

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/27/2014
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NAME OF PROVIDER OR SUPPLIER  MEMORIAL HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 213 US 231 JASPER, IN 47546
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G000000	This was a Federal home health recertification survey. This was a partial extended survey.  Survey Dates: 10-21-14, 10-22-14, 10-23-14, and 10-27-14  Facility #: 005990  Medicaid Vendor #: 100265600A  Surveyor: Vicki Harmon, RN, PHNS  Quality Review: Joyce Elder, MSN, BSN, RN  October 28, 2014	G000000		
G000121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on agency policy review, observation, and interview, the agency failed to ensure care had been provided in accordance with the Centers for Disease Control (CDC) Standard Precautions and the agency's own infection control policies & procedures in 3 (#s 1, 3, and	G000121	The Home Care Director discussed with the employees involved with patient #'s (1,3, and 5) the deficiencies found by the surveyor. An in-service for all Home Care staff regarding Standard Precautions and Agency policies will be held by 11-26-14. To ensure Standard	11/26/2014

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.

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	<p>5) of 6 home visit observations completed creating the potential to affect all of the agency's 113 current patients.</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "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</p>		<p>Precaution and Agency policy compliance in the future a flyer regard Standard Precautions and Agency policy will be developed and given to staff to carry with them. Standard Precautions will be observed with all competency visits made with employees at least annually. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>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 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>2. The agency's 05/2012 "Universal Precautions / Standard Precautions" policy states, "These [standard precautions] shall be observed by all HCWs [health care workers] for all patients . . . Hands are washed or sanitized with an alcohol based hand rub immediately after gloves are removed."</p> <p>A. The agency's 02/2013 "Hand Washing/Hand Antisepsis" policy states, "In the absence of a true emergency, personnel shall always wash their hands . . . After removing gloves."</p> <p>B. The agency's 06/2011 "Equipment Cleaning and High Touch Cleaning" policy states, "Equipment cleaning: . . . put on gloves."</p>			

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	<p>3. A home visit was made to patient number 1, on 10-21-14 at 2:10 PM, with employee R, a home health aide. The aide was observed to assist the patient with a bed bath. The aide was observed to assist the patient with bathing the upper body. The aide assisted the patient to stand and cleansed the anal area using a disposal wipe. Observation noted stool on the wipe. Without cleansing her hands or changing her gloves, the aide then touched the patient's Foley catheter tubing and bag and assisted the patient to remove the patient's pants and lay on the bed. The aide then removed her gloves.</p> <p>A. After removing her gloves, the aide failed to cleanse her hands and reached into her nursing bag to retrieve more gloves. The aide retrieved clean gloves and donned them without cleansing her hands. The aide was observed to cleanse the patient's left groin and abdominal fold and perform catheter care. The aide then cleansed the patient's right groin area and abdominal fold using the same washcloth.</p> <p>B. After cleansing the groin and abdominal fold areas, the aide applied petroleum jelly to abdominal fold and upper legs and assisted the patient to don pants over the feet and ankles. The aide assisted the patient to a sitting position</p>			

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	<p>and, without changing her gloves or cleansing her hands, the aide retrieved more wipes from the patient's bathroom closet. The aide then cleansed the anal area a second time and stool was observed on the wipe. The aide then cleansed the anal area with soap and water, rinsed, and dried the area. Without changing her gloves or cleansing her hands, the aide assisted the patient to completely don the pants, adjusted the patient's shirt, emptied the bath water, retrieved the trash and dirty linens, and put away the lotion and deodorant. The aide then removed her gloves and cleansed her hands.</p> <p>4. A home visit was made to patient number 3, on 10-22-14 at 10:15 AM, with employee F, a registered nurse (RN). The RN was observed to change the dressing to the patient's right foot. The RN washed her hands, touched her paper chart, and prepared the supplies brought from her car. The RN then donned clean gloves without cleansing her hands.</p> <p>The RN removed the old dressing, removed her gloves, and cleansed her hands. The RN then retrieved hydrogen peroxide from the patient's supply and donned clean gloves without cleansing her hands. The RN prepared the hydrogen peroxide/normal saline solution</p>			

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	<p>used to cleanse the wounds. The RN then removed her gloves and, without cleansing her hands, gathered the supplies needed for the dressing change and brought them to the patient's side. The RN then completed the dressing change.</p> <p>5. A home visit was made to patient number 5, on 10-23-14 at 11:40 AM, with employee K, a RN. The RN was observed to perform dressing changes to the patient's bilateral lower extremities and neck. The RN took the patient's vital signs using a thermometer, blood pressure cuff, stethoscope, and pulse oximeter. The RN donned a clean glove to her right hand only and cleansed the equipment and replaced it into her nursing bag.</p> <p>A. The RN cleansed her hands and donned clean gloves and removed the patient's shoe and sock from the patient's left foot. Without changing her gloves or cleansing her hands, the RN then removed the Mepilex silver dressing from the patient's left lower lateral leg. Without changing her gloves or cleansing her hands, the RN then removed the patient's right shoe and sock and dressing from 3 separate areas on the patient's right lower medial and lateral leg.</p>						

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G000158	<p>B. The RN was observed to change 3 separate dressings to the patient's right lower leg. The RN cleansed her hands and donned clean gloves. The RN cleansed all 3 areas without changing her gloves or cleansing her hands between wounds.</p> <p>6. The home visit observations were discussed with the administrator, employee A, on 10-23-14 at 2:25 PM. The administrator agreed the employees had not provided care in accordance with the CDC standard precautions and the agency's own infection control policies and procedures.</p> <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 and agency policy review and interview, the agency failed to ensure medications had been administered as ordered by the physician in 1 (# 6) of 12 records reviewed creating the potential to affect all of the agency's 113 current patients.</p> <p>The findings include:</p>	G000158	The Clinical Supervisor discussed with the Case Manager of patient #6 regard the need for care provided following a plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. An in-service with all nursing staff will be held by 11-26-14 to discuss the issues with patient #6 and to re-educate on the need for following a plan of	11/26/2014			

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	<p>1. Clinical record number 6 included a "Charts / Clinical Notes", dated 10-1-14, that states, "discussion with pt [patient] regarding Neupogen injections and inc [increased] difficulty to get out of the house. Pt has requested that we draw labs when ordered (on Mondays before chemo dose). [The patient] also requests that we come on Thurs and Fridays [sic] for Neupogen injections and dsg [dressing] changes. This will decrease [the patient's] need to get out of the house 3 days. [The patient] will cont [continue] to go on chemo days and when has WCC [wound care center] appt [appointment]. States [the patient's sibling] will cont with dsg changes on w/e [?] and on Tues and Weds. Will plan to see pt M, Thur, and Fri."</p> <p>A. The record included a physician order, dated 9-29-14, that states, "Increase SNV [skilled nurse visit] to 2-4 x wk x 9 wks [2 to 4 times per week for 9 weeks]." Another order, also dated 9-29-14, states, "Neupogen Injection Solution 480 MCG/0.6 ML [480 micrograms per 0.6 milliliters] every day Subcut [subcutaneous] daily x 3 days after each chemotherapy treatment."</p> <p>B. The record included a hospital "Physician Follow-Up Orders - End of Physician Visit Summary", dated</p>		<p>care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric. 10% of all Home Care charts will be audited quarterly for evidence that the plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicines was followed. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>9-30-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday. The record included skilled nurse visit notes, dated 10-2-14 and 10-3-14, that failed to evidence the Neupogen injection had been administered.</p> <p>C. The record included a physician order, dated 10-3-14, that states, "Neupogen Injection Solution 480 MCG/0.6 ML every day Subcut daily x 3 days after each chemotherapy treatment ended on 10-03-14."</p> <p>D. The record included a "Charts / Clinical Notes", dated 10-20-14 (Monday), that states, "Nupagen [sic] given subq [subcutaneous] in R [right] upper arm." The record failed to include an order for the injection. The record included a "Physician Follow-Up Orders - End of Physician Visit Summary", dated 10-21-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday.</p> <p>E. During a home visit to patient number 6, on 10-23-14 at 1:05 PM, employee E, a registered nurse, was observed to administer a Neupogen injection to the patient. The record failed to include an order for the Neupogen injection.</p>						

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G000165	<p>2. The Outcomes Coordinator, employee D, indicated, on 10-22-14 at 4:00 PM, the record did not evidence the Neupogen injections had been administered as ordered.</p> <p>3. The agency's 09/2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine . . . Drugs and treatments are administered by agency staff only as ordered by the physician."</p> <p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had administered medications as ordered by the physician in 1 (# 6) of 12 records reviewed creating the potential to affect all of the agency's 113 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a "Charts / Clinical Notes", dated 10-1-14,</p>	G000165	The Clinical Supervisor discussed with the Case Manager of patient #6 regard the need for drugs and treatments administered by agency staff to be given only as ordered by physician. An in-service with all nursing staff will be held by 11-26-14 to discuss the issues with patient #6 and to re-educate on the need for drugs and treatments administered by agency staff to be only as ordered by physician. 10% of all Home Care charts will be audited quarterly for evidence that the drugs and treatments	11/26/2014

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	<p>that states, "discussion with pt [patient] regarding Neupogen injections and inc [increased] difficulty to get out of the house. Pt has requested that we draw labs when ordered (on Mondays before chemo dose). [The patient] also requests that we come on Thurs and fridays [sic] for Neupogen injections and dsg [dressing] changes. This will decrease [the patient's] need to get out of the house 3 days. [The patient] will cont [continue] to go on chemo days and when has WCC [wound care center] appt [appointment]. States [the patient's sibling] will cont with dsg changes on w/e [?] and on Tues and Weds. Will plan to see pt M, Thur, and Fri."</p> <p>A. The record included a physician order, dated 9-29-14, that states, "Increase SNV [skilled nurse visit] to 2-4 x wk x 9 wks [2 to 4 times per week for 9 weeks]." Another order, also dated 9-29-14, states, "Neupogen Injection Solution 480 MCG/0.6 ML [480 micrograms per 0.6 milliliters] every day Subcut [subcutaneous] daily x 3 days after each chemotherapy treatment."</p> <p>B. The record included a hospital "Physician Follow-Up Orders - End of Physician Visit Summary", dated 9-30-14, that identified the patient had received a chemotherapy treatment on</p>		administered by agency staff to be given only as ordered by physician. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.		

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	<p>9-30-14, a Tuesday. The record included skilled nurse visit notes, dated 10-2-14 and 10-3-14, that failed to evidence the Neupogen injection had been administered.</p> <p>C. The record included a physician order, dated 10-3-14, that states, "Neupogen Injection Solution 480 MCG/0.6 ML every day Subcut daily x 3 days after each chemotherapy treatment ended on 10-03-14."</p> <p>D. The record included a "Charts / Clinical Notes", dated 10-20-14 (Monday), that states, "Nupagen [sic] given subq [subcutaneous] in R [right] upper arm." The record failed to include an order for the injection. The record included a "Physician Follow-Up Orders - End of Physician Visit Summary", dated 10-21-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday.</p> <p>E. During a home visit to patient number 6, on 10-23-14 at 1:05 PM, employee E, a registered nurse, was observed to administer a Neupogen injection to the patient. The record failed to include an order for the Neupogen injection.</p> <p>2. The Outcomes Coordinator, employee</p>						

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G000170	<p>D, indicated, on 10-22-14 at 4:00 PM, the record did not evidence the Neupogen injections had been administered as ordered.</p> <p>3. The agency's 09/2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine . . . Drugs and treatments are administered by agency staff only as ordered by the physician."</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had administered medications as ordered by the physician in 1 (# 6) of 12 records reviewed creating the potential to affect all of the agency's 113 current patients.</p> <p>Findings include:</p> <p>1. Clinical record number 6 included a "Charts / Clinical Notes", dated 10-1-14, that states, "discussion with pt [patient] regarding Neupogen injections and inc</p>	G000170	The Clinical Supervisor discussed with the Case Manager of patient #6 regard the need to furnish Skilled Nursing services in accordance with the plan of care. An in-service with all nursing staff will beheld by 11-26-14 to discuss the issues with patient #6 and to re-educate on the need to furnish Skilled Nursing services in accordance with the plan of care. 10% of all Home Care charts will be audited quarterly for evidence that Skilled Nursing services are provided in accordance with the plan of care. The Director of Home Care is responsible for monitoring these corrective	11/26/2014

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	<p>[increased] difficulty to get out of the house. Pt has requested that we draw labs when ordered (on Mondays before chemo dose). [The patient] also requests that we come on Thurs and fridays [sic] for Neupogen injections and dsg [dressing] changes. This will decrease [the patient's] need to get out of the house 3 days. [The patient] will cont [continue] to go on chemo days and when has WCC [wound care center] appt [appointment]. States [the patient's sibling] will cont with dsg changes on w/e [?] and on Tues and Weds. Will plan to see pt M, Thur, and Fri."</p> <p>A. The record included a physician order, dated 9-29-14, that states, "Increase SNV [skilled nurse visit] to 2-4 x wk x 9 wks [2 to 4 times per week for 9 weeks]." Another order, also dated 9-29-14, states, "Neupogen Injection Solution 480 MCG/0.6 ML [480 micrograms per 0.6 milliliters] every day Subcut [subcutaneous] daily x 3 days after each chemotherapy treatment."</p> <p>B. The record included a hospital "Physician Follow-Up Orders - End of Physician Visit Summary", dated 9-30-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday. The record included skilled nurse visit notes, dated 10-2-14</p>		actions to ensure that this deficiency is corrected and will not recur.				

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	<p>and 10-3-14, that failed to evidence the Neupogen injection had been administered.</p> <p>C. The record included a physician order, dated 10-3-14, that states, "Neupogen Injection Solution 480 MCG/0.6 ML every day Subcut daily x 3 days after each chemotherapy treatment ended on 10-03-14."</p> <p>D. The record included a "Charts / Clinical Notes", dated 10-20-14 (Monday), that states, "Nupagen [sic] given subq [subcutaneous] in R [right] upper arm." The record failed to include an order for the injection. The record included a "Physician Follow-Up Orders - End of Physician Visit Summary", dated 10-21-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday.</p> <p>E. During a home visit to patient number 6, on 10-23-14 at 1:05 PM, employee E, a registered nurse, was observed to administer a Neupogen injection to the patient. The record failed to include an order for the Neupogen injection.</p> <p>2. The Outcomes Coordinator, employee D, indicated, on 10-22-14 at 4:00 PM, the record did not evidence the Neupogen</p>						

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G000186	<p>injections had been administered as ordered.</p> <p>3. The agency's 09/2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine . . . Drugs and treatments are administered by agency staff only as ordered by the physician."</p> <p>484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) Based on clinical record review and interview, the agency failed to ensure the physical therapist had revised the plan of care in 3 (#s 3, 5, and 10) of 6 records reviewed of patients that received physical therapy (PT) services from the agency creating the potential to affect all of the agency's 36 patients that receive PT services from the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a PT plan of care, dated 9-24-14, that identified PT services were to be provided 1 to 3 times per week for 9</p>	G000186	The Home Care Director discussed with the Rehab Director on 10-29-14 the need for the Therapist to do the discharge visit unless the discharge visit is unplanned. The Rehab Director will in-service all Home Care Rehab staff regard the need for the discharge visits being made by Therapist unless the discharge visit is unplanned by 11-26-14. 10% of all charts involving Rehab will be audited quarterly to ensure that the qualified therapist assists the physician in evaluating the patient's level of functioning, and help develop the plan of care. The Director of Home Care is responsible for monitoring	11/26/2014

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	<p>weeks starting on 9-24-14. The record failed to evidence the physical therapist had discharged the patient from therapy services.</p> <p>A. The record included a "Home Health Physical Therapy Discharge Summary", signed and dated by employee EE, a physical therapist assistant (PTA), on 10-2-14, that states, "[The patient] will be discharged from home health physical therapy."</p> <p>B. The record included a "Charts / Clinical Notes", dated 10-2-14, that states, "[Employee EE], PTA reports she dc'd [discontinued] pt [patient] today with goals met."</p> <p>2. Clinical record number 5 included a PT plan of care, dated 8-26-14, that identified PT services were to be provided 1 to 3 times per week for 9 weeks starting on 8-26-14. The record failed to evidence the physical therapist had discharged the patient from therapy services.</p> <p>A. The record included a "Physical Therapy Home Care Discharge Summary", signed and dated by employee EE, a PTA, on 9-17-14. The summary states, "The patient will be discharged at this time, and continue on</p>		these corrective actions to ensure that this deficiency is corrected and will not recur.				

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G000229	<p>their own."</p> <p>B. The record included a "Charts / Clinical Notes", dated 9-18-14, that states, "[Employee EE], PTA, reports that she d/c'd pt yesterday, 091714, with goals met."</p> <p>3. Clinical record number 10 included a PT plan of care that identified PT services were to be provided 1 to 2 times per week for 9 weeks starting on 10-6-14. The record failed to evidence the physical therapist had discharged the patient from therapy services.</p> <p>The record included a "Home Health Physical Therapy Discharge Summary", signed and dated by employee II, a PTA, on 10-23-14 that states, "Plan to discharge from home health physical therapy at this time."</p> <p>4. The Director of Rehabilitation Services, employee FF, indicated, on 10-27-14 at 11:25 AM, the physical therapists do not complete the discharge visit.</p> <p>484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to</p>						

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	<p>the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had completed a supervisory visit at least every 2 weeks in 1 (# 2) of 5 records reviewed of patients that received skilled and home health aide services creating the potential to affect all of the agency' 33 current patients that receive skilled and home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record number 2 included a plan of care established by the physician for the certification period 8-13-14 to 10-11-14 that identified skilled nurse services were to be provided 1 to 2 times per week. The record included an addendum to the plan of care, dated 9-2-14, that added home health aide services 1 to 2 times per week. The record included a plan of care for the certification period 10-12-14 to 12-10-14 that identified skilled nurse and home health aide services were to be provided 1 to 2 times per week.</li> </ol> <p>The record evidenced a home health aide supervisory visit had been completed on 9-15-14 and not again until 10-14-14, a period of 29 days between supervisory</p>	G000229	<p>The Clinical Supervisor discussed with the Case Manager of patient #2 regard the need for the registered nurse (or another health professional described in paragraph (d)(1)of this section) to make an on-site visit to the patient's home no less frequently than every 2 weeks. An in-service with all nursing staff will be held by 11-26-14 to discuss the issues with patient #2 and to re-educate on the need for the registered nurse (or another health professional described in paragraph (d)(1)of this section) to make an on-site visit to the patient's home no less frequently than every 2 weeks. 10% of all Home Care charts will be audited quarterly for evidence that the registered nurse (or another health professional described in paragraph (d)(1)of this section) made an on-site visit to the patient's home no less frequently than every 2 weeks. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	11/26/2014

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N000000	<p>visits.</p> <p>2. The administrator, employee A, stated, on 10-27-14 at 1:45 PM, "There are no other supervisory visits in the record."</p> <p>3. The agency's 09/2008 "Aide Supervision" policy states, "When skilled nursing or physical, speech or occupational therapy are being furnished to a patient in addition to personal care, a registered nurse must make a supervisory visit to the patient's residence at least every two weeks (either when the aide is present to observe and assist, or when the aide is absent) to assess relationships and determine whether goals are being met . . . . When a patient receives no skilled services but does receive home health aide services, a registered nurse must make a supervisory visit to the patient's residence at least once every 30 days."</p> <p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 10-21-14, 10-22-14, 10-23-14, and 10-27-14</p>	N000000		

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N000470	<p>Facility #: 005990</p> <p>Medicaid Vendor #: 100265600A</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 28, 2014</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on agency policy review, observation, and interview, the agency failed to ensure care had been provided in accordance with the Centers for Disease Control (CDC) Standard Precautions and the agency's own infection control policies &amp; procedures in 3 (#s 1, 3, and 5) of 6 home visit observations completed creating the potential to affect all of the agency's 113 current patients.</p> <p>The findings include:</p> <p>1. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand</p>	N000470	The Director discussed with the employees involved with patient #'s (1,3, and 5) the deficiencies found by the surveyor. An in-service for all Home Care staff regarding Standard Precautions and Agency policy will be held by 11-26-14. To ensure Standard Precaution and Agency policy compliance in the future a flyer regard Standard Precautions and Agency policies will be developed and given to staff to carry with them. Standard Precautions and Agency policies will be observed with all competency visits made with employees at least annually. The Director of Home Care is responsible for monitoring these corrective actions to ensure that	11/26/2014

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	<p>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 . . .</p> <p>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 when it can be reasonably anticipated that contact with blood or potentially</p>		this deficiency is corrected and will not recur.				

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	<p>infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."</p> <p>2. The agency's 05/2012 "Universal Precautions / Standard Precautions" policy states, "These [standard precautions] shall be observed by all HCWs [health care workers] for all patients . . . Hands are washed or sanitized with an alcohol based hand rub immediately after gloves are removed."</p> <p>A. The agency's 02/2013 "Hand Washing/Hand Antisepsis" policy states, "In the absence of a true emergency, personnel shall always wash their hands . . . After removing gloves."</p> <p>B. The agency's 06/2011 "Equipment Cleaning and High Touch Cleaning" policy states, "Equipment cleaning: . . . put on gloves."</p> <p>3. A home visit was made to patient number 1, on 10-21-14 at 2:10 PM, with employee R, a home health aide. The aide was observed to assist the patient with a bed bath. The aide was observed to assist the patient with bathing the upper body. The aide assisted the patient to stand and cleansed the anal area using a disposal wipe. Observation noted stool</p>				

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	<p>on the wipe. Without cleansing her hands or changing her gloves, the aide then touched the patient's Foley catheter tubing and bag and assisted the patient to remove the patient's pants and lay on the bed. The aide then removed her gloves.</p> <p>A. After removing her gloves, the aide failed to cleanse her hands and reached into her nursing bag to retrieve more gloves. The aide retrieved clean gloves and donned them without cleansing her hands. The aide was observed to cleanse the patient's left groin and abdominal fold and perform catheter care. The aide then cleansed the patient's right groin area and abdominal fold using the same washcloth.</p> <p>B. After cleansing the groin and abdominal fold areas, the aide applied petroleum jelly to abdominal fold and upper legs and assisted the patient to don pants over the feet and ankles. The aide assisted the patient to a sitting position and, without changing her gloves or cleansing her hands, the aide retrieved more wipes from the patient's bathroom closet. The aide then cleansed the anal area a second time and stool was observed on the wipe. The aide then cleansed the anal area with soap and water, rinsed, and dried the area. Without changing her gloves or cleansing</p>			

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	<p>her hands, the aide assisted the patient to completely don the pants, adjusted the patient's shirt, emptied the bath water, retrieved the trash and dirty linens, and put away the lotion and deodorant. The aide then removed her gloves and cleansed her hands.</p> <p>4. A home visit was made to patient number 3, on 10-22-14 at 10:15 AM, with employee F, a registered nurse (RN). The RN was observed to change the dressing to the patient's right foot. The RN washed her hands, touched her paper chart, and prepared the supplies brought from her car. The RN then donned clean gloves without cleansing her hands.</p> <p>The RN removed the old dressing, removed her gloves, and cleansed her hands. The RN then retrieved hydrogen peroxide from the patient's supply and donned clean gloves without cleansing her hands. The RN prepared the hydrogen peroxide/normal saline solution used to cleanse the wounds. The RN then removed her gloves and, without cleansing her hands, gathered the supplies needed for the dressing change and brought them to the patient's side. The RN then completed the dressing change.</p> <p>5. A home visit was made to patient</p>						

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	<p>number 5, on 10-23-14 at 11:40 AM, with employee K, a RN. The RN was observed to perform dressing changes to the patient's bilateral lower extremities and neck. The RN took the patient's vital signs using a thermometer, blood pressure cuff, stethoscope, and pulse oximeter. The RN donned a clean glove to her right hand only and cleansed the equipment and replaced it into her nursing bag.</p> <p>A. The RN cleansed her hands and donned clean gloves and removed the patient's shoe and sock from the patient's left foot. Without changing her gloves or cleansing her hands, the RN then removed the Mepilex silver dressing from the patient's left lower lateral leg. Without changing her gloves or cleansing her hands, the RN then removed the patient's right shoe and sock and dressing from 3 separate areas on the patient's right lower medial and lateral leg.</p> <p>B. The RN was observed to change 3 separate dressings to the patient's right lower leg. The RN cleansed her hands and donned clean gloves. The RN cleansed all 3 areas without changing her gloves or cleansing her hands between wounds.</p> <p>6. The home visit observations were</p>						

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N000522	<p>discussed with the administrator, employee A, on 10-23-14 at 2:25 PM. The administrator agreed the employees had not provided care in accordance with the CDC standard precautions and the agency's own infection control policies and procedures.</p> <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 and agency policy review and interview, the agency failed to ensure medications had been administered as ordered by the physician in 1 (# 6) of 12 records reviewed creating the potential to affect all of the agency's 113 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a "Charts / Clinical Notes", dated 10-1-14, that states, "discussion with pt [patient] regarding Neupogen injections and inc [increased] difficulty to get out of the house. Pt has requested that we draw labs when ordered (on Mondays before chemo dose). [The patient] also requests that we come on Thurs and fridays [sic] for Neupogen injections and dsg</p>	N000522	<p>The Clinical Supervisor discussed with the Case Manager of patient #6 regard that the care provided must follow a plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. An in-service with all nursing staff will beheld by 11-26-14 to discuss the issues with patient #6 and to re-educate on the need for following a plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric. 10% of all Home Care charts will be audited quarterly for evidence that the plan of care established and periodically reviewed by a doctor of medicine, osteopathy or podiatric medicines was followed. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and</p>	11/26/2014

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	<p>[dressing] changes. This will decrease [the patient's] need to get out of the house 3 days. [The patient] will cont [continue] to go on chemo days and when has WCC [wound care center] appt [appointment]. States [the patient's sibling] will cont with dsg changes on w/e [?] and on Tues and Weds. Will plan to see pt M, Thur, and Fri."</p> <p>A. The record included a physician order, dated 9-29-14, that states, "Increase SNV [skilled nurse visit] to 2-4 x wk x 9 wks [2 to 4 times per week for 9 weeks]." Another order, also dated 9-29-14, states, "Neupogen Injection Solution 480 MCG/0.6 ML [480 micrograms per 0.6 milliliters] every day Subcut [subcutaneous] daily x 3 days after each chemotherapy treatment."</p> <p>B. The record included a hospital "Physician Follow-Up Orders - End of Physician Visit Summary", dated 9-30-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday. The record included skilled nurse visit notes, dated 10-2-14 and 10-3-14, that failed to evidence the Neupogen injection had been administered.</p> <p>C. The record included a physician order, dated 10-3-14, that states,</p>		will not recur.				

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	<p>"Neupogen Injection Solution 480 MCG/0.6 ML every day Subcut daily x 3 days after each chemotherapy treatment ended on 10-03-14."</p> <p>D. The record included a "Charts / Clinical Notes", dated 10-20-14 (Monday), that states, "Nupagen [sic] given subq [subcutaneous] in R [right] upper arm." The record failed to include an order for the injection. The record included a "Physician Follow-Up Orders - End of Physician Visit Summary", dated 10-21-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday.</p> <p>E. During a home visit to patient number 6, on 10-23-14 at 1:05 PM, employee E, a registered nurse, was observed to administer a Neupogen injection to the patient. The record failed to include an order for the Neupogen injection.</p> <p>2. The Outcomes Coordinator, employee D, indicated, on 10-22-14 at 4:00 PM, the record did not evidence the Neupogen injections had been administered as ordered.</p> <p>3. The agency's 09/2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care</p>						

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N000537	<p>established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine . . . Drugs and treatments are administered by agency staff only as ordered by the physician."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse had administered medications as ordered by the physician in 1 (# 6) of 12 records reviewed creating the potential to affect all of the agency's 113 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 6 included a "Charts / Clinical Notes", dated 10-1-14, that states, "discussion with pt [patient] regarding Neupogen injections and inc [increased] difficulty to get out of the house. Pt has requested that we draw labs when ordered (on Mondays before chemo dose). [The patient] also requests that we come on Thurs and fridays [sic] for Neupogen injections and dsq [dressing] changes. This will decrease</p>	N000537	The Clinical Supervisor discussed with the Case Manager of patient #6 regard the need for drugs and treatments administered by agency staff to be given only as ordered by physician. An in-service with all nursing staff will be held by 11-26-14 to discuss the issues with patient #6 and to re-educate on the need for drugs and treatments administered by agency staff to be given only as ordered by physician. 10% of all Home Care charts will be audited quarterly for evidence that the drugs and treatments administered by agency staff to be given only as ordered by physician. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/26/2014

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	<p>[the patient's] need to get out of the house 3 days. [The patient] will cont [continue] to go on chemo days and when has WCC [wound care center] appt [appointment]. States [the patient's sibling] will cont with dsg changes on w/e [?] and on Tues and Weds. Will plan to see pt M, Thur, and Fri."</p> <p>A. The record included a physician order, dated 9-29-14, that states, "Increase SNV [skilled nurse visit] to 2-4 x wk x 9 wks [2 to 4 times per week for 9 weeks]." Another order, also dated 9-29-14, states, "Neupogen Injection Solution 480 MCG/0.6 ML [480 micrograms per 0.6 milliliters] every day Subcut [subcutaneous] daily x 3 days after each chemotherapy treatment."</p> <p>B. The record included a hospital "Physician Follow-Up Orders - End of Physician Visit Summary", dated 9-30-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday. The record included skilled nurse visit notes, dated 10-2-14 and 10-3-14, that failed to evidence the Neupogen injection had been administered.</p> <p>C. The record included a physician order, dated 10-3-14, that states, "Neupogen Injection Solution 480</p>						

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	<p>MCG/0.6 ML every day Subcut daily x 3 days after each chemotherapy treatment ended on 10-03-14."</p> <p>D. The record included a "Charts / Clinical Notes", dated 10-20-14 (Monday), that states, "Nupagen [sic] given subq [subcutaneous] in R [right] upper arm." The record failed to include an order for the injection. The record included a "Physician Follow-Up Orders - End of Physician Visit Summary", dated 10-21-14, that identified the patient had received a chemotherapy treatment on 9-30-14, a Tuesday.</p> <p>E. During a home visit to patient number 6, on 10-23-14 at 1:05 PM, employee E, a registered nurse, was observed to administer a Neupogen injection to the patient. The record failed to include an order for the Neupogen injection.</p> <p>2. The Outcomes Coordinator, employee D, indicated, on 10-22-14 at 4:00 PM, the record did not evidence the Neupogen injections had been administered as ordered.</p> <p>3. The agency's 09/2006 "Medical Supervision / Plan of Care" policy states, "Care follows a written plan of care established and periodically reviewed by</p>			

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N000565	<p>a doctor of medicine, osteopathy, or podiatric medicine . . . Drugs and treatments are administered by agency staff only as ordered by the physician."</p> <p>410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (4) help develop the plan of care (revising as necessary); Based on clinical record review and interview, the agency failed to ensure the physical therapist had revised the plan of care in 3 (#s 3, 5, and 10) of 6 records reviewed of patients that received physical therapy (PT) services from the agency creating the potential to affect all of the agency's 36 patients that receive PT services from the agency.</p> <p>The findings include:</p> <p>1. Clinical record number 3 included a PT plan of care, dated 9-24-14, that identified PT services were to be provided 1 to 3 times per week for 9 weeks starting on 9-24-14. The record failed to evidence the physical therapist had discharged the patient from therapy services.</p> <p>A. The record included a "Home Health Physical Therapy Discharge</p>	N000565	<p>The Home Care Director discussed with the Rehab Director on 10-29-14 the need for the Qualified Therapist to do the discharge visit unless the discharge visit is unplanned. The Rehab Director will in-service all Home Care Rehab staff regard the need for the discharge visits being made by Qualified Therapist unless the discharge visit is unplanned by 11-26-14. 10% of all charts involving Rehab will be audited quarterly to ensure that the qualified therapist assists the physician in evaluating the patient's level of functioning, and help develop the plan of care. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	11/26/2014	

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	<p>Summary", signed and dated by employee EE, a physical therapist assistant (PTA), on 10-2-14, that states, "[The patient] will be discharged from home health physical therapy."</p> <p>B. The record included a "Charts / Clinical Notes", dated 10-2-14, that states, "[Employee EE], PTA reports she dc'd [discontinued] pt [patient] today with goals met."</p> <p>2. Clinical record number 5 included a PT plan of care, dated 8-26-14, that identified PT services were to be provided 1 to 3 times per week for 9 weeks starting on 8-26-14. The record failed to evidence the physical therapist had discharged the patient from therapy services.</p> <p>A. The record included a "Physical Therapy Home Care Discharge Summary", signed and dated by employee EE, a PTA, on 9-17-14. The summary states, "The patient will be discharged at this time, and continue on their own."</p> <p>B. The record included a "Charts / Clinical Notes", dated 9-18-14, that states, "[Employee EE], PTA, reports that she d/c'd pt yesterday, 091714, with goals met."</p>			

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N000597	<p>3. Clinical record number 10 included a PT plan of care that identified PT services were to be provided 1 to 2 times per week for 9 weeks starting on 10-6-14. The record failed to evidence the physical therapist had discharged the patient from therapy services.</p> <p>The record included a "Home Health Physical Therapy Discharge Summary", signed and dated by employee II, a PTA, on 10-23-14 that states, "Plan to discharge from home health physical therapy at this time."</p> <p>4. The Director of Rehabilitation Services, employee FF, indicated, on 10-27-14 at 11:25 AM, the physical therapists do not complete the discharge visit.</p> <p>410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on personnel file review and interview, the agency failed to ensure the state aide registry had been consulted to determine the aides' standing and that home health aides had been entered onto the State aide registry in 2 (files V and</p>	N000597	The Home Care Director checked the aide registry on 10-28-14 for both files V and W and both were in good standing. Both of these employees have worked in the hospital and had had their aide registry checked by the hospital.	11/26/2014			

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	<p>W) of 2 files reviewed of home health aides hired since the previous survey on 1-13-12 creating the potential to affect all of the agency's 33 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file V evidenced the individual had been hired on 7-16-14 to provide home health aide services on behalf of the agency. The file failed to evidence the agency had consulted the State aide registry to determine the aide's standing and failed to evidence the aide had been entered onto the State aide registry.</li> <li>2. Personnel file W evidenced the individual had been hired on 6-17-14 to provide home health aide services on behalf of the agency. The file failed to evidence the agency had consulted the State aide registry to determine the aide's standing and failed to evidence the aide had been entered onto the State aide registry.</li> <li>3. The administrator, employee A, stated, on 10-27-14 at 1:55 PM, "Both aides worked in the hospital on the skilled unit prior to coming over here. They would have been checked by the hospital when they hired in. We did not</li> </ol>		To ensure compliance with this, Home Care staff will check the aide registry for all aides coming to work for Home Care whether non- hospital or current hospital employee. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not				

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N000606	<p>check the home health aide registry when they came over here."</p> <p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) had completed a supervisory visit at least every 2 weeks as required by agency policy in 1 (# 2) of 5 records reviewed of patients that received skilled and home health aide services creating the potential to affect all of the agency' 33 current patients that receive skilled and home health aide services.</p> <p>The findings include:</p> <p>1. Clinical record number 2 included a plan of care established by the physician for the certification period 8-13-14 to 10-11-14 that identified skilled nurse services were to be provided 1 to 2 times per week. The record included an addendum to the plan of care, dated</p>	N000606	The Clinical Supervisor discussed with the Case Manager of patient #2 regard the need for the registered nurse (or another health professional described in paragraph (d)(1)of this section) to make an on-site visit to the patient's home no less frequently than every 2 weeks. An in-service with all nursing staff will be held by 11-26-14 to discuss the issues with patient #2 and to re-educate on the need for the registered nurse (or another health professional described in paragraph (d)(1)of this section) to make an on-site visit to the patient's home no less frequently than every 2 weeks. 10% of all Home Care charts will be audited quarterly for evidence that the registered nurse (or another health professional described in paragraph (d)(1)of this section) made an on-site visit to the patient's home no less frequently	11/26/2014			

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	<p>9-2-14, that added home health aide services 1 to 2 times per week. The record included a plan of care for the certification period 10-12-14 to 12-10-14 that identified skilled nurse and home health aide services were to be provided 1 to 2 times per week.</p> <p>The record evidenced a home health aide supervisory visit had been completed on 9-15-14 and not again until 10-14-14, a period of 29 days between supervisory visits.</p> <p>2. The administrator, employee A, stated, on 10-27-14 at 1:45 PM, "There are no other supervisory visits in the record."</p> <p>3. The agency's 09/2008 "Aide Supervision" policy states, "When skilled nursing or physical, speech or occupational therapy are being furnished to a patient in addition to personal care, a registered nurse must make a supervisory visit to the patient's residence at least every two weeks (either when the aide is present to observe and assist, or when the aide is absent) to assess relationships and determine whether goals are being met . . . . When a patient receives no skilled services but does receive home health aide services, a registered nurse must make a supervisory visit to the patient's</p>		<p>than every 2 weeks. The Director of Home Care is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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

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	residence at least once every 30 days."				