid, individualized care plan is developed that contains appropriate and relevant parameters to monitor each patient's health status. 2. 100% of Verbal Order will be reviewed by the Clinical Manger for content/appropriateness and initialed, then routed to the scheduler for data entry of all pertinent information to facilitate communication regarding changes in orders. These notes will be provided to all clinicians with their daily assignment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014	
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130			
(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			
G000229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on record review and interview, the agency failed to ensure the physical therapist made a home health aide supervisory visit every 14 days in 1 of 1 therapy supervised clinical record reviewed with the potential to affect all patients who receive aide and therapy services. (9)</p> <p>Findings:</p> <p>1. Clinical record 9, start of care 1/4/14, included a plan of care for the certification period 1/4/14 through 3/4/14 with orders for home health aide, skilled nurse until 1/15/14, and physical therapy. The clinical record evidenced a gap of 22 days after the skilled nurse was no longer seeing the patient before the physical therapist made a home health aide supervisory visit, and then another gap of 22 days before the physical therapist made another supervisory visit.</p> <p>2. On 3/14/14 at 10:25 PM, Employee A, Clinical Manager, indicated supervisory visits should be made every 14 days.</p>	G000229	The Director of Operations or designee will re-educated professional clinicians on policies AA-011 (Home Health Aide care Plan assignment) and AA-007b (Services provided /Supervision of Discipline Home health Aide). This will include instructing professional clinicians that a visit will be made to any patient receiving Home Health Aide services no less often than every fourteen days. The Director of Operations will ensure this education is completed no later than April 11, 2014. The Director of Operations will assign the responsibility of the Business Office Specialist to review the schedule calendar at Start of Care,	04/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130		
(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	
N000000	<p>This visit was a home health state relicensure survey.</p> <p>Survey dates: March 10, 11, 12, 13, and 14, 2014</p> <p>Facility #: 006000</p> <p>Medicaid #: 100265560</p> <p>Surveyors: Susan E. Sparks, RN PHNS</p> <p>Agency Census</p> <p>Skilled Patients 968 Home Health Aide Only Patients 0 Personal Service Only Patients 0 Total 968</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 17, 2014</p>	N000000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014	
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130			
(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			
N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review and interview, the agency failed to ensure visits and treatments were performed as ordered on the plan of care in 4 of 16 clinical records reviewed with the potential to affect all 968 patients. (6, 7, 14, and 16)</p> <p>Findings:</p> <p>1. Clinical record 6, start of care (SOC) 2/15/14, included a plan of care for the certification period 2/15/14 through 4/15/14 with physician orders for "SN [skilled nurse] to perform wound care: Cleanse coccyx with SAF CLENS and apply SENSICARE daily." The clinical record failed to evidence wound care was provided 2/28, 3/4, and 3/12/14 and failed to evidence physician notification of wound care not being provided.</p> <p>2. Clinical record 7, SOC 11/4/13, included a plan of care for the certification period 1/3/14 through 3/3/14 with physician orders for the skilled nurse 1 time a week for 1 week, 3 times a week for 8 weeks, and 1 time a week for 1</p>	N000522	Mandatory education for all nursing staff will be provided using policies PCP-001 (hand Hygiene) and WC-001(wound Care/Reference/Resources/Documentation) from the Home Health Administrative Manual. This will also include instructing clinicians on infection control measures related to hand washing requirements when changing gloves performing wound care, and use of equipment. The Director Of Operations will ensure this education is completed no later than 4-11-2014. clinicians will adhere to al infection control policies while preforming care as outlined above. Director Of Operations, Clinical Manager or designee will perform joint visits with clinicians to assess infection control practices in the home. this will be done at a minimum of monthly for 2 months until 100 percent compliance is achieved. one compliance is achieved, home visits will be incorporated into agency quartely performance improvement activities. The Director of Operation or Designee will 1. Complete education for all clinicians regarding Amedisys Policy TX-001 (Physician	04/03/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>week. The clinical record failed to evidence 1 visit in week 1, 3 visits in week 2, and 1 visit in week 10.</p> <p>3. Clinical record 14, SOC 5/1/13, included a plan of care for the certification period 5/1/13 through 6/29/13 with physician orders for the physical therapist 1 time a week for 1 week, 2 times a week for 4 weeks, starting week 7. The clinical record failed to evidence two visits week 9.</p> <p>4. Clinical record 16, SOC 8/21/13, included a plan of care for the certification period 10/20/13 through 2/18/13 that failed to evidence an order for telemonitoring. The record evidenced telemonitoring was completed daily.</p> <p>5. On 3/14/14 at 10:25 AM, Employee A, Clinical Manager, indicated the plan of care was not followed in the above records.</p>		<p>Orders/Medical Supervision of Plan of Care). The Director of Operations will ensure this education is completed no later than April 11, 2014. 2. Assign responsibility to the Clinical Manger for ongoing monitoring. ACCOUNTABILITY PROCESS: 1. Each professional clinician will have access to their daily assignments with current orders prior to making visits for patients. Staff may contact the office by telephone speaking directly with a clinical manager for follow up if unsure about current orders or changes. 2. The professional making the visit is to document any/all changes on the flow sheet in the home for the next clinician and discuss each/all changes with the patient/caregiver in order to facilitate continuity of care among all disciplines & the patient/caregiver. MONITORING PROCESS: 100% - concurrent / ongoing 1.Each Clinical Manager will completed concurrent review daily on all Plans of Care generated by the professional staff to ensure that a clinically valid, individualized care plan is developed that contains appropriate and relevant parameters to monitor each patient's health status. 2. 100% of Verbal Order will be reviewed by the Clinical Manger for content/appropriateness and initialed, then routed to the scheduler for data entry of all pertinent information to facilitate</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157221	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER AMEDISYS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 303 QUARTERMASTER CT JEFFERSONVILLE, IN 47130		
(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	
			communication regarding changes in orders. These notes will be provided to all clinicians with their daily assignment.		