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	157568	A. BUILDING 00 B. WING	11/03/2017

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OMNI HOME CARE	600 N WEINBACK AVE STE 610 EVANSVILLE, IN 47711

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G 0000 Bldg. 00	This visit was for a federal home health recertification survey. The survey was partially extended. Survey Dates: October 30, 31 and November 1, 2, 3 of 2017. Facility ID: 004583 Medicaid Vendor ID: 200538750 12 Month Unduplicated Admissions: 316 Sample: 12 records reviewed/ 6 home visits	G 0000		
G 0107 Bldg. 00	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the	G 0107	Branch Director will review all complaint documentation upon	11/09/2017

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

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	agency failed to ensure the agency conducted a thorough investigation, which met their own policy, of patients' complaints in the 2015 through 2017 complaint log. Findings include: 1. The agency's 2015 through 2017 Complaint Resolution Log was reviewed on 10/30/17 and contained 7 complaints dated 4/14, 4/24, 4/28, 6/12, 6/15, 6/16, and 6/26 of 2015 and a policy titled 3.2 Customer Complaints. The Complaint Resolution Log contained an X mark for resolved. A. On 10/30/17 the Administrator was asked to provide the documentation of the resolutions for the complaints dated 4/14, 4/24, 4/28, 6/12, 6/15, 6/16, and 6/26 of 2015. After review of the agency's complaint policy, inquired as to why the documentation of the resolution to the complaints was not kept in the complaint log per the agency's policy. The Administrator stated that the complaints are kept in the EMR [electronic medical record] under QI [quality improvement] Event Report's. B. On 10/31/17 at 3:50 pm, the Administrator provided a QI Event Report that contained 6 complaints dated 6/15,		receipt in HCHB EMR database. Branch Director to evaluate situation concerning complaint and initiate acceptable resolution of complaint. Branch Director to ensure appropriate documentation is present, completed thoroughly by team member. Branch Director will record findings from complaint form in complaint log once addressed. Branch Director to monitor all complaints by reviewing 100% of complaints for appropriate follow up & follow up with person(s) who initiated complaint to ensure resolution. Branch Director reviewed P&P with clinical staff on 11/9/17, Policy #3.2 Customer Complaints	

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	6/15, 6/16, 6/26, 9/17, and 10/28 of 2015. C. The Administrator also provided 5 Complaint Reports dated 6/15, 6/15, 6/16, 6/26, 9/17 of 2015. D. The agency failed to evidence documentation for complaints dated 4/14, 4/24, 4/28, 6/12, and 10/28 of 2015. The agency failed to enter into the Complaint Resolution Log complaints dated 6/15 (1of 2), 9/17, and 10/28 of 2015. 2. A policy titled 3.2 Customer Complaints Revised 3/15, states, "...6. Upon receipt and documentation of the complaint, the Director shall initiate a recovery process to include the following:...d. evaluation of the circumstances and formulation of a plan for resolution...f. Document the steps to resolution in the Complaint Log. 7. Agency management team members will record their finding on the Complaint Form, as appropriate. When the problem has been addressed the Complaint Form will be placed in a Complaint Log..."			
G 0121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with			

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	accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation and record review, the agency failed to ensure clinicians followed recognized infection control procedures and the agency's policy related to hand hygiene for 3 of 6 (Patients #3,5,6) home visit observations. Findings include: 1. The clinical record of patient #3 was reviewed on 10/31/17, and evidenced a plan of care established by the physician for the certification period 10/16/17 to 12/14/17, start of care 10/16/17. The patient's diagnosis was Alcohol Abuse and history of falls. A. During a home visit (patient #3) on 10/31/17 at 2:15 pm, employee I, a PTA [physical therapy assistant], was observed placing his/her's computer tablet and keyboard on the patient's table without wiping the surface or placing a barrier on the table. The agency failed to apply a barrier and to clean the tablet and keyboard prior to leaving the patient's home. B. In an interview on 11/1/17, the Administrator agreed that a barrier should have been placed down on the table prior to	G 0121	Clinical Manager re-educated staff on 11/9/17 covering Policy # 7.5 Infection Control including Hand Hygiene & bag technique. Bag Technique demonstration performed by clinicians.Hand washing reviewed step by step with clinicians, with clinicians verbally reiterating step by step back to Clinical Manager/ Director. Clinical Manager will have staff demonstrate hand washing once per quarter until staff 100% compliant with P&P. Clinical Manager to make a minimum of 2 home visits per quarter to ensure compliance of P&P's above. Clinical Manager re-educated and enforced use of barriers with all equipment including tablets with approved disinfecting of equipment.	11/09/2017

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	placing the tablet and keyboard down. Inquired about disinfecting the tablet and keyboard wipe, she/he stated they would consider it. 2. The clinical record of patient #5 was reviewed on 11/1/17, and evidenced a plan of care established by the physician for the certification period 10/8/17 to 12/6/17, start of care 4/11/17. The patient's diagnosis was encounter for fitting and adjusting urinary device. A. During a home visit (patient #5) on 11/1/17 at 10:20 am, employee G, a RN [registered nurse], was observed assessing patient #5 bilateral lower legs. The registered nurse was observed removing his/her gloves after assessing the patient's lower legs and picking up his/her computer tablet to document. The registered nurse failed to perform hand hygiene after removing his/her gloves. B. In an interview on 11/1/17, the Administrator was unable to provide any additional information. 3. The clinical record of patient #6 was reviewed on 11/1/17, and evidenced a plan of care established by the physician for the certification period 10/18/17 to 12/16/17,			

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	start of care 10/18/17. The patient's diagnosis was Type II Diabetes. A. Upon arrival at patient #6 apartment, a notice sign was hanging on the wall that stated the apartment building was being treated for pest. During the home visit (patient #6) on 11/1/17 at 3:30 pm, employee H, a registered nurse, was observed placing his/her computer tablet on top of the patient's table next to papers without a barrier. The agency failed to apply a barrier and to clean the tablet prior to leaving the patient's home. B. B. In an interview on 11/1/17, the Administrator agreed that a barrier should have been placed down on the table prior to placing the computer tablet down. Inquired about cleaning the tablet with a disinfectant, she/he stated they would consider it. 4. A policy titled 7.5 Hand Hygiene, Revised 5/16 states, "...Healthcare personnel will follow current CDC guidelines for hand hygiene to prevent the spread of infection...Healthcare personnel will perform hand hygiene...3. each time gloves are removed..." 5. Review of a document, CDC (Centers for Disease Control) guidance for hand			

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	hygiene in healthcare settings, in which it stated healthcare providers should perform hand hygiene "Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed) ... After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings ... After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... After glove removal." 6. Review of a document titled Bag Technique: Preventing and Controlling Infections in Home Care and Hospice (2014) states, "Clean and disinfect the vital sign equipment...and electronic equipment used during patient care (i.e., laptop computer, cell phone)"			
G 0159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent			

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	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 record review and interview the agency failed to ensure all pertinent items were included on the plan of care for 3 of 12 (Patient #2,6,12) clinical records reviewed. Findings include: 1. The clinical record of patient #2 was reviewed on 10/31/17, and evidenced a plan of care established by the physician for the certification period 10/16/17 to 12/14/17, start of care 10/16/17. The patient's diagnosis was muscle weakness. A. During a home visit (patient #2) on 10/31/17 at 1:15 pm, employee J, an OT [occupational therapist], was obsevered transfering patient #2 using a gait belt, rolling walker to a wheel chair. Located a raised toilet seat in the patient's bathroom during the home visit. B. A review of the plan of care dated 10/16/17 states, "...DME supplies: None..."	G 0159	Branch Director will ensure all POC's are updated to include all current medications and subsequent visit notes properly document new, changed or discontinued meds with edits made to medication profiles. All clinicians in-serviced by Clinical MAnager on 11/9/17 covering Policy # 2.26 "Medication Administration" and Medication Reconciliation Process. Clinical Manager to review 100% of POC's created until compliance obtained. All clinicians re-educated in reviewing equipment present in home & address in POC under DME section. Clinical Manager will review POC against visit notes on 100% of POC's to verify compliance of equipment added to POC. Branch Director responsible for monitoring these corrective actions.	11/09/2017

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	The agency failed to include all pertinent items such as a wheel chair, rolling walker, raised toilet seat, and gait belt in the DME [durable medical equipment] section in the plan of care. 2. The clinical record of patient #6 was reviewed on 11/1/17, and evidenced a plan of care established by the physician for the certification period 10/18/17 to 12/16/17, start of care 10/18/17. A. During a home visit (patient #6) on 11/1/17 at 3:30 pm, the patient was observed walking with a quad cane during the visit. A wheel chair and half rail on bath tub were evidenced during the home visit. The agency failed to include a quad cane, wheel chair, and half rail for tub in the DME section in the plan of care. 3. The clinical record of patient #12 was reviewed on 11/3/17, and evidenced a plan of care established by the physician for the certification period 8/24/17 to 10/22/17, start of care 9/4/17. The patient's diagnosis was Pressure Ulcer Stage 4 [muscle/bone exposed]. A. A Visit Note Report narrative dated 10/11/17 states, "...red area on Rt buttock fading to pink and applied Calazime for			

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	protection..." A Home Health Certification and Plan of Care dated 9/5/17 failed to include Calazime on the medication list. B. A Home Health Certification and Plan of Care dated 9/5/17 included a treatment for Bactroban topical as directed for irritation as needed/prn, apply sparingly to affected area. The agency failed to evidence a specific anatomical location for the treatment to be applied. C. In an interview on 11/3/17 the Administrator and Clinical Nurse Manager were unable to provide any additional information.			
G 0164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE			

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Bldg. 00	Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on record review and interview, the agency failed to ensure physician notification of changes that may have required a need to alter the plan of care in 2 of 12 (Patient #5,11) records reviewed. Findings include: 1. The clinical record of patient #5 was reviewed on 11/1/17 and evidenced a plan of care established by the physician for the certification period 10/8/17 to 12/6/17, start of care 4/11/17. The patient's diagnosis was hypertension heart and chronic kidney disease with heart failure and stage 1-4/unspecific chronic kidney. A. During a home visit (patient 5) on 11/1/17 at 10:20 a.m., employee G, a registered nurse, was obsevered discussing with the patient his/her concerns about experiencing auditory hallucinations with the use of Aricept [medication for mild to moderate dementia/Alzheimer] for the past week. The registered nurse instructed patient 5 to continue to hold the Aricept to see if the auditory hallucinations ceased. Patient 5 responded that he/she was no longer taking Aricept. The agency failed to update the physician on the patient's	G 0164	Re-education with all agency staff regarding Policy # 2.6 "Assessment/Reassessment" as it relates to MD notification of any changes that suggest the need to alter the POC was completed 11/9/17 by clinical manager. Branch Director and clinical manager to complete 100% review of Initial Comprehensive Assessment and visit notes to ensure clinicians are following POC established with MD approval. Chart Audits, in the amount of 5 per quarter will be completed by Branch Director to monitor compliance. Reporting of clinical changes that require alteration to a POC will be documented in Physician notification coordination note & new orders obtained.	11/09/2017

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	condition and failed to obtain an order to hold the Aricept. B. A Visit Note Report dated 10/25/17 states, "Is the patient taking all medications as ordered by the physician? No If not why? Aricept causes auditory hallucinations-holding to see if symptoms cease" The narrative note for 10/25/17 states, "...pt noted to have increased memory issues, pt states [patient] is noticing increased forgetfulness and becomes easily distracted. pt at times can't remember if has taken meds so is starting to turn prescription bottle upside down after [patient] takes medicine to prevent double dosing" C. A Visit Note Report narrative dated 11/1/17 states, "Discussed with pt decision to stop [patient] Aricept due to continued auditory hallucinations, pt states that the music is less profound but still present at times. Medication profile updated. SN notified [Dr.] office [nurse] that pt no longer taking after visit" D. In an interview on 11/2/17 the Administrator was made aware the patient's medication was held without a physician's order and was unable to provide any additional information.			

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	2. The clinical record of patient #11 was reviewed on 11/3/17 and evidenced a plan of care established by the physician for the certification period 9/23/17 to 11/21/17, start of care 5/26/17. The patient's diagnosis was Pressure Ulcer Stage 3 [full thickness of skin loss]. A. A review of the plan of care dated 10/20/17 included an order for "skilled nurse for administration...wound care to bilat upper posterior thigh, cleanse with adhesive remover then wound cleanser pat dry. apply medihoney to wound bed then cover with polymen and cover with mepilex dressing..." B. A Visit Note Report narrative dated 9/25/17 states, "...cleaned with adhesive remover then wound cleaner pat dry applied skin prep then medihoney to wound bed..." A Visit Note Report narrative dated 9/28/17 states, "changed dressing to RT and left upper thigh posterior, cleaned with adhesive remover then wound cleanser pat dry applied skin prep then medihoney to wound bed..." The agency failed to evidence the physician was notified that skin prep was being used. 3. A policy titled 2.6 Assessment/Reassessment revised 9/16, states, "...6. Significant Change in Condition.			

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	Professional Staff will consult with the Clinical Manager to report a change in patient condition to determine after review of the findings if the Follow up Oasis Comprehensive Patient Assessment should be conducted at the next skilled visit. The significant change in condition is reported to the physician in conjunction with the results of the comprehensive assessment and a supplemental order is obtained to update the plan of care...a significant decline in function impacting patient safety... A Physician Notification of Condition Change, Incidents, Significant Events policy states, "7. failure of patient to respond therapeutically to prescribed medications or treatments...11. new onset of signs/symptoms..."			
G 0334 Bldg. 00	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of			

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	care. Based on clinical record review and interview, the agency failed to ensure comprehensive assesments were complete and accurately reflected the patient's needs for 3 of 12 (Pateint #1,3,6) clinical records reviewed. Findings include: 1. The clinical record of patient #1 was reviewed on 10/30/17, and evidenced a plan of care established by the physician for the certification period 9/2/17 to 10/31/17, start of care 9/2/17. The patient's diagnosis was encounter for surgical after care following surgery of the digestive system. A. A Visit Note Report Oasis Admission dated 9/2/17 failed to evidence a Nutrional Risk Assessment Score to determine if the patient was a nutrional risk. B. A Visit Note Report RN Resumption of Care dated 9/8/17 failed to evidence a Nutrional Risk Assessment Score to determine if the patient was a nutritional risk. 2. The clinical record of patient #3 was reviewed on 10/31/17, and evidenced a plan of care established by the physician for the certification period 10/16/17 to	G 0334	Clinical Manager Review of Policy # 2.6 “Assessment/Reassessment” on 11/9/17. Reinforced with RN’s & clinicians performing initial assessments /Reassessments focus of assess & document findings of each patient with admission. Clinicians to perform ongoing reassessments including nutritional status as warranted by patient’s condition. Clinical manager reeducated clinicians on standardized nutritional risk assessment tool (MNA- mini nutritional assessment) to be completed every initial assessment/ reassessment and as needed as patient condition is assessed. Clinical manager to review 100% of Initial Comprehensive Assessment/ reassessments and visit notes for nutritional needs until compliance with 100% is met. Branch Director to oversee monitoring.	11/09/2017

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	12/14/17, start of care 10/16/17. The patient's diagnosis was Alcohol Abuse and a personal history of self-harm. A. A Visit Note Report RN Oasis Admission dated 10/16/17 failed to evidence a Nutritional Risk Assessment Score to determine if the patient was a nutritional risk. B. In an interview on 11/2/17, the Administrator and Clinical Nurse Manager were inquired as to why there was no nutrional risk score for patient #3 and how does the agency determine if the patient is at a nutritional risk. The Administrator stated that the Nestle Mini Nutritional Assessment was another tool and option the clinician could use. The Administrator evidenced a document titled Nutritional Assessment Process. The Administrator and Clinical Nurse Manager were unable to provide any additional information as to how a patient was determined to be at a nutritional risk and why a nutritional risk score was not evidenced. 3. The clinical record of patient #6 was reviewed on 11/1/17, and evidenced a plan of care established by the physician for the certification period 10/18/17 to 12/16/17, start of care 10/18/17. The patient's			

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	diagnosis was Type II Diabetes. A. A Visit Note Report RN Oasis Admission dated 10/18/17 failed to evidence a Nutritional Risk Assessment Score to determine if the patient was a nutritional risk. 4. A policy titled 2.6 Assessment/Reassessment revised 9/16 states, "Registered Nursing staff...assess and document findings of each patient upon admission and perform reassessments on an ongoing basis as appropriate to the patient's condition...Nutritional status is assessed at time of admission and on an ongoing basis as warranted by the patient condition. Using a standardized nutritional risk assessment tool, risk factors are identified, and a total sum of the assessment tool score determines the level of risk for the patient..." 5. A document titled Nutrional Assessment Process (Almost Family Inc.) was evidenced by the Administrator on 11/2/17 and states, "...The MNA [mini nutritional assessment] is a component of the Almost Family comprehensive OASIS patient assessment...the MNA is conducted at the time of admission, as appropriate throughout the patient's plan of treatment, and minimally every 60 days. MNA results are			

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	documented in the medical record. Six risk factors are scored and totaled. The level of nutritional risk is as follows: 12-14 pts, normal nutritional risk; 8-11 pts, at risk for malnutrition; 0-7 pts, malnourished...Recent /current height and height measurements available in the medical record should be used as a priority..."			
N 0000 Bldg. 00	This visit was for a state home health recertification survey. Survey Dates: October 30, 31 and November 1, 2, 3 of 2017. Facility ID: 004583 Medicaid Vendor ID: 200538750 12 Month Unduplicated Admissions: 316 Sample: 12 records reviewed/ 6 home visits	N 0000		

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N 0514 Bldg. 00	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the agency failed to ensure the agency conducted a thorough investigation, which met their own policy, of patients' complaints in the 2015 through 2017 complaint log. Findings include: 1. The agency's 2015 through 2017 Complaint Resolution Log was reviewed on 10/30/17 and contained 7 complaints dated 4/14, 4/24, 4/28, 6/12, 6/15, 6/16, and 6/26 of 2015 and a policy titled 3.2 Customer Complaints. The Complaint Resolution Log contained an X mark for resolved. A. On 10/30/17 the Administrator was	N 0514	Branch Director will review all complaint documentation upon receipt in HCHB EMR database. Branch Director to evaluate situation concerning complaint and initiate acceptable resolution of complaint. Branch Director to ensure appropriate documentation is present, completed thoroughly by team member. Branch Director will record findings from complaint form in complaint log once addressed. Branch Director to monitor all complaints by reviewing 100% of complaints for appropriate follow up & follow up with person(s) who initiated complaint to ensure resolution Branch Director reviewed P&P with clinical staff on 11/9/17, Policy #3.2 Customer Complaints	11/09/2017

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	asked to provide the documentation of the resolutions for the complaints dated 4/14, 4/24, 4/28, 6/12, 6/15, 6/16, and 6/26 of 2015. After review of the agency's complaint policy, inquired as to why the documentation of the resolution to the complaints was not kept in the complaint log per the agency's policy. The Administrator stated that the complaints are kept in the EMR [electronic medical record] under QI [quality improvement] Event Report's. B. On 10/31/17 at 3:50 pm, the Administrator provided a QI Event Report that contained 6 complaints dated 6/15, 6/15, 6/16, 6/26, 9/17, and 10/28 of 2015. C. The Administrator also provided 5 Complaint Reports dated 6/15, 6/15, 6/16, 6/26, 9/17 of 2015. D. The agency failed to evidence documentation for complaints dated 4/14, 4/24, 4/28, 6/12, and 10/28 of 2015. The agency failed to enter into the Complaint Resolution Log complaints dated 6/15 (1of 2), 9/17, and 10/28 of 2015. 2. A policy titled 3.2 Customer Complaints Revised 3/15, states, "...6. Upon receipt and documentation of the complaint, the Director shall initiate a recovery process to include			

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	the following:...d. evaluation of the circumstances and formulation of a plan for resolution...f. Document the steps to resolution in the Complaint Log. 7. Agency management team members will record their finding on the Complaint Form, as appropriate. When the problem has been addressed the Complaint Form will be placed in a Complaint Log..."			
N 0524 Bldg. 00	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.			

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	(xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview the agency failed to ensure all pertinent items were included on the plan of care for 3 of 12 (Patient #2,6,12) clinical records reviewed. Findings include: 1. The clinical record of patient #2 was reviewed on 10/31/17, and evidenced a plan of care established by the physician for the certification period 10/16/17 to 12/14/17, start of care 10/16/17. The patient's diagnosis was muscle weakness. A. During a home visit (patient #2) on 10/31/17 at 1:15 pm, employee J, an OT [occupational therapist], was obsevered transfering patient #2 using a gait belt, rolling walker to a wheel chair. Located a raised toilet seat in the patient's bathroom during the home visit. B. A review of the plan of care dated 10/16/17 states, "...DME supplies: None..." The agency failed to include all pertinent items such as a wheel chair, rolling walker, raised toilet seat, and gait belt in the DME [durable medical equipment] section in the plan of care.	N 0524	Branch Director will ensure all POC's are updated to include all current medications and subsequent visit notes properly document new, changed or discontinued meds with edits made to medication profiles. All clinicians in-serviced on 11/9/17 covering Policy # 2.26 "Medication Administration" and Medication Reconciliation Process. Clinical Manager to review 100% of POC's created until compliance obtained. All clinicians re-educated in reviewing equipment present in home & address in POC under DME section. Clinical Manager will review POC against visit notes on 100% of POC's to verify compliance of equipment added to POC. Branch Director responsible for monitoring these corrective actions.	11/09/2017

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	2. The clinical record of patient #6 was reviewed on 11/1/17, and evidenced a plan of care established by the physician for the certification period 10/18/17 to 12/16/17, start of care 10/18/17. A. During a home visit (patient #6) on 11/1/17 at 3:30 pm, the patient was observed walking with a quad cane during the visit. A wheel chair and half rail on bath tub were evidenced during the home visit. The agency failed to include a quad cane, wheel chair, and half rail for tub in the DME section in the plan of care. 3. The clinical record of patient #12 was reviewed on 11/3/17, and evidenced a plan of care established by the physician for the certification period 8/24/17 to 10/22/17, start of care 9/4/17. The patient's diagnosis was Pressure Ulcer Stage 4 [muscle/bone exposed]. A. A Visit Note Report narrative dated 10/11/17 states, "...red area on Rt buttock fading to pink and applied Calazime for protection..." A Home Health Certification and Plan of Care dated 9/5/17 failed to include Calazime on the medication list. B. A Home Health Certification and Plan			

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	of Care dated 9/5/17 included a treatment for Bactroban topical as directed for irritation as needed/prn, apply sparingly to affected area. The agency failed to evidence a specific anatomical location for the treatment to be applied. C. In an interview on 11/3/17 the Administrator and Clinical Nurse Manager were unable to provide any additional information.			
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the agency failed to ensure physician notification of changes that may have required a need to alter the plan of care in 2 of 12 (Patient #5,11) records reviewed. Findings include: 1. The clinical record of patient #5 was reviewed on 11/1/17 and evidenced a plan of care established by the physician for the certification period 10/8/17 to 12/6/17, start of care 4/11/17. The patient's diagnosis was	N 0527	Re-education with all agency staff regarding Policy # 2.6 "Assessment/Reassessment" as it relates to MD notification of any changes that suggest the need to alter the POC was completed 11/9/17 by clinical manager. Branch Director and clinical manager to complete 100% review of Initial Comprehensive Assessment and visit notes to ensure clinicians are following POC established with MD approval. Chart Audits, in the amount of 5 per quarter will be completed by Branch Director to monitor compliance. Reporting of clinical changes that	11/09/2017

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	hypertension heart and chronic kidney disease with heart failure and stage 1-4/unspecific chronic kidney. A. During a home visit (patient 5) on 11/1/17 at 10:20 a.m., employee G, a registered nurse, was obsevered discussing with the patient his/her concerns about experiencing auditory hallucinations with the use of Aricept [medication for mild to moderate dementia/Alzheimer] for the past week. The registered nurse instructed patient 5 to continue to hold the Aricept to see if the auditory hallucinations ceased. Patient 5 responded that he/she was no longer taking Aricept. The agency failed to update the physician on the patient's condition and failed to obtain an order to hold the Aricept. B. A Visit Note Report dated 10/25/17 states, "Is the patient taking all medications as ordered by the physician? No If not why? Aricept causes auditory hallucinations-holding to see if symptoms cease" The narrative note for 10/25/17 states, "...pt noted to have increased memory issues, pt states [patient] is noticing increased forgetfulness and becomes easily distracted. pt at times can't remember if has taken meds so is starting to turn prescription bottle upside down after [patient] takes		require alteration to a POC will be documented in Physician notification coordination note & new orders obtained.	

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	medicine to prevent double dosing" C. A Visit Note Report narrative dated 11/1/17 states, "Discussed with pt decision to stop [patient] Aricept due to continued auditory hallucinations, pt states that the music is less profound but still present at times. Medication profile updated. SN notified [Dr.] office [nurse] that pt no longer taking after visit" D. In an interview on 11/2/17 the Administrator was made aware the patient's medication was held without a physician's order and was unable to provide any additional information. 2. The clinical record of patient #11 was reviewed on 11/3/17 and evidenced a plan of care established by the physician for the certification period 9/23/17 to 11/21/17, start of care 5/26/17. The patient's diagnosis was Pressure Ulcer Stage 3 [full thickness of skin loss]. A. A review of the plan of care dated 10/20/17 included an order for "skilled nurse for administration...wound care to bilat upper posterior thigh, cleanse with adhesive remover then wound cleanser pat dry. apply medihoney to wound bed then cover with polymen and cover with mepilex dressing..."			

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	B. A Visit Note Report narrative dated 9/25/17 states, "...cleaned with adhesive remover then wound cleaner pat dry applied skin prep then medihoney to wound bed..." A Visit Note Report narrative dated 9/28/17 states, "changed dressing to RT and left upper thigh posterior, cleaned with adhesive remover then wound cleanser pat dry applied skin prep then medihoney to wound bed..." The agency failed to evidence the physician was notified that skin prep was being used. 3. A policy titled 2.6 Assessment/Reassessment revised 9/16, states, "...6. Significant Change in Condition. Professional Staff will consult with the Clinical Manager to report a change in patient condition to determine after review of the findings if the Follow up Oasis Comprehensive Patient Assessment should be conducted at the next skilled visit. The significant change in condition is reported to the physician in conjunction with the results of the comprehensive assessment and a supplemental order is obtained to update the plan of care...a significant decline in function impacting patient safety... A Physician Notification of Condition Change, Incidents, Significant Events policy states, "7. failure of patient to respond therapeutically to			

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	prescribed medications or treatments...11. new onset of signs/symptoms..."			
N 0539 Bldg. 00	410 IAC 17-14-1(a)(1) Scope of Services Rule 14 Sec. 1(a)(1) The registered nurse shall perform nursing duties in accordance with the Indiana Nurse Practice Act (IC 25-23). Based on observation and record review, the agency failed to ensure clinicians followed recognized infection control procedures and the agency's policy related to hand hygiene for 3 of 6 (Patients #3,5,6) home visit observations. Findings include: 1. The clinical record of patient #3 was reviewed on 10/31/17, and evidenced a plan of care established by the physician for the certification period 10/16/17 to 12/14/17, start of care 10/16/17. The patient's diagnosis was Alcohol Abuse and history of falls. A. During a home visit (patient #3) on 10/31/17 at 2:15 pm, employee I, a PTA [physical therapy assistant], was observed	N 0539	Clinical Manager re-educated staff on 11/9/17 covering Policy # 7.5 Infection Control including Hand Hygiene & bag technique. Bag Technique demonstration performed by clinicians. Hand washing reviewed step by step with clinicians, with clinicians verbally reiterating step by step back to Clinical Manager/ Director. Clinical Manager will have staff demonstrate hand washing once per quarter until staff 100% compliant with P&P. Clinical Manager to make a minimum of 2 home visits per quarter to ensure compliance of P&P's above. Clinical Manager re-educated and enforced use of barriers with all equipment including tablets with approved disinfecting of equipment.	11/09/2017

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	placing his/her's computer tablet and keyboard on the patient's table without wiping the surface or placing a barrier on the table. The agency failed to apply a barrier and to clean the tablet and keyboard prior to leaving the patient's home. B. In an interview on 11/1/17, the Administrator agreed that a barrier should have been placed down on the table prior to placing the tablet and keyboard down. Inquired about disinfecting the tablet and keyboard wipe, she/he stated they would consider it. 2. The clinical record of patient #5 was reviewed on 11/1/17, and evidenced a plan of care established by the physician for the certification period 10/8/17 to 12/6/17, start of care 4/11/17. The patient's diagnosis was encounter for fitting and adjusting urinary device. A. During a home visit (patient #5) on 11/1/17 at 10:20 am, employee G, a RN [registered nurse], was observed assessing patient #5 bilateral lower legs. The registered nurse was observed removing his/her gloves after assessing the patient's lower legs and picking up his/her computer tablet to document. The registered nurse failed to perform hand hygiene after			

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	removing his/her gloves. B. In an interview on 11/1/17, the Administrator was unable to provide any additional information. 3. The clinical record of patient #6 was reviewed on 11/1/17, and evidenced a plan of care established by the physician for the certification period 10/18/17 to 12/16/17, start of care 10/18/17. The patient's diagnosis was Type II Diabetes. A. Upon arrival at patient #6 apartment, a notice sign was hanging on the wall that stated the apartment building was being treated for pest. During the home visit (patient #6) on 11/1/17 at 3:30 pm, employee H, a registered nurse, was observed placing his/her computer tablet on top of the patient's table next to papers without a barrier. The agency failed to apply a barrier and to clean the tablet prior to leaving the patient's home. B. B. In an interview on 11/1/17, the Administrator agreed that a barrier should have been placed down on the table prior to placing the computer tablet down. Inquired about cleaning the tablet with a disinfectant, she/he stated they would consider it.			

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	4. A policy titled 7.5 Hand Hygiene, Revised 5/16 states, "...Healthcare personnel will follow current CDC guidelines for hand hygiene to prevent the spread of infection...Healthcare personnel will perform hand hygiene...3. each time gloves are removed..." 5. Review of a document, CDC (Centers for Disease Control) guidance for hand hygiene in healthcare settings, in which it stated healthcare providers should perform hand hygiene "Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed) ... After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings ... After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient ... After glove removal." 6. Review of a document titled Bag Technique: Preventing and Controlling Infections in Home Care and Hospice (2014) states, "Clean and disinfect the vital sign equipment...and electronic equipment used during patient care (i.e., laptop computer, cell phone)"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157568	A. BUILDING 00 B. WING	11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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