

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157629	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/27/2016
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NAME OF PROVIDER OR SUPPLIER  EPIC HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
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G 0000  Bldg. 00	<p>This revisit was for a Federal recertification / validation survey with survey dates of 4/4/16 - 4/8/16 that was conducted at Epic Health Services, a deemed facility. This was a fully extended survey.</p> <p>Survey dates: 5/26/16 - 5/27/16</p> <p>Facility #: 12050</p> <p>Medicaid Vendor #: 200942280</p> <p>Medicare #: 157629</p> <p>Skilled unduplicated census in the past 12 months: 67 patients</p> <p>Epic Health Services, Inc. is precluded from providing its own home health training and competency evaluation for a period of two years beginning 4/8/16 - 4/8/18 due to being found out of compliance with the Condition 42 CFR 484.14 Organization, Services, and Administration, the Condition of Participation 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision, the Condition, 42 CFR 484.30 Skilled Nursing Services, and the</p>	G 0000		
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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 0121 Bldg. 00	<p>Condition of Participation 484.48 Medical Records.</p> <p>During this survey, 4 condition level and 16 standard level deficiencies were found corrected. 4 standard level deficiencies were recited.</p> <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 home visit observation and interview, the agency failed to ensure staff had provided services in accordance with the agency's infection control policies and procedures in 1 of 1 home visits completed (#16) with a Registered Nurse (DD).</p> <p>The findings include:</p> <p>1. During a home visit observation on 5/27/16 at 10:20 AM, Employee DD, Registered Nurse was observed to complete wound care on patient #16 with</p>	G 0121	Employee observed during the home visit has been re-educated on hand washing and dressing change procedure on 5/27/16. Employee also received disciplinary action due to non-compliance for following infection control procedures policy. All clinical staff will be re-educated on the dressing change procedure via a blast email by the Nursing Director. During monthly home visits all staff will be observed for compliance with infection control protocol. Any continued break in infection control practices by any field staff will be documented as	07/05/2016

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	<p>gloved hands. She removed the patient's dressing and then proceeded to measure the wound and apply Bactroban with a cotton swabbed applicator. She did not change her gloves or wash her hands at this time. She proceeded to apply a new dressing to the wound. This wound was on the patient's left lower back.</p> <p>2. During an interview on 5/27/16 at 10:30 AM, Employee DD indicated gloves should be changed and hands washed after the dressing is removed.</p> <p>3. The agency procedure titled "Application of Dry Dressing" with no date stated, "Remove old dressing. Pull tape toward the dressing. Hold soiled dressing in hands and remove glove to wrap inside out around dressing. Repeat with second glove and discard in disposable bag.... don second pair of gloves."</p> <p>4. The agency procedure titled "Handwashing" with a date of 2002 stated, "Handwashing Purpose to prevent the spread of infection by contaminated hands. To remove soil and transient organisms from the hands and to reduce total microbial counts over time ... The Center for Disease Control recommends routinely washing in the following</p>		<p>adisciplinary measure. Responsible Party: Nursing Director and Nursing Supervisors Completion Date: 07/05/16 Follow Up: TheNursing Director will review all supervisory visit notes for 3 weeks to ensure compliance. Once 100% compliance is met,the Nursing Director will review a random sample of 10 supervisory visits eachmonth ongoing to ensure that compliance is maintained.</p>	

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G 0158  Bldg. 00	<p>situations ... before and after handling dressings or touching open wounds."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on record review and interview, the agency failed to ensure the skilled nurse followed the plan of care for 1 of 5 clinical records reviewed (#14).</p> <p>The findings include:</p> <p>1. Clinical record #14, start of care 12/16/09 and diagnosis of fracture of neck unspecified, included a plan of care for the certification period of 3/14/16 - 5/12/16. This plan of care identified the skilled nurse was to complete wound care on the patient's right upper back with normal saline and clean around the skin with skin prep. The plan of care also stated the following: "SN [skilled nurse] to maintain patient's 6.5 Bivona, cuffed at all times. SN to keep spare trach with client at all times. SN to change every and prn [as needed] dislodgement occlusion." This plan of care failed to evidence how often the trach change would routinely occur and that the skilled nurse did not complete the wound care,</p>	G 0158	<p>All field nurses were educated via email to the agency's Physician Order policy. During all home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by Nursing Director to agency's policies for Physician Order and Care Plan Development and the need to review all orders prior to sending to the physician for accuracy and completeness. During all home visits, the POC will be reviewed with staff nurse/aid to ensure that all orders are being carried out. Any issues identified that need clarification or change will be documented and communicated to physician.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors, QA nurse Completion Date: 07/05/16 Follow Up: The QA nurse will review 50% of each working nurse/aid documentation each week to ensure compliance with POC for the next 4 weeks, then the QA will review 10% of each working nurse/aid</p>	07/05/2016

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	<p>but instead the wound care was completed by the informal caregiver. This is evidenced as follows:</p> <p>A. A skilled nursing flowsheet dated 5/1/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>B. A skilled nursing flowsheet dated 5/2/16 and signed by Employee EE, Registered Nurse, evidenced the patient had a wound on the right posterior chest and had a trach change on 4/29/16. There was no documentation that wound care had been completed.</p> <p>C. A skilled nursing flowsheet dated 5/3/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/2/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>D. A skilled nursing flowsheet dated 5/4/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that</p>		<p>documentation each week ongoing to ensure compliance. During quarterly record review, the NursingDirector will review 10% of census or a minimum of 10 files for compliance withthis requirement. These requirementswill also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%. Any break in policy found will result inre-education with any staff involved; continued non-compliance may result indisciplinary measures.</p>		

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	<p>the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>E. A skilled nursing flowsheet dated 5/5/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>F. A skilled nursing flowsheet dated 5/9/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>G. A skilled nursing flowsheet dated 5/10/16 and signed by Employee FF, Licensed Practical Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. The nurse documented, "Bed bath given ... [informal caregiver] to perform wound dressing tonight. MD [medical doctor] appt [appointment] on 5/9/16."</p>				

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	<p>H. A skilled nursing flowsheet dated 5/12/16 and signed by Employee FF evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>I. A oasis certification assessment dated 5/12/16 and signed by Employee N, Registered Nurse, evidenced the informal caregiver completed the trachestomy change weekly and had last occurred on 5/7/16. This assessment also evidenced the patient had a unhealed pressure ulcer at Stage II. A stage description on the form was marked with a number "1." This stated, "Stage II Partial Thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open / ruptured serum filled blister." There was a measurement of the wound: 2 cm [centimeter] X 1.5 cm.</p> <p>2. During an interview on 5/27/16 at 3:30 PM, the administrator indicated the patient's informal caregiver indicated the informal caregiver was completing the upper back wound care and the skilled nurse did not complete this as stated on the plan of care and the informal caregiver aslo changed the trach cuff routinely and this was not stated on the</p>			

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G 0159  Bldg. 00	<p>plan of care.</p> <p>3. The agency policy titled "Care Plan Development" with a date of 5/2014 stated, "The registered nurse will develop each patient's plan of care in conjunction with the physician, other providers and other team members involved in the care ... the physician's plan of treatment may serve as the care - planning document."</p> <p>4. The agency policy titled "Physicians Orders" with a date of 5/14 stated, "Physician orders must be obtained for services ... by all healthcare personnel as required by state regulation."</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</p>						

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	<p>treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on record review and interview, the agency failed to ensure the plan of care was accurate for 1 of 5 clinical records reviewed (#14).</p> <p>The findings include:</p> <p>1. Clinical record #14, start of care 12/16/09 and diagnosis of fracture of neck unspecified, included a plan of care for the certification period of 3/14/16 - 5/12/16. This plan of care identified the skilled nurse was to complete wound care on the patient's right upper back with normal saline and clean around the skin with skin prep. The plan of care also stated the following: "SN [skilled nurse] to maintain patient's 6.5 Bivona, cuffed at all times. SN to keep spare trach with client at all times. SN to change every and prn [as needed] dislodgement occlusion." This plan of care failed to evidence how often the trach change would routinely occur and that the skilled nurse did not complete the wound care, but instead the wound care was completed by the informal caregiver. This is evidenced as follows:</p>	G 0159	<p>All field nurses were educated via email to the agency's Physician Order policy. During all home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by Nursing Director to agency's policies for Physician Order and Care Plan Development and the need to review all orders prior to sending to the physician for accuracy and completeness. During all home visits, the POC will be reviewed with staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be documented and communicated to physician.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors, QA nurse Completion Date: 07/05/16 Follow Up: The QA nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC for the next 4 weeks, then the QA will review 10% of each working nurse/aide documentation each week ongoing to ensure compliance. During quarterly record review, the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be</p>	07/05/2016

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	<p>A. A skilled nursing flowsheet dated 5/1/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>B. A skilled nursing flowsheet dated 5/2/16 and signed by Employee EE, Registered Nurse, evidenced the patient had a wound on the right posterior chest and had a trach change on 4/29/16. There was no documentation that wound care had been completed.</p> <p>C. A skilled nursing flowsheet dated 5/3/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/2/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>D. A skilled nursing flowsheet dated 5/4/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p>		<p>reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>	

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	<p>E. A skilled nursing flowsheet dated 5/5/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>F. A skilled nursing flowsheet dated 5/9/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>G. A skilled nursing flowsheet dated 5/10/16 and signed by Employee FF, Licensed Practical Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. The nurse documented, "Bed bath given ... [informal caregiver] to perform wound dressing tonight. MD [medical doctor] appt [appointment] on 5/9/16."</p> <p>H. A skilled nursing flowsheet dated 5/12/16 and signed by Employee FF evidenced the date of the last trach change was 5/7/16 and that the patient</p>			

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	<p>had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>I. A oasis certification assessment dated 5/12/16 and signed by Employee N, Registered Nurse, evidenced the informal caregiver completed the trachestomy change weekly and had last occurred on 5/7/16. This assessment also evidenced the patient had a unhealed pressure ulcer at Stage II. A stage description on the form was marked with a number "1." This stated, "Stage II Partial Thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open / ruptured serum filled blister." There was a measurement of the wound: 2 cm [centimeter] X 1.5 cm.</p> <p>2. During an interview on 5/27/16 at 3:30 PM, the administrator indicated the patient's informal caregiver indicated the informal caregiver was completing the upper back wound care and the skilled nurse did not complete this as stated on the plan of care and the informal caregiver aslo changed the trach cuff routinely and this was not stated on the plan of care.</p> <p>3. The agency policy titled "Care Plan Development" with a date of 5/2014</p>			

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G 0170 Bldg. 00	<p>stated, "The registered nurse will develop each patient's plan of care in conjunction with the physician, other providers and other team members involved in the care ... the physician's plan of treatment may serve as the care - planning document."</p> <p>4. The agency policy titled "Physicians Orders" with a date of 5/14 stated, "Physician orders must be obtained for services ... by all healthcare personnel as required by state regulation."</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>Based on record review and interview, the agency failed to ensure the skilled nurse (Employee EE, Registered Nurse and Employee FF, Licensed Practical Nurse) followed the plan of care for 1 of 5 clinical records reviewed (#14).</p> <p>The findings include:</p>	G 0170	All field nurses were educated via email to the agency's Physician Order policy. During all home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by Nursing Director to agency's policies for Physician Order and Care Plan Development and the need to review all orders prior to sending to the physician for accuracy and	07/05/2016

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	<p>1. Clinical record #14, start of care 12/16/09 and diagnosis of fracture of neck unspecified, included a plan of care for the certification period of 3/14/16 - 5/12/16. This plan of care identified the skilled nurse was to complete wound care on the patient's right upper back with normal saline and clean around the skin with skin prep. The plan of care also stated the following: "SN [skilled nurse] to maintain patient's 6.5 Bivona, cuffed at all times. SN to keep spare trach with client at all times. SN to change every and prn [as needed] dislodgement occlusion." This plan of care failed to evidence how often the trach change would routinely occur and that the skilled nurse did not complete the wound care, but instead the wound care was completed by the informal caregiver. This is evidenced as follows:</p> <p>A. A skilled nursing flowsheet dated 5/1/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>B. A skilled nursing flowsheet dated 5/2/16 and signed by Employee EE, Registered Nurse, evidenced the patient</p>		<p>completeness. During all home visits, the POC will be reviewed with staff nurse/aideto ensure that all orders are being carried out. Any issues identified that need clarification or change will be documented and communicated to physician.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors, QA nurse Completion Date: 07/05/16 Follow Up: The QAnurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC for the next 4 weeks, then the QA will review 10% of each working nurse/aide documentation each week ongoing to ensure compliance. During quarterly record review, the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>				

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	<p>had a wound on the right posterior chest and had a trach change on 4/29/16. There was no documentation that wound care had been completed.</p> <p>C. A skilled nursing flowsheet dated 5/3/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/2/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>D. A skilled nursing flowsheet dated 5/4/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>E. A skilled nursing flowsheet dated 5/5/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>F. A skilled nursing flowsheet dated 5/9/16 and signed by Employee EE,</p>						

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	<p>Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>G. A skilled nursing flowsheet dated 5/10/16 and signed by Employee FF, Licensed Practical Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. The nurse documented, "Bed bath given ... [informal caregiver] to perform wound dressing tonight. MD [medical doctor] appt [appointment] on 5/9/16."</p> <p>H. A skilled nursing flowsheet dated 5/12/16 and signed by Employee FF evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>I. A oasis certification assessment dated 5/12/16 and signed by Employee N, Registered Nurse, evidenced the informal caregiver completed the trachostomy change weekly and had last occurred on 5/7/16. This assessment also evidenced the patient had a unhealed pressure ulcer at Stage II. A stage description on the</p>			

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	<p>form was marked with a number "1." This stated, "Stage II Partial Thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open / ruptured serum filled blister." There was a measurement of the wound: 2 cm [centimeter] X 1.5 cm.</p> <p>2. During an interview on 5/27/16 at 3:30 PM, the administrator indicated the patient's informal caregiver indicated the informal caregiver was completing the upper back wound care and the skilled nurse did not complete this as stated on the plan of care and the informal caregiver aslo changed the trach cuff routinely and this was not stated on the plan of care.</p> <p>3. The agency policy titled "Care Plan Development" with a date of 5/2014 stated, "The registered nurse will develop each patient's plan of care in conjunction with the physician, other providers and other team members involved in the care ... the physician's plan of treatment may serve as the care - planning document."</p> <p>4. The agency policy titled "Physicians Orders" with a date of 5/14 stated, "Physician orders must be obtained for services ... by all healthcare personnel as required by state regulation."</p>			

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N 0000  Bldg. 00	<p>This revisit was for a State relicensure survey dates of 4/4/16 - 4/8/16.</p> <p>Survey dates: 5/26/16 - 5/27/16</p> <p>Facility #: 12050</p> <p>Medicaid Vendor #: 200942280</p> <p>Medicare #: 157629</p> <p>Skilled unduplicated census in the past 12 months: 67 patients</p> <p>During this survey, 16 deficiencies were found corrected. 4 deficiencies were recited.</p>	N 0000		

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N 0470  Bldg. 00	<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 home visit observation and interview, the agency failed to ensure staff had provided services in accordance with the agency's infection control policies and procedures in 1 of 1 home visits completed (#16) with a Registered Nurse (DD).</p> <p>The findings include:</p> <p>1. During a home visit observation on 5/27/16 at 10:20 AM, Employee DD, Registered Nurse was observed to complete wound care on patient #16 with gloved hands. She removed the patient's dressing and then proceeded to measure the wound and apply Bactroban with a cotton swabbed applicator. She did not change her gloves or wash her hands at this time. She proceeded to apply a new dressing to the wound. This wound was on the patient's left lower back.</p>			N 0470	<p>Employee observed during the home visit has been re-educated on hand washing and dressing change procedure on 5/27/16. Employee also received disciplinary action due to non-compliance for following infection control procedures policy. All clinical staff will be re-educated on the dressing change procedure via a blast email by the Nursing Director. During monthly home visits all staff will be observed for compliance with infection control protocol. Any continued break in infection control practices by any field staff will be documented as a disciplinary measure. Responsible Party: Nursing Director and Nursing Supervisors Completion Date: 07/05/16 Follow Up: The Nursing Director will review all supervisory visit notes for 3 weeks to ensure compliance. Once 100% compliance is met, the Nursing Director will review a random sample of 10 supervisory visits each month ongoing to ensure that compliance is maintained.</p>		07/05/2016

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N 0522 Bldg. 00	<p>2. During an interview on 5/27/16 at 10:30 AM, Employee DD indicated gloves should be changed and hands washed after the dressing is removed.</p> <p>3. The agency procedure titled "Application of Dry Dressing" with no date stated, "Remove old dressing. Pull tape toward the dressing. Hold soiled dressing in hands and remove glove to wrap inside out around dressing. Repeat with second glove and discard in disposable bag.... don second pair of gloves."</p> <p>4. The agency procedure titled "Handwashing" with a date of 2002 stated, "Handwashing Purpose to prevent the spread of infection by contaminated hands. To remove soil and transient organisms from the hands and to reduce total microbial counts over time ... The Center for Disease Control recommends routinely washing in the following situations ... before and after handling dressings or touching open wounds."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or</p>			

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	<p>podiatrist, as follows: Based on record review and interview, the agency failed to ensure the skilled nurse followed the plan of care for 1 of 5 clinical records reviewed (#14).</p> <p>The findings include:</p> <p>1. Clinical record #14, start of care 12/16/09 and diagnosis of fracture of neck unspecified, included a plan of care for the certification period of 3/14/16 - 5/12/16. This plan of care identified the skilled nurse was to complete wound care on the patient's right upper back with normal saline and clean around the skin with skin prep. The plan of care also stated the following: "SN [skilled nurse] to maintain patient's 6.5 Bivona, cuffed at all times. SN to keep spare trach with client at all times. SN to change every and prn [as needed] dislodgement occlusion." This plan of care failed to evidence how often the trach change would routinely occur and that the skilled nurse did not complete the wound care, but instead the wound care was completed by the informal caregiver. This is evidenced as follows:</p> <p>A. A skilled nursing flowsheet dated 5/1/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that</p>	N 0522	<p>All field nurses were educated via email to the agency's Physician Order policy. During all home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by Nursing Director to agency's policies for Physician Order and Care Plan Development and the need to review all orders prior to sending to the physician for accuracy and completeness. During all home visits, the POC will be reviewed with staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be documented and communicated to physician.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors, QA nurse Completion Date: 07/05/16 Follow Up: The QA nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC for the next 4 weeks, then the QA will review 10% of each working nurse/aide documentation each week ongoing to ensure compliance. During quarterly record review, the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%.</p>	07/05/2016	

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	<p>the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>B. A skilled nursing flowsheet dated 5/2/16 and signed by Employee EE, Registered Nurse, evidenced the patient had a wound on the right posterior chest and had a trach change on 4/29/16. There was no documentation that wound care had been completed.</p> <p>C. A skilled nursing flowsheet dated 5/3/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/2/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>D. A skilled nursing flowsheet dated 5/4/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>E. A skilled nursing flowsheet dated 5/5/16 and signed by Employee EE, Registered Nurse, evidenced the date of</p>		Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.	

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	<p>the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>F. A skilled nursing flowsheet dated 5/9/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>G. A skilled nursing flowsheet dated 5/10/16 and signed by Employee FF, Licensed Practical Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. The nurse documented, "Bed bath given ... [informal caregiver] to perform wound dressing tonight. MD [medical doctor] appt [appointment] on 5/9/16."</p> <p>H. A skilled nursing flowsheet dated 5/12/16 and signed by Employee FF evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p>			

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	<p>I. A oasis certification assessment dated 5/12/16 and signed by Employee N, Registered Nurse, evidenced the informal caregiver completed the trachestomy change weekly and had last occurred on 5/7/16. This assessment also evidenced the patient had a unhealed pressure ulcer at Stage II. A stage description on the form was marked with a number "1." This stated, "Stage II Partial Thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open / ruptured serum filled blister." There was a measurement of the wound: 2 cm [centimeter] X 1.5 cm.</p> <p>2. During an interview on 5/27/16 at 3:30 PM, the administrator indicated the patient's informal caregiver indicated the informal caregiver was completing the upper back wound care and the skilled nurse did not complete this as stated on the plan of care and the informal caregiver aslo changed the trach cuff routinely and this was not stated on the plan of care.</p> <p>3. The agency policy titled "Care Plan Development" with a date of 5/2014 stated, "The registered nurse will develop each patient's plan of care in conjunction with the physician, other providers and other team members involved in the care</p>			

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N 0524 Bldg. 00	<p>... the physician's plan of treatment may serve as the care - planning document."</p> <p>4. The agency policy titled "Physicians Orders" with a date of 5/14 stated, "Physician orders must be obtained for services ... by all healthcare personnel as required by state regulation."</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:</p> <p>(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:</p> <p>(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.</p>			

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	<p>Based on record review and interview, the agency failed to ensure the plan of care was accurate for 1 of 5 clinical records reviewed (#14).</p> <p>The findings include:</p> <p>1. Clinical record #14, start of care 12/16/09 and diagnosis of fracture of neck unspecified, included a plan of care for the certification period of 3/14/16 - 5/12/16. This plan of care identified the skilled nurse was to complete wound care on the patient's right upper back with normal saline and clean around the skin with skin prep. The plan of care also stated the following: "SN [skilled nurse] to maintain patient's 6.5 Bivona, cuffed at all times. SN to keep spare trach with client at all times. SN to change every and prn [as needed] dislodgement occlusion." This plan of care failed to evidence how often the trach change would routinely occur and that the skilled nurse did not complete the wound care, but instead the wound care was completed by the informal caregiver. This is evidenced as follows:</p> <p>A. A skilled nursing flowsheet dated 5/1/16 and signed by Employee EE, Registered Nurse, evidenced the date of</p>	N 0524	<p>All field nurses were educated via email to the agency's Physician Order policy. During all home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by Nursing Director to agency's policies for Physician Order and Care Plan Development and the need to review all orders prior to sending to the physician for accuracy and completeness. During all home visits, the POC will be reviewed with staff nurse/aide to ensure that all orders are being carried out. Any issues identified that need clarification or change will be documented and communicated to physician.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors, QA nurse Completion Date: 07/05/16 Follow Up: The QA nurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC for the next 4 weeks, then the QA will review 10% of each working nurse/aide documentation each week ongoing to ensure compliance. During quarterly record review, the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%. Any break in policy found will result</p>	07/05/2016			

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	<p>the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>B. A skilled nursing flowsheet dated 5/2/16 and signed by Employee EE, Registered Nurse, evidenced the patient had a wound on the right posterior chest and had a trach change on 4/29/16. There was no documentation that wound care had been completed.</p> <p>C. A skilled nursing flowsheet dated 5/3/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/2/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>D. A skilled nursing flowsheet dated 5/4/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>E. A skilled nursing flowsheet dated 5/5/16 and signed by Employee EE,</p>		<p>inre-education with any staff involved; continued non-compliance may result indisciplinatory measures.</p>	

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NAME OF PROVIDER OR SUPPLIER  EPIC HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3206 CASCADE DR STE A VALPARAISO, IN 46383
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	<p>Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>F. A skilled nursing flowsheet dated 5/9/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>G. A skilled nursing flowsheet dated 5/10/16 and signed by Employee FF, Licensed Practical Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. The nurse documented, "Bed bath given ... [informal caregiver] to perform wound dressing tonight. MD [medical doctor] appt [appointment] on 5/9/16."</p> <p>H. A skilled nursing flowsheet dated 5/12/16 and signed by Employee FF evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p>			

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	<p>I. A oasis certification assessment dated 5/12/16 and signed by Employee N, Registered Nurse, evidenced the informal caregiver completed the trachestomy change weekly and had last occurred on 5/7/16. This assessment also evidenced the patient had a unhealed pressure ulcer at Stage II. A stage description on the form was marked with a number "1." This stated, "Stage II Partial Thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open / ruptured serum filled blister." There was a measurement of the wound: 2 cm [centimeter] X 1.5 cm.</p> <p>2. During an interview on 5/27/16 at 3:30 PM, the administrator indicated the patient's informal caregiver indicated the informal caregiver was completing the upper back wound care and the skilled nurse did not complete this as stated on the plan of care and the informal caregiver aslo changed the trach cuff routinely and this was not stated on the plan of care.</p> <p>3. The agency policy titled "Care Plan Development" with a date of 5/2014 stated, "The registered nurse will develop each patient's plan of care in conjunction with the physician, other providers and</p>			
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N 0537 Bldg. 00	<p>other team members involved in the care ... the physician's plan of treatment may serve as the care - planning document."</p> <p>4. The agency policy titled "Physicians Orders" with a date of 5/14 stated, "Physician orders must be obtained for services ... by all healthcare personnel as required by state regulation."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:</p> <p>Based on record review and interview, the agency failed to ensure the skilled nurse (Employee EE, Registered Nurse and Employee FF, Licensed Practical Nurse) followed the plan of care for 1 of 5 clinical records reviewed (#14).</p> <p>The findings include:</p> <p>1. Clinical record #14, start of care 12/16/09 and diagnosis of fracture of neck unspecified, included a plan of care for the certification period of 3/14/16 - 5/12/16. This plan of care identified the skilled nurse was to complete wound care on the patient's right upper back with normal saline and clean around the skin</p>	N 0537	<p>All field nurses were educated via email to the agency's Physician Order policy. During all home visits, the staff nurse's documentation will be reviewed to ensure compliance with policy. Nursing Supervisors were re-educated by Nursing Director to agency's policies for Physician Order and Care Plan Development and the need to review all orders prior to sending to the physician for accuracy and completeness. During all home visits, the POC will be reviewed with staff nurse/aid to ensure that all orders are being carried out. Any issues identified that need clarification or change will be documented and communicated to physician.</p> <p>Responsible Party: Nursing Director, Nursing Supervisors, QA nurse</p>	07/05/2016

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	<p>with skin prep. The plan of care also stated the following: "SN [skilled nurse] to maintain patient's 6.5 Bivona, cuffed at all times. SN to keep spare trach with client at all times. SN to change every and prn [as needed] dislodgement occlusion." This plan of care failed to evidence how often the trach change would routinely occur and that the skilled nurse did not complete the wound care, but instead the wound care was completed by the informal caregiver. This is evidenced as follows:</p> <p>A. A skilled nursing flowsheet dated 5/1/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>B. A skilled nursing flowsheet dated 5/2/16 and signed by Employee EE, Registered Nurse, evidenced the patient had a wound on the right posterior chest and had a trach change on 4/29/16. There was no documentation that wound care had been completed.</p> <p>C. A skilled nursing flowsheet dated 5/3/16 and signed by Employee EE, Registered Nurse, evidenced the date of</p>		<p>Completion Date: 07/05/16 Follow Up: The QAnurse will review 50% of each working nurse/aide documentation each week to ensure compliance with POC for the next 4 weeks, then the QA will review 10% of each working nurse/aide documentation each week ongoing to ensure compliance. During quarterly record review, the Nursing Director will review 10% of census or a minimum of 10 files for compliance with this requirement. These requirements will also be reviewed during the corporate compliance quarterly audits. The threshold for these audits is 100%. Any break in policy found will result in re-education with any staff involved; continued non-compliance may result in disciplinary measures.</p>		

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	<p>the last trach change was 4/2/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>D. A skilled nursing flowsheet dated 5/4/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>E. A skilled nursing flowsheet dated 5/5/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 4/3/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>F. A skilled nursing flowsheet dated 5/9/16 and signed by Employee EE, Registered Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>G. A skilled nursing flowsheet dated</p>			

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	<p>5/10/16 and signed by Employee FF, Licensed Practical Nurse, evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. The nurse documented, "Bed bath given ... [informal caregiver] to perform wound dressing tonight. MD [medical doctor] appt [appointment] on 5/9/16."</p> <p>H. A skilled nursing flowsheet dated 5/12/16 and signed by Employee FF evidenced the date of the last trach change was 5/7/16 and that the patient had a wound on the right posterior lateral chest. There was no documentation that wound care had been completed.</p> <p>I. A oasis certification assessment dated 5/12/16 and signed by Employee N, Registered Nurse, evidenced the informal caregiver completed the trachostomy change weekly and had last occurred on 5/7/16. This assessment also evidenced the patient had a unhealed pressure ulcer at Stage II. A stage description on the form was marked with a number "1." This stated, "Stage II Partial Thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open / ruptured serum filled blister." There was a measurement of the wound: 2 cm [centimeter] X 1.5 cm.</p>			

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	<p>2. During an interview on 5/27/16 at 3:30 PM, the administrator indicated the patient's informal caregiver indicated the informal caregiver was completing the upper back wound care and the skilled nurse did not complete this as stated on the plan of care and the informal caregiver aslo changed the trach cuff routinely and this was not stated on the plan of care.</p> <p>3. The agency policy titled "Care Plan Development" with a date of 5/2014 stated, "The registered nurse will develop each patient's plan of care in conjunction with the physician, other providers and other team members involved in the care ... the physician's plan of treatment may serve as the care - planning document."</p> <p>4. The agency policy titled "Physicians Orders" with a date of 5/14 stated, "Physician orders must be obtained for services ... by all healthcare personnel as required by state regulation."</p>			