STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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 Federal home health recertification and complaint investigation survey. Extended 5-19-16. Complaint #: IN00173876; Substantiated, deficiencies related to the complaint are cited at 42 CFR 484.12(c), 484.18, 484.18(b), 484.30, & 484.30(a). Survey Dates: 5-17-16, 5-18-6, 5-19-16, and 5-20-16. Facility #: 005940 Medicare Provider # 15-7223 Medicaid Vendor #: N/A ViaQuest Home Health of Indiana was found to be out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision, 42 CFR 494.30 Skilled Nursing Services, and 42 CFR 484.36 Home Health Aide Services. ViaQuest Home Health of Indiana is precluded from providing its own home health aide training and/or competency evaluation program for a period of two	G 0000	Please see Plan of Correction beginning with tag# G108.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	(2) years beginning 5-20-16 due to being found out of compliance with Conditions of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision, 42 CFR 494.30 Skilled Nursing Services, and 42 CFR 484.36 Home Health Aide Services.			
G 0108 Bldg. 00	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. Based on record review and interview, the agency failed to ensure patients had been informed in advance of the proposed frequency of visits in 7 (#s 1, 2, 4, 6, 7, 8, & 9) of 12 records reviewed. The findings include: 1. Clinical record number 1 included an "Admission Service Agreement" dated	G 0108	All clinical staff have been educated on the following: ·The requirements of 484.10 (c)(1) ·That all patients must be informed, in advance, of the proposed frequency of visits in writing on the Admission Service Agreement Clinical staff will include the proposed frequency of visits on the Admission Service Agreement for all patients admitted to the agency. The	06/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	5-4-16. The service agreement identified skilled nursing, physical and occupational therapy, and home health aide services were to be provided. The agreement failed to evidence the proposed frequency of the services to be provided. 2. Clinical record number 2 included a "Home Health Admission Service Agreement" dated 2-15-16. The service agreement identifies skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 3. Clinical record number 4 included an "Admission Service Agreement" dated 4-26-16. The service agreement identified skilled nursing and physical and occupational therapy services were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 4. Clinical record number 6 evidenced a start of care date of 3-31-16. The record failed to evidence the patient had been informed of the care to be furnished or the proposed frequency of visits proposed to be furnished. 5. Clinical record number 7 included a "Home Health Admission Service		agency's Admission Service Agreement has been revised to include a line for each discipline's frequency. Each SOC will be audited, weekly for 6 weeks, until compliance threshold of 90% is achieved, for the presence of the proposed frequency of visits of each discipline on the Admission Service Agreement. After achieving compliance threshold, audits will continue of 10% of clinical records quarterly. The Clinical Director/designee is responsible for correcting this deficiency and for monitoring the corrective action to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	Agreement" dated 11-5-15. The service agreement identified skilled nursing, physical and occupational therapy, home health aide services, and medical social services were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 6. Clinical record number 8 included an "Admission Service Agreement" dated 2-12-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 7. Clinical record number 9 included an "Admission Service Agreement" dated 4-6-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 8. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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 0110 Bldg. 00	484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review and interview, the agency failed to ensure patients had been provided with a description of applicable State law with regards to advance directives in 12 (#s 1 through 12) of 12 records reviewed. The findings include: 1. Clinical records numbered 1 through 12 evidenced the patients had been provided with the agency's "Welcome to ViaQuest Home Health Services" booklet upon admission. The booklet included an "Advance Directive Information Statement." The booklet failed to evidence the Indiana State Department of Health (ISDH) description of applicable	G 0110	All agency staff were educated on the following: ·The requirements of 484.10 (c) (2) (ii) ·That the agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law before care is provided. ·Agency Policy C-430 (Advance Directives) The Indiana State Department of Health (ISDH) description of applicable State law, “Your Right to Decide” dated July 2013 will be included in all admission packets to be provided to all patients admitted to the agency prior to care being provided. The ISDH description of applicable State law, “Your Right to Decide” dated	06/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	State law, "Your Right To Decide" July 2013. 2. The Clinical Director indicated, on 5-19-16 at 2:40 PM, the information provided to patients with regards to advance directives did not include the ISDH prepared description of applicable State law, "Your Right To Decide" July 2013. 3. The agency's June 2013 "Advance Directives" policy and procedure number C-430 (C) states, "During the initial visit, prior to coming under ViaQuest Care, the patient will be provided with written information concerning the patient's rights under state law (both statutory and case law) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives."		July2013 was distributed to all current patients of the agency. 50% of admission packets will be audited weekly for 6 weeks, or until compliance threshold of 90% is achieved, to ensure inclusion of the appropriate ISDH advance directive information. After compliance threshold is achieved, auditswill continue of 10% of admission packets quarterly. The Clinical Director/designee is responsible for correcting this deficiency and for monitoring the corrective action to ensure that this deficiency is corrected.	
G 0121 Bldg. 00	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 observation, interview, and record review, the agency failed to ensure staff had provided care in accordance with the agency's own infection control	G 0121	All clinical staff, including Employees G, K, and B will be educated on the following: ·Agency Policy B-400 (Infection Prevention and Control Plan)-see supporting documentation	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	policies and procedures and with the Centers for Disease Control (CDC) guidelines in 3 (#s 1, 2, & 3) of 6 home visit observations completed. The findings include: 1. Employee G, a registered nurse (RN), was observed to complete an assessment and dressing change on patient number 1 on 5-18-16 at 10:00 AM (observation # 1). The RN was observed to remove the old dressing using a pair of bandage scissors. The RN removed her gloves and cleansed her hands. The RN cleaned the scissors used to remove the old dressing and donned clean gloves without cleansing her hands. 2. Employee K, an RN, was observed to complete dressing changes to patient number 2 on 5-18-16 at 12:15 PM (observation number 2). The RN cleansed her hands and donned clean gloves. The RN removed the dressing from the patient's left lower leg, changed her gloves and cleansed her hands, and then removed the dressings from the right lower leg. The RN cleansed her hands and changed her gloves. The RN then cleansed the right lower leg and the left lower leg. The RN failed to change her gloves and cleanse her hands between the two.		·Agency Policy B-410 (Standard Precautions for All Health CareWorkers)-see supporting documentation ·Centers for Disease Control's (CDC) Guidelines related to Infection Control and Standard Precautions ·The requirements of 484.12 (c) – Compliance with Accepted Professional Standards Agency clinical staff will provide care in accordance with the agency's infection control policies and procedures and with the CDC guidelines, which will be reviewed and distributed to all clinical staff. Infection control competency of all clinical staff will be re-assessed to ensure compliance with agency policies and procedures and CDC guidelines related to infection control and standard precautions by 6/19/16. Monthly in-services will be developed, and presented to all clinical staff, related to infection control, standard precautions, and related topics. Documentation will be maintained of content and attendance. Home visits to observe wound care performed by RNs will be initiated on a quarterly basis, beginning with quarter 3 of 2016, for the remainder of the year, in order to audit/review appropriate technique, staff competency and compliance with infection control policies and procedures. These home visit audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	A. The RN was observed to obtain clean supplies needed for the dressing changes to the bilateral lower extremities. The RN was observed to place the clean supplies on a rug on the floor without a barrier. B. After cleansing the lower extremities, the RN cleansed her hands and changed her gloves. The RN measured the left lower leg wound and applied a clean Telfa dressing. The RN cleansed her hands and changed her gloves and applied a a Kerlix wrap and Coban wrap to the left lower leg. The RN then applied a Kerlix wrap to the right lower leg without cleansing her hands or changing her gloves. C. The Clinical Director indicated, on 5-18-16 at 12:50 PM, employee K had not performed the dressing change in accordance with facility policy. 3. Employee B, an RN, was observed to perform a dressing change on patient number 3 on 5-18-16 at 2:40 PM (observation # 3). The RN was observed to cleanse her hands and obtain the needed supplies from the patient's dresser. The RN donned clean gloves without cleansing her hands.		documented on a focused audit tool. Non compliance will be addressed with clinicians on a one-to-one basis until 100% compliant. Home visits will then continue annually to ensurecontinued compliance. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	A. The RN was observed to apply a gel to two dressings with a gloved finger and then apply the dressings to the wounds on the patient's buttocks. B. The Clinical Director indicated, on 5-18-16 at 3:05 PM, employee B had not performed the dressing change in accordance with facility policy. 4. The agency's June 2013 "Infection Prevention & Control Plan" policy and procedure number B-400 (C) states, "ViaQuest has developed, and implemented infection control practices that conform to OSHA regulations, CDC guidelines, accreditation requirements, state and local regulations and currently accepted standards of practice." 5. The agency's September 2013 "Standard Precautions For All Health Care Workers" policy and procedure number B-410 states, "ViaQuest has established Standard Precautions for All Health Care Workers. Employees should assume that blood and all body fluids, with or without visible blood, from all patients are potentially infectious." 6. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	nonintact skin, or potentially contaminated intact skin . . . could occur."			
G 0156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on record review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure ensure services and treatments had been provided in accordance with physician orders in 5 of 12 records reviewed (See G 158); by failing to ensure plans of care care were specific to the assessment and included all treatments in 3 of 12 records reviewed (See G 159); by failing to ensure orders for therapy services included the specific procedures to be used in 1 of 9 records reviewed of patients that received therapy services (See G 161); by failing to ensure staff had alerted the physician to changes in the patients' needs and condition in 4 of 12 records reviewed (See G 164); and by failing to ensure verbal orders had been put into writing by the registered nurse (RN) or therapist in 2 of 12 records reviewed (See G 166). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this	G 0156	The corrective actions, monitoring plans and responsible parties for this Condition are located under G158, G159, G161 and G164. 42 CFR 484 18 Acceptance of Patients Plan of Care Medical Supervision	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	condition, 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.			
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 record review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician orders in 5 (#s 2, 3, 5, 11, and 12) of 12 records reviewed. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 4-16-16 to 6-13-16. The plan of care states, "Skilled assessment with focus on CHF [congestive heart failure]: medication management, edema, weight, dyspnea levels, cardiac assessment, oxygen safety and management . . . Instruct to record weight daily and to report weight gain of 2 lbs. in one day or 5 lbs in one week or as per physician order.' A. Skilled nurse (SN) visit notes,	G 0158	All agency clinical staff will be educated on the following: ·Requirements of 484.18 (Acceptance of Patients, Plan of Care andMedical Supervision ·Care must follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, orpodiatric medicine ·Services and treatments must be provided in accordance with physician orders ·Agency Policy C-635 (Physician Orders) ·All clinical staff will be educated on individualizing each patient's plan of care based on the assessment and needs of the patient and that the plan of care must be followed. ·Agency clinical software generated care plans/guidelines will be revised to exclude inappropriate auto-populated interventions. A clinical record review of 25% of active patients will be	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16, failed to evidence the SN had assessed and monitored the patient's weight. B. A SN recertification visit note dated 4-14-16 states, "Patient is incontinent [urinary]." The plan of care for the certification period 4-16-16 to 6-13-16 included interventions to address the incontinence. The plan states, "Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . Assess/instruct caregivers not to rush patient, to give frequent cues and reminders during an activity, accompany them to bathroom (allow privacy)." SN visit notes, dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16, failed to evidence the SN had assessed and addressed the urinary incontinence. The SN visit notes identifies the patient's urinary status was "WNL [within normal limits]." C. The plan of care for the certification period 4-16-16 to 6-13-16 states, "Hgb A1C [blood test to assess how well diabetes is being controlled]		conducted to determine compliance with the requirements of G158. Clinical Record number 2: A.The physician was notified that the SN failed to assess and monitor the patient's weight per the plan of care. Physician order was obtained to discontinue daily weights. B.One on one education will be provided to the SN who failed to assess and address the patient's urinary incontinence as it was identified on the assessment and included in the plan of care. SN will assess and address patient's incontinence on every visit. C. SN drew HbA1c prior to initially ordered date, per written physician order obtained by patient, so results would be available for physician's appointment.SN failed to discontinue the original order for the lab to be drawn on 5/19/16and SN failed to place the written order in the clinical record or call to clarify, via verbal order, that the HbA1c was to be drawn early. One on one education will be provided to this SN and SN will obtain written or verbal orders for all changes to the plan of care. Clinical Record number 3: A.SN failed to document how the dressing change was performed. Education providedto all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	due 5/19/16." 1.) A SN visit note dated 5-12-16 states, "SN drew ordered labs from [name of physician] via venipuncture." The record failed to include an order for the venipuncture on 5-12-16. 2.) The record failed to evidence the Hgb A1C had been drawn on 5-19-16 per the plan of care. 3.) The record included a "Case Communication Report" dated 5-9-16 that states, "SN has written order from [name of physician] given to patient for SN to draw hgba1c before upcoming appt on 5-19-16." The record failed to evidence the written order. 2. Clinical record number 3 included a physician's orders dated 4-25-16 that states, "OK for SN to change wound care order to Hyrogel on wounds, then Aquacel Ag, cover with foam dressing. Dressing change will remain 3 times per week as previously scheduled." A. SN visit notes, dated 4-27-16 and 4-29-16, failed to evidence how the dressing change was performed. The notes state, "wound care performed." B. SN visit notes, dated 5-13-16 and		B.SN failed to document at the Hydrogel was applied to wound per physician order.Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 5: A.Occupational therapy failed to complete an evaluation per physician order;physician will be notified that the Occupational Therapy evaluation was not completed. All therapy staff will be educated regarding following physician orders and appropriate documentation and physician notification when changes tothe plan of care are necessary. B.The Occupational Therapy evaluation was not provided as indicated on the Admission Service Agreement and the physician will be notified that it was not completed. All clinical staff will be educated that services must be provided per physician orders and physician notification is required when changes to the plan of care/physician orders are necessary. Clinical Record number 11: A. SN failed to document how the dressing change was performed. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	5-16-16, failed to evidence the SN had applied the Hydrogel per the physician's order. 3. Clinical record number 5 included a "Home Health Order Request" signed and date by the physician on 4-15-16. The order states, "To evaluate and treat . . . Physical Therapy, Occupational Therapy." A. The record failed to evidence an occupational therapy evaluation had been completed. B. The record included an "Admission Service Agreement", signed and dated by the patient on 4-21-16, that identifies an occupational therapy evaluation would be provided. C. The Clinical Director stated, on 5-20-16 at 11:10 AM, "The order was missed." 4. Clinical record number 11 included a plan of care established by the physician for the certification period 4-26-16 to 6-24-16. The plan of care states, "Wound Care Orders for Right buttocks: Cleanse with ns [normal saline] and pat dry with gauze, apply Prisma to area, cover with foam."		wound care performed. B. SN failed to document that the wound care had been performed. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. C. SN failed to document wound care appropriately. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 12: The SN failed to document, on 5/6/16, that the patient's legs had been wrapped per the physician order; however, per this SN she did wrap the patient's legs per physician order but failed to document the procedure. SN instructed to annotate the visit note of 5/6/16 to include this documentation. Patient had seen physician on 5/3/16 and the physician had removed the wraps to patient's legs and failed to reapply them, per documentation in the clinical record. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	A. A SN visit note dated 4-30-16 failed to evidence how the wound care was performed. The note states, "wound care performed. pt [patient] tolerated well." B. A SN visit note dated 5-2-16 failed to evidence the wound care had been performed. C. A SN visit note dated 5-13-16 evidenced the foal dressing was applied, but failed to evidence the Prisma was applied per the physician's order. 5. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to 6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 layer profor dressing with 3 layer being in figure 8 fashion. Wrap toes with cotton roll or kerlix and then cover with coban." A SN visit note dated 5-6-16 failed to evidence the patient's legs had been wrapped per the physician's order. The note identifies the patient was not wrapped upon the SN's arrival and that the patient had gone 3 days without wraps.		educated on the requirement of following physician orders. 25% of all visit notes will be reviewed weekly for compliance of providing care in accordance with physician orders/plan of care beginning week of 6/13/16 for a period of 6 weeks. Compliance threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits will be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	6. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 7. The agency's August 2013 "Physician Orders" policy and procedure number C-635 states,"All care and service provided will be in accordance with physician orders."			
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 record review and interview, the agency failed to ensure plans of care care were specific to the assessment and included all treatments in 3 (#s 4, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 4 included a start of care comprehensive assessment dated 4-26-16. The assessment identifies the patient had no urinary incontinence.	G 0159	Education will be provided to agency clinical staff on the following: ·The requirements of 484.18 (a) (Plan of Care) ·That 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	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	The plan of care, established by the physician for the certification period 4-26-16 to 6-24-16, includes interventions related to the management of urinary incontinence. The plan of care states, "Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . assess/instruct caregivers not to rush patient, to give frequent cues and reminders during activity, accompany them to the bathroom allow privacy." 2. Clinical record number 6 included a start of care comprehensive assessment dated 3-31-16. The assessment identifies the patient had no urinary incontinence. The plan of care, established by the physician for the certification period 3-31-16 to 5-29-16, includes interventions related to the management of urinary incontinence. The plan of care states, "Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . assess/instruct caregivers not to rush patient, to give frequent cues and reminders during activity, accompany them to the bathroom allow privacy." 3. Clinical record number 8 included a plan of care established by the physician		and treatments, any safety measures to protect against injury, instructions for timely discharge or referral andany other appropriate items ·The plan of care must be specific to the assessment of the patient's needs ·Agency Policy C-580 (Plan of Care) ·Agency clinical software generated care plans/guidelines will berevised to exclude inappropriate auto-populated interventions to allow the individualizing of patient-specific interventions. A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of G159: that the plan of care is based on the patient's comprehensive assessment and contains all of the required elements. Clinical Record #4: This patient had no urinary incontinence. A physician order will be obtained to correct the plan of care to remove the interventions related to urinary incontinence. The agency clinical software generated interventions un-related to the patient's assessment that were erroneously included in the plan of care. The agency clinical software will be revised to exclude inappropriate, auto-populated interventions to allow individualization. Clinical Record #6:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	for the certification period 4-12-16 to 6-10-16. The plan of care included orders for occupational therapy visits 2 times per week for 4 weeks. The orders for the occupational therapy failed to include the specific treatments to be provided. 4. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 5. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "The Plan of Care is based on a comprehensive assessment and information provided by the patient/family and health team members . . . The Plan of Care shall be completed in full to include: . . . Specific procedures and modalities for therapy services . . .Medications, treatments, and procedures."		This patient had no urinary incontinence. A physician order will be obtained to correct the plan of care to remove the interventions related to urinary incontinence. The agency clinical software generated interventions un-related to the patient's assessment that were erroneously included in the plan of care.The agency clinical software will be revised to exclude inappropriate, auto-populated interventions to allow individualization. Clinical Record #8: A physician order will be obtained to amend the plan of care to include thespecific Occupational Therapy treatments to be provided. All therapists will be educated on the requirement to include specific treatments to be provided on all therapy orders for services. Beginning with plans of care dated 6/13/16 and later, 100% of all Plan of Cares will be audited weekly to ensure that the plan of care is specific to the assessment and the patient's needs. This audit will also ensure that the plans of careinclude the all pertinent diagnoses, including mental status, types of servicesand equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements,medications and treatments, any safety measures to protect against injury,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
			instructions for timely discharge or referral and any other appropriate items.This audit will continue for a period of 6 weeks. Threshold is 90%. If threshold of 90% is met 6 consecutive weeks in a row, the chart audits can decreased to a 10% quarterly chart audit. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
G 0161 Bldg. 00	484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. Based on record review and interview, the agency failed to ensure orders for therapy services included the specific procedures to be used in 1 (# 8) of 9 records reviewed of patients that received therapy services. The findings include: 1. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care included orders for occupational therapy visits 2 times per week for 4 weeks. The orders for the occupational therapy failed to include the specific procedures to be used and treatments to be provided.	G 0161	All agency therapy staff will be educated on the following: ·Requirements of 484.18 (a) (Plan of Care) ·Orders for therapy services must include the specific proceduresand modalities To be used and the amount,frequency and duration of treatment ·Agency Policy C-580 (Plan of Care) A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of G161: that orders for therapy services must include the specific procedures and modalities to be used and the amount, frequency and duration of treatment. Clinical Record #8: The plan of	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	2. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 3. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "The Plan of Care is based on a comprehensive assessment and information provided by the patient/family and health team members . . . The Plan of Care shall be completed in full to include: . . . Specific procedures and modalities for therapy services . . .Medications, treatments, and procedures."		care did not contain the specific procedures to be used and treatments to be provided to the patient. A physician order will be obtained to amend the plan of care to include the specific procedures and treatments to be provided to the patient. All therapy staff will be educated on including the specific procedures and treatments on the plan of care for all patients to receive therapy services. Beginning with plans of care dated 6/13/16 and later, 100% of all plans of care will be audited weekly to ensure that the orders for therapy services include thespecific procedures and modalities to be used and the amount, frequency and duration of treatment. This audit will continue for a period of 6 weeks.Threshold is 90%. If threshold of 90% ismet 6 consecutive weeks in a row, the chart audits can decreased to a 10% quarterly chart audit. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
G 0164 Bldg. 00	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on record review and interview, the agency failed to ensure staff had alerted the physician to changes in the patients' needs and condition in 4 (#s 2,	G 0164	All agency professional staff will be educated on the following: ·Requirements of 484.18 (b) (Periodic Review of the Plan of Care)	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	3, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 2 failed to evidence the registered nurse (RN) had informed the physician of a change in the size of the patient's wound and a change in the character of the wound drainage. A. A skilled nurse (SN) recertification visit note dated 4-14-16 evidenced the wound was located on the left shin and measured 0.5 centimeters (cm) in length and 0.2 cm in width. The note classified the wound as an abrasion with a scant amount of serous drainage. B. A SN visit note dated 4-25-16 evidenced the wound was located on the patient's left knee, was 0.5 cm in length and 0.2 cm in width with a "moderate amount serous purulent (yellow/tan) drainage." C. A SN visit note dated 5-5-16 evidenced the wound was located on the left knee and was 3.5 cm in width and 0.5 cm in length with a "small" amount of "purulent (yellow/tan) drainage." D. On 5-18-16 at 12:45 PM, during a home visit to patient number 2, employee K, the RN, stated, "The open area was		·Agency professional staff must promptly alert the physician to anychanges that suggest a need to alter the plan of care ·Agency Policy C-580 (Plan of Care) ·Appropriate use of case communication notes and appropriate carecoordination ·Agency clinical software-generated care plans/guidelines have been modified to include appropriate interventions, including interventions directedat patients on whom a weight is not able to be obtained A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of G164: that agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Agency professional staff will alert the physician to any changes that suggest a need to alter the plan of care and document the physician notification in the clinical record in the visit note or using a case communication note. Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to the physician; however, the wound measurements were not included. The SN failed to document evidence of physician notification related to changes in the size andcondition of the patient’s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	scabbed. Two weeks ago it started draining yellow fluid. I did tell the physician. [The patient] goes to see the PCP [primary care physician] tomorrow." 2. Clinical record number 3 included a plan of care established by the physician for the certification period 3-22-16 to 5-20-16. The plan evidenced interventions to address congestive heart failure including daily weights. The plan states, "Instruct to record weight daily and to report weight gain of 2 lbs in one day or 5 lbs in one week or as per physician order." A. A SN visit note dated 4-6-16 identifies the patient is unable to weigh daily due to "morbid obesity" and "it would also be unsafe for [the patient] to stand on a scale due to morbid obesity and living alone." B. The record failed to evidence the physician had been informed of the patient's inability to complete daily weights to monitor for fluid retention and signs and symptoms of congestive heart failure. 3. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care evidenced		wound. No harm came to this patient as a result of the failure of the SN to document the required physician notification and the physician was notified of the changes in the patient's wound. This SN was educated and counseled on the requirements of G164: to promptly alert the physician to any changes that suggest a need to alter the plan of care and appropriate documentation of that notification. Clinical Record #3 (A-B) This patient is unable to weight daily but interventions on the plan of care did include daily weights. The SN did identify this but failed to notify the physician of the patient's inability to complete daily weights. The physician has been notified of the patient's inability to complete the daily weights and the plan of care amended to reflect the patient's inability to do so. Clinical Record #6 (A-C) The plan of care contained interventions to address blood glucose control,including blood glucose testing. The SN documented that the patient does not comply with blood glucose testing and did exhibit s/s related to hypoglycemia.The SN failed to document physician notification of the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's noncompliance with blood glucose testing. This SN is no longer employed by this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	interventions to address blood glucose control. The plan states, "SN to perform with focus on diabetes: . . . blood glucose testing and evaluation." A. SN visit notes, dated 4-6-16, 4-8-16, 4-13-16, 4-18-16, 4-27-16, 5-6-16, and 5-13-16 evidenced the patient does not "check blood sugar regularly" and that the patient can tell by "how [the patient] feels." B. An "Admission Note Report" dated 3-31-16 states, "Patient had fallen OOB [our of bed] and was noted to have a blood sugar in the 40's. New compression fractures found." C. The record failed to evidence the physician had been informed of the patient's reluctance to perform blood sugar testing. 4. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care states, "SN/CG [caregiver] Pt [patient] to cleanse wound bed with NS [normal saline] and gauze using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape."		agency. All nursing staff have been educated regarding the requirement to notify the physician of any changes in patient condition that suggest a need to alter the plan ofcare. Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient's wound and wound care no longer being needed and failed to document wound care performed on the 5/13/16 visit. The wound care was not discontinued and the patient performed wound care on 5/18/16as observed and documented by the SN. The physician has been notified of the condition/improvement of the wound. This SN has been educated regarding the requirement of G164: that agency professional staff must promptly alert the physician to any changes that suggest a need to alter the plan of care. PT failed to notify the physician that PT services were discontinued per patient request. The physician has been notified and the therapist educated regarding the requirement of G164: that the physician must promptly be alerted to any changes that suggest a need to alter the plan of care. 25% of all visit notes will be reviewed weekly for compliance of documentation that the physician was informed promptly of any changes that suggest a need to alter the plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up." B. The record failed to evidence the physician had been notified of the condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the		of care beginning week of 6/13/16 for a period of 6 weeks. Threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	Plan of Care."			
G 0166 Bldg. 00	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. Based on record review and interview, the agency failed to ensure verbal orders had been put into writing by the registered nurse (RN) or therapist in 2 (#s 8 and 10) of 12 records reviewed. The findings include: 1. Clinical record number 8 included verbal physician's orders, dated 4-26-16, 5-9-16, and 5-10-16 for medication dose changes. The orders evidenced the licensed practical nurse (LPN), employee M, had put the orders into writing and signed and dated the orders. 2. Clinical record number 10 included a verbal physician's order dated 4-6-16 for medical social services to be provided 2 times per month for 1 month. The order evidenced the medical social worker, employee N, had put the order into writing and signed and dated the order. 3. The Clinical Director indicated, on	G 0166	All clinical staff will be educating on the following: ·Requirements of 484.18 (c) (Conformance with Physician Orders) ·That verbal orders must be put in writing and signed and dated with the date of receipt by the RN or qualified therapist responsible for furnishing or supervising the ordered services. ·Orders taken by an MSW must be reviewed and co-signed by the supervising RN ·Orders taken by an LPN must be reviewed and co-signed by the supervising RN A clinical record review of 25% of physician orders will be conducted to determine compliance with the requirements of G166. Clinical Record #8 The orders dated 4/26/16, 5/9/16 and 5/10/16 were reviewed and co-signed by the RN responsible for supervising the ordered services and these were located in the medical record housed in the Forcura system. The agency failed to print the co-signed order for the surveyor. Supporting	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	5-20-16 at 10:35 AM, she thought this was acceptable practice.		documentation attached. Clinical Record #10 The Medical Social Worker accepted and put into writing a physician order forsocial work services. The MSW was educated that verbal orders must be put in writing and signed and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered services. All clinical staff we reeducated regarding the requirements of G166. Beginning the week of 6/13/16, 25% of all visit notes will be reviewed weekly, for a period of 6 weeks, to ensure that physician orders are reviewed, signed and dated by the RN or qualified therapist. Compliance threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
G 0168 Bldg. 00	484.30 SKILLED NURSING SERVICES Based on record review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure services and treatments had been provided in accordance with physician orders in 4 of 12 records reviewed (See G 170); by failing to ensure the registered nurse (RN	G 0168	The corrective actions, monitoring plans and responsible parties for this Condition are located under G170, G173, G176 and G178 . 42 CFR 494.30 Skilled Nursing Services	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	had initiated necessary revisions to the plan of care in 4 of 12 records reviewed (See G 173); by failing to ensure the registered nurse (RN)had alerted the physician to changes in the patients' needs and condition in 4 of 12 records reviewed (See G 176); and by failing to ensure ensure the registered nurse (RN) had supervised the licensed practical nurse (LPN) in 2 of 2 records reviewed of patients that received services from the LPN (See G 178). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 494.30 Skilled Nursing Services.			
G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician orders in 4 (#s 2, 3, 11, and 12) of 12 records reviewed. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 4-16-16 to 6-13-16. The plan of care states, "Skilled	G 0170	All agency clinical staff will be educated on the following: • Requirements of 484.30 (Skilled Nursing Services) • Services and treatments must be provided in accordance with physician orders • Agency Policy C-635 (Physician Orders) A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of G170. Clinical Record number 2: A.The physician was notified that the SN failed to assess and	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	assessment with focus on CHF [congestive heart failure]: medication management, edema, weight, dyspnea levels, cardiac assessment, oxygen safety and management . . . Instruct to record weight daily and to report weight gain of 2 lbs. in one day or 5 lbs in one week or as per physician order.' A. Skilled nurse (SN) visit notes, dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16, failed to evidence the SN had assessed and monitored the patient's weight. B. A SN recertification visit note dated 4-14-16 states, "Patient is incontinent [urinary]." The plan of care for the certification period 4-16-16 to 6-13-16 included interventions to address the incontinence. The plan states, "Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . Assess/instruct caregivers not to rush patient, to give frequent cues and reminders during an activity, accompany them to bathroom (allow privacy)." SN visit notes, dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16,		monitor the patient's weight per the plan of care. Physician order was obtained to discontinue daily weights. B. One on one education will be provided to the SN who failed to assess and address the patient's urinary incontinence as it was identified on the assessment and included in the plan of care. SN will assess and address patient's incontinence on every visit. C. SN drew HbA1c prior to initially ordered date, per written physician order obtained by patient, so results would be available for physician's appointment.SN failed to discontinue the original order for the lab to be drawn on 5/19/16and SN failed to place the written order in the clinical record or call to clarify, via verbal order, that the HbA1c was to be drawn early. One on one education will be provided to this SN and SN will obtain written or verbal orders for all changes to the plan of care. Clinical Record number 3: A. SN failed to document how the dressing change was performed. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. B.SN failed to document at the Hydrogel was applied to wound per physician order.Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	failed to evidence the SN had assessed and addressed the urinary incontinence. The SN visit notes identifies the patient's urinary status was "WNL [within normal limits]." C. The plan of care for the certification period 4-16-16 to 6-13-16 states, "Hgb A1C [blood test to assess how well diabetes is being controlled] due 5/19/16." 1.) A SN visit note dated 5-12-16 states, "SN drew ordered labs from [name of physician] via venipuncture." The record failed to include an order for the venipuncture on 5-12-16. 2.) The record failed to evidence the Hgb A1C had been drawn on 5-19-16 per the plan of care. 3.) The record included a "Case Communication Report" dated 5-9-16 that states, "SN has written order from [name of physician] given to patient for SN to draw hgba1c before upcoming appt on 5-19-16." The record failed to evidence the written order. 2. Clinical record number 3 included a physician's orders dated 4-25-16 that states, "OK for SN to change wound care order to Hyrogel on wounds, then		appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 5: A.Occupational therapy failed to complete an evaluation per physician order;physician will be notified that the Occupational Therapy evaluation was not completed. All therapy staff will be educated regarding following physician orders and appropriate documentation and physician notification when changes tothe plan of care are necessary. B.The Occupational Therapy evaluation was not provided as indicated on the Admission Service Agreement and the physician will be notified that it was not completed. All clinical staff will be educated that services must be provided per physician orders and physician notification is required when changes to the plan of care/physician orders are necessary. Clinical Record number 11: A. SN failed to document how the dressing change was performed. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. B. SN failed to document that the wound care had been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	Aquacel Ag, cover with foam dressing. Dressing change will remain 3 times per week as previously scheduled." A. SN visit notes, dated 4-27-16 and 4-29-16, failed to evidence how the dressing change was performed. The notes state, "wound care performed." B. SN visit notes, dated 5-13-16 and 5-16-16, failed to evidence the SN had applied the Hydrogel per the physician's order. 3. Clinical record number 11 included a plan of care established by the physician for the certification period 4-26-16 to 6-24-16. The plan of care states, "Wound Care Orders for Right buttocks: Cleanse with ns [normal saline] and pat dry with gauze, apply Prisma to area, cover with foam." A. A SN visit note dated 4-30-16 failed to evidence how the wound care was performed. The note states, "wound care performed. pt [patient] tolerated well." B. A SN visit note dated 5-2-16 failed to evidence the wound care had been performed. C. A SN visit note dated 5-13-16		performed. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated onthe requirement of following physician orders. C. SN failed to document wound care appropriately. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated onthe requirement of following physician orders. Clinical Record number 12: The SN failed to document, on 5/6/16, that the patient's legs had been wrapped perthe physician order; however, per this SN she did wrap the patient's legs perphysician order but failed to document the procedure. SN instructed to annotate the visit note of 5/6/16 to include this documentation. Patient had seen physician on 5/3/16 and the physician had removed the wraps to patient's legs and failed to reapply them, per documentation in the clinical record. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated on the requirement of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	evidenced the foal dressing was applied, but failed to evidence the Prisma was applied per the physician's order. 4. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to 6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 layer profor dressing with 3 layer being in figure 8 fashion. Wrap toes with cotton roll or kerlix and then cover with coban." A SN visit note dated 5-6-16 failed to evidence the patient's legs had been wrapped per the physician's order. The note identifies the patient was not wrapped upon the SN's arrival and that the patient had gone 3 days without wraps. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 7. The agency's August 2013 "Physician Orders" policy and procedure number C-635 states,"All care and service provided will be in accordance with physician orders."		following physician orders. 25% of all visit notes will be reviewed weekly for compliance of providing care in accordance with physician orders/plan ofcare beginning week of 6/13/16 for a period of 6 weeks. Compliance threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits will be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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 0173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on record review and interview, the agency failed to ensure the registered nurse (RN had initiated necessary revisions to the plan of care in 4 (#s 2, 3, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 2 failed to evidence the registered nurse (RN) had informed the physician of a change in the size of the patient's wound and a change in the character of the wound drainage and initiated a change in the plan of care. A. A skilled nurse (SN) recertification visit note dated 4-14-16 evidenced the wound was located on the left shin and measured 0.5 centimeters (cm) in length and 0.2 cm in width. The note classified the wound as an abrasion with a scant amount of serous drainage. B. A SN visit note dated 4-25-16 evidenced the wound was located on the patient's left knee, was 0.5 cm in length and 0.2 cm in width with a "moderate amount serous purulent (yellow/tan) drainage."	G 0173	All agency professional staff will be educated on the following: • Requirements of 484.30 (a) (Duties ofthe Registered Nurse) • The RN initiates the plan of care and necessary revisions • Agency Policy C-360 (Coordination ofPatient Care) A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of G173: that the RN initiates the plan ofcare and necessary revisions. Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to the physician; however, the wound measurements were not included. The SN failed to document evidence of physician notification related to changes in the size and condition of the patient's wound. No harm came to this patient as a result ofthe failure of the SN to document the required physician notification and the physician was notified of the changes in the patient's wound. This SN was educated and counseled on the requirements of G164: to promptly alert the physician to any changes that suggest a need to alter the plan of care and appropriate documentation of that	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	C. A SN visit note dated 5-5-16 evidenced the wound was located on the left knee and was 3.5 cm in width and 0.5 cm in length with a "small" amount of "purulent (yellow/tan) drainage." D. On 5-18-16 at 12:45 PM, during a home visit to patient number 2, employee K, the RN, stated, "The open area was scabbed. Two weeks ago it started draining yellow fluid. I did tell the physician. [The patient] goes to see the PCP [primary care physician] tomorrow." 2. Clinical record number 3 included a plan of care established by the physician for the certification period 3-22-16 to 5-20-16. The plan evidenced interventions to address congestive heart failure including daily weights. The plan states, "Instruct to record weight daily and to report weight gain of 2 lbs in one day or 5 lbs in one week or as per physician order." A. A SN visit note dated 4-6-16 identifies the patient is unable to weigh daily due to "morbid obesity" and "it would also be unsafe for [the patient] to stand on a scale due to morbid obesity and living alone." B. The record failed to evidence the		notification. Clinical Record #3 (A-B) This patient is unable to weight daily but interventions on the plan of care did include daily weights. The SN did identify this but failed to notify the physician of the patient's inability to complete daily weights. The physician has been notified of the patient's inability to complete the daily weights and the plan of care amended to reflect the patient's inability to do so. Clinical Record #6 (A-C) The plan of care contained interventions to address blood glucose control, including blood glucose testing. The SN documented that the patient does not comply with blood glucose testing and did exhibit s/s related to hypoglycemia. The SN failed to document physician notification of the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's noncompliance with blood glucose testing. This SN is no longer employed by this agency. All nursing staff have been educated regarding the requirement to notify the physician of any changes in patient condition that suggest a need to alter the plan of care. Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient's wound and wound care no longer being needed and failed to document wound care performed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	physician had been informed of the patient's inability to complete daily weights to monitor for fluid retention and signs and symptoms of congestive heart failure and that the RN had initiated a change in the plan of care to address the patient's inability to complete daily weights. 3. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care evidenced interventions to address blood glucose control. The plan states, "SN to perform with focus on diabetes: . . . blood glucose testing and evaluation." A. SN visit notes, dated 4-6-16, 4-8-16, 4-13-16, 4-18-16, 4-27-16, 5-6-16, and 5-13-16 evidenced the patient does not "check blood sugar regularly" and that the patient can tell by "how [the patient] feels." B. An "Admission Note Report" dated 3-31-16 states, "Patient had fallen OOB [our of bed] and was noted to have a blood sugar in the 40's. New compression fractures found." C. The record failed to evidence the physician had been informed of the patient's reluctance to perform blood		on the 5/13/16 visit. The wound care was not discontinued and the patient performed wound care on 5/18/16as observed and documented by the SN. The physician has been notified of the condition/improvement of the wound. This SN has been educated regarding the requirement of G164: that agency professional staff must promptly alert the physician to any changes that suggest a need to alter the plan of care. PT failed to notify the physician that PT services were discontinued per patient request. The physician has been notified and the therapist educated regarding the requirement of G164: that the physician must promptly be alerted to any changes that suggest a need to alter the plan of care. 25%of all RN visit notes will be reviewed weekly, beginning week of 6/13/16, for compliance of the RN initiating necessary revisions to the plan of care, for a period of 6 weeks. Threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	sugar testing and the RN had initiated a change in the plan of care to address the patient's reluctance. 4. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care states, "SN/CG [caregiver] Pt [patient] to cleanse wound bed with NS [normal saline] and gauze using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape." A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up." B. The record failed to evidence the physician had been notified of the condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's September 2013 "Coordination of Patient Care" policy and procedure number C-360 (HH) states, "The primary care Nurse or Therapist will assume responsibility for updating/changing the Care Plan and communication changes to caregivers within twenty-four (24) hours following the conference or changes. The physician will be contacted when his/her approval for the change is necessary and to alert physician to changes in the patient condition."			
G 0176 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on record review and interview, the agency failed to ensure the registered nurse (RN)had alerted the physician to changes in the patients' needs and	G 0176	All agency clinical staff will be educated on the following: ·Requirements of 484.30 (a) Duties of the Registered Nurse ·The RN prepares clinical and	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	condition in 4 (#s 2, 3, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 2 failed to evidence the registered nurse (RN) had informed the physician of a change in the size of the patient's wound and a change in the character of the wound drainage. A. A skilled nurse (SN) recertification visit note dated 4-14-16 evidenced the wound was located on the left shin and measured 0.5 centimeters (cm) in length and 0.2 cm in width. The note classified the wound as an abrasion with a scant amount of serous drainage. B. A SN visit note dated 4-25-16 evidenced the wound was located on the patient's left knee, was 0.5 cm in length and 0.2 cm in width with a "moderate amount serous purulent (yellow/tan) drainage." C. A SN visit note dated 5-5-16 evidenced the wound was located on the left knee and was 3.5 cm in width and 0.5 cm in length with a "small" amount of "purulent (yellow/tan) drainage." D. On 5-18-16 at 12:45 PM, during a home visit to patient number 2, employee		progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. ·The RN must alert the physician to changes in the patient's needs and condition ·Agency Policy C-580 (Plan of Care) A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of G176: that the RN alerts the physician to changes in the patient's needs and condition Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to the physician; however, the wound measurements were not included. The SN failed to document evidence of physician notification related to changes in the size and condition of the patient's wound. No harm came to this patient as a result of the failure of the SN to document the required physician notification and the physician was notified ofthe changes in the patient's wound. This SN was educated and counseled on the requirements of G164: to promptly alert the physician to any changes that suggest a need to alter the plan of care and appropriate documentation of that notification. Clinical Record #3 (A-B) This patient is unable to weight daily but interventions on the plan of care did include daily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	K, the RN, stated, "The open area was scabbed. Two weeks ago it started draining yellow fluid. I did tell the physician. [The patient] goes to see the PCP [primary care physician] tomorrow." 2. Clinical record number 3 included a plan of care established by the physician for the certification period 3-22-16 to 5-20-16. The plan evidenced interventions to address congestive heart failure including daily weights. The plan states, "Instruct to record weight daily and to report weight gain of 2 lbs in one day or 5 lbs in one week or as per physician order." A. A SN visit note dated 4-6-16 identifies the patient is unable to weigh daily due to "morbid obesity" and "it would also be unsafe for [the patient] to stand on a scale due to morbid obesity and living alone." B. The record failed to evidence the RN had informed the physician of the patient's inability to complete daily weights to monitor for fluid retention and signs and symptoms of congestive heart failure. 3. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to		weights. The SN did identify this but failed to notify the physician of the patient's inability to complete daily weights. The physician has been notified of the patient's inability to complete the daily weights and the plan of care amended to reflect the patient's inability to do so. Clinical Record #6 (A-C) The plan of care contained interventions to address blood glucose control, including blood glucose testing. The SN documented that the patient does not comply with blood glucose testing and did exhibit s/s related to hypoglycemia. The SN failed to document physician notification of the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's non-compliance with blood glucose testing This SN is no longer employed by this agency. All nursing staff have been educated regarding the requirement to notify thephysician of any changes in patient condition that suggest a need to alter the plan of care. Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient's wound and wound care no longer being needed and failed to document wound care performed on the 5/13/16 visit. The wound care was not discontinued and the patient performed wound care on 5/18/16 as observed and documented by the SN. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	5-29-16. The plan of care evidenced interventions to address blood glucose control. The plan states, "SN to perform with focus on diabetes: . . . blood glucose testing and evaluation." A. SN visit notes, dated 4-6-16, 4-8-16, 4-13-16, 4-18-16, 4-27-16, 5-6-16, and 5-13-16 evidenced the patient does not "check blood sugar regularly" and that the patient can tell by "how [the patient] feels." B. An "Admission Note Report" dated 3-31-16 states, "Patient had fallen OOB [our of bed] and was noted to have a blood sugar in the 40's. New compression fractures found." C. The record failed to evidence the RN had informed the physician of the patient's reluctance to perform blood sugar testing. 4. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care states, "SN/CG [caregiver] Pt [patient] to cleanse wound bed with NS [normal saline] and gauze using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape."		physician has been notified of the condition/improvement of the wound. This SN has been educated regarding the requirement of G164: that agency professional staff must promptly alert the physician to any changes that suggest a need to alter the plan of care. PT failed to notify the physician that PTservices were discontinued per patient request. The physician has been notified and the therapist educated regarding the requirement of G164: that the physician must promptly be alerted to any changes that suggest a need to alter the plan of care. 25% of all visit notes will be reviewed weekly, beginning week of 6/13/16, for compliance of the RN or qualified therapist alerting the physician to changes in the patient's needs and condition, for a period of 6 weeks. Threshold is 90%. If Threshold of90% is achieved for 6 consecutive weeks then chart audits can be decreased to10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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

A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up."

B. The record failed to evidence the RN had informed the physician of the condition of the wound and that the dressing change was no longer needed.

C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request."

The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered.

5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM.

6. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "Professional staff shall promptly alert the physician to any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	changes that suggest a need to alter the Plan of Care."			
G 0178 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. Based on record review and interview, the agency failed to ensure the registered nurse (RN) had supervised the licensed practical nurse (LPN) in 2 (#s 8 & 10) of 2 records reviewed of patients that received services from the LPN. The findings include: 1. Clinical record number 8 included skilled nurse visit notes, signed and dated by the LPN, that failed to evidence supervision of the LPN by the RN. A. A skilled nurse visit note, signed and dated by the LPN, employee M, on 4-22-16, states, "INR [blood test used to monitor patients being treated with blood thinning medications] 2.0 via fingerstick method, pt [patient] tolerated well and without incident and results called to [name of physician] and spoke with [name of office personnel]." The record included a verbal physician's order for medication changes	G 0178	All clinical staff will be educated on: ·The requirements of 484.30(a) -Duties of the Registered Nurse ·The RN participates in in-service programs and supervises and teaches other nursing personnel. ·The RN must supervise the LPN A clinical record review of 25% of active patients receiving nursing services delivered by the LPN will be conducted to determine compliance with the requirements of G178: that the RN supervises the LPN, that the record reflects communication between the LPN and the RN. Clinical Record #8 1.The record included a verbal physician's order for medication changes and lab test that was signed/dated by the LPN and reviewed and co-signed by the RN. Supporting documentation attached. 2.The clinical record contains a communication note, dated 5/10/16, between the LPN and RN,regarding the PT/INR that demonstrates communication between the LPN and RN.Supporting documentation	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	and another blood test signed and dated by employee M on 4-26-16. B. A skilled nurse visit note, signed and dated by the LPN, employee M, on 5-9-16, states, "PT/INR right middle finger called to [name of physician]." The record failed to evidence any communication between the LPN and the RN. The record included a verbal physician's order, signed and dated by employee M on 5-9-16 for the fingerstick blood test on 5-9-16. C. A skilled nurse visit note, signed and dated by the LPN, employee M, on 5-16-16, states, "PT/INR right middle finger results called to [name of physician]." The record failed to evidence any communication between the LPN and the RN. The record included a verbal physician's order, signed and dated by employee M on 5-10-16, for a medication change and further blood testing. D. The record failed to evidence any communication between the RN and the LPN regarding the blood test results and the resulting medication changes.		attached. 3.The clinical record contains a communication note, dated 5/17/16, between the LPN and RN,regarding the PT/INR that demonstrates communication between the LPN and RN.Supporting documentation attached. 4.The clinical record does contain evidence of communication, as noted in A-C, between the LPNand RN regarding blood test results and the resulting medication changes and supporting documentation is attached. 100% of all patient charts that are receiving LPN services will be reviewed weekly,beginning 6/13/16, to ensure that the RN is supervising the LPN appropriately as required, for a period of 6 weeks. Threshold is 95%. If Threshold of 95% is achieved consistently for 6 weeks then chart audits can be decreased to10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	2. Clinical record number 10 included a skilled nurse visit note signed and dated by the LPN, employee O, on 4-20-16. The note states, "spoke with patient and [spouse] about perhaps obtaining urine specimen for UA [urinalysis], I would speak with RN about the situation, explained the goal of nursing services is to not only educate disease process but if we can prevent another hospitalization, [spouse] verbalizes agreement, patient stubbornly agrees that avoiding going back to hospital is in best interest." A. The record failed to evidence the RN had consulted with the LPN regarding the possibility of obtaining a urine specimen. The record failed to evidence any urinalysis results. B. The RN, employee K, stated, on 5-20-16 at 2:00 PM, "I spoke with the LPN. The [spouse] refused. It is not documented." 3. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 4. The agency's September 2013 "Supervision" policy and procedure number C-300 states, "Licensed Practical			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	Nurse Supervision. ViaQuest shall provide Licensed Practical Nurse services under the direction and supervision of a Registered Professional Nurse when services are indicated and ordered by the physician."			
G 0202 Bldg. 00	484.36 HOME HEALTH AIDE SERVICES Based on record review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure the competency evaluation addressed all of the required subject areas in 1 of 2 home health aide files reviewed (See G 213); by failing to ensure the competency evaluation addressed all of the required subject areas and had been evaluated after performance of the aide's performance of the tasks with a patient in 1 of 2 home health aide files reviewed (See G 218); and by failing to ensure written instructions had been prepared for the home health aide in 1 of 6 records reviewed of patients that received home health aide services (See G 224). The cumulative effect of these systemic problems resulted in the agency's inability to maintain compliance with this condition, 42 CFR 484.36 Home Health Aide Services.	G 0202	The corrective actions, monitoring plans and responsible parties for this Condition are located under G213, G218, and G224. 42 CFR 484.36 Home Health Aide Services	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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 0213 Bldg. 00	484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) of this section. Based on record review and interview, the agency failed to ensure the competency evaluation addressed all of the required subject areas in 1 (file I) of 2 home health aide files reviewed. The findings include: 1. Personnel file I evidenced the individual had been hired on 2-24-16 to provide home health aide services on behalf of the agency. The file identified a competency evaluation had been provided to the aide on 3-3-16. The competency evaluation failed to address sponge, tub, or shower bath (484.36(a)(1)(ix)(B)), safe transfer techniques (484.36(a)(1)(x)), toileting and elimination (484.36(a)(1)(ix)(F), and reading and recording temperature, pulse, and respiration (484.36(a)(1)(iii). 2. The Clinical Director indicated, on 5-20-16 at 4:00 PM, the competency evaluation provided to employee I did not address all of the required subject areas.	G 0213	Agency staff will be educated on the following: ·The requirements of 484.36(b)(2)(i)-The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) ·Review of the specific required content of the home health aide competency evaluation ·Agency Policy C-220 (Aide Services) A review of the personnel record of all home health aides employed by this agency will be conducted to ensure compliance with G213: that the home health aide competency evaluation addresses all subject matter required. Any areas of noncompliance identified will result in a reassessment of the home health aide's competency by an outside agency. In personnel file I, the home health aide was hired on 2/24/16 and competency was evaluated on 3/3/16 and 3/4/16 using the incorrect form. The information was placed on the correct form, provided by the Indiana Association for Home and Hospice Care, that contains all of	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	3. The agency's August 2013 "Aide Services" policy and procedure number C-220 (C) states, "All individuals providing aide services will be qualified through training and/or competency evaluations."		the subjects required by G213. However, the incorrect form was left in the personnel file, along with an additional competency assessment performed to meet the requirements of the Home Health Aide Registry. Therefore, there appeared to be discrepancies related to the competency evaluation. Going forward, the agency will only utilize the IAHHC aide competency evaluation to evaluate competency of home health aides (once the 2 year preclusion is lifted). 100% of newly hired home health aide personnel files will be audited to ensure that the home health aide competency evaluation addresses all of the required subject areas. Compliance threshold is 100%. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
G 0218 Bldg. 00	484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The subject areas listed at paragraphs (a)(1)(iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient. Based on record review and interview, the agency failed to ensure the	G 0218	Agency staff will be educated on the following:	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	competency evaluation addressed all of the required subject areas and had been evaluated after performance of the aide's performance of the tasks with a patient in 1 (file I) of 2 home health aide files reviewed. The findings include: 1. Personnel file I evidenced the individual had been hired on 2-24-16 to provide home health aide services on behalf of the agency. The file identified a competency evaluation had been provided to the aide on 3-3-16. The competency evaluation failed to address sponge, tub, or shower bath (484.36(a)(1)(ix)(B)), safe transfer techniques (484.36(a)(1)(x)), toileting and elimination (484.36(a)(1)(ix)(F), and reading and recording temperature, pulse, and respiration (484.36(a)(1)(iii). 2. The Clinical Director indicated, on 5-20-16 at 4:00 PM, the competency evaluation provided to employee I did not address all of the required subject areas. 3. The agency's August 2013 "Aide Services" policy and procedure number C-220 (C) states, "All individuals providing aide services will be qualified through training and/or competency evaluations."		·The requirements of 484.36(b)(2)(i)-The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) ·Review of the specific required content of the home health aide competency evaluation ·Agency Policy C-220 (Aide Services) A review of the personnel record of all home health aides employed by this agency will be conducted to ensure compliance with G213: that the home health aide competency evaluation addresses all subject matter required. Any areas of noncompliance identified will result in a reassessment of the home health aide's competency by an outside agency. In personnel file I, the home health aide was hired on 2/24/16 and competency was evaluated on 3/3/16 and 3/4/16 using the incorrect form. The information was placed on the correct form, provided by the Indiana Association for Home and Hospice Care, that contains all of the subjects required by G213. However, the incorrect form was left in the personnel file, along with an additional competency assessment performed to meet the requirements of the Home Health Aide Registry. Therefore, there appeared to be discrepancies related to the competency evaluation. Going forward, the agency will only	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
			utilize the IAHHC aide competency evaluation to evaluate competency of home health aides (once the 2 year preclusion is lifted). 100% of newly hired home health aide personnel files will be audited to ensure that the home health aide competency evaluation addresses all of the required subject areas, including those required to be evaluated after performance of the aide's performance of tasks with a patient . Compliance threshold is 100%. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
G 0224 Bldg. 00	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on record review and interview, the agency failed to ensure written instructions had been prepared for the home health aide in 1 (#6) of 6 records reviewed of patients that received home health aide services. The findings include: 1. Clinical record number 6 included a	G 0224	All clinical staff will be educated on the following: ·The requirements of 484.36(c)(1)-Assignment and Duties of the HomeHealth Aide ·Written patient care instructions for the home health aide must beprepared by the RN or other appropriate professional who is responsible for thesupervision of the home health aide.	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care included orders for home health aide services 1 time per week for 8 weeks. The record evidenced the home health aide services had been provided 1 time per week. The record failed to evidence the registered nurse (RN) had prepared written instructions for the home health aide services to be provided. 2. Employee L, the software support person, stated, on 5-19-16 at 2:35 PM, "There is no aide assignment sheet per the RN in the computer." 3. The agency's August 2013 "Aide Care Plan" policy and procedure number C-751 (C) states, "A complete and appropriate Care Plan, identifying duties to be performed by the Aide, shall be developed by a Registered Nurse or Therapist."		·Agency Policy C-751 (Aide Care Plan) A clinical record review of 25% active clinical records of patients receiving home health aide services will be reviewed to ensure that written patient care instructions for the home health aide are present as required by G224. Clinical Record #6 The RN did fail to prepare written instructions for the home health aide services to be provided. Written instructions for the home health aide have now been prepared and are present in the clinical record. This RN is no longer employed with this agency. 100% of all patient charts that are receiving aide services will be reviewed every two weeks, beginning week of 6/13/16, for compliance that each patient record shows evidence of written patient care instructions for the home health aide are prepared by the RN, for a period of 2 months. Threshold is 90%. If Threshold of 90% is achieved consistently for 2 months then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
G 0250 Bldg. 00	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. Based on record review and interview, the agency failed to ensure health professionals representing the scope of the program had participated in the quarterly clinical record review in 4 (2nd 2015, 3rd 2015, 4th 2015, and 1st 2016) of 4 quarters reviewed. The findings include: 1. The agency's clinical record review documentation for the 2nd, 3rd, and 4th quarter of 2015 and the 1st quarter of 2016 failed to evidence a physical therapist, occupational therapist, medical social worker, or speech language pathologist had participated in the record review. 2. The quality assurance registered nurse, employee P, stated per telephone interview, on 5-20-16 at 3:05 PM. "[Employee Q] and I are the only ones that do clinical record reviews. We do not have any therapists or anyone else that does it." 3. The administrator indicated, on 5-20-16 at 3:15 PM the agency had provided physical therapy, occupational therapy, speech therapy, and/or medical	G 0250	All clinical staff will be educated on the following: ·The requirements of 484.52(b) -Clinical Record Review ·At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed infurnishing services directly or under arrangement. ·Agency Policy B-260 (QAPI) ·Agency Policy B-220 (Clinical Record Review) Quarterly clinical record reviews will be conducted by appropriate health professionals, representing at least the scope of the program, on both active and closed clinical records beginning with Quarter 1, 2016 record reviews by 6/19/16 and moving forward. The Quality Improvement and Performance Review (QAPI) committee will monitor ongoing compliance with G250, on a quarterly basis, by ensuring that the appropriate health professionals, representing the scope of the program, review clinical records at least quarterly. This will be monitored by adding this item to the QAPI committee meeting agenda. The Clinical Director/designee will be responsible for monitoring these	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	social services to patients during the 2nd, 3rd, and 4th quarters of 2015 and the 1st quarter of 2016. 4. The agency's September 2013 "Record Review" policy and procedure states, "At least quarterly the Clinical Director will ensure, appropriate Health professionals, representing at least the scope of the program review a sample of both active and discharged/closed charts."		corrective actions to ensure that this deficiency is corrected.	
N 0000 Bldg. 00	This was a State home health re-licensure and complaint investigation survey. Complaint #: IN00173876; Substantiated, deficiencies related to the complaint are cited at 410 IAC 17-12-1(m), 410 IAC 17-13-1(a), 410 IAC 17-13-1(a)(2), 410 IAC 17-14-1(a), 410 IAC 17-14-1(a)(1)(C), & 410 IAC 17-14-1(a)(1)(G). Survey Dates: 5-17-16, 5-18-6, 5-19-16, and 5-20-16. Facility #: 005940 Medicare Provider # 15-7223	N 0000	Please see Plan of Correction beginning with tag# N456.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	Medicaid Vendor #: N/A			
N 0456 Bldg. 00	410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview, the administrator failed to ensure the agency's quality assessment and performance improvement program included quarterly clinical record review by health professionals representing the scope of the program in 4 (2nd 2015, 3rd 2015, 4th 2015, and 1st 2016) of 4 quarters reviewed. The findings include: 1. The agency's clinical record review documentation for the 2nd, 3rd, and 4th quarter of 2015 and the 1st quarter of 2016 failed to evidence a physical therapist, occupational therapist, medical social worker, or speech language pathologist had participated in the record review.	N 0456	All clinical staff will be educated on the following: ·The requirements of 410 IAC 17-12-1 (e) Home Health agency administration/management ·At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closedclinical records to determine whether established policies are followed infurnishing services directly or under arrangement. ·Agency Policy B-260 (QAPI) ·Agency Policy B-220 (Clinical Record Review) Quarterly clinical record reviews will be conducted by appropriate health professionals, representing at least the scope of the program, on both active and closed clinical records beginning with Quarter 1, 2016 record reviews by 6/19/16 and moving forward. The Quality Improvement and Performance	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	2. The quality assurance registered nurse, employee P, stated per telephone interview, on 5-20-16 at 3:05 PM. "[Employee Q] and I are the only ones that do clinical record reviews. We do not have any therapists or anyone else that does it." 3. The administrator indicated, on 5-20-16 at 3:15 PM the agency had provided physical therapy, occupational therapy, speech therapy, and/or medical social services to patients during the 2nd, 3rd, and 4th quarters of 2015 and the 1st quarter of 2016. 4. The agency's September 2013 "Record Review" policy and procedure states, "At least quarterly the Clinical Director will ensure, appropriate Health professionals, representing at least the scope of the program review a sample of both active and discharged/closed charts."		Review (QAPI) committee will monitor ongoing compliance with N456, on a quarterly basis, by ensuring that the appropriate health professionals, representing the scope of the program, review clinical records at least quarterly. This will be monitored by adding this item to the QAPI committee meeting agenda The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure personnel files included a copy of limited criminal history from the Indiana State Police repository in 1 (file C) of 10 personnel files reviewed. The findings include: 1. Personnel C evidenced the individual had been hired on 5-16-16 to provide physical therapy services to patients on behalf of the agency. The file failed to evidence a copy of the individual's limited criminal history from the Indiana State Police repository. 2. The Clinical Director indicated, on 5-20-16 at 2:30 PM, personnel file C did not include a copy of the individual's limited criminal history from the Indiana State Police repository as required.	N 0458	Agency staff will be educated on the requirements of 410 IAC 17-12-1(f) The agency will conduct a 100% review of all personnel files to ensure that each employee has had a limited criminal history from the Indiana State Police repository conducted. Annual audits of personnel files will be conducted to ensure ongoing compliance with N458, with a compliance threshold of 100%. All new employees hired will have the appropriate criminal history conducted. The Human Resource Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	06/19/2016
N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	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 record review and interview, the agency failed to ensure personnel files included physical examinations in 1 (file F) of 10 personnel files reviewed. The findings include: 1. Personnel file F evidenced the individual had been hired on 5-16-16 to provide occupational therapy services to patients on behalf of the agency. The file failed to evidence a pre-employment physical examination. 2. The Clinical Director indicated on 5-20-16 at 2:30 PM, personnel file F did not include a copy of the individual's physical examination. 3. The agency's June 2013 "Health Screening" policy and procedure number B-403 states, "Pre-employment physical examination will be performed by a physician or nurse practitioner as mandated by state law or ViaQuest policy.	N 0462	Agency staff will be educated on the requirements of 410 IAC 17-12-1(h) The agency will conduct a 100% review of all personnel files to ensure that each employee has had a physical examination by a physician or nurse practitioner nomore than 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. All new employees hired will have a physical examination by a physician or nurse practitioner no more than 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. 100% of new hire personnel files will be audited to ensure that employees hired have had the required physical examination no more than 180 days before the date	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
			that the employee has direct patient contact. Compliance threshold is 100%. Annual audits of personnel files will be conducted to ensure ongoing compliance with acompliance threshold of 100%. The Human Resource Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
N 0470 Bldg. 00	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. Based on observation, interview, and record review, the agency failed to ensure staff had provided care in accordance with the agency's own infection control policies and procedures and with the Centers for Disease Control (CDC) guidelines in 3 (#s 1, 2, & 3) of 6 home visit observations completed. The findings include: 1. Employee G, a registered nurse (RN), was observed to complete an assessment and dressing change on patient number 1 on 5-18-16 at 10:00 AM (observation # 1). The RN was observed to remove the old dressing using a pair of bandage scissors. The RN removed her gloves	N 0470	All clinical staff, including Employees G, K, and B will be educated on thefollowing: ·Agency Policy B-400 (Infection Prevention and Control Plan)-see supporting documentation ·Agency Policy B-410 (Standard Precautions for All Health CareWorkers)-see supporting documentation ·Centers for Disease Control's (CDC) Guidelines related to Infection Control and Standard Precautions ·The requirements of 410 IAC 17-12-1(m) – Home health agency administration/management: policies and procedures shall be written and implemented for the control of communicable disease in compliance with federal and	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	and cleansed her hands. The RN cleaned the scissors used to remove the old dressing and donned clean gloves without cleansing her hands. 2. Employee K, an RN, was observed to complete dressing changes to patient number 2 on 5-18-16 at 12:15 PM (observation number 2). The RN cleansed her hands and donned clean gloves. The RN removed the dressing from the patient's left lower leg, changed her gloves and cleansed her hands, and then removed the dressings from the right lower leg. The RN cleansed her hands and changed her gloves. The RN then cleansed the right lower leg and the left lower leg. The RN failed to change her gloves and cleanse her hands between the two. A. The RN was observed to obtain clean supplies needed for the dressing changes to the bilateral lower extremities. The RN was observed to place the clean supplies on a rug on the floor without a barrier. B. After cleansing the lower extremities, the RN cleansed her hands and changed her gloves. The RN measured the left lower leg wound and applied a clean Telfa dressing. The RN cleansed her hands and changed her		state laws. Agency clinical staff will provide care in accordance with the agency's infection control policies and procedures and with the CDC guidelines, which will be reviewed and distributed to all clinical staff. Infection control competency of all clinical staff will be re-assessed to ensure compliance with agency policies and procedures and CDC guidelines related to infection control and standard precautions by 6/19/16. Monthly in-services will be developed, and presented to all clinical staff, related to infection control, standard precautions, and related topics. Documentation will be maintained of content and attendance. Home visits to observe wound care performed by RNs will be initiated on a quarterly basis, beginning with quarter 3 of 2016, for the remainder of the year, in order to audit/review appropriate technique, staff competency and compliance with infection control policies and procedures. These home visit audits will be documented on a focused audit tool. Noncompliance will be addressed with clinicians on a one-to-one basis until 100% compliant. Home visits will then continue annually to ensure continued compliance. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	gloves and applied a a Kerlix wrap and Coban wrap to the left lower leg. The RN then applied a Kerlix wrap to the right lower leg without cleansing her hands or changing her gloves. C. The Clinical Director indicated, on 5-18-16 at 12:50 PM, employee K had not performed the dressing change in accordance with facility policy. 3. Employee B, an RN, was observed to perform a dressing change on patient number 3 on 5-18-16 at 2:40 PM (observation # 3). The RN was observed to cleanse her hands and obtain the needed supplies from the patient's dresser. The RN donned clean gloves without cleansing her hands. A. The RN was observed to apply a gel to two dressings with a gloved finger and then apply the dressings to the wounds on the patient's buttocks. B. The Clinical Director indicated, on 5-18-16 at 3:05 PM, employee B had not performed the dressing change in accordance with facility policy. 4. The agency's June 2013 "Infection Prevention & Control Plan" policy and procedure number B-400 (C) states, "ViaQuest has developed, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	implemented infection control practices that conform to OSHA regulations, CDC guidelines, accreditation requirements, state and local regulations and currently accepted standards of practice." 5. The agency's September 2013 "Standard Precautions For All Health Care Workers" policy and procedure number B-410 states, "ViaQuest has established Standard Precautions for All Health Care Workers. Employees should assume that blood and all body fluids, with or without visible blood, from all patients are potentially infectious." 6. 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).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	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 infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur."			
N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the agency failed to ensure the agency's quality assessment and performance improvement program included quarterly clinical record review by health professionals representing the scope of the program in 4 (2nd 2015, 3rd 2015, 4th 2015, and 1st 2016) of 4 quarters reviewed. The findings include: 1. The agency's clinical record review documentation for the 2nd, 3rd, and 4th quarter of 2015 and the 1st quarter of 2016 failed to evidence a physical therapist, occupational therapist, medical social worker, or speech language pathologist had participated in the record review. 2. The quality assurance registered nurse, employee P, stated per telephone interview, on 5-20-16 at 3:05 PM. "[Employee Q] and I are the only ones that do clinical record reviews. We do not have any therapists or anyone else that does it."	N 0472	All clinical staff will be educated on the following: ·The requirements of 410 IAC 17-12-2 (a) QA and Performance Review ·The agency's quality assessment and performance improvement program will include quarterly clinical record review by health professionals representing the scope of the program. ·Agency Policy B-260 (QAPI) ·Agency Policy B-220 (Clinical Record Review) Quarterly clinical record reviews will be conducted by appropriate health professionals, representing at least the scope of the program, on both active and closed clinical records beginning with Quarter 1, 2016 record reviews by 6/19/16 and moving forward. The Quality Improvement and Performance Review (QAPI) committee will monitor ongoing compliance with N472, on a quarterly basis, by ensuring that the appropriate health professionals, representing the scope of the program, review clinical records at least quarterly. This will be monitored by adding this item to the QAPI committee meeting agenda The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	3. The administrator indicated, on 5-20-16 at 3:15 PM the agency had provided physical therapy, occupational therapy, speech therapy, and/or medical social services to patients during the 2nd, 3rd, and 4th quarters of 2015 and the 1st quarter of 2016. 4. The agency's September 2013 "Record Review" policy and procedure states, "At least quarterly the Clinical Director will ensure, appropriate Health professionals, representing at least the scope of the program review a sample of both active and discharged/closed charts."		this deficiency is corrected.	
N 0504 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on record review and interview, the agency failed to ensure patients had been informed in advance of the proposed frequency of visits in 7 (#s 1, 2,	N 0504	All clinical staff have been educated on the following: ·The requirements of 410 IAC 17-12-3 (b)(2)(D)(i) Patient Rights ·That all patients must be	06/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	4, 6, 7, 8, & 9) of 12 records reviewed. The findings include: 1. Clinical record number 1 included an "Admission Service Agreement" dated 5-4-16. The service agreement identified skilled nursing, physical and occupational therapy, and home health aide services were to be provided. The agreement failed to evidence the proposed frequency of the services to be provided. 2. Clinical record number 2 included a "Home Health Admission Service Agreement" dated 2-15-16. The service agreement identifies skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 3. Clinical record number 4 included an "Admission Service Agreement" dated 4-26-16. The service agreement identified skilled nursing and physical and occupational therapy services were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 4. Clinical record number 6 evidenced a start of care date of 3-31-16. The record failed to evidence the patient had been		informed, in advance, of the proposed frequency of visits, in writing, on the Admission Service Agreement Clinical staff will include the proposed frequency of visits on the Admission Service Agreement for all patients admitted to the agency. The agency's Admission Service Agreement has been revised to include a line for each discipline's frequency. Each SOC will be audited, weekly for 6 weeks, until compliance threshold of 90% is achieved, for the presence of the proposed frequency of visits of each discipline on the Admission Service Agreement. After achieving compliance threshold, audits will continue of 10% of clinical records quarterly. The Clinical Director/designee is responsible for correcting this deficiency and for monitoring the corrective action to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	informed of the care to be furnished or the proposed frequency of visits proposed to be furnished. 5. Clinical record number 7 included a "Home Health Admission Service Agreement" dated 11-5-15. The service agreement identified skilled nursing, physical and occupational therapy, home health aide services, and medical social services were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 6. Clinical record number 8 included an "Admission Service Agreement" dated 2-12-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 7. Clinical record number 9 included an "Admission Service Agreement" dated 4-6-16. The service agreement identified skilled nursing and physical and occupational therapy were to be provided. The agreement failed to evidence the proposed frequency of visits to be provided. 8. The Clinical Director was unable to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM.			
N 0518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review and interview, the agency failed to ensure patients had been provided with a description of applicable State law with regards to advance directives in 12 (#s 1 through 12) of 12 records reviewed. The findings include: 1. Clinical records numbered 1 through 12 evidenced the patients had been provided with the agency's "Welcome to ViaQuest Home Health Services" booklet upon admission. The booklet included an "Advance Directive Information	N 0518	All agency staff were educated on the following: ·The requirements of 410 IAC 17-12-3 (e) Patient Rights ·That the agency must inform and distribute written information to the patient, in advance of care being provided, concerning its policies on advance directives, including a description of applicable State law ·Agency Policy C-430 (Advance Directives) The Indiana State Department of Health (ISDH) description of applicable State law, “Your Right to Decide” dated July 2013 will be included in all admission packets to be provided to all patients	06/15/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	Statement." The booklet failed to evidence the Indiana State Department of Health (ISDH) description of applicable State law, "Your Right To Decide" July 2013. 2. The Clinical Director indicated, on 5-19-16 at 2:40 PM, the information provided to patients with regards to advance directives did not include the ISDH prepared description of applicable State law, "Your Right To Decide" July 2013. 3. The agency's June 2013 "Advance Directives" policy and procedure number C-430 (C) states, "During the initial visit, prior to coming under ViaQuest Care, the patient will be provided with written information concerning the patient's rights under state law (both statutory and case law) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives."		admitted to the agency prior to care being provided. The ISDH description of applicable State law, “Your Right to Decide” dated July 2013 was distributed to all current patients of the agency. 50% of admission packets will be audited weekly for 6 weeks, or until compliance threshold of 90% is achieved, to ensure inclusion of the appropriate ISDH advance directive information. After compliance threshold is achieved, audits will continue of 10% of admission packets quarterly. The Clinical Director/designee is responsible for correcting this deficiency and for monitoring the corrective action to ensure that this deficiency is corrected.	
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 record review and interview,	N 0522	All agency clinical staff will be	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	the agency failed to ensure services and treatments had been provided in accordance with physician orders in 5 (#s 2, 3, 5, 11, and 12) of 12 records reviewed. The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 4-16-16 to 6-13-16. The plan of care states, "Skilled assessment with focus on CHF [congestive heart failure]: medication management, edema, weight, dyspnea levels, cardiac assessment, oxygen safety and management . . . Instruct to record weight daily and to report weight gain of 2 lbs. in one day or 5 lbs in one week or as per physician order.' A. Skilled nurse (SN) visit notes, dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16, failed to evidence the SN had assessed and monitored the patient's weight. B. A SN recertification visit note dated 4-14-16 states, "Patient is incontinent [urinary]." The plan of care for the certification period 4-16-16 to 6-13-16 included interventions to address the incontinence. The plan states,		educated on the following: • Requirements of 410 IAC 17-13-1(a) • Medical care shall follow a written medical plan of care established and periodically reviewed by the physician; services and treatments will be provided in accordance with physician orders • Agency Policy C-635 (Physician Orders) A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of N522 Clinical Record number 2: A.The physician was notified that the SN failed to assess and monitor the patient's weight per the plan of care. Physician order was obtained to discontinue daily weights. B.One on one education will be provided to the SN who failed to assess and address the patient's urinary incontinence as it was identified on the assessment and included in the plan of care. SN will assess and address patient's incontinence on every visit. C.SN drew HbA1c prior to initially ordered date, per written physician order obtained by patient, so results would be available for physician's appointment.SN failed to discontinue the original order for the lab to be drawn on 5/19/16and SN failed to place the written order in the clinical record or call to clarify, via verbal order, that the HbA1c was to be drawn early. One on one education will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	"Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . Assess/instruct caregivers not to rush patient, to give frequent cues and reminders during an activity, accompany them to bathroom (allow privacy)." SN visit notes, dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16, failed to evidence the SN had assessed and addressed the urinary incontinence. The SN visit notes identifies the patient's urinary status was "WNL [within normal limits]." C. The plan of care for the certification period 4-16-16 to 6-13-16 states, "Hgb A1C [blood test to assess how well diabetes is being controlled] due 5/19/16." 1.) A SN visit note dated 5-12-16 states, "SN drew ordered labs from [name of physician] via venipuncture." The record failed to include an order for the venipuncture on 5-12-16. 2.) The record failed to evidence the Hgb A1C had been drawn on 5-19-16 per the plan of care.		be provided to this SN and SN will obtain written or verbal orders for all changes to the plan of care. Clinical Record number 3: A. SN failed to document how the dressing change was performed. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. B. SN failed to document that the Hydrogel was applied to wound per physician order. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 5: A.Occupational therapy failed to complete an evaluation per physician order; physician will be notified that the Occupational Therapy evaluation was not completed. All therapy staff will be educated regarding following physician orders and appropriate documentation and physician notification when changes to the plan of care are necessary. B.The Occupational Therapy evaluation was not provided as indicated on the Admission Service Agreement and the physician will be notified that it was not completed. All clinical staff will be educated that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	3.) The record included a "Case Communication Report" dated 5-9-16 that states, "SN has written order from [name of physician] given to patient for SN to draw hgba1c before upcoming appt on 5-19-16." The record failed to evidence the written order. 2. Clinical record number 3 included a physician's orders dated 4-25-16 that states, "OK for SN to change wound care order to Hyrogel on wounds, then Aquacel Ag, cover with foam dressing. Dressing change will remain 3 times per week as previously scheduled." A. SN visit notes, dated 4-27-16 and 4-29-16, failed to evidence how the dressing change was performed. The notes state, "wound care performed." B. SN visit notes, dated 5-13-16 and 5-16-16, failed to evidence the SN had applied the Hydrogel per the physician's order. 3. Clinical record number 5 included a "Home Health Order Request" signed and date by the physician on 4-15-16. The order states, "To evaluate and treat . . . Physical Therapy, Occupational Therapy." A. The record failed to evidence an		services must be provided per physician orders and physician notification is required when changes to the plan of care/physician orders are necessary. Clinical Record number 11: A. SN failed to document how the dressing change was performed. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. B. SN failed to document that the wound care had been performed. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated on the requirement of following physician orders. C. SN failed to document wound care appropriately. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 12: The SN failed to document, on 5/6/16, that the patient's legs had been wrapped per the physician order; however, per this SN she did wrap the patient's legs per	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	occupational therapy evaluation had been completed. B. The record included an "Admission Service Agreement", signed and dated by the patient on 4-21-16, that identifies an occupational therapy evaluation would be provided. C. The Clinical Director stated, on 5-20-16 at 11:10 AM, "The order was missed." 4. Clinical record number 11 included a plan of care established by the physician for the certification period 4-26-16 to 6-24-16. The plan of care states, "Wound Care Orders for Right buttocks: Cleanse with ns [normal saline] and pat dry with gauze, apply Prisma to area, cover with foam." A. A SN visit note dated 4-30-16 failed to evidence how the wound care was performed. The note states, "wound care performed. pt [patient] tolerated well." B. A SN visit note dated 5-2-16 failed to evidence the wound care had been performed. C. A SN visit note dated 5-13-16 evidenced the foal dressing was applied,		physician order but failed to document the procedure. SN instructed to annotate the visit note of 5/6/16 to include this documentation. Patient had seen physician on 5/3/16 and the physician had removed the wraps to patient's legs and failed to reapply them, per documentation in the clinical record. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting documentation. In addition, all clinical staff will be educated on the requirement of following physician orders. 25% of all visit notes will be reviewed weekly for compliance of providing care in accordance with physician orders/plan of care beginning week of 6/13/16 for a period of 6 weeks. Compliance threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits will be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	but failed to evidence the Prisma was applied per the physician's order. 5. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to 6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 layer profor dressing with 3 layer being in figure 8 fashion. Wrap toes with cotton roll or kerlix and then cover with coban." A SN visit note dated 5-6-16 failed to evidence the patient's legs had been wrapped per the physician's order. The note identifies the patient was not wrapped upon the SN's arrival and that the patient had gone 3 days without wraps. 6. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 7. The agency's August 2013 "Physician Orders" policy and procedure number C-635 states,"All care and service provided will be in accordance with physician orders."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 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 record review and interview, the agency failed to ensure plans of care care were specific to the assessment and included all treatments in 3 (#s 4, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 4 included a start of care comprehensive assessment dated 4-26-16. The assessment identifies the patient had no urinary incontinence.	N 0524	Education will be provided to agency clinical staff on the following: ·The requirements of 410 IAC 17-13-1(a)(1)-Patient Care ·That 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	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	The plan of care, established by the physician for the certification period 4-26-16 to 6-24-16, includes interventions related to the management of urinary incontinence. The plan of care states, "Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . assess/instruct caregivers not to rush patient, to give frequent cues and reminders during activity, accompany them to the bathroom allow privacy." 2. Clinical record number 6 included a start of care comprehensive assessment dated 3-31-16. The assessment identifies the patient had no urinary incontinence. The plan of care, established by the physician for the certification period 3-31-16 to 5-29-16, includes interventions related to the management of urinary incontinence. The plan of care states, "Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . assess/instruct caregivers not to rush patient, to give frequent cues and reminders during activity, accompany them to the bathroom allow privacy." 3. Clinical record number 8 included a plan of care established by the physician		treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items ·The plan of care must be specific to the assessment of the patient's needs ·Agency Policy C-580 (Plan of Care) ·Agency clinical software generated care plans/guidelines will be revised to exclude inappropriate auto-populated interventions to allow the individualizing of patient-specific interventions. A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of N524: that the plan of care is based on the patient's comprehensive assessment and contains all of the required elements. Clinical Record #4: This patient had no urinary incontinence. A physician order will be obtained to correct the plan of care to remove the interventions related to urinary incontinence. The agency clinical software generated interventions un-related to the patient's assessment that were erroneously included in the plan of care.The agency clinical software will be revised to exclude inappropriate, auto-populated interventions to allow individualization. Clinical Record #6: This patient had no urinary incontinence. A	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	for the certification period 4-12-16 to 6-10-16. The plan of care included orders for occupational therapy visits 2 times per week for 4 weeks. The orders for the occupational therapy failed to include the specific treatments to be provided. 4. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 5. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "The Plan of Care is based on a comprehensive assessment and information provided by the patient/family and health team members . . . The Plan of Care shall be completed in full to include: . . . Specific procedures and modalities for therapy services . . .Medications, treatments, and procedures."		physician order will be obtained to correct the plan of care to remove the interventions related to urinary incontinence. The agency clinical software generated interventions un-related to the patient's assessment that were erroneously included in the plan of care.The agency clinical software will be revised to exclude inappropriate, auto-populated interventions to allow individualization. Clinical Record #8: A physician order will be obtained to amend the plan of care to include the specific Occupational Therapy treatments to be provided. All therapists will be educated on the requirement to include specific treatments to be provided on all therapy orders for services. Beginning with plans of care dated 6/13/16 and later, 100% of all Plan of Cares will be audited weekly to ensure that the plan of care is specific to the assessment and the patient's needs. This audit will also ensure that the plans of care include the all pertinent diagnoses, including mental status, types of servicesand 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
			appropriate items.This audit will continue for a period of 6 weeks. Threshold is 90%. If threshold of 90% is met 6 consecutive weeks in a row, the chart audits can decreased to a 10% quarterly chart audit. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the agency failed to ensure staff had alerted the physician to changes in the patients' needs and condition in 4 (#s 2, 3, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 2 failed to evidence the registered nurse (RN) had informed the physician of a change in the size of the patient's wound and a change in the character of the wound drainage. A. A skilled nurse (SN) recertification visit note dated 4-14-16 evidenced the wound was located on the left shin and measured 0.5 centimeters	N 0527	All agency professional staff will be educated on the following: ·Requirements of 410 IAC 17-13-1 (a)(2) Patient Care ·Agency professional staff must promptly alert the physician to any changes that suggest a need to alter the plan of care ·Agency Policy C-580 (Plan of Care) ·Appropriate use of case communication notes and appropriate care coordination ·Agency clinical software-generated care plans/guidelines have been modified to include appropriate interventions, including interventions directed at patients on whom a weight is not able to be obtained A clinical record review of 25%	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	(cm) in length and 0.2 cm in width. The note classified the wound as an abrasion with a scant amount of serous drainage. B. A SN visit note dated 4-25-16 evidenced the wound was located on the patient's left knee, was 0.5 cm in length and 0.2 cm in width with a "moderate amount serous purulent (yellow/tan) drainage." C. A SN visit note dated 5-5-16 evidenced the wound was located on the left knee and was 3.5 cm in width and 0.5 cm in length with a "small" amount of "purulent (yellow/tan) drainage." D. On 5-18-16 at 12:45 PM, during a home visit to patient number 2, employee K, the RN, stated, "The open area was scabbed. Two weeks ago it started draining yellow fluid. I did tell the physician. [The patient] goes to see the PCP [primary care physician] tomorrow." 2. Clinical record number 3 included a plan of care established by the physician for the certification period 3-22-16 to 5-20-16. The plan evidenced interventions to address congestive heart failure including daily weights. The plan states, "Instruct to record weight daily and to report weight gain of 2 lbs in one day or 5 lbs in one week or as per		of active patients will be conducted to determine compliance with the requirements of N527: that agency professional staff promptly alert the physician to any changes that suggest a need to alter theplan of care. Agency professional staff will alert the physician to any changes that suggest a need to alter the plan of care and document the physician notification in the clinical record in the visit note or using a case communication note. Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to the physician; however, the wound measurements were not included. The SN failed to document evidence of physician notification related to changes in the size and condition of the patient's wound. No harm came to this patient as a result of the failure of the SN to document the required physician notification and the physician was notified of the changes in the patient's wound. This SN was educated and counseled on the requirements of N527: to promptly alert the physician to any changes that suggest a need to alter the plan of care and appropriate documentation of that notification. Clinical Record #3 (A-B) This patient is unable to obtain weight daily but interventions on the plan of care did include daily weights. The SN did identify this but failed to notify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	physician order." A. A SN visit note dated 4-6-16 identifies the patient is unable to weigh daily due to "morbid obesity" and "it would also be unsafe for [the patient] to stand on a scale due to morbid obesity and living alone." B. The record failed to evidence the physician had been informed of the patient's inability to complete daily weights to monitor for fluid retention and signs and symptoms of congestive heart failure. 3. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care evidenced interventions to address blood glucose control. The plan states, "SN to perform with focus on diabetes: . . . blood glucose testing and evaluation." A. SN visit notes, dated 4-6-16, 4-8-16, 4-13-16, 4-18-16, 4-27-16, 5-6-16, and 5-13-16 evidenced the patient does not "check blood sugar regularly" and that the patient can tell by "how [the patient] feels." B. An "Admission Note Report" dated 3-31-16 states, "Patient had fallen		the physician of the patient's inability to complete daily weights. The physician has been notified of the patient's inability to complete the daily weights and the plan of care amended to reflect the patient's inability to do so. Clinical Record #6 (A-C) The plan of care contained interventions to address blood glucose control, including blood glucose testing. The SN documented that the patient does not comply with blood glucose testing and did exhibit s/s related to hypoglycemia. The SN failed to document physician notification of the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's noncompliance with blood glucose testing. This SN is no longer employed by this agency. All nursing staff have been educated regarding the requirement to notify the physician of any changes in patient condition that suggest a need to alter the plan of care. Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient's wound and wound care no longer being needed and failed to document wound care performed on the 5/13/16 visit. The wound care was not discontinued and the patient performed wound care on 5/18/16 as observed and documented by the SN. The physician has been notified of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	OOB [our of bed] and was noted to have a blood sugar in the 40's. New compression fractures found." C. The record failed to evidence the physician had been informed of the patient's reluctance to perform blood sugar testing. 4. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care states, "SN/CG [caregiver] Pt [patient] to cleanse wound bed with NS [normal saline] and gauze using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape." A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up." B. The record failed to evidence the physician had been notified of the condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record		condition/improvement of the wound. This SN has been educated regarding the requirement of N527: that agency professional staff must promptly alert the physician to any changes that suggest a need to alter the plan of care. PT failed to notify the physician that PT services were discontinued per patient request. The physician has been notified and the therapist educated regarding the requirement of N527: that the physician must promptly be alerted to any changes that suggest a need to alter the plan of care. 25% of all visit notes will be reviewed weekly for compliance of documentation that the physician was informed promptly of any changes that suggest a need to alterthe plan of care beginning week of 6/13/16 for a period of 6 weeks. Threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."			
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 record review and interview, the agency failed to ensure services and treatments had been provided in accordance with physician orders in 4 (#s 2, 3, 11, and 12) of 12 records reviewed.	N 0537	All agency clinical staff will be educated on the following: ·Requirements of 410 iac 17-14-1(a): Scope of Services ·The agency shall provide services by an RN or LPN in accordance with the medical plan	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	The findings include: 1. Clinical record number 2 included a plan of care established by the physician for the certification period 4-16-16 to 6-13-16. The plan of care states, "Skilled assessment with focus on CHF [congestive heart failure]: medication management, edema, weight, dyspnea levels, cardiac assessment, oxygen safety and management . . . Instruct to record weight daily and to report weight gain of 2 lbs. in one day or 5 lbs in one week or as per physician order.' A. Skilled nurse (SN) visit notes, dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16, failed to evidence the SN had assessed and monitored the patient's weight. B. A SN recertification visit note dated 4-14-16 states, "Patient is incontinent [urinary]." The plan of care for the certification period 4-16-16 to 6-13-16 included interventions to address the incontinence. The plan states, "Assess instruct on incontinence management, i.e. kegals, time-voiding, suggest they wear protection in undergarments at night . . . Assess/instruct caregivers not to rush patient, to give frequent cues and		of care. ·Agency Policy C-580 (Plan of Care) Clinical Record number 2: A. The physician was notified that the SN failed to assess and monitor the patient's weight per the plan of care. Physician order was obtained to discontinue daily weights. B. One on one education will be provided to the SN who failed to assess and address the patient's urinary incontinence as it was identified on the assessment and included in the plan of care. SN will assess and address patient's incontinence on every visit. C. SN drew HbA1c prior to initially ordered date, per written physician order obtained by patient, so results would be available for physician's appointment.SN failed to discontinue the original order for the lab to be drawn on 5/19/16 and SN failed to place the written order in the clinical record or call to clarify, via verbal order, that the HbA1c was to be drawn early. One on one education will be provided to this SN and SN will obtain written or verbal orders for all changes to the plan of care. Clinical Record number 3: A. SN failed to document how the dressing change was performed. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. See supporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	reminders during an activity, accompany them to bathroom (allow privacy)." SN visit notes, dated 4-18-16, 4-21-16, 4-25-16, 4-28-16, 5-2-16, 5-5-16, 5-9-16, 5-12-16, and 5-16-16, failed to evidence the SN had assessed and addressed the urinary incontinence. The SN visit notes identifies the patient's urinary status was "WNL [within normal limits]." C. The plan of care for the certification period 4-16-16 to 6-13-16 states, "Hgb A1C [blood test to assess how well diabetes is being controlled] due 5/19/16." 1.) A SN visit note dated 5-12-16 states, "SN drew ordered labs from [name of physician] via venipuncture." The record failed to include an order for the venipuncture on 5-12-16. 2.) The record failed to evidence the Hgb A1C had been drawn on 5-19-16 per the plan of care. 3.) The record included a "Case Communication Report" dated 5-9-16 that states, "SN has written order from [name of physician] given to patient for SN to draw hgba1c before upcoming appt on 5-19-16." The record failed to		documentation. B. SN failed to document that the Hydrogel was applied to wound per physician order. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 11: A. SN failed to document how the dressing change was performed. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. B. SN failed to document that the wound care had been performed. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. C. SN failed to document wound care appropriately. Education provided to all clinical staff, on 5/24/16 and5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. Clinical Record number 12: The SN failed to document, on 5/6/16, that the patient's legs had been wrapped per the physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	evidence the written order. 2. Clinical record number 3 included a physician's orders dated 4-25-16 that states, "OK for SN to change wound care order to Hyrogel on wounds, then Aquacel Ag, cover with foam dressing. Dressing change will remain 3 times per week as previously scheduled." A. SN visit notes, dated 4-27-16 and 4-29-16, failed to evidence how the dressing change was performed. The notes state, "wound care performed." B. SN visit notes, dated 5-13-16 and 5-16-16, failed to evidence the SN had applied the Hydrogel per the physician's order. 3. Clinical record number 11 included a plan of care established by the physician for the certification period 4-26-16 to 6-24-16. The plan of care states, "Wound Care Orders for Right buttocks: Cleanse with ns [normal saline] and pat dry with gauze, apply Prisma to area, cover with foam." A. A SN visit note dated 4-30-16 failed to evidence how the wound care was performed. The note states, "wound care performed. pt [patient] tolerated well."		order; however, per this SN she did wrap the patient's legs per physician order but failed to document the procedure. SN instructed to annotate the visit note of 5/6/16 to include this documentation. Patient had seen physician on 5/3/16 and the physician had removed the wraps to patient's legs and failed to reapply them, per documentation in the clinical record. Education provided to all clinical staff, on 5/24/16 and 5/25/16, regarding appropriate documentation of wound care performed. In addition, all clinical staff will be educated on the requirement of following physician orders. 25% of all visit notes will be reviewed weekly for compliance of providing care in accordance with physician orders/plan of care beginning week of 6/13/16 for a period of 6 weeks. Compliance threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits will be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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

B. A SN visit note dated 5-2-16 failed to evidence the wound care had been performed.

C. A SN visit note dated 5-13-16 evidenced the foal dressing was applied, but failed to evidence the Prisma was applied per the physician's order.

4. Clinical record number 12 included a plan of care established by the physician for the certification period 5-2-16 to 6-30-16. The plan of care states, "Sn to perform wound care. Cleanse legs with soap and water, pat dry. Apply Aquafor cream, or equivalent, and wrap legs in 4 layer profor dressing with 3 layer being in figure 8 fashion. Wrap toes with cotton roll or kerlix and then cover with coban."

A SN visit note dated 5-6-16 failed to evidence the patient's legs had been wrapped per the physician's order. The note identifies the patient was not wrapped upon the SN's arrival and that the patient had gone 3 days without wraps.

5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	7. The agency's August 2013 "Physician Orders" policy and procedure number C-635 states,"All care and service provided will be in accordance with physician orders."			
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the agency failed to ensure the registered nurse (RN had initiated necessary revisions to the plan of care in 4 (#s 2, 3, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 2 failed to evidence the registered nurse (RN) had informed the physician of a change in the size of the patient's wound and a change in the character of the wound drainage and initiated a change in the plan of care. A. A skilled nurse (SN) recertification visit note dated 4-14-16 evidenced the wound was located on the	N 0542	All agency professional staff will be educated on the following: • Requirements of 410 IAC 17-14-1(a)1(C)-Scope of Services • The RN initiates the plan of care and necessary revisions • Agency Policy C-360 (Coordination of Patient Care) A clinical record review of 25% of active patients will be conducted to determinecompliance with the requirements of N542: that the RN initiates the plan ofcare and necessary revisions. Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to the physician; however, the wound measurements were not included. The SN failed to document evidence of physician notification related to changes in the size and	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	left shin and measured 0.5 centimeters (cm) in length and 0.2 cm in width. The note classified the wound as an abrasion with a scant amount of serous drainage. B. A SN visit note dated 4-25-16 evidenced the wound was located on the patient's left knee, was 0.5 cm in length and 0.2 cm in width with a "moderate amount serous purulent (yellow/tan) drainage." C. A SN visit note dated 5-5-16 evidenced the wound was located on the left knee and was 3.5 cm in width and 0.5 cm in length with a "small" amount of "purulent (yellow/tan) drainage." D. On 5-18-16 at 12:45 PM, during a home visit to patient number 2, employee K, the RN, stated, "The open area was scabbed. Two weeks ago it started draining yellow fluid. I did tell the physician. [The patient] goes to see the PCP [primary care physician] tomorrow." 2. Clinical record number 3 included a plan of care established by the physician for the certification period 3-22-16 to 5-20-16. The plan evidenced interventions to address congestive heart failure including daily weights. The plan states, "Instruct to record weight daily and to report weight gain of 2 lbs in one		condition of the patient's wound. No harm came to this patient as a result ofthe failure of the SN to document the required physician notification and the physician was notified of the changes in the patient's wound. This SN was educated and counseled on the requirements of N542: The RN initiates the plan of care and necessary revisions Clinical Record #3 (A-B) This patient is unable to weight daily but interventions on the plan of care did include daily weights. The SN did identify this but failed to notify the physician of the patient's inability to complete daily weights. The physician has been notified of the patient's inability to complete the daily weights andthe plan of care amended to reflect the patient's inability to do so. Clinical Record #6 (A-C) The plan of care contained interventions to address blood glucose control, including blood glucose testing. The SN documented that the patient does not comply with blood glucose testing and did exhibit s/s related to hypoglycemia. The SN failed to document physician notification of the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's noncompliance with blood glucose testing. This SN is no longer employed by this agency. All nursing staff havebeen educated regarding the requirement to notify the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	day or 5 lbs in one week or as per physician order." A. A SN visit note dated 4-6-16 identifies the patient is unable to weigh daily due to "morbid obesity" and "it would also be unsafe for [the patient] to stand on a scale due to morbid obesity and living alone." B. The record failed to evidence the physician had been informed of the patient's inability to complete daily weights to monitor for fluid retention and signs and symptoms of congestive heart failure and that the RN had initiated a change in the plan of care to address the patient's inability to complete daily weights. 3. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care evidenced interventions to address blood glucose control. The plan states, "SN to perform with focus on diabetes: . . . blood glucose testing and evaluation." A. SN visit notes, dated 4-6-16, 4-8-16, 4-13-16, 4-18-16, 4-27-16, 5-6-16, and 5-13-16 evidenced the patient does not "check blood sugar regularly" and that the patient can tell by "how [the		physician of any changes in patient condition that suggest a need to alter the plan of care. Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient'swound and wound care no longer being needed and failed to document wound care performed on the 5/13/16 visit. The wound care was not discontinued and the patient performed wound care on 5/18/16 as observed and documented by the SN. The physician has been notified of the condition/improvement of the wound. This SN has been educated regarding the requirement of N542: The RN initiates the plan of care and necessary revisions PT failed to notify the physician or the RN that PT services were discontinued per patient request. The physician has been notified and the therapist educated regarding the requirement of N542: The RN initiates the plan of care and necessary revisions 25% of all RN visit notes will be reviewed weekly, beginning week of 6/13/16, for compliance of the RN initiating necessary revisions to the plan of care, for a period of 6 weeks. Threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits can be decreased to 10% quarterly chart reviews. . The Clinical Director/designee will be responsible for monitoring these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	patient] feels." B. An "Admission Note Report" dated 3-31-16 states, "Patient had fallen OOB [our of bed] and was noted to have a blood sugar in the 40's. New compression fractures found." C. The record failed to evidence the physician had been informed of the patient's reluctance to perform blood sugar testing and the RN had initiated a change in the plan of care to address the patient's reluctance. 4. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care states, "SN/CG [caregiver] Pt [patient] to cleanse wound bed with NS [normal saline] and gauze using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape." A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up." B. The record failed to evidence the physician had been notified of the		corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated 4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's September 2013 "Coordination of Patient Care" policy and procedure number C-360 (HH) states, "The primary care Nurse or Therapist will assume responsibility for updating/changing the Care Plan and communication changes to caregivers within twenty-four (24) hours following the conference or changes. The physician will be contacted when his/her approval for the change is necessary and to alert physician to changes in the patient condition."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview, the agency failed to ensure the registered nurse (RN)had alerted the physician to changes in the patients' needs and condition in 4 (#s 2, 3, 6, and 8) of 12 records reviewed. The findings include: 1. Clinical record number 2 failed to evidence the registered nurse (RN) had informed the physician of a change in the size of the patient's wound and a change in the character of the wound drainage. A. A skilled nurse (SN) recertification visit note dated 4-14-16 evidenced the wound was located on the left shin and measured 0.5 centimeters (cm) in length and 0.2 cm in width. The	N 0546	All agency clinical staff will be educated on the following: ·Requirements of 410 IAC 17-14-1(a)(1)(G)-Scope of Services ·The RN alerts the physician to changes in the patient's condition and needs. ·Agency Policy C-580 (Plan of Care) A clinical record review of 25% of active patients will be conducted to determine compliance with the requirements of N546: that the RN alerts the physician to changes in the patient's needs and condition Clinical Record #2 (A-D) The SN documented the presence of the wound in the 60-day summary provided to the physician; however, the wound measurements were not included. The SN failed to document evidence of physician notification related to changes in the size and	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	note classified the wound as an abrasion with a scant amount of serous drainage. B. A SN visit note dated 4-25-16 evidenced the wound was located on the patient's left knee, was 0.5 cm in length and 0.2 cm in width with a "moderate amount serous purulent (yellow/tan) drainage." C. A SN visit note dated 5-5-16 evidenced the wound was located on the left knee and was 3.5 cm in width and 0.5 cm in length with a "small" amount of "purulent (yellow/tan) drainage." D. On 5-18-16 at 12:45 PM, during a home visit to patient number 2, employee K, the RN, stated, "The open area was scabbed. Two weeks ago it started draining yellow fluid. I did tell the physician. [The patient] goes to see the PCP [primary care physician] tomorrow." 2. Clinical record number 3 included a plan of care established by the physician for the certification period 3-22-16 to 5-20-16. The plan evidenced interventions to address congestive heart failure including daily weights. The plan states, "Instruct to record weight daily and to report weight gain of 2 lbs in one day or 5 lbs in one week or as per physician order."		condition of the patient's wound. No harm came to this patient as a result of the failure of the SN to document the required physician notification and the physician was notified ofthe changes in the patient's wound. This SN was educated and counseled on the requirements of N546: to alert the physician to any changes in the patient's needs and condition. Clinical Record #3 (A-B) This patient is unable to weigh daily but interventions on the plan of care did include daily weights. The SN did identify this but failed to notify the physician of the patient's inability to complete daily weights. The physician has been notified of the patient's inability to complete the daily weights and the plan of care amended to reflect the patient's inability to do so. Clinical Record #6 (A-C) The plan of care contained interventions to address blood glucose control, including blood glucose testing. The SN documented that the patient does not comply with blood glucose testing and did exhibit s/s related to hypoglycemia. The SN failed to document physician notification of the patient's reluctance to perform blood glucose testing. The physician has been notified of the patient's noncompliance with blood glucose testing This SN is no longer employed by this agency. All nursing staff have been educated regarding the requirement to notify the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	A. A SN visit note dated 4-6-16 identifies the patient is unable to weigh daily due to "morbid obesity" and "it would also be unsafe for [the patient] to stand on a scale due to morbid obesity and living alone." B. The record failed to evidence the RN had informed the physician of the patient's inability to complete daily weights to monitor for fluid retention and signs and symptoms of congestive heart failure. 3. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care evidenced interventions to address blood glucose control. The plan states, "SN to perform with focus on diabetes: . . . blood glucose testing and evaluation." A. SN visit notes, dated 4-6-16, 4-8-16, 4-13-16, 4-18-16, 4-27-16, 5-6-16, and 5-13-16 evidenced the patient does not "check blood sugar regularly" and that the patient can tell by "how [the patient] feels." B. An "Admission Note Report" dated 3-31-16 states, "Patient had fallen OOB [our of bed] and was noted to have		physician of any changes in patient's condition or needs Clinical Record #8 (A-C) The SN failed to document physician notification of improvement to the patient's wound and wound care no longer being needed and failed to document wound care performed on the 5/13/16 visit. The wound care was not discontinued and the patient performed wound care on 5/18/16 as observed and documented by the SN. The physician has been notified of the condition/improvement of the wound. This SN has been educated regarding the requirement of N546: that agency professional staff must alert the physician to any changes in the patient's condition or needs. PT failed to notify the physician or the RN that PT services were discontinued per patient request. The physician has been notified and the therapist educated regarding the requirement of N546: that the physician must promptly be alerted to any changes in the patient's condition or needs. 25% of all visit notes will be reviewed weekly, beginning week of 6/13/16, for compliance of the RN or qualified therapist alerting the physician to changes in the patient's needs and condition, for a period of 6 weeks. Threshold is 90%. If Threshold of 90% is achieved for 6 consecutive weeks then chart audits can be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	a blood sugar in the 40's. New compression fractures found." C. The record failed to evidence the RN had informed the physician of the patient's reluctance to perform blood sugar testing. 4. Clinical record number 8 included a plan of care established by the physician for the certification period 4-12-16 to 6-10-16. The plan of care states, "SN/CG [caregiver] Pt [patient] to cleanse wound bed with NS [normal saline] and gauze using aseptic technique. Using aseptic technique apply Muprocin to wound bed, cover with 4x4 gauze, wrap with Kerlix and secure with tape." A. A SN visit note dated 5-13-16 notes "wound has covered over with scab and no active drainage notes. Pt advised that wound may still be open some underneath and could open back up." B. The record failed to evidence the RN had informed the physician of the condition of the wound and that the dressing change was no longer needed. C. The plan of care included orders for physical therapy (PT) services 2 times per week for 4 weeks. The record included a PT discharge note dated		decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	4-25-16 that states, "D/C [discontinue] PT at this time per patient request." The record failed to evidence the physician had been notified PT services had been discontinued prior to the end of the 4 weeks as ordered. 5. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 6. The agency's 3-28-13 "Plan of Care" policy and procedure number C-580 (HH) states, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."			
N 0549 Bldg. 00	410 IAC 17-14-1(a)(1)(J) Scope of Services Rule 14 Sec. 1(a) (1)(J) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (J) Direct the activities of the licensed practical nurse. Based on record review and interview, the agency failed to ensure the registered nurse (RN) had directed and supervised the licensed practical nurse (LPN) in 2	N 0549	All clinical staff will be educated on: ·The requirements of 410 IAC 17-14-1(a)(1)(J)-Scope of Services	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	(#s 8 & 10) of 2 records reviewed of patients that received services from the LPN. The findings include: 1. Clinical record number 8 included skilled nurse visit notes, signed and dated by the LPN, that failed to evidence supervision of the LPN by the RN. A. A skilled nurse visit note, signed and dated by the LPN, employee M, on 4-22-16, states, "INR [blood test used to monitor patients being treated with blood thinning medications] 2.0 via fingerstick method, pt [patient] tolerated well and without incident and results called to [name of physician] and spoke with [name of office personnel]." The record included a verbal physician's order for medication changes and another blood test signed and dated by employee M on 4-26-16. B. A skilled nurse visit note, signed and dated by the LPN, employee M, on 5-9-16, states, "PT/INR right middle finger called to [name of physician]." The record failed to evidence any communication between the LPN and the RN.		·The RN shall direct and supervise the activities of the LPN ·Agency Policy C-300 (Supervision) A clinical record review of 25% of active patients receiving nursing services delivered by the LPN will be conducted to determine compliance with the requirements of N549: that the RN directs and supervises the LPN and that the record reflects communication between the LPN and the RN. Clinical Record #8 1.The record included a verbal physician's order for medication changes and lab test that was signed/dated by the LPN and reviewed and co-signed by the RN. Supporting documentation attached. 2.The clinical record contains a communication note, dated 5/10/16, between the LPN and RN, regarding the PT/INR that demonstrates communication between the LPN and RN. Supporting documentation attached. 3.The clinical record contains a communication note, dated 5/17/16, between the LPN and RN, regarding the PT/INR that demonstrates communication between the LPN and RN. Supporting documentation attached. 4.The clinical record does contain evidence of communication, as noted in A-C, between the LPN and RN regarding blood test results and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	The record included a verbal physician's order, signed and dated by employee M on 5-9-16 for the fingerstick blood test on 5-9-16. C. A skilled nurse visit note, signed and dated by the LPN, employee M, on 5-16-16, states, "PT/INR right middle finger results called to [name of physician]." The record failed to evidence any communication between the LPN and the RN. The record included a verbal physician's order, signed and dated by employee M on 5-10-16, for a medication change and further blood testing. D. The record failed to evidence any communication between the RN and the LPN regarding the blood test results and the resulting medication changes. 2. Clinical record number 10 included a skilled nurse visit note signed and dated by the LPN, employee O, on 4-20-16. The note states, "spoke with patient and [spouse] about perhaps obtaining urine specimen for UA [urinalysis], I would speak with RN about the situation, explained the goal of nursing services is to not only educate disease process but if we can prevent another hospitalization, [spouse] verbalizes agreement, patient		the resulting medication changes and supporting documentation is attached. 100% of all patient charts that are receiving LPN services will be reviewed weekly,beginning 6/13/16, to ensure that the RN is supervising the LPN appropriately as required, for a period of 6 weeks. Threshold is 95%. If Threshold of95% is achieved consistently for 6 weeks then chart audits can be decreased to10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	stubbornly agrees that avoiding going back to hospital is in best interest." A. The record failed to evidence the RN had consulted with the LPN regarding the possibility of obtaining a urine specimen. The record failed to evidence any urinalysis results. B. The RN, employee K, stated, on 5-20-16 at 2:00 PM, "I spoke with the LPN. The [spouse] refused. It is not documented." 3. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 4. The agency's September 2013 "Supervision" policy and procedure number C-300 states, "Licensed Practical Nurse Supervision. ViaQuest shall provide Licensed Practical Nurse services under the direction and supervision of a Registered Professional Nurse when services are indicated and ordered by the physician."			
N 0559 Bldg. 00	410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse. Based on record review and interview, the agency failed to ensure the licensed practical nurse (LPN) had consulted with the registered nurse (RN) in 2 (#s 8 & 10) of 2 records reviewed of patients that received services from the LPN. The findings include: 1. Clinical record number 8 included skilled nurse visit notes, signed and dated by the LPN, that failed to evidence supervision of the LPN by the RN. A. A skilled nurse visit note, signed and dated by the LPN, employee M, on 4-22-16, states, "INR [blood test used to monitor patients being treated with blood thinning medications] 2.0 via fingerstick method, pt [patient] tolerated well and without incident and results called to [name of physician] and spoke with [name of office personnel]." The record included a verbal physician's order for medication changes and another blood test signed and dated by employee M on 4-26-16.	N 0559	All clinical staff will be educated on: ·The requirements of 410 IAC 17-14-1(a)(2)(G) ·The LPN must consult with the RN ·Agency Policy C-300 (Supervision) A clinical record review of 25% of active patients receiving nursing services delivered by the LPN will be conducted to determine compliance with the requirements of N559: that the The LPN must consult with the RN ClinicalRecord #8 1.The record included a verbal physician's order for medication changes and lab test that was signed/dated by the LPN and reviewed and co-signed by the RN. Supporting documentation attached. 2.The clinical record contains a communication note, dated 5/10/16, between the LPN and RN,regarding the PT/INR that demonstrates communication between the LPN and RN. Supporting documentation attached. 3.The clinical record contains a communication note, dated 5/17/16, between the LPN and RN,regarding the PT/INR that	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	B. A skilled nurse visit note, signed and dated by the LPN, employee M, on 5-9-16, states, "PT/INR right middle finger called to [name of physician]." The record failed to evidence any communication between the LPN and the RN. The record included a verbal physician's order, signed and dated by employee M on 5-9-16 for the fingerstick blood test on 5-9-16. C. A skilled nurse visit note, signed and dated by the LPN, employee M, on 5-16-16, states, "PT/INR right middle finger results called to [name of physician]." The record failed to evidence any communication between the LPN and the RN. The record included a verbal physician's order, signed and dated by employee M on 5-10-16, for a medication change and further blood testing. D. The record failed to evidence any communication between the RN and the LPN regarding the blood test results and the resulting medication changes. 2. Clinical record number 10 included a skilled nurse visit note signed and dated		demonstrates communication between the LPN and RN. Supporting documentation attached. 4.The clinical record does contain evidence of communication, as noted in A-C, between the LPN and RN regarding blood test results and the resulting medication changes and supporting documentation is attached. Clinical Record #10 (A-B) The RN failed to document communication between the RN and LPN or the refusal of the patient's spouse in providing a urine specimen and having a urinalysis.This RN was educated regarding the requirements of N559. In addition, all nursing staff will be educated regarding the requirements of N559 and the acceptable modes of communication. 100% of all patient charts that are receiving LPN services will be reviewed weekly, beginning 6/13/16, to ensure that the RN is supervising the LPN appropriately as required, for a period of 6 weeks. Threshold is 95%. If Threshold of95% is achieved consistently for 6 weeks then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	by the LPN, employee O, on 4-20-16. The note states, "spoke with patient and [spouse] about perhaps obtaining urine specimen for UA [urinalysis], I would speak with RN about the situation, explained the goal of nursing services is to not only educate disease process but if we can prevent another hospitalization, [spouse] verbalizes agreement, patient stubbornly agrees that avoiding going back to hospital is in best interest." A. The record failed to evidence the LPN had consulted with the RN regarding the possibility of obtaining a urine specimen. The record failed to evidence any urinalysis results. B. The RN, employee K, stated, on 5-20-16 at 2:00 PM, "I spoke with the LPN. The [spouse] refused. It is not documented." 3. The Clinical Director was unable to provide any additional documentation and/or information when asked on 5-19-16 at 2:40 PM and on 5-20-16 at 10:35 AM. 4. The agency's September 2013 "Supervision" policy and procedure number C-300 states, "Licensed Practical Nurse Supervision. ViaQuest shall provide Licensed Practical Nurse services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	under the direction and supervision of a Registered Professional Nurse when services are indicated and ordered by the physician."			
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 record review and interview, the agency failed to ensure the competency evaluation addressed all of the required subject areas in 1 (file I) of 2 home health aide files reviewed. The findings include: 1. Personnel file I evidenced the individual had been hired on 2-24-16 to provide home health aide services on behalf of the agency. The file identified a competency evaluation had been provided to the aide on 3-3-16. The competency evaluation failed to address sponge, tub, or shower bath (410 IAC 17-14-1(h)(9)(B)), safe transfer	N 0596	Agency staff will be educated on the following: ·The requirements of 410 IAC 17-14-1(l)(A) Scope of Services ·Review of the specific required content of the home health aide competency evaluation ·Agency Policy C-220 (Aide Services) A review of the personnel record of all home health aides employed by this agency will be conducted to ensure compliance with N596: that the home health aide competency evaluation addresses all subject matter required. Any areas of noncompliance identified will result in a reassessment of the home health aide's competency by an outside agency. In	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	techniques (410 IAC 17-14-1(h)(10)), toileting and elimination (410 IAC 17-14-1(h)(9)(F)), and reading and recording temperature, pulse, and respiration (410 IAC 17-14-1(h)(3)). 2. The Clinical Director indicated, on 5-20-16 at 4:00 PM, the competency evaluation provided to employee I did not address all of the required subject areas. 3. The agency's August 2013 "Aide Services" policy and procedure number C-220 (C) states, "All individuals providing aide services will be qualified through training and/or competency evaluations."		personnel file I, the home health aide was hired on 2/24/16 and competency was evaluated on 3/3/16 and 3/4/16 using the incorrect form. The information was placed on the correct form, provided by the Indiana Association for Home and Hospice Care, that contains all of the subjects required by N596. However, the incorrect form was left in the personnel file, along with an additional competency assessment performed to meet the requirements of the Home Health Aide Registry. Therefore, there appeared to be discrepancies related to the competency evaluation. Going forward, the agency will only utilize the IAHHC aide competency evaluation to evaluate competency of home health aides (once the 2 year preclusion is lifted). 100% of newly hired home health aide personnel files will be audited to ensure that the home health aide competency evaluation addresses all of the required subject areas. Compliance threshold is 100%. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	
N 0602 Bldg. 00	410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide shall be assigned to a particular patient by a registered nurse (or therapist in therapy only			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	cases). Based on record review and interview, the agency failed to ensure written instructions had been prepared for the home health aide in 1 (#6) of 6 records reviewed of patients that received home health aide services. The findings include: 1. Clinical record number 6 included a plan of care established by the physician for the certification period 3-31-16 to 5-29-16. The plan of care included orders for home health aide services 1 time per week for 8 weeks. The record evidenced the home health aide services had been provided 1 time per week. The record failed to evidence the registered nurse (RN) had prepared written instructions for the home health aide services to be provided. 2. Employee L, the software support person, stated, on 5-19-16 at 2:35 PM, "There is no aide assignment sheet per the RN in the computer." 3. The agency's August 2013 "Aide Care Plan" policy and procedure number C-751 (C) states, "A complete and appropriate Care Plan, identifying duties to be performed by the Aide, shall be developed by a Registered Nurse or	N 0602	All clinical staff will be educated on the following: ·The requirements of 410 IAC 17-14-1(m) Scope of Services ·The home health aide must be assigned to a particular patient by an RN or therapist; Written patient care instructions for the home health aide must be prepared by the RN or other appropriate professional who is responsible for the supervision of the home health aide. ·Agency Policy C-751 (Aide Care Plan) A clinical record review of 25% active clinical records of patients receiving home health aide services will be reviewed to ensure that written patient care instructions for the home health aide are present as required by N602. Clinical Record #6 The RN did fail to prepare written instructions for the home health aide services to be provided. Written instructions for the home health aide have now been prepared and are present in the clinical record. This RN is no longer employed with this agency. 100% of all patient charts that are receiving aide services will be reviewed every two weeks, beginning week of 6/13/16, for compliance that each patient record shows evidence of written patient care instructions for the home health aide are prepared by the RN, for a period of 2 months. Threshold is 90%. If Threshold of	06/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157223	A. BUILDING 00 B. WING	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIAQUEST HOME HEALTH OF INDIANA, LLC	14649 HIGHWAY 41 NORTH EVANSVILLE, IN 47725

(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
	Therapist."		90% is achieved consistently for 2 months then chart audits can be decreased to 10% quarterly chart reviews. The Clinical Director/designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.	