

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157163	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/15/2014
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NAME OF PROVIDER OR SUPPLIER  ANCHOR HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383
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G000000	<p>This was a revisit for the extended home health Federal complaint survey on August 6 - 14, 2014.</p> <p>Complaint: IN00153427 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies were also cited.</p> <p>Survey date: 10/14/14 and 10/15/14</p> <p>Facility: 005336</p> <p>Medicaid #: 100264420A</p> <p>Surveyor: Ingrid Miller, RN, PHNS Deborah Franco, RN, PHNS Bridget Boston, RN, PHNS</p> <p>During this survey, 5 conditions and 25 standard level deficiencies were corrected and 3 standard level deficiencies were recited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN  October 17, 2014</p>	G000000	<p><b><u>Credible Allegation of Correction And Compliance:</u></b> For purposes of any allegation that Anchor Home Health Care is not in compliance with regulations as set forth in this statement of deficiencies, this Plan of Correction constitutes credible allegation of correction and compliance. The preparation and execution of this Response and Plan of Correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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G000121	<p>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.</p> <p>Based on observation, interview, and review of procedures, the agency failed to ensure staff had provided services in accordance with agency procedures in 1 of 1 home visit observation (patient #2) with a Registered Nurse creating the potential to affect any patients cared for by Employee PP, Registered Nurse.</p> <p>The findings include</p> <p>1. On 10/15/14 at 6:55 AM Eastern Standard Time (EST), Employee PP, Registered Nurse, was observed to wash her hands with soap and water at the patient's bathroom sink. She turned off the sink faucets with her bare wet hands and dried her hands on the patient's bath towel. This towel was hanging on a towel rack with other towels. She entered the patient's room where the</p>	G000121	<p>The Director of Nursing, Clinical Nursing Supervisors, and Director of Human Resources will in-service staff regarding infection control; including hand washing/hand hygiene and bag technique during quarterly employee meetings from 11/3/14 to 11/14/14. The Clinical Nursing Supervisors will be responsible for observing new direct care staff demonstrate proper technique and complete a competency evaluation in hand washing/hand hygiene in accordance with agency policy, and will review the technique with those employees who have attended previous in-services. The Director of Human Resources has disciplined the RN, employee PP, and the Director of Quality Assurance has retrained employee PP by reviewing the policies and procedures regarding hand washing/hand hygiene. This documentation has been added to the employee personnel</p>	11/14/2014
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	<p>patient was observed in a hospital bed. She used hand gel on her hands before taking the patient's vital signs. Employee PP gelled her hands and put on gloves to remove a left hip wound dressing and measured the wound. She took her gloves off and donned new gloves without washing her hands or using a hand sanitizer. After cleaning the wound and placing iodoform into the wound, she took her gloves off and donned new gloves without washing her hands or using a hand sanitizer. She placed a dressing on the wound. She took her gloves off and did not wash or sanitize her hands. She donned clean gloves and completed a PICC line infusion of an antibiotic. She removed her gloves and washed her hands. She donned clean gloves and completed the patient's bowel program. She removed her gloves. She donned new gloves and used hand sanitizer on her gloved hands. She removed the patient's dressing in the scrotal area. She removed her gloves. She donned new gloves and put hand sanitizer on her gloved hands. She measured the patient's wound. She cleansed the wound area. She removed her gloves. She washed her hands at the bathroom sink and used the patient's hand towel which was hanging by the sink to dry her hands. She put on clean gloves and measured the patient's wound by</p>		<p>record. Ongoing in-services will beheld monthly by the Human Resources Director and/or the Clinical Nursing Supervisors to ensure and reinforce policy compliance. Infection Control pocket guides were distributed to staff during in-service meetings to reinforce agency policy. Completion will be by 11/14/14, and ongoing to ensure compliance.</p>	

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	<p>placing a sterile applicator into the deep wound. She placed the same applicator into the wound two more times and measured how far the applicator went into the wound. She removed her gloves and gelled her hands and donned new gloves. She used skin prep around the wound. She placed Flagyl tablets as ordered into the wound. She removed her gloves. She did not wash her hands. She donned new gloves and placed a duoderm cut to size around this wound. She removed gloves. She donned new gloves without washing her hands or using a hand sanitizer. She placed a strip of green foam into the wound and used an avance drape to dress the wound. She removed her gloves and did not wash her hands. She donned clean gloves and turned on the wound vac. She removed her gloves and washed her hands at the bathroom sink and dried with the patient's hand towel.</p> <p>2. On 10/15/14 at 8:55 AM EST, Employee PP indicated the employee did not follow infection control procedures at the visit.</p> <p>3. The agency policy titled "Infection Control" with no date noted stated, "Remove gloves and wash hands after each contact."</p>			

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G000159	<p>4. The agency procedure titled "Handwashing Competency Evaluation" with no date stated, "Dries hands completely using a paper towel or a clean hand towel. Turned off faucet with the paper towel or cloth towel."</p> <p>5. The agency procedure titled "Wound Measurement / staging / care" with no date stated, "h. Assessing for tunneling by inserting sterile swab into wound and measuring length of tunneling."</p> <p>6. The agency procedure titled "Standard Infection Control Procedures for Home Care" with no date stated, "Wash hands before and after client care and after removing gloves."</p> <p>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.</p>	G000159	The agency will develop a plan of care in consultation with agency staff covering all pertinent diagnoses, including mental	11/14/2014			

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	<p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all pertinent diagnoses for 1 of 4 (Patient #2) clinical records reviewed with the potential to affect the agency's 153 active patients.</p> <p>Findings included:</p> <p>1. Clinical record #2 included a plan of care with start of care of 9-26-14, certification period of 9-26 to 11-24-14. The plan of care failed to evidence the secondary diagnosis of deep vein thrombosis (DVT). Patient #2 was discharged from an acute care hospital on 9-25-14. The hospital's discharge summary, dated 9-25-14, in the agency's clinical record included the discharge diagnosis of deep vein thrombosis of right lower extremity. The patient's plan of care included visits to the hospital's anti-coagulation clinic 3 times a week for monitoring of Prothrombin time (PT)/ International Normalized Ratio (INR) with Warfarin dosage adjustments as needed per the hospital's anti-coagulation clinic.</p> <p>2. Agency policy "Physician's Plan of Care", last reviewed/revised 9-1-14, page 2, #5 stated, "The Physician's Plan of Care shall cover primary and secondary</p>		<p>status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items. Mandatory in-services for all direct care staff were implemented, including review of the policies for the physician's plan of care. This will be reviewed again at quarterly meetings scheduled for 11/3/14 to 11/14/14. A minimum of 10% of clinical records will be reviewed/audited weekly by the quality assurance department to ensure the plan of care contains all required elements and that visit documentation evidences these elements. Individual plans of care are reviewed and updated if necessary by the Clinical Nursing Supervisors to ensure completeness and accuracy of client information including, but not limited to, the inclusion of both primary and secondary diagnoses. The Administrator will monitor all above processes and procedures weekly to ensure compliance with desired outcomes and delivery of quality patient care. Completion will be achieved by 11/14/14.</p>		

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	<p>diagnoses."</p> <p>3. During interview with the Administrator on 10-15-14 at 3:00 PM, the Administrator confirmed the findings in patient #2's clinical record. The Administrator indicated the agency does not always list all of the patients' secondary diagnosis on the plan of care if not pertinent to the episode of care and DVT might not have been pertinent. When queried if DVT was pertinent for patient #2 based upon the start of care of 9-26-14 following hospitalization 9-17 to 9-25-14, plan of care provision for anti-coagulation clinic visits with PT/INR 3 times a week, and Warfarin dosage adjustments per the clinic and the hospital's discharge summary (which was part of patient #2's clinical record) listing DVT as a discharge diagnosis, the Administrator indicated the agency should have contacted the physician regarding the patient's DVT and confirmed it as a pertinent secondary diagnosis.</p>			

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G000334	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Registered Nurse (RN) made a complete comprehensive assessment as per facility policy for 1 of 4 records reviewed (patient #2) with the potential to affect the agency's 153 active patients.</p> <p>Findings included:</p> <p>1. Clinical record #2 included a plan of care with start of care of 9-26-14, certification period of 9-26 to 11-24-14. The attending physician's start of care orders included International Normalized Ratio (INR) 3 times a week and fax results. The start of care Comprehensive Assessment (C.A.) on 9-26-14 by the RN</p>	G000334	<p>The agency will complete a comprehensive assessment in a timely manner that is consistent with the client's immediate needs, but no later than 5 calendar days after the start of care. The Clinical Nursing Supervisor will review 100% of his/her client's plans of care to ensure completeness of the Comprehensive Assessment information, including relevant diagnoses as per agency policy. The quality assurance department will review 10% of client charts monthly for the completeness of information on comprehensive assessments to ensure compliance. The Director of Nursing and the Director of Quality Assurance are and will be responsible to collectively monitor both the QA audit sheets and the clinical chart audit forms weekly to ensure compliance. The Administrator will monitor</p>	11/07/2014

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	<p>failed to evidence any assessments or physical findings pertinent to the patient's right lower extremity deep vein thrombosis. Page 3 of the C.A. under Pain Profile, listed "RLE [right lower extremity] and thigh" rated at 3 on scale to 10. Page 7 of the C.A., under cardiac status, the assessment of cardiovascular was marked "within normal limits". Page 3, Primary diagnosis and other diagnoses failed to evidence DVT as an other diagnosis. Patient #2 was discharged from an acute care hospital on 9-25-14. The hospitals discharge summary dated 9-25-14, which was part of the patient's clinical record, included the discharge diagnosis of deep vein thrombosis of right lower extremity. Patient #2 was discharged from the hospital on 2 milligram (mg) of Warfarin daily and the agency plan of care medication profile of 9-26-14 included Warfarin 2 mg daily.</p> <p>2. Agency policy "Initial Assessments/Comprehensive Assessments", last reviewed/revised 9-1-14, page 2, #5 stated on page 1, Procedure, "Each patient admitted will receive a comprehensive assessment." and on page 3, "The Initial Comprehensive Assessment also includes : Relevant diagnoses, Relevant medical history, Physical assessment / review of systems and pertinent physical findings."</p>		<p>compliance of both the quality assurance and clinical departments monthly. Completion will be achieved by 11/7/14.</p>				

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N000000	<p>3. During interview with the Administrator on 10-15-14 at 3:00 PM, the Administrator confirmed the findings in patient #2's clinical record. The Administrator stated the hospital discharge summary may not have been available to the RN at the time of the start of care C.A. on 9-26-14. The Administrator indicated, based on the medication profile, the attending physician's orders at start of care to monitor INR 3 times a week, and the patients ability to provide medical history of the recent hospitalization, the RN's C.A. of 9-26-14 was not complete in that it failed to evidence DVT as a relevant secondary diagnosis and failed to evidence assessments and/or review of systems to include assessments related to patient's DVT.</p> <p>This was a revisit for the home health complaint survey completed August 6 - 14, 2014.</p> <p>Complaints: IN00153427 - Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies were also cited.</p>	N000000	<p><b><u>Credible Allegation of Correction And Compliance:</u></b> For purposes of any allegation that Anchor Home Health Care is not in compliance with regulations as set forth in this statement of deficiencies, this Plan of Correction constitutes credible allegation of correction and compliance. The preparation and execution of this Response and Plan of Correction do not</p>	

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N000470	<p>Survey date: 10/14/14 and 10/15/14</p> <p>Facility: IN005336</p> <p>Medicaid #: 100264420A</p> <p>Surveyor: Ingrid Miller, RN, PHNS Deborah Franco, RN, PHNS Bridget Boston, RN, PHNS</p> <p>During this survey, 18 deficiencies were found corrected and 2 deficiencies were recited.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 17, 2014</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of procedures, the agency failed to ensure staff had provided services in</p>	N000470	<p>constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p> <p>The Director of Nursing, Clinical Nursing Supervisors, and Director of Human Resources will in-service staff regarding infection control; including hand washing/hand hygiene and bag</p>	11/14/2014			

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	<p>accordance with agency procedures in 1 of 1 home visit observation (patient #2) with a Registered Nurse creating the potential to affect any patients cared for by Employee PP, Registered Nurse.</p> <p>The findings include</p> <p>1. On 10/15/14 at 6:55 AM Eastern Standard Time (EST), Employee PP, Registered Nurse, was observed to wash her hands with soap and water at the patient's bathroom sink. She turned off the sink faucets with her bare wet hands and dried her hands on the patient's bath towel. This towel was hanging on a towel rack with other towels. She entered the patient's room where the patient was observed in a hospital bed. She used hand gel on her hands before taking the patient's vital signs. Employee PP gelled her hands and put on gloves to remove a left hip wound dressing and measured the wound. She took her gloves off and donned new gloves without washing her hands or using a hand sanitizer. After cleaning the wound and placing iodoform into the wound, she took her gloves off and donned new gloves without washing her hands or using a hand sanitizer. She placed a dressing on the wound. She took her gloves off and did not wash or sanitize her hands. She donned clean gloves and</p>		<p>technique during quarterly employee meetings from 11/3/14 to 11/14/14. The Clinical Nursing Supervisors will be responsible for observing new direct care staff demonstrate proper technique and complete a competency evaluation in hand washing/hand hygiene in accordance with agency policy, and will review the technique with those employees who have attended previous in-services. The Director of Human Resources has disciplined the RN, employee PP, and the Director of Quality Assurance has retrained employee PP by reviewing the policies and procedures regarding hand washing/hand hygiene. This documentation has been added to the employee personnel record. Ongoing in-services will be held monthly by the Human Resources Director and/or the Clinical Nursing Supervisors to ensure and reinforce policy compliance. Infection Control pocket guides were distributed to staff during in-service meetings to reinforce agency policy. Completion will be by 11/14/14, and ongoing to ensure compliance.</p>				

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	<p>completed a PICC line infusion of an antibiotic. She removed her gloves and washed her hands. She donned clean gloves and completed the patient's bowel program. She removed her gloves. She donned new gloves and used hand sanitizer on her gloved hands. She removed the patient's dressing in the scrotal area. She removed her gloves. She donned new gloves and put hand sanitizer on her gloved hands. She measured the patient's wound. She cleansed the wound area. She removed her gloves. She washed her hands at the bathroom sink and used the patient's hand towel which was hanging by the sink to dry her hands. She put on clean gloves and measured the patient's wound by placing a sterile applicator into the deep wound. She placed the same applicator into the wound two more times and measured how far the applicator went into the wound. She removed her gloves and gelled her hands and donned new gloves. She used skin prep around the wound. She placed Flagyl tablets as ordered into the wound. She removed her gloves. She did not wash her hands. She donned new gloves and placed a duoderm cut to size around this wound. She removed gloves. She donned new gloves without washing her hands or using a hand sanitizer. She placed a strip of green foam into the wound and used</p>			

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	<p>an avance drape to dress the wound. She removed her gloves and did not wash her hands. She donned clean gloves and turned on the wound vac. She removed her gloves and washed her hands at the bathroom sink and dried with the patient's hand towel.</p> <p>2. On 10/15/14 at 8:55 AM EST, Employee PP indicated the employee did not follow infection control procedures at the visit.</p> <p>3. The agency policy titled "Infection Control" with no date noted stated, "Remove gloves and wash hands after each contact."</p> <p>4. The agency procedure titled "Handwashing Competency Evaluation" with no date stated, "Dries hands completely using a paper towel or a clean hand towel. Turned off faucet with the paper towel or cloth towel."</p> <p>5. The agency procedure titled "Wound Measurement / staging / care" with no date stated, "h. Assessing for tunneling by inserting sterile swab into wound and measuring length of tunneling."</p> <p>6. The agency procedure titled "Standard Infection Control Procedures for Home Care" with no date stated, "Wash hands</p>			

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NAME OF PROVIDER OR SUPPLIER  ANCHOR HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SILHAVY RD STE 200 VALPARAISO, IN 46383
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N000524	<p>before and after client care and after removing gloves."</p> <p><i>Boston, Bridget</i></p> <p>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</p>			

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	<p>referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all pertinent diagnoses for 1 of 4 (Patient #2) clinical records reviewed with the potential to affect the agency's 153 active patients.</p> <p>Findings included:</p> <p>1. Clinical record #2 included a plan of care with start of care of 9-26-14, certification period of 9-26 to 11-24-14. The plan of care failed to evidence the secondary diagnosis of deep vein thrombosis (DVT). Patient #2 was discharged from an acute care hospital on 9-25-14. The hospital's discharge summary, dated 9-25-14, in the agency's clinical record included the discharge diagnosis of deep vein thrombosis of right lower extremity. The patient's plan of care included visits to the hospital's anti-coagulation clinic 3 times a week for monitoring of Prothrombin time (PT)/ International Normalized Ratio (INR) with Warfarin dosage adjustments as needed per the hospital's anti-coagulation</p>	N000524	<p>The agency will develop a plan of care in consultation with agency staff covering all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, any safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items. Mandatory in-services for all direct care staff were implemented, including review of the policies for the physician's plan of care. This will be reviewed again at quarterly meetings scheduled for 11/3/14 to 11/14/14. A minimum of 10% of clinical records will be reviewed/audited weekly by the quality assurance department to ensure the plan of care contains all required elements and that visit documentation evidences these elements. Individual plans of care are reviewed and updated if necessary by the Clinical Nursing Supervisors to ensure completeness and accuracy of client information including, but not limited to, the inclusion of both primary and secondary diagnoses. The Administrator will monitor all above processes and procedures weekly to ensure</p>	11/14/2014			

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	<p>clinic.</p> <p>2. Agency policy "Physician's Plan of Care", last reviewed/revised 9-1-14, page 2, #5 stated, "The Physician's Plan of Care shall cover primary and secondary diagnoses."</p> <p>3. During interview with the Administrator on 10-15-14 at 3:00 PM, the Administrator confirmed the findings in patient #2's clinical record. The Administrator indicated the agency does not always list all of the patients' secondary diagnosis on the plan of care if not pertinent to the episode of care and DVT might not have been pertinent. When queried if DVT was pertinent for patient #2 based upon the start of care of 9-26-14 following hospitalization 9-17 to 9-25-14, plan of care provision for anti-coagulation clinic visits with PT/INR 3 times a week, and Warfarin dosage adjustments per the clinic and the hospital's discharge summary (which was part of patient #2's clinical record) listing DVT as a discharge diagnosis, the Administrator indicated the agency should have contacted the physician regarding the patient's DVT and confirmed it as a pertinent secondary diagnosis.</p>		<p>compliance with desired outcomes and delivery of quality patient care. Completion will be achieved by 11/14/14.</p>				

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