

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715
--	---

(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
G 000 Bldg. 00	<p>This was a Federal home health recertification survey. This was a partial extended survey.</p> <p>Survey Dates: 3-19-15, 3-20-15, 3-23-15, and 3-24-15</p> <p>Facility #: 002416</p> <p>Medicaid Vendor #: 200252140</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 1, 2015</p>	G 000		
G 190 Bldg. 00	<p>484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL</p> <p>Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist.</p> <p>Based on clinical record and agency policy review, interview, and review of the Indiana State Practice Act, the agency failed to ensure services provided by the physical therapy assistant (PTA) had</p>	G 190	G190The Administrator called all company PTAs and PTs on 4/3/15 and reviewed 484.32(a) CoP Therapy Service, 844 IAC 6-1-2 Indiana State Practice Act, and agency Policy SD1-1 Scope	04/21/2015

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: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2015
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715		
(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>been supervised in accordance with agency policy and the Indiana Practice Act in 5 (#s 1,3, 9, 10, & 11) of 6 records reviewed of patients that received services from the PTA.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 844 IAC 6-1-2 (g) states, "'Direct supervision' means that the supervising physical therapist or physician at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant . . . unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or physician at least once each working day to review all patients' treatments." The agency's August 2009 "Scope of Services" policy number SD1-1 states, "The agency will comply with accepted professional standards and principles which apply to professionals furnishing services." Clinical record number 1 evidenced physical therapy services had been 		<p>of Services. The PTAs were all reminded and instructed they must report to the supervising PT and discuss each patient's treatment at least once each day. The call to the supervising PT must be documented on each patient daily. This practice will be documented in all patient records going forward from today with a formal in-service on 4/14/15. The Clinical Director contacted the supervising therapists for Progressive Rehab by phone on 4/3/15 and reviewed 484.32(a) CoP Therapy Service, 844 IAC 6-1-2 Indiana State Practice Act, and agency Policy SD1-1 Scope of Services. The supervising therapist agreed that the Progressive Rehab PTA/COTA practice of reporting and documenting, at least once daily, discussion of each patient's treatment with the supervising therapists would begin immediately, starting today, and be formally in-serviced on 4/21/15. Formal in-service conducted by the Administrator, Director of Clinical Services, and QASpecialist on 4/14/15. Reviewed 484.32(a) CoP Therapy Service, 844 IAC 6-1-2 Indiana State Practice Act, and agency Policy SD1-1 Scope of Services. Instruction and reinforcement during this in-service that all PTAs shall consult with the supervising physical therapist at least once daily and all COTAs shall consult</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715
--	---

(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>ordered by the physician 1 time per week for 1 week, 2 times per week for 1 week, and 1 time per week for 2 weeks beginning the week of 2-24-15. The record evidenced the PTA, employee D, had provided services to the patient on 3-2-15 and 3-4-15.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>4. Clinical record number 3 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 4 weeks beginning the week of 3-4-15. The record evidenced the PTA, employee D, had provided services to the patient on 3-9-15, 3-12-15, 3-16-15, and 3-18-15.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>5. Clinical record number 9 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 3 weeks beginning the week of 10-6-14.</p>		<p>with the supervising occupational therapist at least oncedaily. This daily supervisionconsultation must review each patient's treatment daily and this supervisionmust be documented in the patient's record on a daily basis.</p> <p>10% of all clinicalrecords will be audited quarterly for evidence the PTAs are consulting with thesupervising PT at least once daily and COTAs are consulting with thesupervising OT at least once daily regarding each patient's therapytreatment. The Director of ClinicalServices will be responsible for monitoring these corrective actions to ensurethat this deficiency is corrected and will not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715
--	---

(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>The record evidenced the PTA, employee D, had provided services to the patient on 10-17-14 and 10-22-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>6. Clinical record number 10 evidenced physical therapy services had been ordered by the physician 2 times per week for 4 weeks beginning the week of 9-15-14. The record evidenced the PTA, employee KK, had provided services to the patient on 9-16-14, 9-22-14, 9-24-14, and 9-29-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>7. Clinical record number 11 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 4 weeks beginning 2-23-15. The record evidenced the PTA, employee D, had provided services to the patient on 3-13-15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715
--	---

(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
N 000 Bldg. 00	<p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>8. The Supervising Nurse, employee P, indicated, on 3-19-15 at 3:55 PM, the above-mentioned records did not evidence daily contact by the PTA with the supervising physical therapist.</p>	N 000		
N 570	<p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 3-19-15, 3-20-15, 3-23-15, and 3-24-15</p> <p>Facility #: 002416</p> <p>Medicaid Vendor #: 200252140</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 1, 2015</p>			
	410 IAC 17-14-1(d)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715
--	---

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

Bldg. 00	<p>Scope of Services</p> <p>Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may:</p> <p>(1) direct the activities of any therapy assistant; or</p> <p>(2) delegate duties and tasks to other individuals as appropriate.</p> <p>Based on clinical record and agency policy review, interview, and review of the Indiana State Practice Act, the agency failed to ensure services provided by the physical therapy assistant (PTA) had been supervised in accordance with agency policy and the Indiana Practice Act in 5 (#s 1,3, 9, 10, & 11) of 6 records reviewed of patients that received services from the PTA.</p> <p>The findings include:</p> <p>1. 844 IAC 6-1-2 (g) states, "'Direct supervision' means that the supervising physical therapist or physician at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant . . . unless the supervising physical therapist or physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist or</p>	N 570	<p>N570The Administrator called all company PTAs and PTs on 4/3/15 and reviewed 844IAC 6-1-2 Indiana State Practice Act, and agency Policy SD1-1 Scope of Services. The PTAs were all reminded and instructed they must report to the supervising PT and discuss each patient's treatment at least once each day. The call to the supervising PT must be documented on each patient daily. This practice will be documented in all patient records going forward from today with a formal in-service on 4/14/15. The Clinical Director contacted the supervising therapists for Progressive Rehab by phone on 4/3/15 and reviewed 844 IAC 6-1-2 Indiana State Practice Act, and agency Policy SD1-1 Scope of Services. The supervising therapist agreed that the Progressive Rehab PTA/COTA practice of reporting and documenting, at least once daily, discussion of each patient's treatment with the supervising therapists would begin immediately, starting today, and be formally in-serviced on 4/21/15. Formal in-service conducted by the Administrator, Director of</p>	04/21/2015
----------	--	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2015
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715		
(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>physician at least once each working day to review all patients' treatments."</p> <p>2. The agency's August 2009 "Scope of Services" policy number SD1-1 states, "The agency will comply with accepted professional standards and principles which apply to professionals furnishing services."</p> <p>3. Clinical record number 1 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week, 2 times per week for 1 week, and 1 time per week for 2 weeks beginning the week of 2-24-15. The record evidenced the PTA, employee D, had provided services to the patient on 3-2-15 and 3-4-15.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>4. Clinical record number 3 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 4 weeks beginning the week of 3-4-15. The record evidenced the PTA, employee D, had provided services to the patient on 3-9-15, 3-12-15, 3-16-15, and 3-18-15.</p>		<p>Clinical Services, and QASpecialist on 4/14/15. Reviewed 844 IAC6-1-2 Indiana State Practice Act, and agency Policy SD1-1 Scope ofServices. Instruction and reinforcementduring this in-service that all PTAs shall consult with the supervisingphysical therapist at least once daily and all COTAs shall consult with thesupervising occupational therapist at least once daily. This daily supervision consultation mustreview each patient's treatment daily and this supervision must be documentedin the patient's record on a daily basis. 10% of all clinicalrecords will be audited quarterly for evidence the PTAs are consulting with thesupervising PT at least once daily and COTAs are consulting with thesupervising OT at least once daily regarding each patient's therapytreatment. The Director of ClinicalServices will be responsible for monitoring these corrective actions to ensurethat this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715
--	---

(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>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>5. Clinical record number 9 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 3 weeks beginning the week of 10-6-14. The record evidenced the PTA, employee D, had provided services to the patient on 10-17-14 and 10-22-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>6. Clinical record number 10 evidenced physical therapy services had been ordered by the physician 2 times per week for 4 weeks beginning the week of 9-15-14. The record evidenced the PTA, employee KK, had provided services to the patient on 9-16-14, 9-22-14, 9-24-14, and 9-29-14.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157529	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/24/2015
NAME OF PROVIDER OR SUPPLIER SPECIALTY HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 331 KIMBER LN DEPT A EVANSVILLE, IN 47715		
(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>working day to review this patient's treatment.</p> <p>7. Clinical record number 11 evidenced physical therapy services had been ordered by the physician 1 time per week for 1 week and 2 times per week for 4 weeks beginning 2-23-15. The record evidenced the PTA, employee D, had provided services to the patient on 3-13-15.</p> <p>The record failed to evidence the PTA had consulted with the supervising physical therapist at least once each working day to review this patient's treatment.</p> <p>8. The Supervising Nurse, employee P, indicated, on 3-19-15 at 3:55 PM, the above-mentioned records did not evidence daily contact by the PTA with the supervising physical therapist.</p>				