

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157172	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/20/2015
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NAME OF PROVIDER OR SUPPLIER  FAMILY HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 108 SOUTH JEFFERSON STREET BERNE, IN 46711
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(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
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G 000  Bldg. 00	<p>This was a federal home health recertification survey. This was a partial extended survey.</p> <p>Survey Dates: February 17, 18, 19, and 20, 2015 Partial Extended Dates: February 19 and 20, 2015.</p> <p>Facility Number: IN005340</p> <p>Medicaid Number: 201026410A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 105 Home Health Aide Only: 31 Personal Care Only: 31 Total: 136</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 27, 2015</p>	G 000		
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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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G 121  Bldg. 00	<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. Based on observation, interview, and policy review, the agency failed to ensure staff followed infection control policies and procedures for 2 of 5 observations with the potential to affect all the agency's patients. (#s 4, and 5)</p> <p>Findings include</p> <p>1. During home visit observation with patient #4 on 2/18/15 at 1:15 PM, employee J, a licensed practical nurse, was observed collecting a wound culture from abdominal wound site. Employee J failed to cleanse the wound with normal saline prior to collecting the sample, and failed to ensure the culture collection sticks remained sterile during the collection. Employee J's non-sterile gloves touched the top of the collection sticks.</p> <p>On 2/19/15 at 9:30 AM, surveyor informed employees A, B, C, and D of</p>			G 121	<p>G0121 The Home Health Director and DON has in-serviced nursing staff to the policies and procedures,(1) "Skin Care: Wound Culture – Swab Technique," specifically addressing the procedure to place the culture swab in appropriate container immediately, making sure not to touch swab tip or inner surface of collector container. (2A) "Infection Control: Sterile Technique,"specifically addressing the placement of sterile items on a sterile surface. This may include sterile tray or cloth (may be paper). The inside of the sterile package can be used as the sterile surface, if it has not touched a non-sterile item. (2B) "Infusion Therapy: Venous Catheter Transparent Semi-permeable Adhesive Dressing Change,"specifically addressing to don non-sterile gloves and mask prior to removing old dressings. Remove gloves. Perform hand hygiene. Open all packages for cleansing</p>		03/22/2015

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	<p>home visit 4 observation findings. No responses were received concerning this finding.</p> <p>2. During home visit observation with patient #5 on 2/19/15 at 8:30 AM, employee H, a registered nurse, was observed performing a peripherally inserted central catheter (PICC) dressing change. Employee H failed to ensure the sterile field remained sterile, failed to ensure his/her mask was covering his/her nose during the dressing change, failed to ensure biopatch landed on non-contaminated area of sterile field, and failed to change gloves and perform hand washing after removing the old dressing and prior to cleansing the site and applying new dressing.</p> <p>A. Employee H opened the sterile supplies and then placed the packet in the middle of the sterile field, picked up the package and moved it to the edge of the sterile field, leaving approximately 1 inch of the package on the sterile field, then proceeded to push the package further back to approximately .5 inch on the sterile field. Employee H then proceeded to open the biopatch which landed on the sterile field approximately .5-.75 inches from the sterile supply package, on a contaminated area of the sterile field where the sterile supply package had</p>		<p>of site and place on clean surface. Perform hand hygiene. Don sterile gloves to clean the exit site. 02/24/15 All nursing staff will perform a post test on aforementioned in-service of policies and procedures with required 100% nursing staff achieving scores of 100%. 03/13/15 The Home Health Director and/or DON will make home visits with 100% LPN and 50% RN to observe competency with an expected 100% threshold of 100%. 03/22/15 The Director of Home Health Care will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>already been prior to pushing it back.</p> <p>B. Employee H placed mask on face, only covering mouth. Employee H failed to pull the mask up over nose.</p> <p>C. Employee H removed the old dressing from the PICC site and proceeded to clean the site using the same gloves. Employee H failed to remove gloves, perform hand washing, and apply new gloves prior to cleansing the site.</p> <p>D. During interview on 2/19/15 at 9:45 AM, employee C indicated the nurse should have had the mask up over their nose.</p> <p>3. The agency's policy titled "Skin Care; Wound Culture Swab Technique," # Skin Care 7-7, revised January 1, 2002, states "Procedure: ... 5. Thoroughly and gently rinse the wound with sterile normal saline before culturing. ... 7. Place culture swab in appropriate container immediately, making sure not to touch swab tip or inner surface of collection container."</p> <p>4. The agency's policy titled "Infusion Therapy: Peripherally Inserted Central catheter (PICC) Maintenance and Management of Potential</p>				

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G 172 Bldg. 00	<p>Complications," # Infusion Therapy 9-15, revised November, 2002, states "procedure: ... 6. Don sterile gloves and mask. 7. Slowly loosen transparent dressing at the distal end while anchoring catheter with the other hand. ... 9. Remove contaminated gloves and don new sterile gloves."</p> <p>5. The agency's policy titled "Infection Control: Sterile Technique," # 14-4, revised January 1, 2002, states "Procedure: ... 6. Always place sterile items only on a sterile surface. This may include a separate sterile tray or cloth (may be paper). The inside of the sterile package can be used as the sterile surface, if it has not touched a non-sterile item."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) measured wounds weekly for 1 of 3 clinical records reviewed of patients with wound care orders, creating the potential to affect all the agency's patients. (#4)</p>	G 172	G0172 The Home Health Director and DON will in-service all registered nurses on the policy and procedure entitled, "Skilled Nursing Services," which specifically outlines the duties of the registered nurses' responsibilities as follows: conducts the initial assessment of	03/22/2015			

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	<p>Findings include</p> <p>1. Clinical record # 4, start of care (SOC) date 1/21/15, contained a plan of care dated 1/21-3/21/15 with orders for skilled nursing (SN) 2 times a week for 1 week, 2 times a week for 4 weeks, 1-2 times a week for 4 weeks, and 6 as needed visits for catheter, wound, and ileostomy issues. SN to provide wound care on days of visits, family or primary care giver to provide on non-visit days.</p> <p>A. The SOC assessment dated 1/21/15 evidenced three wounds were noted on admission: vertical mid abdomen surgical incision, surgical wound left lower abdomen, and anus surgical incision.</p> <p>B. The SN visit note dated 2/2/15 evidenced the anus wound was not measured. The SN failed to measure the wound per policy.</p> <p>2. During interview on 2/19/15 at 1:15 PM, employee C indicated open wounds are to be measured on admission and on the first visit of each week.</p> <p>3. The agency's policy titled "Skin Care: Dressing Changes," # 7-9, revised January 1, 2002, states "Procedure: ... 6.</p>		<p>the patient's nursing needs, conducts ongoing assessments of the patient's nursing needs, establishes the initial plan of care and revises as necessary, and coordinates the patient's care. 03/10/015</p> <p>The Home Health Director and DON has in-serviced all nursing on the policy and procedure entitled, "Skin Care: Dressing Changes," specifically related to the assessment of wound size including length, width, and depth, which is to be documented by the RN or LPN weekly and PRN. 02/24/15</p> <p>10% of the current average daily census, of which 1/3 will be closed clinical records will be audited quarterly for evidence that 1) registered nurses are assessing the patient's nursing needs, providing ongoing assessments of the patient's nursing needs, establishing and revising the plan of care as needed, and coordinating the patient's care; and 2) that the assessment of wound size including length, width, and depth is documented by the RN or LPN weekly and PRN.</p> <p>The Director of Home Health Care will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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N 000  Bldg. 00	<p>Observe for: a. Wound size including length, width, and depth. Document weekly and PRN."</p> <p>This was a home health state licensure survey.</p> <p>Survey Dates: February 17, 18, 19, and 20, 2015</p> <p>Facility Number: IN005340</p> <p>Medicaid Number: 201026410A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 105 Home Health Aide Only: 31 Personal Care Only: 31 Total: 136</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p>	N 000		

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N 470  Bldg. 00	<p>February 27, 2015</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 policy review, the agency failed to ensure staff followed infection control policies and procedures for 2 of 5 observations with the potential to affect all the agency's patients. (#s 4, and 5)</p> <p>Findings include</p> <p>1. During home visit observation with patient #4 on 2/18/15 at 1:15 PM, employee J, a licensed practical nurse, was observed collecting a wound culture from abdominal wound site. Employee J failed to cleanse the wound with normal saline prior to collecting the sample, and failed to ensure the culture collection sticks remained sterile during the collection. Employee J's non-sterile gloves touched the top of the collection sticks.</p>	N 470	N0470 The Home Health Director and DON has in-serviced nursing staff to the policies and procedures,(1) "Skin Care: Wound Culture – Swab Technique," specifically addressing the procedure to place the culture swab in appropriate container immediately, making sure not to touch swab tip or inner surface of collector container. (2A) "Infection Control: Sterile Technique," specifically addressing the placement of sterile items on a sterile surface. This may include sterile tray or cloth (may be paper). The inside of the sterile package can be used as the sterile surface, if it has not touched a non-sterile item. (2B) "Infusion Therapy: Venous Catheter Transparent Semi-permeable Adhesive Dressing Change," specifically addressing to don non-sterile gloves and mask prior to	03/22/2015	

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	<p>On 2/19/15 at 9:30 AM, surveyor informed employees A, B, C, and D of home visit 4 observation findings. No responses were received concerning this finding.</p> <p>2. During home visit observation with patient #5 on 2/19/15 at 8:30 AM, employee H, a registered nurse, was observed performing a peripherally inserted central catheter (PICC) dressing change. Employee H failed to ensure the sterile field remained sterile, failed to ensure his/her mask was covering his/her nose during the dressing change, failed to ensure biopatch landed on non-contaminated area of sterile field, and failed to change gloves and perform hand washing after removing the old dressing and prior to cleansing the site and applying new dressing.</p> <p>A. Employee H opened the sterile supplies and then placed the packet in the middle of the sterile field, picked up the package and moved it to the edge of the sterile field, leaving approximately 1 inch of the package on the sterile field, then proceeded to push the package further back to approximately .5 inch on the sterile field. Employee H then proceeded to open the biopatch which landed on the sterile field approximately .5-.75 inches</p>		<p>removing gold dressings. Remove gloves. Perform hand hygiene. Open all packages for cleansing of site and place on clean surface. Perform hand hygiene. Don sterile gloves to clean the exit site. 02/24/15</p> <p>All nursing staff will perform a post test on aforementioned in-service of policies and procedures with required 100% nursing staff achieving scores of 100%. 03/13/15 The Home Health Director and/or DON will make home visits with 100% LPN and 50% RN to observe competency with an expected 100% threshold of 100%. 03/22/15</p> <p>The Director of Home Health Care will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>from the sterile supply package, on a contaminated area of the sterile field where the sterile supply package had already been prior to pushing it back.</p> <p>B. Employee H placed mask on face, only covering mouth. Employee H failed to pull the mask up over nose.</p> <p>C. Employee H removed the old dressing from the PICC site and proceeded to clean the site using the same gloves. Employee H failed to remove gloves, perform hand washing, and apply new gloves prior to cleansing the site.</p> <p>D. During interview on 2/19/15 at 9:45 AM, employee C indicated the nurse should have had the mask up over their nose.</p> <p>3. The agency's policy titled "Skin Care; Wound Culture Swab Technique," # Skin Care 7-7, revised January 1, 2002, states "Procedure: ... 5. Thoroughly and gently rinse the wound with sterile normal saline before culturing. ... 7. Place culture swab in appropriate container immediately, making sure not to touch swab tip or inner surface of collection container."</p> <p>4. The agency's policy titled "Infusion</p>			

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N 541 Bldg. 00	<p>Therapy: Peripherally Inserted Central catheter (PICC) Maintenance and Management of Potential Complications," # Infusion Therapy 9-15, revised November, 2002, states "procedure: ... 6. Don sterile gloves and mask. 7. Slowly loosen transparent dressing at the distal end while anchoring catheter with the other hand. ... 9. Remove contaminated gloves and don new sterile gloves."</p> <p>5. The agency's policy titled "Infection Control: Sterile Technique," # 14-4, revised January 1, 2002, states "Procedure: ... 6. Always place sterile items only on a sterile surface. This may include a separate sterile tray or cloth (may be paper). The inside of the sterile package can be used as the sterile surface, if it has not touched a non-sterile item."</p> <p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p>			
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	<p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) measured wounds weekly for 1 of 3 clinical records reviewed of patients with wound care orders, creating the potential to affect all the agency's patients. (#4)</p> <p>Findings include</p> <p>1. Clinical record # 4, start of care (SOC) date 1/21/15, contained a plan of care dated 1/21-3/21/15 with orders for skilled nursing (SN) 2 times a week for 1 week, 2 times a week for 4 weeks, 1-2 times a week for 4 weeks, and 6 as needed visits for catheter, wound, and ileostomy issues. SN to provide wound care on days of visits, family or primary care giver to provide on non-visit days.</p> <p>A. The SOC assessment dated 1/21/15 evidenced three wounds were noted on admission: vertical mid abdomen surgical incision, surgical wound left lower abdomen, and anus surgical incision.</p> <p>B. The SN visit note dated 2/2/15 evidenced the anus wound was not measured. The SN failed to measure the wound per policy.</p> <p>2. During interview on 2/19/15 at 1:15</p>	N 541	<p>N541 The Home Health Director and DON will in-service all registered nurses on the policy and procedure entitled, "Skilled Nursing Services," which specifically outlines the duties of the registered nurses' responsibilities as follows: conducts the initial assessment of the patient's nursing needs, conducts ongoing assessments of the patient's nursing needs, establishes the initial plan of care and revises as necessary, and coordinates the patient's care. 03/10/15</p> <p>The Home Health Director and DON has in-serviced all nursing on the policy and procedure entitled, "Skin Care: Dressing Changes," specifically related to the assessment of wound size including length, width, and depth, which is to be documented by the RN or LPN weekly and PRN. 02/24/15</p> <p>10% of the current average daily census, of which 1/3 will be closed clinical records will be audited quarterly for evidence that</p> <p>1) registered nurses are assessing the patient's nursing needs, providing ongoing assessments of the patient's nursing needs, establishing and revising the plan of care as needed, and coordinating the patient's care; and 2) that the assessment of wound size including length, width, and depth is documented by the RN or LPN weekly and</p>	03/22/2015			

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	<p>PM, employee C indicated open wounds are to be measured on admission and on the first visit of each week.</p> <p>3. The agency's policy titled "Skin Care: Dressing Changes," # 7-9, revised January 1, 2002, states "Procedure: ... 6. Observe for: a. Wound size including length, width, and depth. Document weekly and PRN."</p>		<p>PRN. The Director of Home Health Care will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		