STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157583	A. BUILDING 00 B. WING	08/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEDISYS HOME HEALTH	2200 LAKE AVE STE 150 FORT WAYNE, IN 46805

(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 0000 Bldg. 00	This was a home health federal recertification survey. This was a partial extended survey. Survey Dates: August 13, 14, 17, 18, and 19, 2015 Partial Extended Dates: August 14, 17, 18, and 19, 2015 Facility Number: IN011110 Medicaid Number: 200841710B Census Service Type: Skilled: 426 Home Health Aide Only: 0 Personal Service Only: 0 Total: 426 Sample: RR w/HV: 6 RR w/o HV: 6 Total: 12 QA; LD, R.N.	G 0000		

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

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

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G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review, policy review, and interview, the agency failed to ensure care followed a written plan of care (POC) established by a doctor of medicine in 5 of 12 clinical records reviewed. (# 2, 4, 5, 7, and 8) Findings include 1. Clinical record #2, start of care (SOC) date 6/17/15, contained a POC dated 6/17-8/15/15 with orders for SN 5 times a week for 1 week, 7 times a week for 1 week, 2 times a week for 1 week, and 2 as needed (PRN) visits for infusion complications. Lab draws and site care to be done each Monday until discontinued by physician. The SN failed to measure the peripherally inserted central catheter (PICC) line every week as ordered, and per agency policy. A. The record evidenced the patient had the PICC line place on 6/15/15 at the hospital prior to admission to the agency. B. The record evidenced a physician order dated 7/15/15 for SN to administer	G 0158	The Administrator/DOO of the agency will be responsible for correcting this deficiency. An in-service was conducted for agency staff on 8/20/15 where multiple policies were reviewed in regards to identified deficiencies per exit conference with state surveyor. (1)Policy *Central Venous Access Device (CVAD) Dressing Change (IV-009)*, revised 01/2015, was reviewed as policy states under procedure section, step 9, "Measure external segment with tape measure and record." Written policy was provided to all nursing staff. (2) Policy *Wound Care Reference/Resources/Documentation (WC-001)*, revised 07/2013, was reviewed as policy states under procedure, letter G, "Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week). Written policy was provided to all nursing staff. (3) Policy *Urinary Catheter Insertion-Straight, Indwelling or Suprapubic Catheter (UR-001)*, revised 03/2013 was reviewed as the first step is to "verify physician's orders". Written policy was provided to nursing staff. (4) Policy	08/20/2015

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	Ceftriaxone 2 grams intravenous (IV) push over 5 minutes daily for 7 days, complete site care to central line every 7 days via sterile technique. C. The IV Assessment sheets dated 6/28, 7/5, 7/20, 7/27, 8/3, 8/10, and 8/14 failed to evidence the SN measured the PICC line. D. During interview on 8/17/15 at 1:40 PM, employee C, the Clinical Manager, indicated the nurses should be doing PICC care every Monday. E. During interview on 8/17/15, employee C, indicated she did not realize we still measure PICC lines that are sutured in place. 2. Clinical record #4, SOC date 7/29/15, contained a POC dated 7/29-9/26/15 with diagnosis of pressure ulcer to buttocks, and orders for SN 1 time a week for 5 weeks, Home Health Aide (HHA) 2 times a week for 3 weeks, and Physical Therapy (PT) to evaluate week of 8/3/15. SN to measure and record wound dimensions weekly. A. The SN Notes dated 8/10 and 8/13/15 failed to evidence the wound had been measured.		*Coordination of Care (TX-002),* revised 01/2015 states "A missed visit communication note is completed when a home care visit is unable to be completed as schedule and cannot be rescheduled within the patient's Medicare treatment week. A. The physician will be notified by: the clinician and documented on the missed visit note, or by way of faxing/mailing the missed visit communications note to physician's office with FAX confirmation attached or noted as mailed with initials/date mailed. B. If the clinician or the Clinical Manager notifies the physician of the missed visit, this communication will be noted on the Missed Visit Communication Note. C. There are no exceptions, in which the physician does not have to be notified of a missed visit. D. If the Missed Visit is by a Home Health Aide then the Aide will report the missed visit to the Case Manager or DOO who will notify the physician and complete the Missed Visit Communication Note." DOO also reviewed interoffice process of communicating missed visits to appropriate staff so that appropriate and supporting documentation can be completed. Monitoring Process: The DOO or CM will complete 5 chart audits per month. Once 90% compliance is	

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	B. The record failed to evidence the HHA began services until 8/4/15. C. The HHA care plan dated 8/4/15 stated "Frequency/Duration: 2 times a week for 3 weeks, the week of 8/3/15." D. During interview on 8/18/15 at 9:25 AM, employee C indicated they could not find documentation of a reason for the HHA not starting care prior to 8/4/15. E. During interview on 8/17/15 at 3:30 PM, employee C indicated the wound was not measured the week of 8/10-8/16/15 for patient # 4. 3. Clinical record # 5, SOC date 7/19/15, contained a POC dated 7/19-9/16/15 with diagnosis of pressure ulcer to buttock, and orders for SN 1 time a week for 1 week, 2 times a week for 3 weeks, and 1 time a week for 2 weeks; SN to measure and record wound dimensions weekly. A. The SN Notes dated 7/28 and 8/1/15 failed to evidence the wound had been measured. B. During interview on 8/18/15 at 9:50 AM, employee C indicated she could not find any wound measurements for the week of 7/27-8/2/15 for patient #		met, review will be incorporated into the quarterly performance improvement auditing process.	

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	5. 4. Clinical record # 7, SOC date 7/8/13, contained a POC dated 7/8-9/5/15 with orders for SN 1 time a week for 1 week, 2 times a week fro 8 weeks, 2 PRN wound complications and/or catheter complications; SN to change Foley catheter 20 french 30 cubic centimeter (cc) balloon every 1 months. A. The record failed to evidence the Foley catheter had been changed between 7/10/15 through 8/14/15. B. During interview on 8/18/15 at 12:34 AM, employee C indicated she spoke with [employee I] the licensed practical nurse who changed the catheter last, and this employee said the patient requested the catheter not be changed at the last visit, but she did not document this request. 5. Clinical record # 8, SOC date 8/19/14, contained a POC dated 6/15-8/13/15 with orders for SN 1 time a month for 1 month, 2 times a month for 1 month effective week of 6/15 and 2 PRN for catheter changes/complications. A physician order dated 7/30/15 added HHA services for 1 time a week for 3 weeks.			

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	A. The record failed to evidence the HHA began visits until 8/3/15 and failed to evidence the physician was notified of a missed visit for the dates 7/30-8/2/15. B. The record evidenced the HHA provided two visits the week of 8/10-8/13/15; on 8/10 and 8/13/15. C. During interview on 8/18/15 at 12:50 PM, employee C indicated they did not see a missed visit form for 7/30-8/2/15 and they are not sure why the HHA provided two visits from 8/10-8/13/15. 6. The agency's policy titled "Central Venous Access Device (CVAD) Dressing Change," # IV-009, revised 01/2015 states, "Special Considerations: ... The greatest risk of catheter dislodgement occurs during the first few weeks after catheter insertion. Clients require instruction to avoid pulling on the catheter, and to be alert for signs of dislodgement, such as a greater length of catheter being visible. ... Procedure: ... 9. Measure external segment with tape measure and record. ... Document in the Clinical Record: ... Length of external segment measured." 7. The agency's policy titled "Wound Care			

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	reference/Resources/Documentation," # WC-001, revised 7/2013 states, "Procedure ... g. Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week). 8. The agency's policy titled "Coordination of Care," # TX-002, revised 01/2015 states, "13. A missed visit communication notes is completed when a home care visit is unable to be completed as scheduled and can not be rescheduled within the patient's Medicare treatment week. a. The Physician will be notified by: The clinician; or By way of faxing/mailing the missed visit communications note to physician's office; or by the DOO, Clinical Manager or other Clinical Management Representative. b. If the clinician or the Clinical Manager notifies the physician of the missed visit, this communication will be noted on the Missed Visit Communication Note. c. There are no exceptions, in which the physician does not have to be notified of a missed visit. d. If the Missed Visit is by a Home Health Aide then the Aide will report the missed visit to the Case Manager or DOO who will notify the physician and complete the Missed Visit Communication Note."			

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G 0159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent 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 clinical record review, observation, policy review, and interview, the agency failed to ensure all durable medical equipment (DME) used by patients was included on the plan of care (POC) for 5 of 6 home visit observations. (# 1, 2, 3, 4, and 5) Findings include 1. Clinical record # 1, start of care date (SOC) 7/28/15, contained a POC dated 7/28-9/25/15 with DME listed: gloves, blood glucose monitor, lancets, strips, alcohol wipes, walker and wheelchair. The POC failed to include the toilet seat riser and grab bars. A. During observations on 8/13/15 at 1:00 PM, the toilet seat riser and grab	G 0159	The Administrator/DOO of the agency will be responsible for correcting this deficiency. All agency personnel were instructed on 8/20/15: (1)Billable and non-billable supplies provided to the patient by agency personnel, and durable medical equipment used by the patient in the home will be included on the 485/Plan of Care in the section identified as *Locator 14. Durable Medical Equipment and Supplies.* (2) Policy *AA-014, Plan of Care/Care Planning Process*, revised 5/2013, was reviewed with particular attention to identifying the types of DME and supplies the patient uses and/or requires for home use. Rehab Clinicians responsible for Therapy Only Comprehensive	08/20/2015

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	bars were observed in the patient's bathroom. B. Clinical record review on 8/17/15 failed to evidence the toilet seat riser and grab bars were new since admission to the agency. 2. Clinical record #2, SOC date 6/17/15, contained a POC dated 6/17-8/15/15 with DME listed: gloves, alcohol wipes, Intravenous (IV) supplies, Incontinent supplies, wheelchair, coagucheck monitor, sterile gloves, oxygen, tape, straight catheter, syringes, catheter insertion tray, drainage bag, large gauze, strips, and Band-Aids. The POC failed to include the hospital bed and a hoyer lift. A. During observation on 8/13/15 at 2:00 PM, the patient was in a hospital bed. B. The agency's SOC assessment dated 6/17/15 evidenced the hospital bed and hoyer lift were present at SOC. C. During interview on 8/17/15 at 2:00 PM, employee C, the clinical manager, indicated this patient does have a hoyer lift. 3. Clinical record # 3, SOC date 12/5/14,		Assessments/Reassessments and development of the Plan of Care received additional training regarding identification of, and steps to ensure inclusion of DME such as grab bars, toilet seat risers, Hoyer lift, shower chair, hospital bed, and bi-pap machines and Supplies in the 485/Plan of Care. Rehab clinicians instructed to re-evaluate if any new equipment had been obtained since the 485/Plan of care was established and to document this equipment in 30 day Functional Assessment. On 9/10/15, Policy TX-001 Physician's Orders and Medical Supervision of Plan of Care, revised 6/2015, will be reviewed with all agency personnel as policy states under procedure section, step 7, "Types of Orders and Requirements to include frequency and duration of service" for all ordered disciplines. Monitoring Process: The DOO or CM will complete 5 chart audits per month to identify inclusion of all DME in medical record. Once 90% compliance is met, review will be incorporated into the quarterly performance improvement auditing process. The DOO or CM will also review all 485's and/or verbal orders to ensure all orders contain a frequency and duration prior to sending out to the physician for signature.	

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	contained a POC dated 8/2-9/30/15 with DME listed: gloves, 4 x 4's, 2 x 2's, alcohol wipes, wound care/dressing supplies, large gauze, mepilex border, wheelchair, walker, and incontinent supplies. The POC failed to include the shower chair. A. During observation on 8/14/15 at 9:00 AM, DME in the home included a shower chair. B. Clinical record review on 8/17/15 failed to evidence shower chair was new since admission to the agency. C. During interview on 8/17/15 at 2:30 PM, employee C indicated the shower chair was not listed in the record. 4. Clinical record #4, SOC date 7/29/15, contained a POC dated 7/29-9/26/15 with DME listed: gloves, wound care/dressing supplies, walker, and skin prep. The POC failed to include the shower bench and toilet riser. A. During observation on 8/14/15 at 10:30 AM, DME observed in the home included a shower bench and toilet riser. B. Clinical record review on 8/17/15 failed to evidence shower chair was new since admission to the agency.			

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	5. Clinical record # 5, SOC date 7/19/15, contained a POC dated 7/19-9/16/15 with DME listed: gloves, 4 x 4's, alcohol wipes, wound care/dressing supplies, large gauze, aquacel, skin prep, and walker. The POC failed to include the bipap machine. A. During observation on 8/14/15 at 11:30 AM, DME observed in the home included a bipap machine. B. During interview on 8/14/15 at 11:30 AM, patient # 5 indicated they use the bipap machine at night or while napping during the day. C. Clinical record review on 8/17/15 failed to evidence the bipap machine was new since admission to the agency. 6. The agency's policy titled "Plan of Care (POC)/Care Planning Process," # AA-014, dated 05/2013 states, "Purpose: A Plan of Care will be developed through a care planning process, which is designed to provide care, treatment, and services that are appropriate to the patient's individual needs. ... 484.18(a) Standard: Plan of Care: The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including ... types of services			

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	and equipment required, frequency of visits ... 1. The Plan of Care will be established through the used of the admission evaluation assessment and initiated by a physician's order."			
G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record review, policy review, and interview, the agency failed to ensure the skilled nurse (SN) furnished services in accordance with the plan of care (POC) for 4 of 12 clinical records reviewed. (# 2, 4, 5, and 7) Findings include 1. Clinical record #2, start of care (SOC) date 6/17/15, contained a POC dated 6/17-8/15/15 with orders for SN 5 times a week for 1 week, 7 times a week for 1 week, 2 times a week for 1 week, and 2 as needed (PRN) visits for infusion complications. Lab draws and site care to be done each Monday until discontinued by physician. The SN failed to measure the peripherally inserted central catheter (PICC) line every week as ordered, and per agency policy. A. The record evidenced the patient	G 0170	The Administrator/DOO of the agency will be responsible for correcting this deficiency. An in-service was conducted for agency staff on 8/20/15 where multiple policies were reviewed in regards to identified deficiencies per exit conference with state surveyor. (1)Policy *Central Venous Access Device (CVAD) Dressing Change (IV-009)*, revised 01/2015, was reviewed as policy states under procedure section, step 9, "Measure external segment with tape measure and record." Written policy was provided to all nursing staff. (2) Policy *Wound Care Reference/Resources/Documentation (WC-001)*, revised 07/2013, was reviewed as policy states under procedure, letter G, "Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week). Written policy was provided to all nursing staff. (3) Policy *Urinary Catheter*	08/20/2015

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	had the PICC line place on 6/15/15 at the hospital prior to admission to the agency. B. The record evidenced a physician order dated 7/15/15 for SN to administer Ceftriaxone 2 grams intravenous (IV) push over 5 minutes daily for 7 days, complete site care to central line every 7 days via sterile technique. C. The IV Assessment sheets dated 6/28, 7/5, 7/20, 7/27, 8/3, 8/10, and 8/14 failed to evidence the SN measured the PICC line. D. During interview on 8/17/15 at 1:40 PM, employee C, the Clinical Manager, indicated the nurses should be doing PICC care every Monday. E. During interview on 8/17/15, employee C, the Clinical Manager, indicated she did not realize we still measure PICC lines that are sutured in place. 2. Clinical record #4, SOC date 7/29/15, contained a POC dated 7/29-9/26/15 with diagnosis of pressure ulcer to buttocks, and orders for SN 1 time a week for 5 weeks; SN to measure and record wound dimensions weekly. A. The SN Notes dated 8/10 and		*Insertion-Straight, Indwelling or Suprapubic Catheter (UR-001),* revised 03/2013 was reviewed as the first step is to "verify physician's orders". Written policy was provided to nursing staff. Monitoring Process: The DOO or CM will complete 5 chart audits per month. Once 90% compliance is met, review will be incorporated into the quarterly performance improvement auditing process.	

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	8/13/15 failed to evidence the wound had been measured. B. During interview on 8/17/15 at 3:30 PM, employee C indicated the wound was not measured the week of 8/10-8/16/15 for patient # 4. 3. Clinical record # 5, SOC date 7/19/15, contained a POC dated 7/19-9/16/15 with diagnosis of pressure ulcer to buttock, and orders for SN 1 time a week for 1 week, 2 times a week for 3 weeks, and 1 time a week for 2 weeks; SN to measure and record wound dimensions weekly. A. The SN Notes dated 7/28 and 8/1/15 failed to evidence the wound had been measured. B. During interview on 8/18/15 at 9:50 AM, employee C indicated she could not find any wound measurements for the week of 7/27-8/2/15 for patient # 5. 4. Clinical record # 7, SOC date 7/8/13, contained a POC dated 7/8-9/5/15 with orders for SN 1 time a week for 1 week, 2 times a week fro 8 weeks, 2 PRN wound complications and/or catheter complications; SN to change Foley catheter 20 french 30 cubic centimeter			

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	157583	A. BUILDING 00 B. WING	08/19/2015

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	(cc) balloon every 1 months. A. The record failed to evidence the Foley catheter had been changed between 7/10/15 through 8/14/15. B. During interview on 8/18/15 at 12:34 AM, employee C indicated she spoke with [employee I] the licensed practical nurse who changed the catheter last, and this employee said the patient requested the catheter not be changed at the last visit, but she did not document this request. 5. The agency's policy titled "Central Venous Access Device (CVAD) Dressing Change," # IV-009, revised 01/2015 states, "Special Considerations: ... The greatest risk of catheter dislodgement occurs during the first few weeks after catheter insertion. Clients require instruction to avoid pulling on the catheter, and to be alert for signs of dislodgement, such as a greater length of catheter being visible. ... Procedure: ... 9. Measure external segment with tape measure and record. ... Document in the Clinical Record: ... Length of external segment measured." 6. The agency's policy titled "Wound Care reference/Resources/Documentation," #			

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	WC-001, revised 7/2013 states, "Procedure ... g. Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week).			
G 0212 Bldg. 00	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. Based on employee file review, policy review, and interview, the agency failed to ensure home health aide (HHA) skills competencies were completed at date of hire (DOH) and before patient contact for 1 of 1 HHA files reviewed. (H) Findings include 1. Employee file H, a HHA, DOH and first patient contact date 8/25/14, failed to evidence a skills competency was performed at hire. The file evidenced a skills competency was not performed until June 2015. 2. During interview on 8/19/15 at 10:00 AM, employee A, Administrator, indicated she did the competency evaluation with the HHA at hire and would not let the HHA go see patients without this being completed first.	G 0212	A meeting was conducted on September 2, 2015 with BOM and DOO to review Policy *Personnel File Requirements for Agency Staff (HR-001),* revised 08/2015, as it states under 10 of Procedure, "Personnel files may include but are not limited to the following documents as appropriate to the job function(s)…On Hire- HHA Skills Competency Checklist (Per state specific requirements)." New hire checklist was also attached to Home Health Aide's employee e-file to correct deficiency. The Administrator/DOO of the agency will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. Monitoring Process: DOO and BOM	09/02/2015

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	Employee A indicated they cannot find the documentation, but the HHA does have a copy of it, but she is out of state this week. 2. The agency's policy titled "Personnel File Requirements for Agency Staff," # HR-001(a), revised 08/2015 states, "10. Personnel files may include but are not limited to the following documents as appropriate to the job function(s). ... On-Hire- HHA Skills Competency Checklist (Per state specific requirements)."		will complete personnel record audits of current employees to ensure all documentation is appropriately attached to employee e-file along with the review of the new hire process to ensure future employees have all documentation attached.	
N 0000 Bldg. 00	This was a home health state license survey. Survey Dates: August 13, 14, 17, 18, and 19, 2015 Facility Number: IN011110 Medicaid Number: 200841710B Census Service Type: Skilled: 426 Home Health Aide Only: 0 Personal Service Only: 0	N 0000		

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	Total: 426 Sample: RR w/HV: 6 RR w/o HV: 6 Total: 12 QA; LD, R.N.			
N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on employee file review, policy review, and interview, the agency failed to ensure each employee providing direct patient care had a physical examination no more than 180 days before the date the employees had direct patient contact for 1 of 6 employee files reviewed. (L) Findings include	N 0462	A meeting was conducted on September 2, 2015 with BOM and DOO to review Policy *Personnel File Requirements for Agency Staff (HR-001)*, revised 08/2015, as it states under the specific state requirements that "each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner not more than one hundred eighty	09/02/2015

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	1. Employee file L, a Physical Therapist, date of hire and first patient contact date 5/4/15, failed to contain a physical. A. The file evidenced a physician script dated September 26, 2014 stating "[employee L] is free of communicable diseases." B. During interview on 8/19/15 at 9:00 AM, employee D, the Business Office Manager, indicated that employee L called his physician for the last physical, and found out it was done just 6 weeks short of the 6 month mark. 2. The agency's policy titled "Personnel File Requirements for Agency Staff," # HR-001(a), revised 08/2015 states, "11. Confidential File: ... Health Assessment/MD Statement of Good Health Condition and free of communicable disease. ... State Specific Requirements ... Indiana Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner not more than one hundred eighty (180) days before the date that the employee has direct patient contact."		(180) days before the date that the employee has direct patient contact. The physical examination shall be sufficient of scope to ensure that the employee will not spread infectious or communicable disease to patients." A physical examination for this employee has been obtained for the appropriate timeframe and has been attached to the employee e-file. BOM has been provided a written copy of the policy for reference along with verbal discussion focusing on the appropriate time frame of completion of physical exam. Monitoring Process: DOO and BOM will complete personnel record audits of current employees to ensure all documentation is appropriately attached to employee e-file along with the review of the new hire process to ensure future employees have all documentation attached.	

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N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on			

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	a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on employee file review, and policy review, the agency failed to ensure each employee having direct patient contact had been evaluated yearly for tuberculosis screenings for 1 of 6 employee files reviewed. (F) Findings include 1. Employee file F, Occupational Therapist, date of hire and first patient contact date 8/24/09, contained a Chest X-ray due to intolerance to Mantoux serum. The file failed to evidence an annual Tuberculosis Risk Assessment form for the years 2010 and 2011. 2. The agency's policy titled "Personnel File Requirements for Agency Staff," # HR-001(a), revised 08/2015 states, "11. Confidential File: ... TB Skin Test On hire and annually VS only, AM and AE, DOO/CM (or as mandated by state home health licensure requirements) ... TB	N 0464	A meeting was conducted on September 2, 2015 with BOM and DOO to review Policy *Personnel File Requirements for Agency Staff (HR-001)*, revised 08/2015, as it states under Procedure, number 11, that "TB Skin Test On hire and annually VS only, AM and AE, DOO/CM (or as mandated by state home health licensure requirements). DOO also reviewed with BOM the utilization of the Forthcoming Expirations Report to ensure no further annual TB screenings are missed. BOM able to demonstrate ability to generate and utilize report accordingly. Policy also reviewed in regards to appropriate saving in employee's confidential file within their e-file. Monitoring Process: DOO and BOM will complete personnel record audits of current employees to ensure all documentation is appropriately attached to employee e-file along with the review of the new hire process to ensure future employees have all	09/02/2015

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	test/screening results/chest X ray results (if applicable)."		documentation attached.	
N 0466 Bldg. 00	410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on employee file review, policy review, and interview, the agency failed to ensure employee medical information was kept in a separate electronic file from non-medical personnel information for 3 of 6 employee files reviewed. (F, H, and I) Findings include 1. The agency's employee files are all electronic. A separate file is labeled as Confidential and Medical. 2. Employee file F, Occupational Therapist, date of hire (DOH) and first patient contact date (FPCD) 8/24/09, failed to evidence all medical information was kept in a separate electronic file. A. The Tuberculosis (TB) Annual	N 0466	A meeting was conducted on September 2, 2015 with BOM and DOO to review Policy *Personnel File Requirements for Agency Staff (HR-001),* revised 08/2015, as it states under Procedure, number 11 “Confidential File: The Federal Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires employers and health care providers to protect medical records as confidential, separate, and apart from other business records. Medical information should not be maintained in a personnel file. Any document that contains private medical information about the employee or the employee’s family should be maintained in the Confidential/Medical File.” DOO and BOM executed saving appropriate documents into all employees’ confidential files and then contacted HR to have them	09/02/2015

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	Risk Assessments dated 2012, 2013, and 2014 were not contained within the Confidential Medical file. B. During interview on 8/18/15 at 2:00 PM, employee D, the Business Office Manager, indicated the 3 assessments were not in separate confidential medical files of the computer. 3. Employee file H, a Home Health Aide, DOH and FPCD 8/25/14, failed to evidence at the TB and physical were contained within the Confidential Medical file. 4. Employee file I, a licensed practical nurse, DOH and FPCD 4/30/12, failed to evidence the 2014 TB was contained within the Confidential Medical file. 5. During interview on 8/18/15 at 2:20 PM, employee A, Administrator, indicated she is not sure why some of the information is not in the separate file. Employee A indicated some was put into the computer before she started here. 6. The agency's policy titled "Personnel File Requirements for Agency Staff," # HR-001(a), revised 08/2015 states, "Procedure: ... 2. Each staff member, as appropriate, will have a personnel		removed from the general employee e-file. A hard copy of the policy was provided to the BOM along with review of documents that are to be saved under the confidential file. The Administrator/DOO of the agency will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur. Monitoring Process: DOO and BOM will complete personnel record audits of current employees to ensure all documentation is appropriately attached to employee e-file along with the review of the new hire process to ensure future employees have all documentation attached.	

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	confidential file. ... The electronic personnel file and the electronic Confidential/Medical Records File are created at the time a new hire completes his/her eForms (New Hire paperwork) for employees hired later March 2008. Access to the files is controlled by job role security. 11. Confidential File: ... Medical information should not be maintained in a personnel file. Any document that contains private medical information about the employee or the employee's family should be maintained in the Confidential/Medical File. The Confidential/Medical Files may include but are not limited to the following documents as appropriate to the job function(s). Health Assessment/MD Statement of good Health condition and free of communicable disease. ... TB Skin Test On hire and annually VS only, AM and AE, DOO/CM (or as mandated by state home health licensure requirements), HBV Declination/Acceptance VS only, TB fit test (if applicable), TB test/screening results/chest X ray results (if applicable), Hepatitis B consent/declination form, Evidence of Hepatitis B Vaccine Administration if employee consents to receiving, Worker's compensation report, health Statement post hire form, Accident/incident/exposure report."			

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N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure care followed a written plan of care (POC) established by a doctor of medicine in 5 of 12 clinical records reviewed. (# 2, 4, 5, 7, and 8) Findings include 1. Clinical record #2, start of care (SOC) date 6/17/15, contained a POC dated 6/17-8/15/15 with orders for SN 5 times a week for 1 week, 7 times a week for 1 week, 2 times a week for 1 week, and 2 as needed (PRN) visits for infusion complications. Lab draws and site care to be done each Monday until discontinued by physician. The SN failed to measure the peripherally inserted central catheter (PICC) line every week as ordered, and per agency policy. A. The record evidenced the patient had the PICC line place on 6/15/15 at the	N 0522	The Administrator/DOO of the agency will be responsible for correcting this deficiency. An in-service was conducted for agency staff on 8/20/15 where multiple policies were reviewed in regards to identified deficiencies per exit conference with state surveyor. (1)Policy *Central Venous Access Device (CVAD) Dressing Change (IV-009)*, revised 01/2015, was reviewed as policy states under procedure section, step 9, "Measure external segment with tape measure and record." Written policy was provided to all nursing staff. (2) Policy *Wound Care Reference/Resources/Documentation (WC-001),* revised 07/2013, was reviewed as policy states under procedure, letter G, "Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week). Written policy was provided to all nursing staff. (3) Policy *Urinary Catheter Insertion-Straight, Indwelling or*	08/20/2015

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	hospital prior to admission to the agency. B. The record evidenced a physician order dated 7/15/15 for SN to administer Ceftriaxone 2 grams intravenous (IV) push over 5 minutes daily for 7 days, complete site care to central line every 7 days via sterile technique. C. The IV Assessment sheets dated 6/28, 7/5, 7/20, 7/27, 8/3, 8/10, and 8/14 failed to evidence the SN measured the PICC line. D. During interview on 8/17/15 at 1:40 PM, employee C, the Clinical Manager, indicated the nurses should be doing PICC care every Monday. E. During interview on 8/17/15, employee C, indicated she did not realize we still measure PICC lines that are sutured in place. 2. Clinical record #4, SOC date 7/29/15, contained a POC dated 7/29-9/26/15 with diagnosis of pressure ulcer to buttocks, and orders for SN 1 time a week for 5 weeks, Home Health Aide (HHA) 2 times a week for 3 weeks, and Physical Therapy (PT) to evaluate week of 8/3/15. SN to measure and record wound dimensions weekly.		*Suprapubic Catheter (UR-001),* revised 03/2013 was reviewed as the first step is to "verify physician's orders". Written policy was provided to nursing staff. (4) Policy *Coordination of Care (TX-002),* revised 01/2015 states "A missed visit communication note is completed when a home care visit is unable to be completed as schedule and cannot be rescheduled within the patient's Medicare treatment week. A. The physician will be notified by: the clinician and documented on the missed visit note, or by way of faxing/mailing the missed visit communications note to physician's office with FAX confirmation attached or noted as mailed with initials/date mailed; or by the DOO, Clinical Manager, or other Clinical Management Representative. B. If the clinician or the Clinical Manager notifies the physician of the missed visit, this communication will be noted on the Missed Visit Communication Note. C. There are no exceptions, in which the physician does not have to be notified of a missed visit. D. If the Missed Visit is by a Home Health Aide then the Aide will report the missed visit to the Case Manager or DOO who will notify the physician and complete the Missed Visit Communication Note." DOO also reviewed interoffice process of communicating missed visits to appropriate staff so that	

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	A. The SN Notes dated 8/10 and 8/13/15 failed to evidence the wound had been measured. B. The record failed to evidence the HHA began services until 8/4/15. C. The HHA care plan dated 8/4/15 stated "Frequency/Duration: 2 times a week for 3 weeks, the week of 8/3/15." D. During interview on 8/18/15 at 9:25 AM, employee C indicated they could not find documentation of a reason for the HHA not starting care prior to 8/4/15. E. During interview on 8/17/15 at 3:30 PM, employee C indicated the wound was not measured the week of 8/10-8/16/15 for patient # 4. 3. Clinical record # 5, SOC date 7/19/15, contained a POC dated 7/19-9/16/15 with diagnosis of pressure ulcer to buttock, and orders for SN 1 time a week for 1 week, 2 times a week for 3 weeks, and 1 time a week for 2 weeks; SN to measure and record wound dimensions weekly. A. The SN Notes dated 7/28 and 8/1/15 failed to evidence the wound had been measured.		appropriate and supporting documentation can be completed. Monitoring Process: The DOO or CM will complete 5 chart audits per month. Once 90% compliance is met, review will be incorporated into the quarterly performance improvement auditing process.	

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	157583	A. BUILDING 00 B. WING	08/19/2015

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	B. During interview on 8/18/15 at 9:50 AM, employee C indicated she could not find any wound measurements for the week of 7/27-8/2/15 for patient # 5. 4. Clinical record # 7, SOC date 7/8/13, contained a POC dated 7/8-9/5/15 with orders for SN 1 time a week for 1 week, 2 times a week fro 8 weeks, 2 PRN wound complications and/or catheter complications; SN to change Foley catheter 20 french 30 cubic centimeter (cc) balloon every 1 months. A. The record failed to evidence the Foley catheter had been changed between 7/10/15 through 8/14/15. B. During interview on 8/18/15 at 12:34 AM, employee C indicated she spoke with [employee I] the licensed practical nurse who changed the catheter last, and this employee said the patient requested the catheter not be changed at the last visit, but she did not document this request. 5. Clinical record # 8, SOC date 8/19/14, contained a POC dated 6/15-8/13/15 with orders for SN 1 time a month for 1 month, 2 times a month for 1 month effective week of 6/15 and 2 PRN for catheter changes/complications. A			

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	physician order dated 7/30/15 added HHA services for 1 time a week for 3 weeks. A. The record failed to evidence the HHA began visits until 8/3/15 and failed to evidence the physician was notified of a missed visit for the dates 7/30-8/2/15. B. The record evidenced the HHA provided two visits the week of 8/10-8/13/15; on 8/10 and 8/13/15. C. During interview on 8/18/15 at 12:50 PM, employee C indicated they did not see a missed visit form for 7/30-8/2/15 and they are not sure why the HHA provided two visits from 8/10-8/13/15. 6. The agency's policy titled "Central Venous Access Device (CVAD) Dressing Change," # IV-009, revised 01/2015 states, "Special Considerations: ... The greatest risk of catheter dislodgement occurs during the first few weeks after catheter insertion. Clients require instruction to avoid pulling on the catheter, and to be alert for signs of dislodgement, such as a greater length of catheter being visible. ... Procedure: ... 9. Measure external segment with tape measure and record. ... Document in the Clinical Record: ... Length of external			

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	segment measured." 7. The agency's policy titled "Wound Care reference/Resources/Documentation," # WC-001, revised 7/2013 states, "Procedure ... g. Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week). 8. The agency's policy titled "Coordination of Care," # TX-002, revised 01/2015 states, "13. A missed visit communication notes is completed when a home care visit is unable to be completed as scheduled and can not be rescheduled within the patient's Medicare treatment week. a. The Physician will be notified by: The clinician; or By way of faxing/mailing the missed visit communications note to physician's office; or by the DOO, Clinical Manager or other Clinical Management Representative. b. If the clinician or the Clinical Manager notifies the physician of the missed visit, this communication will be noted on the Missed Visit Communication Note. c. There are no exceptions, in which the physician does not have to be notified of a missed visit. d. If the Missed Visit is by a Home Health Aide then the Aide will report the missed visit to the Case Manager or DOO			

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	who will notify the physician and complete the Missed Visit Communication Note."			
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. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record review, observation, policy review, and interview, the agency failed to ensure all durable medical equipment (DME) used	N 0524	The Administrator/DOO of the agency will be responsible for correcting this deficiency. All agency	08/20/2015

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	by patients was included on the plan of care (POC) for 5 of 6 home visit observations (# 1, 2, 3, 4, and 5), and failed to ensure the duration of services was indicated for 8 of 12 active clinical records reviewed. (# 1, 2, 3, 4, 5, 6, 7, and 8) Findings include 1. Clinical record # 1, start of care date (SOC) 7/28/15, contained a POC dated 7/28-9/25/15 with orders for Skilled Nursing (SN) 1 time a week time 5 weeks, Physical Therapy (PT) evaluation, Occupational Therapy evaluation, and DME listed: gloves, blood glucose monitor, lancets, strips, alcohol wipes, walker and wheelchair. The SN services failed to contain a duration, and the DME failed to include the toilet seat riser and grab bars. A. During observations on 8/13/15 at 1:00 PM, the toilet seat riser and grab bars were observed in the patient's bathroom. B. Clinical record review on 8/17/15 failed to evidence the toilet seat riser and grab bars were new since admission to the agency. 2. Clinical record #2, SOC date 6/17/15,		personnel were instructed on 8/20/15: (1)Billable and non-billable supplies provided to the patient by agency personnel, and durable medical equipment used by the patient in the home will be included on the 485/Plan of Care in the section identified as *Locator 14. Durable Medical Equipment and Supplies.* (2) Policy *AA-014, Plan of Care/Care Planning Process*, revised 5/2013, was reviewed with particular attention to identifying the types of DME and supplies the patient uses and/or requires for home use. Rehab Clinicians responsible for Therapy Only Comprehensive Assessments/Reassessments and development of the Plan of Care received additional training regarding identification of, and steps to ensure inclusion of DME such as grab bars, toilet seat risers, Hoyer lift, shower chair, hospital bed, and bi-pap machines and Supplies in the 485/Plan of Care. Rehab clinicians instructed to re-evaluate if any new equipment had been obtained since the 485/Plan of care was established and to document this equipment in 30 day Functional Assessment. On 9/10/15, Policy TX-001 Physician's Orders and Medical Supervision of Plan of Care, revised 6/2015, will be reviewed with all agency personnel as policy states under procedure section, step 7,	

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	contained a POC dated 6/17-8/15/15 with orders for SN 5 times a week for 1 week, 7 times a week for 1 week, 2 times a week for 1 week, and 2 as needed (PRN) visits for infusion complications; DME listed: gloves, alcohol wipes, Intravenous (IV) supplies, Incontinent supplies, wheelchair, coagucheck monitor, sterile gloves, oxygen, tape, straight catheter, syringes, catheter insertion tray, drainage bag, large gauze, strips, and Band-Aids. The SN services failed to contain a duration and the DME failed to include the hospital bed. A. During observation on 8/13/15 at 2:00 PM, the patient was in a hospital bed. B. The agency's SOC assessment dated 6/17/15 evidenced the hospital bed and hoyer lift were present at SOC. C. During interview on 8/17/15 at 2:00 PM, employee C, the clinical manager, indicated this patient does have a hoyer lift. 3. Clinical record # 3, SOC date 12/5/14, contained a POC dated 8/2-9/30/15 with orders for SN 1 time a week for 1 week, 7 times a week for 4 weeks, and DME listed: gloves, 4 x 4's, 2 x 2's, alcohol wipes, wound care/dressing supplies,		"Types of Orders and Requirements to include frequency and duration of service" for all ordered disciplines. Monitoring Process: The DOO or CM will complete 5 chart audits per month. Once 90% compliance is met, review will be incorporated into the quarterly performance improvement auditing process. The DOO or CM will also review all 485's and/or verbal orders to ensure all orders contain a frequency and duration prior to sending out to the physician for signature.	

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	large gauze, mepilex border, wheelchair, walker, and incontinent supplies. The SN services failed to contain a duration, and the DME failed to include the shower chair. A. During observation on 8/14/15 at 9:00 AM, DME in the home included a shower chair. B. Clinical record review on 8/17/15 failed to evidence shower chair was new since admission to the agency. C. During interview on 8/17/15 at 2:30 PM, employee C indicated the shower chair was not listed in the record. 4. Clinical record #4, SOC date 7/29/15, contained a POC dated 7/29-9/26/15 with orders for SN 1 time a week for 5 weeks, PT evaluation, and Home Health Aide (HHA) 2 times a week for 3 weeks, and DME listed: gloves, wound care/dressing supplies, walker, and skin prep. The SN and HHA services failed to contain a duration, and the DME failed to include the shower bench and toilet riser. A. During observation on 8/14/15 at 10:30 AM, DME observed in the home included a shower bench and toilet riser. B. Clinical record review on 8/17/15			

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	failed to evidence shower chair was new since admission to the agency. 5. Clinical record # 5, SOC date 7/19/15, contained a POC dated 7/19-9/16/15 with orders for SN 1 time a week for 1 week, 2 times a week for 3 weeks, and 1 time a week for 2 weeks; and DME listed: gloves, 4 x 4's, alcohol wipes, wound care/dressing supplies, large gauze, aquacel, skin prep, and walker. The SN services failed to contain a duration, and the DME failed to include the bipap machine. A. During observation on 8/14/15 at 11:30 AM, DME observed in the home included a bipap machine. B. During interview on 8/14/15 at 11:30 AM, patient # 5 indicated they use the bipap machine at night or while napping during the day. C. Clinical record review on 8/17/15 failed to evidence the bipap machine was new since admission to the agency. 6. Clinical record # 6, SOC date 6/25/15, contained a POC dated 6/25-8/23/15 with orders for PT 1 time a week for 1 week, 2 times a week for 6 weeks, 1 time a week for 2 weeks, OT evaluation, and Speech Therapy (ST) 1 time a week for 3 weeks			

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	and 2 times a week for 3 weeks. The PT and ST services failed to contain a duration. 7. Clinical record # 7, SOC date 7/8/13, contained a POC dated 7/8-9/5/15 with orders for SN 1 time a week for 1 week, 2 times a week fro 8 weeks, 2 PRN wound complications and/or catheter complications; HHA 1 time a week for 1 week, 2 times a week fro 8 weeks (effective 7/13/15). The SN and HHA services failed to contain a duration. 8. Clinical record # 8, SOC date 8/19/14, contained a POC dated 6/15-8/13/15 with orders for SN 1 time a month for 1 month, 2 times a month for 1 month effective week of 6/15 and 2 PRN for catheter changes/complications. The SN services failed to contain a duration. 9. The agency's policy titled "Plan of Care (POC)/Care Planning Process," # AA-014, dated 05/2013 states, "Purpose: A Plan of Care will be developed through a care planning process, which is designed to provide care, treatment, and services that are appropriate to the patient's individual needs. ... 484.18(a) Standard: Plan of Care: The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including ... types of services			

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	and equipment required, frequency of visits ... 1. The Plan of Care will be established through the used of the admission evaluation assessment and initiated by a physician's order."			
N 0537 Bldg. 00	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 review, policy review, and interview, the agency failed to ensure the skilled nurse (SN) furnished services in accordance with the plan of care (POC) for 4 of 12 clinical records reviewed. (# 2, 4, 5, and 7) Findings include 1. Clinical record #2, start of care (SOC) date 6/17/15, contained a POC dated 6/17-8/15/15 with orders for SN 5 times a week for 1 week, 7 times a week for 1 week, 2 times a week for 1 week, and 2 as needed (PRN) visits for infusion complications. Lab draws and site care to be done each Monday until discontinued by physician. The SN failed to measure the peripherally inserted	N 0537	The Administrator/DOO of the agency will be responsible for correcting this deficiency. An in-service was conducted for agency staff on 8/20/15 where multiple policies were reviewed in regards to identified deficiencies per exit conference with state surveyor. (1)Policy *Central Venous Access Device (CVAD) Dressing Change (IV-009)*, revised 01/2015, was reviewed as policy states under procedure section, step 9, "Measure external segment with tape measure and record." Written policy was provided to all nursing staff. (2) Policy *Wound Care Reference/Resources/Documentation (WC-001),* revised 07/2013, was reviewed as policy states under procedure, letter G, "Measure	08/20/2015

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	central catheter (PICC) line every week as ordered, and per agency policy. A. The record evidenced the patient had the PICC line place on 6/15/15 at the hospital prior to admission to the agency. B. The record evidenced a physician order dated 7/15/15 for SN to administer Ceftriaxone 2 grams intravenous (IV) push over 5 minutes daily for 7 days, complete site care to central line every 7 days via sterile technique. C. The IV Assessment sheets dated 6/28, 7/5, 7/20, 7/27, 8/3, 8/10, and 8/14 failed to evidence the SN measured the PICC line. D. During interview on 8/17/15 at 1:40 PM, employee C, the Clinical Manager, indicated the nurses should be doing PICC care every Monday. E. During interview on 8/17/15, employee C, the Clinical Manager, indicated she did not realize we still measure PICC lines that are sutured in place. 2. Clinical record #4, SOC date 7/29/15, contained a POC dated 7/29-9/26/15 with diagnosis of pressure ulcer to buttocks, and orders for SN 1 time a week for 5		wounds at a minimum frequency of once each calendar week (usually the first visit of the week). Written policy was provided to all nursing staff. (3) Policy *Urinary Catheter Insertion-Straight, Indwelling or Suprapubic Catheter (UR-001),* revised 03/2013 was reviewed as the first step is to "verify physician's orders". Written policy was provided to nursing staff. Monitoring Process: The DOO or CM will complete 5 chart audits per month. Once 90% compliance is met, review will be incorporated into the quarterly performance improvement auditing process.	

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	weeks; SN to measure and record wound dimensions weekly. A. The SN Notes dated 8/10 and 8/13/15 failed to evidence the wound had been measured. B. During interview on 8/17/15 at 3:30 PM, employee C indicated the wound was not measured the week of 8/10-8/16/15 for patient # 4. 3. Clinical record # 5, SOC date 7/19/15, contained a POC dated 7/19-9/16/15 with diagnosis of pressure ulcer to buttock, and orders for SN 1 time a week for 1 week, 2 times a week for 3 weeks, and 1 time a week for 2 weeks; SN to measure and record wound dimensions weekly. A. The SN Notes dated 7/28 and 8/1/15 failed to evidence the wound had been measured. B. During interview on 8/18/15 at 9:50 AM, employee C indicated she could not find any wound measurements for the week of 7/27-8/2/15 for patient # 5. 4. Clinical record # 7, SOC date 7/8/13, contained a POC dated 7/8-9/5/15 with orders for SN 1 time a week for 1 week,			

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	2 times a week fro 8 weeks, 2 PRN wound complications and/or catheter complications; SN to change Foley catheter 20 french 30 cubic centimeter (cc) balloon every 1 months. A. The record failed to evidence the Foley catheter had been changed between 7/10/15 through 8/14/15. B. During interview on 8/18/15 at 12:34 AM, employee C indicated she spoke with [employee I] the licensed practical nurse who changed the catheter last, and this employee said the patient requested the catheter not be changed at the last visit, but she did not document this request. 5. The agency's policy titled "Central Venous Access Device (CVAD) Dressing Change," # IV-009, revised 01/2015 states, "Special Considerations: ... The greatest risk of catheter dislodgement occurs during the first few weeks after catheter insertion. Clients require instruction to avoid pulling on the catheter, and to be alert for signs of dislodgement, such as a greater length of catheter being visible. ... Procedure: ... 9. Measure external segment with tape measure and record. ... Document in the Clinical Record: ... Length of external segment measured."			

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	6. The agency's policy titled "Wound Care reference/Resources/Documentation," # WC-001, revised 7/2013 states, "Procedure ... g. Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week).			
N 0596 Bldg. 00	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on employee file review, policy review, and interview, the agency failed to ensure home health aide (HHA) skills competencies were completed at date of hire (DOH) and before patient contact for 1 of 1 HHA files reviewed. (H) Findings include 1. Employee file H, a HHA, DOH and	N 0596	A meeting was conducted on September 2, 2015 with BOM and DOO to review Policy *Personnel File Requirements for Agency Staff (HR-001),* revised 08/2015, as it states under 10 of Procedure, "Personnel files may include but are not limited to the following documents as appropriate to the job function(s)…On Hire- HHA Skills Competency Checklist (Per state	09/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157583	A. BUILDING 00 B. WING	08/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	first patient contact date 8/25/14, failed to evidence a skills competency was performed at hire. The file evidenced a skills competency was not performed until June 2015. 2. During interview on 8/19/15 at 10:00 AM, employee A, Administrator, indicated she did the competency evaluation with the HHA at hire and would not let the HHA go see patients without this being completed first. Employee A indicated they cannot find the documentation, but the HHA does have a copy of it, but she is out of state this week. 2. The agency's policy titled "Personnel File Requirements for Agency Staff," # HR-001(a), revised 08/2015 states, "10. Personnel files may include but are not limited to the following documents as appropriate to the job function(s). ... On-Hire- HHA Skills Competency Checklist (Per state specific requirements)."		specific requirements)." New hire checklist was also attached to Home Health Aide's employee e-file to correct deficiency. Monitoring Process: DOO and BOM will complete personnel record audits of current employees to ensure all documentation is appropriately attached to employee e-file along with the review of the new hire process to ensure future employees have all documentation attached.	