

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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G000000	<p>This was a Federal home health recertification survey.</p> <p>Survey Dates: 12-2-13, 12-3-13, 12-4-13, and 12-5-13</p> <p>Facility #: 003248</p> <p>Medicaid Vendor #: 200387670</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Sullivan County Community Hospital Home Health is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 12-5-13 due to being found out of compliance with Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration, 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision, and 42 CFR 484.55 Comprehensive Assessment of Patients.</p> <p>The Home Health Director and the hospital Clinical Nursing Director were informed of this preclusion during the exit conference held at this agency on 12-5-13 at 1:30 PM.</p> <p>Current Census:</p>	G000000		

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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	<p>34 skilled patients 0 home health aide only patients 0 personal services patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 12, 2013</p>			

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G000110	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of the agency's policy regarding advance directives in 12 (#s 1 through 12) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical records numbered 1 through 12 failed to evidence the agency had provided the patients with information concerning the agency's own policies regarding advance directives. 2. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when 	G000110	G-0110 The "Patient Information Guide" was reviewed and does contain the HHA's policy on Advanced Directives. The guide also includes the ISDH's "Advance Directives: Your Right To Decide". Upon admission the guide is reviewed with the patient and/or legal representative and acknowledgement of such is documented by signature on the Admission Agreement/Consent For Care Form. This form has been revised by the HHA Administrator to reflect receipt of the Patient Information Guide by the patient/legal representative. The Administrator will inservice the clinical staff on the form change. The Administrator will be responsible for monitor the acknowledgement of receipt of Advance Directive information through the initial chart audit process. Documentation Attached	12/20/2013

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	<p>asked on 12-5-13 at 11:15 AM.</p> <p>3. The agency's April 2002 "Advance Directive" policy number 900.95 states, "The agency will provide each adult individual, during the initial visit, written information describing the individual's rights under state statutes and court decisions to accept or refuse medical or surgical treatment and to formulate advance directives. The information will also include the agency's policies regarding the right to make health care decisions, including the right to accept or refuse treatment and formulate advance directives . . . The agency does not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. Nor will the agency discriminate against a patient based on the specific content of an advance directive."</p>				

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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 and agency policy and document review and interview the agency failed to ensure its staff provided care in accordance with the agency's infection control policies and procedures in 4 (patients # 1, 2, 5, and 9) of 6 home visit observations completed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The agency's May 2005 "Surveillance, Prevention, and Control of Infection" policy number 900.105 states, "Standard Precautions will be observed routinely regarding all patients, procedures and equipment when there is a potential for exposure to blood and other body fluids." The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean hands from environmental surfaces and 	G000121	<p>G-0121 A- The Infection Control Preventist/Employee Health Nurse will inservice all clinical staff 12/19/13 on the CDC's Standard Precautions measures and Hand Hygiene. This inservice is mandatory for all clinical staff.B- All agency staff will also be inserviced on Infection Control Prevention Measures through Healthstream's "Infection Control" education module with competency testing completed. The Healthstream module will be assigned by the Administrator for completion by 12/23/13 and will occur annually thereafter.The HHA adopted hospital Infection Control Policies # 245.39 and #245.175. C- The Administrator revised policy 900.105 to reflect appropriate equipment cleaning measures. The policy originally stated only "visibly soiled" instruments/equipment were to be disinfected prior to being returned to the bag. This policy now states "All instruments and/or equipment" are to be cleaned prior to being returned to the bag.The Administrator will inservice clinical staff on the revisions to policy 900.105 and proper equipment cleaning and bag technique at the Monday</p>	12/23/2013

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	<p>transmission of pathogens from contaminated hands to surfaces . . . Perform hand hygiene: IV.A.3.a. Before having direct contact with patients. IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings. IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient). IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p> <p>3. A home visit was made to patient</p>		<p>Morning Staff Meeting 12/23/13. The Administrator will ensure compliance with Standard Precautions and Infection Control Prevention through quarterly supervisory visits per clinician with the first visits being conducted in January 2014.</p>		

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	<p>number 1 on 12-4-13 at 1:30 PM with employee B, a registered nurse (RN). The employee was observed to place her stethoscope, blood pressure cuff and pulse oximeter on the patient's bed. After using the equipment on the patient, the RN replaced it in her bag without cleaning it. The RN assessed the patient and failed to cleanse her hands after removing her gloves after completing the assessment. The RN failed to cleanse her hands after removing her gloves during the dressing change to the patient's abdomen. The employee was observed to place the wound vacuum tubing connector on the patient's bed and not on a clean field. The employee was not observed to cleanse her hands after leaving the patient's room and entering another room to obtain more supplies.</p> <p>4. A home visit was made to patient number 2 on 12-2-13 at 1:20 PM with employee E, a RN. The RN was observed to perform a clean dressing change to the patient's right knee incision. The RN washed her hands, donned clean gloves, then retrieved the supplies for the dressing change from a supply in the patient's home. The RN removed the old dressing, removed her gloves and washed her hands. The RN took the patient's temperature and a pulse oximetry reading. The RN replaced the thermometer and</p>			

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	<p>pulse oximeter into her nursing bag without cleaning them. The RN took the patient's blood pressure and then placed the stethoscope around her neck. She replaced the blood pressure cuff into her nursing bag without cleaning it. The RN removed the stethoscope from around her neck and listened to the patient's lungs and checked for bowel sounds. The RN then replaced the stethoscope back into her nursing bag without cleaning it.</p> <p>The RN washed her hands and donned clean gloves and cleansed the incision with a Hibiclens soaked gauze. The RN removed her gloves and, without cleansing her hands, retrieved more supplies from her nursing bag. The RN then donned clean gloves and cut the Xeroform dressing to size using scissors. The RN replaced the scissors into her bag without cleaning them. The RN then changed her gloves without cleansing her hands and completed the dressing change.</p> <p>5. A home visit was made to patient number 5 on 12-3-13 at 1:05 PM with the occupational therapist (OT), employee D. The OT took the patient's blood pressure and replaced the cuff into her bag without cleaning it. The OT replaced the stethoscope and only the cleaned the bell of the stethoscope and failed to clean the tubing portion.</p>						

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	<p>The OT took the patient's temperature using a thermometer with a disposable plastic sheath. Without wearing gloves, the OT removed the thermometer from the patient's mouth, removed the sheath, and disposed of it. The OT failed to cleanse her hands after removing the thermometer and the protective sheath. The OT replaced the thermometer into her bag without cleaning it.</p> <p>6. A home visit was made to patient number 9 on 12-4-13 at 10:30 AM with employee F, a home health aide. The aide was observed to provide a bath to the patient. The aide assisted the patient to ambulate a few steps from the wheelchair to sit on the toilet with the lid closed. The aide took the patient's temperature and blood pressure. The patient's temperature was 99 degrees and the patient stated, "I have had diarrhea this morning." The aide replaced the thermometer and blood pressure cuff into her bag without cleaning it.</p> <p>The aide washed her hands, donned clean gloves, and washed the patient's upper body. The aide removed the patient's shoes and socks, assisted the patient to stand, and removed the patient's pants and a soiled Depends. The aide changed her gloves without cleansing her</p>			

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	<p>hands. The aide completed the bath and assisted the patient back to the wheelchair.</p> <p>7. The home visit observations were presented to the Home Care Director, employee H on 12-5-13 at 11:15 AM. The director indicated the employees had not followed the agency's infection control policies and procedures.</p>				

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G000122	<p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION</p> <p>Based on personnel file and agency policy review and interview, it was determined the agency failed to maintain compliance with condition by failing to ensure annual performance evaluations had been completed at least annually in 3 of 5 employee files reviewed of individuals employed for greater than 1 year and failing to ensure home health aides received at least 12 hours of inservice training in 1 of 1 home health aide file reviewed of aides employed for all of 2012 creating the potential to affect all of the agency's 34 current patients (See G 134); failing to ensure the individual authorized to act in the absence of the administrator was qualified creating the potential to affect all of the agency's 34 current patients (See G 137); failing to ensure the individual authorized to act in the absence of the supervising nurse was qualified creating the potential to affect all of the agency's 34 current patients (See G 139); failing to ensure it's policies for an annual tuberculosis (TB) Mantoux skin test or screening was followed in 1 of 5 personnel files reviewed of individuals that had been employed by the agency for greater than 1 year creating the potential to affect all of the agency's 34 current patients (See G 141); failing to ensure it</p>	G000122	<p>G-0122 Annual Performance Evaluation Hospital HR policy sets forth the requirement for annual staff performance evaluations. Personnel File B: The employee originally employed PRN on 2/17/11. She had a 90 day evaluation completed in 5/11. Employee then left the HHA and transferred to another department on 9/26/11 and thus no longer with the HHA for an annual evaluation. On 3/11/13 employee again began PRN status in Home Health and became full time on 11/25/13. Employee will have a 90 day eval completed in 2/14 and an annual performance evaluation completed in 11/14 and annually thereafter. (Documentation Attached) Personnel File D: The employee is an OT and had an annual evaluation completed by the Rehab Services Director in 1/13. The HHA Administrator will immediately complete a performance evaluation and the employee will have an annual evaluation completed in 12/14 and annually thereafter. (Documentation Attached) Personnel File G: The employee has had a performance evaluation completed annually with the last evaluation completed in 3/13. The employee will have an evaluation completed in 3/14</p>	12/30/2013

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	had maintained communication with other service providers in 2 of 2 records reviewed of patients that received services from other care providers and failed to ensure coordination of care among disciplines had occurred in 1 of 1 record reviewed of patients that received services from more than 1 discipline and had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients (See G 143); failing to ensure clinical records or minutes of case conferences established that the agency had maintained communication with other service providers in 2 of 2 records reviewed of patients that received services from other care providers and failing to ensure the records identified coordination of care among disciplines had occurred in 1 of 1 record reviewed of patients that received services from more than 1 discipline and had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients (See G 144); and failing to ensure written summary reports had been sent to the physician at least every sixty (60) days in 2 of 3 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients (See G 145).		and continue annually thereafter. (Documentation Attached)Home Health Aide Education RequirementsHome Health Policy #900.39 indicates the the Home Health Aide's requirement for a minimum 12 hours of inservice education per year. Personnel File A: Employee had 14 hours of continuing education in 2012. (Documentation Attached). The HHA Administrator will be responsible for completing annual performance evaluations for all HHA staff. Human Resource Director/Designee will inform HHA Administrator when evaluations are due.HHA Administrator is responsible for ensuring each aide has the minimum education requirements annually.Authorized Individual:The HHA informed ISDH of Administrative changes by mail on 10/30/13. On 11/20/13, the Hospital CNO contacted a "Bobbie" at the ISDH to inquire about receipt of changes. Was informed she would have "Samantha" call back the next day. On 11/21/13 "Samantha" from the ISDH returned call. Samantha informed CNO that letter dated 11/13/13 had been mailed to HHA informing need for additional info for Alternate Designee. Samantha emailed copy of letter to CNO. CNO emailed Samantha updated resume for designee on 11/26/13. HHA Administrator received letter dated 12/5/13 from		

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	The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this Condition of Participation 42 CFR 484.14 Organization, Services, and Administration.		the ISDH informing that Alternate could not qualify and requests a new designee be submitted. On 12/11/13 a new application for Alternate designee was submitted and a letter dated 12/12/13 approving new designee was received by HHA Administrator. (Documentation Attached).The HHA Administrator/Alternate will ensure the continued presence of authorized individuals approved by the ISDH. Annual TB Testing Hospital Employee Health Policy #250.05/245.143 indicates the need for annual TB testing during the employees anniversary month. Personnel File A: Employee's last TB test completed prior to anniversary month causing a miscalculation for next test. Employee has completed TB test in 12/13 and will do so annually thereafter. (Documentation Attached)The Employee Health Nurse is responsible for ensuring annual employee health requirements are met. The EH Nurse will monitor compliance. Coordination of Care Home Health Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy	

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			#900.101 has been revised to indicate coordination of care among disciplines and providers. (Documentation Attached)The HHA Administrator is responsible for ensuring Case Conferences are held according to policy. The presence of Care Plan Update Forms will be monitored through the chart audit process.Written Summary of CarePolicy #900.77 addresses the Written Summary of Care guidelines. This policy and appropriate documentation guidelines will be reviewed by the Administrator with clinical staff during Monday Morning Staff Meeting. The Administrator will ensure clinical staff knowledge of appropriate entry of summary in the patient EHR.The HHA Administrator will monitor continued compliance through the chart audit process.	

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G000134	<p>484.14(c) ADMINISTRATOR</p> <p>The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. Based on personnel file and agency policy review and interview, the administrator failed to ensure annual performance evaluations had been completed at least annually in 3 (files B, D, and G) of 5 employee files reviewed of individuals employed for greater than 1 year and failed to ensure home health aides received at least 12 hours of inservice training in 1 (file A) of 1 home health aide file reviewed of aides employed for all of 2012 creating the potential to affect all of the agency's 34 current patients.</p> <p>Regarding annual performance evaluations:</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file B evidenced the individual had been hired on 2-17-11 to provide skilled nursing services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 5-14-11. 2. Personnel file D evidenced the individual had been hired on 5-31-02 to 	G000134	<p>G-0134 Annual Performance Evaluation Hospital HR policy sets forth the requirement for annual staff performance evaluations. Personnel File B: The employee originally employed PRN on 2/17/11. She had a 90 day evaluation. Employee then left the HHA and transferred to another department on 9/26/11 and thus no longer with the HHA for an annual evaluation. On 3/11/13 employee again began PRN status in Home Health and became full time on 11/25/13. Employee will have a 90 day eval completed in 2/14 and an annual performance evaluation completed in 11/14 and annually thereafter. (Documentation Attached) Personnel File D: The employee is an OT and had an annual evaluation completed by the Rehab Services Director in 1/13. The HHA Administrator will immediately complete a performance evaluation and the employee will have an annual evaluation completed in 12/14 and annually thereafter. (Documentation Attached) Personnel File G: The employee has had a performance evaluation completed annually</p>	12/17/2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
(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			
	<p>provide occupational therapy services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 4-15-11.</p> <p>3. Personnel file G evidenced the individual had been hired on 3-19-07 to provide physical therapy assistant services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 3-27-12.</p> <p>4. The Home Care Director, employee H, indicated, on 12-5-13 at 2 PM, the personnel files were not up-to-date.</p> <p>5. The agency's April 2002 "Personnel Files" policy states, "Files contain complete information as listed on the Personnel File Checklist Form. Files are kept current by entering relevant employment information as listed on the checklist. Notification is sent to staff members by the Director, or designee, as current data is required - such as CPR Certification, license renewal."</p> <p>Regarding home health aide inservice training:</p> <p>The findings include:</p> <p>1. Personnel file A evidenced the</p>		<p>with the last evaluation completed in 3/13. The employee will have an evaluation completed in 3/14 and continue annually thereafter. (Documentation Attached)Home Health Aide Education RequirementsHome Health Policy #900.39 indicates the the Home Health Aide's requirement for a minimum 12 hours of inservice education per year. Personnel File A: Employee had 14 hours of continuing education in 2012. (Documentation Attached). The HHA Administrator will be responsible for completing annual performance evaluations for all HHA staff. Human Resource Director/Designee will inform HHA Administrator when evaluations are due.HHA Administrator is responsible for ensuring each aide has the minimum education requirements annually.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>individual had been hired on 12-8-08 to provide aide services on behalf of the agency. The file failed to evidence the individual had completed 12 hours of in-service training in 2012.</p> <p>2. The agency's April 2002 "Education and Staff Development" policy number 900.39 states, "Certified home health aides are required to attend a minimum of 12 hours of inservice education per year."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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G000137	<p>484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator. Based on administrative record and personnel file review and interview, the agency failed to ensure the individual authorized to act in the absence of the administrator was qualified creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records identified employee E had been authorized to act in the absence of the agency's administrator. 2. Personnel file E identified the individual is a registered nurse. The file failed to evidence the individual possessed any supervisory or administrative experience. 3. A letter to the agency from the Indiana State Department of Health dated 11-13-13 identified the agency had been informed employee E did not meet the qualifications for alternate administrator. 3. Employee E indicated, on 12-5-13 at 11:10 AM, her supervisory experience consisted of having been a unit charge nurse at a local hospital and case 	G000137	G-0137Authorized Individual:The HHA informed ISDH of Administrative changes by mail on 10/30/13. On 11/20/13, the Hospital CNO contacted a "Bobbie" at the ISDH to inquire about receipt of changes. Was informed she would have "Samantha" call back the next day. On 11/21/13 "Samantha" from the ISDH returned call. Samantha informed CNO that letter dated 11/13/13 had been mailed to HHA informing need for additional info for Alternate Designee. Samantha emailed copy of letter to CNO. CNO emailed Samantha updated resume for designee on 11/26/13. HHA Administrator received letter dated 12/5/13 from the ISDH informing that Alternate could not qualify and requests a new designee be submitted. On 12/11/13 a new application for Alternate designee was submitted and a letter dated 12/12/13 approving new designee was received by HHA Administrator. (Documentation Attached).The HHA Administrator/Alternate will ensure the continued presence of authorized individuals approved by the ISDH.	12/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	management of home health clients.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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G000139	<p>484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE</p> <p>Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse).</p> <p>This person, or similarly qualified alternate, is available at all times during operating hours.</p> <p>Based on administrative record and personnel file review and interview, the agency failed to ensure the individual authorized to act in the absence of the supervising nurse was qualified creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records identified employee E had been authorized to act in the absence of the agency's supervising nurse. 2. Personnel file E identified the individual is a registered nurse. The file failed to evidence the individual possessed any supervisory or administrative experience. 3. A letter to the agency from the Indiana State Department of Health dated 11-13-13 identifies the agency had been 	G000139	G-0139Authorized Individual:The HHA informed ISDH of Administrative changes by mail on 10/30/13. On 11/20/13, the Hospital CNO contacted a "Bobbie" at the ISDH to inquire about receipt of changes. Was informed she would have "Samantha" call back the next day. On 11/21/13 "Samantha" from the ISDH returned call. Samantha informed CNO that letter dated 11/13/13 had been mailed to HHA informing need for alternate Designee. Samantha emailed copy of letter to CNO. CNO emailed Samantha updated resume for designee on 11/26/13. HHA Administrator received letter dated 12/5/13 from the ISDH informing that Alternate could not qualify and requests a new designee be submitted. On 12/11/13 a new application for Alternate designee was submitted and a letter dated 12/12/13 approving new designee was received by HHA Administrator. (Documentation Attached).The	12/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>informed employee E did not meet the qualifications for alternate supervising nurse.</p> <p>4. Employee E indicated, on 12-5-13 at 11:10 AM, her supervisory experience consisted of having been a unit charge nurse at a local hospital and case management of home health clients.</p>		HHA Administrator/Alternate will ensure the continued presence of authorized individuals approved by the ISDH.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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G000141	<p>484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies.</p> <p>Personnel records include qualifications and licensure that are kept current. Based on personnel file and agency policy review and interview, the agency failed to ensure it's policies for an annual tuberculosis (TB) Mantoux skin test or screening was followed in 1 (file A) of 5 personnel files reviewed of individuals that had been employed by the agency for greater than 1 year creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The agency's April 2002 "Personnel Files" policy number 250.05/245.143 states, "Each year during the employee's anniversary month, the employee must complete annual medical screening. 1. Request for annual screening shall be forwarded to the employee who is responsible for completing annual employee health requirements. 1.1 Tuberculin skin test of TB Health Screening form." Personnel file A evidenced the individual had been hired on 12-8-08 to 	G000141	<p>G-0141Annual TB TestingHospital Employee Health Policy #250.05/245.143 indicates the need for annual TB testing during the employees anniversaty month. Personnel File A: Employee's last TB test completed prior to anniversary month causing a miscalculation for next test. Employee has completed TB test in 12/13 and will do so annually thereafter. (Documentation Attached)The Employee Health Nurse is responsible for ensuring annual employee health requirements are met. The EH Nurse will monitor compliance.</p>	12/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>provide home health aide services on behalf of the agency. The file failed to evidence a TB skin test or screening had been completed since 9-24-12.</p> <p>3. The Home Care Director, employee K, indicated, on 12-5-13 at 2 PM, she was aware the individual had not had a TB test for over 1 year.</p>						

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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G000143	<p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure it had maintained communication with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received services from other care providers and failed to ensure coordination of care among disciplines had occurred in 1 (# 9) of 1 record reviewed of patients that received services from more than 1 discipline and had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a start of care comprehensive assessment dated 11-18-13 that states, "SUPPORTIVE ASSISTANCE Names of Organizations Providing Assistance: Choice [a payer source] HMK [homemaker]."</p> <p>A. During a home visit to patient number 5, on 12-3-13 at 1:05 PM, the patient indicated another home health agency provided assistance with bathing,</p>	G000143	G-0143Coordination of Care: Case Conferences had been held per policy but documentation was maintained in a Case Conference Log with no formal documentation in the patient chart. Home Health Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy #900.101 has been revised to indicate coordination of care among disciplines and providers. The "Care Plan Update Note" will be filed in the patients chart. (Documentation Attached)The HHA Administrator is responsible for ensuring Case Conferences are held according to policy. The presence of Care Plan Update Forms will be monitored by the Administrator through the chart audit process.	12/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
(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	
	<p>dressing, meal preparation, and housekeeping. The patient indicated staff from the other home health agency "soak my feet every day in vinegar and then apply triple antibiotic ointment."</p> <p>B. The clinical record failed to evidence any communication and/or coordination with the other home health agency providing services to the patient.</p> <p>2. Clinical record number 9 included a recertification comprehensive assessment dated 8-28-13 that identifies the patient had a "R upper chest dialysis cath site" and listed "renal failure [with] dialysis." The record also included a resumption of care comprehensive assessment dated 8-16-13 that identified the patient "has renal failure on dialysis."</p> <p>A. During a home visit to patient number 9, on 12-4-13 at 10:30 AM, the patient indicated dialysis treatment were provided 3 times per week for 4 hours each treatment.</p> <p>B. The clinical record failed to evidence any communication and/or coordination with the dialysis facility that provided the patient's incenter hemodialysis treatments.</p> <p>C. The record evidenced SN, home</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
(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	
	<p>health aide, and physical and occupational therapy had been provided to the patient during the certification periods 7-1-13 to 8-29-13, 8-30-13 to 10-28-13, and 10-29-13 to 12-27-13. The record failed to evidence planned case conferences had been held at least every 60 days per the agency's own policy.</p> <p>3. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>4. The agency's April 2002 "Coordination of Services/Case Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis. The coordination may be achieved by phone calls of on site conferences and should be documented in the patient's record. All services will be listed on the patient's plan of care (CMS 485)."</p> <p>The policy identifies the purpose of the policy was to "provide guidelines for coordination of multidisciplinary services to patients" The policy states, "Essential components of service coordination/case management include the following: . . . Communicating in planned and spontaneous case conferences to evaluate progress and consider revision to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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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
	interventions and goals to meet changing needs. Planned case conferences will be held at least every 60 days for care planning and evaluation."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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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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G000144	<p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record and agency policy review and interview, the agency failed to ensure clinical records or minutes of case conferences established that the agency had maintained communication with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received services from other care providers and failed to ensure the records identified coordination of care among disciplines had occurred in 1 (# 9) of 1 record reviewed of patients that received services from more than 1 discipline and had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a start of care comprehensive assessment dated 11-18-13 that states, "SUPPORTIVE ASSISTANCE Names of Organizations Providing Assistance: Choice [a payer source] HMK [homemaker]."</p> <p>A. During a home visit to patient</p>	G000144	G-0144Coordination of CareHome Health Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy #900.101 has been revised to indicate coordination of care among disciplines and providers. The "Care Plan Update Note" will be filed in the patients chart. (Documentation Attached)The HHA Administrator is responsible for ensuring Case Conferences are held according to policy. The presence of Care Plan Update Forms will be monitored by the Administrator through the chart audit process.	12/23/2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>number 5, on 12-3-13 at 1:05 PM, the patient indicated another home health agency provided assistance with bathing, dressing, meal preparation, and housekeeping. The patient indicated staff from the other home health agency "soak my feet every day in vinegar and then apply triple antibiotic ointment."</p> <p>B. The clinical record failed to evidence any communication and/or coordination with the other home health agency providing services to the patient.</p> <p>2. Clinical record number 9 included a recertification comprehensive assessment dated 8-28-13 that identifies the patient had a "R upper chest dialysis cath site" and listed "renal failure [with] dialysis." The record also included a resumption of care comprehensive assessment dated 8-16-13 that identified the patient "has renal failure on dialysis."</p> <p>A. During a home visit to patient number 9, on 12-4-13 at 10:30 AM, the patient indicated dialysis treatment were provided 3 times per week for 4 hours each treatment.</p> <p>B. The clinical record failed to evidence any communication and/or coordination with the dialysis facility that provided the patient's incenter</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>hemodialysis treatments.</p> <p>C. The record evidenced SN, home health aide, and physical and occupational therapy had been provided to the patient during the certification periods 7-1-13 to 8-29-13, 8-30-13 to 10-28-13, and 10-29-13 to 12-27-13. The record failed to evidence planned case conferences had been held at least every 60 days per the agency's own policy.</p> <p>3. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>4. The agency's April 2002 "Coordination of Services/Case Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis. The coordination may be achieved by phone calls of on site conferences and should be documented in the patient's record. All services will be listed on the patient's plan of care (CMS 485)."</p> <p>The policy identifies the purpose of the policy was to "provide guidelines for coordination of multidisciplinary services to patients" The policy states, "Essential components of service coordination/case management include the following: . . .</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	Communicating in planned and spontaneous case conferences to evaluate progress and consider revision to interventions and goals to meet changing needs. Planned case conferences will be held at least every 60 days for care planning and evaluation."			

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G000145	<p>484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>Based on clinical record review and interview, the agency failed to ensure written summary reports had been sent to the physician at least every sixty (60) days in 2 (#s 10 and 12) of 3 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 10, start of care 9-5-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced skilled nursing (SN) services had been provided 1 to 2 times per week during the certification period 9-5-13 to 11-3-13 and every other week during the certification period 11-4-13 to 1-2-13. 2. Clinical record number 12, start of care 8-12-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced 	G000145	G-0145Written Summary of CarePolicy #900.77 addresses the Written Summary of Care guidelines. This policy and appropriate documentation guidelines will be reviewed by the Administrator with clinical staff during Monday Morning Staff Meeting. Clinical Records #10 and #12 have updated summaries which have been sent to the appropriate physicians. The Administrator will ensure clinical staff knowledge of appropriate entry of summary in the patient EHR. The HHA Administrator will monitor continued compliance through the chart audit process.	12/23/2013	

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	<p>SN had been provided 1 to 2 times per week during the certification periods 8-12-13 to 10-10-13 and 10-11-13 to 12-9-13.</p> <p>3. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p>				

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G000156	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure services and procedures had been provided as ordered by the physician in 3 of 12 records reviewed creating the potential to affect all of the agency's 34 current patients (See G 158); by failing to ensure plans of care included all services required and all medications in 2 of 12 records reviewed creating the potential to affect all of the agency's 34 current patients (See G 159); and by failing to ensure orders for therapy services included the specific procedures and duration of services in 2 of 7 records reviewed of patients that received therapy services from the agency creating the potential to affect all the agency's 10 current patients that receive therapy services from the agency (See G 161).</p> <p>The cumulative effect of these systemic problems resulted in the agency's inability to be in compliance with this Condition of Participation 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.</p>	G000156	<p>G-0156Acceptance of Patients, POC and Medication SupervisionPolicy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. The HHA Administrator will review the policy with all clinical staff and ensure compliance with the POC through the chart audit process.G-0159Coordination of CareHome Health Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy #900.101 has been revised to indicate coordination of care among disciplines and providers. (Documentation Attached)The HHA Administrator is responsible for ensuring Case Conferences are held according to policy. The presence of Care Plan Update Forms will be monitored by the Administrator through the chart</p>	12/23/2013			

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			audit process. Acceptance of Patients, POC and Medication Supervision:Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. The HHA Administrator will review the policy with all clinical staff and ensure compliance with the POC through the chart audit process.	

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G000158	<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.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure services and procedures had been provided as ordered by the physician in 3 (#s 1, 2, & 8) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 1 included an addendum to the plan of care established by the physician for the certification period 10-12-13 to 12-10-13 dated 11-13-13. The addendum to the plan of care identified a negative pressure wound therapy vacuum dressing change was to be performed 3 times per week and the pressure maintained at 125 mm/Hg (millimeters of mercury) continuously. <p>Skilled nurse (SN) visit notes dated 11-25-13, 11-27-13, and 11-29-13, failed to evidence the nurse had re-applied the wound vacuum at 125 mm/Hg per the physician's order.</p> <ol style="list-style-type: none"> 2. Clinical record number 2 included a 	G000158	<p>Acceptance of Patients, POC and Medication Supervision Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. Discipline visits are tracked weekly for compliance with frequency. Orders are obtained as needed. The HHA Administrator will review the policy and wound care documentation guidelines with all clinical staff and ensure compliance with the POC and appropriate documentation through the chart audit process.</p>	12/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
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	<p>plan of care established by the physician for the certification period 11-23-13 to 1-21-13. The plan of care states, "Keep inc [incision] clean & dry. Cleanse site w [with] /betadine, cover w/xeroform, apply 4 x 4, secure w/foam tape."</p> <p>SN visit notes, dated 11-25-13 and 11-27-13, evidenced the SN used Hibiclens to cleanse the incision. The plan of care failed to include an order for the Hibiclens.</p> <p>3. Clinical record number 8 included a plan of care established by the physician for the certification period 11-11-13 to 01-09-14. The plan of care identified SN visits were to be provided 1 time per week for 2 weeks then every other week and that occupational therapy (OT) visits were to be provided 2 times per week for 1 week then 2 times per week for 4 weeks.</p> <p>A. The record failed to evidence any SN visits had been provided the week of 11-17-13 (week # 2).</p> <p>B. The record evidenced only 1 OT visit had been provided the week of 11-17-13 (week # 2).</p> <p>4. The Home Care Director, employee H, was unable to provide any additional</p>				

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	documentation and/or information when asked on 12-5-13 at 11:15 AM. 5. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."			

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G000159	<p>484.18(a) PLAN OF CARE</p> <p>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> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all services required and all medications in 2 (#s 5 & 9) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a plan of care established by the physician for the certification period 11-18-13 to 01-16-14. The plan of care failed to include home health services being provided to the patient by another home health agency.</p> <p>A. The record included a start of care comprehensive assessment dated 11-18-13 that states, "Names of organizations providing assistance: Choice [payor source] HMK</p>	G000159	G-0159Coordination of CareHome Health Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy #900.101 has been revised to indicate coordination of care among disciplines and providers. (Documentation Attached)The HHA Administrator is responsible for ensuring Case Conferences are held according to policy. The presence of Care Plan Update Forms will be monitored by the Administrator through the chart audit process. Acceptance of Patients, POC and Medication Supervision:Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to	12/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>[homemaker]."</p> <p>B. During a home visit to patient number 5, on 12-3-13 at 1:05 PM, the patient indicated an individual from another home health agency provided total assistance with activities of daily living, such as dressing, bathing, and combing hair, and meal preparation and housekeeping.</p> <p>C. The Home Care Director, employee H, indicated, on 12-3-13 at 2:30 PM, the patient did receive home health aide services from another agency and that the services had not been included on the plan of care.</p> <p>2. Clinical record number 9 included plans of care established by the physician for the certification periods 7-1-13 to 8-29-13, 8-30-13 to 10-28-13, and 10-29-13 to 12-27-13. The plans of care failed to evidence medications being administered to the patient during dialysis treatments 3 times per week.</p> <p>A. The Home Care Director, employee H, indicated, on 12-3-13 at 4 PM, the plans of care did not include medications being administered to the patient during dialysis treatments.</p> <p>B. The Home Care Director obtained</p>		<p>ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. The HHA Administrator will review the policy with all clinical staff and ensure compliance with the POC through the chart audit process.</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>a list of medications from the dialysis facility on 12-3-13 at 3:55 PM. The list identified the patient had been on dialysis since 8-17-13 and that the patient received acetaminophen 650 milligrams (mg) as needed, heparin lock solution 1000 units in each dialysis catheter port every treatment, 7400 units of EPO every treatment 3 times per week, Iron sucrose 50 mg 1 time per week, and Nitroglycerin 0.4 mg sublingual as needed for chest pain.</p> <p>3. The agency's April 2002 "Plan of Care" policy number 900.86 states, "The plan of care covers all pertinent diagnoses, including . . . types of services and equipment required . . . medications and treatments."</p> <p>4. The agency's April 2002 "Coordination of Service/Case Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis . . . All services will be listed on the patient's plan of care (CMS 485)."</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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G000161	<p>484.18(a) PLAN OF CARE Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.</p> <p>Based on clinical record review and interview, the agency failed to ensure orders for therapy services included the specific procedures and duration of services in 2 (#s 9 and 11) of 7 records reviewed of patients that received therapy services from the agency creating the potential to affect all the agency's 10 current patients that receive therapy services from the agency.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 9 included orders for physical therapy services dated 10-31-13. The orders failed to specify how many weeks the therapy services would be provided. 2. Clinical record 11 included orders for speech therapy services dated 11-13-13. The orders failed to include the specific procedures the speech language pathologist planned to use to treat the patient. 3. The Home Care Director, employee H, stated, on 12-5-13 at 11:15 AM, "We have told the therapist not to use a range 	G000161	G-0161Acceptance of Patients, POC and Medication Supervision:Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services, interventions and frequency/durations. The HHA Administrator will review the policy with all clinical and contract staff. Contract physical therapists will be inserviced on appropriate use of frequency/duration. The HHA Administrator will ensure compliance with the POC and appropriate frequencies through the chart audit process.	12/26/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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	for the duration of visits." The Director indicated the orders for the speech therapy did not include the specific procedures to be used.			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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G000168	<p>484.30 SKILLED NURSING SERVICES</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure skilled nursing services and procedures had been provided as ordered by the physician in 3 of 12 records reviewed creating the potential to affect all of the agency's 34 current patients (See G 170); by failing to ensure the registered nurse initiated revisions to the plan of care to address identified nutritional needs in 1 of 12 records reviewed creating the potential to affect all of the agency's 34 current patients (See G 173); and by failing to ensure the registered nurse coordinated with the physician regarding medication changes in 1 of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this Condition of Participation 42 CFR 484.30 Skilled Nursing Services.</p>	G000168	G-0168Acceptance of Patients, POC and Medication SupervisionPolicy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. The HHA Administrator will review the policy with all clinical staff and ensure compliance with the POC through the chart audit process.	12/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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G000170	<p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services and procedures had been provided as ordered by the physician in 3 (#s 1, 2, & 8) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 included an addendum to the plan of care established by the physician for the certification period 10-12-13 to 12-10-13 dated 11-13-13. The addendum to the plan of care identified a negative pressure wound therapy vacuum dressing change was to be performed 3 times per week and the pressure maintained at 125 mm/Hg (millimeters of mercury) continuously. Skilled nurse (SN) visit notes dated 11-25-13, 11-27-13, and 11-29-13, failed to evidence the nurse had re-applied the wound vacuum at 125 mm/Hg per the physician's order. Clinical record number 2 included a plan of care established by the physician for the certification period 11-23-13 to 	G000170	<p>G-0170 Per the HHA Administrator, SN visit notes for Clinical Record #1 dated 11/25/13, 11/27/13, and 11/29/13 were reviewed with the case manager and the need to document the wound vac pressure setting was discussed. Clinical Record #2: The POC and SN visit notes were reviewed by the Administrator with the case manager. The administrator discussed with employee the importance of following the POC and the appropriate process to make addendums/adjustments to the POC through physician contact and orders. Clinical Record # 8: SN visit frequency reviewed by Administrator and noted verbal order dated 11/21/13 for missed SN visit per patient/family request. Additional visit offered and declined by patient/family. (Document Attached). Acceptance of Patients, POC and Medication Supervision Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. Discipline visits are tracked</p>	12/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>1-21-13. The plan of care states, "Keep inc [incision] clean & dry. Cleanse site w [with] /betadine, cover w/xeroform, apply 4 x 4, secure w/foam tape."</p> <p>SN visit notes, dated 11-25-13 and 11-27-13, evidenced the SN used Hibiclens to cleanse the incision. The plan of care failed to include an order for the Hibiclens.</p> <p>3. Clinical record number 8 included a plan of care established by the physician for the certification period 11-11-13 to 01-09-14. The plan of care identified SN visits were to be provided 1 time per week for 2 weeks then every other week and that occupational therapy (OT) visits were to be provided 2 times per week for 1 week then 2 times per week for 4 weeks.</p> <p>The record failed to evidence any SN visits had been provided the week of 11-17-13 (week # 2).</p> <p>4. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>5. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the</p>		<p>weekly for compliance with frequencies. Orders are obtained as needed. The HHA Administrator will review the policy with all clinical staff and the Administrator will be responsible for ensuring compliance with the POC through the chart audit process.</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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G000173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse initiated revisions to the plan of care to address identified nutritional needs in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 5 identified the patient began receiving services from the agency on 11-18-13 and had diagnoses of systemic sclerosis, rheumatoid arthritis, and Raynaud's Syndrome. The record included a start of care comprehensive assessment completed by the registered nurse (RN), employee I, on 11-18-13. The assessment identified the patient had lost more than 10 pounds in the last 3 months but had a "Good Nutritional Status" and was on a regular diet. <p>A. A home visit was made to patient number 5 with the occupational therapist (OT), employee D, on 12-4-13 at 1:05 PM. Observation noted the patient to be very thin and emaciated. The patient indicated the patient's weight was approximately 88 pounds. The patient</p>	G000173	G-0173 Policy #900.25 and #900.114 reviewed with clinical staff at staff meeting. Revision to POC was discussed. Policy #900.63 was reviewed and revised per the Administrator to provide criteria for implementation of nutritional interventions and consultation with Registered Dietician. This policy was reviewed with clinical staff by the Administrator. The POC and the presence of or need for revision will be monitored by the HHA Administrator through the formal chart audit process. Issues and/or trends will be identified and a plan/recommendation will be implemented. The results of chart audits will be reviewed quarterly at the QAPI quarterly meeting. (Documentation Attached)	12/27/2013			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>stated, "I should weigh about 110 pounds. I drink shakes with protein powder in them."</p> <p>B. The record failed to evidence the patient's nutritional status had been communicated to the physician and the plan of care revised to address the patient's compromised nutritional status.</p> <p>2. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>3. The agency's April 2002 "Clinical Staff Functions" policy number 900.25 states, "Professional nursing service is provided by a registered nurse (RN) . . . Skilled nursing services may include, but are not limited to: . . . Developing and revising the plan of care in collaborations with . . . the patient's physician."</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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G000176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) coordinated with the physician regarding medication changes in 1 (# 1) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a hospital "Discharge Instructions" dated 11-12-13. The instructions state, "STOP taking these medicines: bisoprolol-hydrochlorothiazide 5 mg-6.25 mg 1 tables once a day by mouth. Comment: BP low in the hospital, so please check with PCP [primary care provider] prior to restarting."</p> <p>The record failed to evidence the RN had coordinated with the patient's physician regarding the medication change.</p> <p>2. The Home Care Director was unable to</p>	G000176	G-0176Acceptance of Patients, POC and Medication Supervision: Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. The HHA Administrator will review the policy with all clinical staff and the HHA Administrator will be responsible for ensuring compliance with the POC through the initial chart audit process.	12/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>provide any additional documentation/information when asked on 12-2-13 at 3:40 PM and on 12-5-13 at 11:15 AM.</p> <p>3. The agency's April 2002 "Clinical Staff Functions" policy number 900.25 states, "Professional nursing services is provided by a registered nurse . . . Skilled nursing services may include, but are not limited to: . . . Coordinating services with other disciplines and facilities, as indicated."</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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G000190	<p>484.32(a) SUPERVISION OF PHYSICAL & OCCUPATIONAL Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist. Based on clinical record and agency policy review, interview, and review of the Indiana State Practice Act, the agency failed to ensure services provided by the physical therapy assistant (PTA) had been supervised in accordance with agency policy and the Indiana Practice Act in 6 (#s 3, 4, 5, 7, 8, & 9) of 6 records reviewed of patients that received services from the PTA creating the potential to affect all of the agency's 6 current patients that receive physical therapy services.</p> <p>The findings include:</p> <p>1. 844 IAC 6-1-2 (g) states, "'Direct supervision' means that the supervising physical therapist or physician at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant . . . unless the supervising physical therapist of</p>	G000190	G-0190PTA Supervision: Policy #900.25 and #900.70 were reviewed by the HHA Administrator. They were noted to be significantly redundant in nature. Policy #900.25 was revised to include the 5 day window to complete therapy evaluation and to clarify client re-evaluation to occur at the 13th visit and again at the 19th visit. Supervision of the PTA will occur according to regulation and can be completed daily by telephone call. Calls are to be logged on form which was reviewed during survey. Policy #900.70 has been retired. The HHA Administrator will be responsible for monitoring compliance through the formal Active chart audit process. PT, OT, ST will be required to participate in the chart audit process and review compliance with standards. (Documentation Attached)	12/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>physician is on the premises to provide constant supervision, the physical therapist's assistant shall consult with the supervising physical therapist of physician at least once each working day to review all patients' treatments."</p> <p>2. The agency's April 2002 "Client Home Health Care Visit Protocol for Rehabilitation Services" policy number 900.70 states, "When the patient is seen by the pts [physical therapy assistant], progress notes will be co-signed by the physical therapist . . . The P.T.A. shall consult with the supervising physical therapist or physician at least once each working day to review all client's treatment . . . The consultation may be in person, by telephone, so long as there is interactive communication concerning client care."</p> <p>3. Clinical record number 3 evidenced physical therapy services had been provided 1 to 2 times per week during the certification period 7-2-13 to 8-30-13. The record evidenced the physical therapy assistant (PTA), employee L, had provided services to the patient on 7-12-13, 7-18-13, 7-25-13, 8-2-13, and 8-9-13.</p> <p>A. The visit notes dated 7-12-13, 7-18-13, 7-25-13, 8-2-13, and 8-9-13</p>						

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>failed to evidenced a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>4. Clinical record number 4 evidenced physical therapy services had been provided 1 to 3 times per week during the certification period 3-1-13 to 4-29-13. The record evidenced the PTA, employee L, had provided services to the patient on 3-5-13, 3-7-13, 3-12-13, 3-13-13-, 3-15-13, 3-19-13, and 3-27-13.</p> <p>A. The visit notes dated 3-5-13, 3-7-13, 3-12-13, 3-13-13-, 3-15-13, 3-19-13, and 3-27-13 failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>5. Clinical record number 5 evidenced physical therapy services had been provided 1 to 2 times per week during the certification period 11-18-13 to 1-16-13.</p>						

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>The record evidenced the PTA, employee L, had provided services to the patient on 11-25-13 and 11-26-13.</p> <p>A. The visit notes dated 11-25-13 and 11-26-13 failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>6. Clinical record number 7 evidenced physical therapy services had been provided 1 to 2 times per week during the certification period 9-25-13 to 11-23-13. The record evidenced the PTA, employee L, had provided services to the patient on 10-15-13, 10-16-13, 10-23-13, .10-25-13, 10-30-13, 11-1-13, and 11-7-13.</p> <p>A. The visit notes, dated .10-25-13, 10-30-13, 11-1-13, and 11-7-13, failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p>			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>7. Clinical record number 8 evidenced physical therapy services had been provided 1 to 2 times per week during the certification period 11-11-13 to 01-09-14. The record evidenced the PTA, employee L, had provided services to the patient on 11-22-13 and 11-25-13.</p> <p>A. The visit notes, dated 11-22-13 and 11-25-13, failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>8. Clinical record number 9 evidenced physical therapy services had been provided 2 to 3 times per week starting 10-31-13. The record evidenced the PTA, employee L, had provided services to the patient on 11-8-13, 11-15-13, 11-18-13, and 11-20-13.</p> <p>A. The visit notes, dated 11-8-13, 11-15-13, 11-18-13, and 11-20-13, failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the</p>			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>9. The PTA, employee L, indicated, on 12-4-13 at 10 AM, she did speak with the supervising physical therapist per telephone every day. The PTA stated, "We don't talk about every patient I saw that day, only about new evaluations or problems."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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G000215	<p>484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.</p> <p>Based on personnel file and agency policy review, the agency failed to ensure home health aides received at least 12 hours of inservice training in 1 (file A) of 1 home health aide file reviewed of aides employed for all of 2012 creating the potential to affect all of the agency's 6 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A evidenced the individual had been hired on 12-8-08 to provide aide services on behalf of the agency. The file failed to evidence the individual had completed 12 hours of in-service training in 2012. 2. The agency's April 2002 "Education and Staff Development" policy number 900.39 states, "Certified home health aides are required to attend a minimum of 12 hours of inservice education per year." 	G000215	<p>G-0215Home Health Aide Education RequirementsHome Health Policy #900.39 indicates the the Home Health Aide's requirement for a minimum 12 hours of inservice education per year. Personnel File A: Employee had 14 hours of continuing education in 2012.</p> <p>(Documentation Attached).The HHA Administrator is responsible for ensuring staff education requirements are met. The Administrator tracks education hours and ensures each aide has at a minimum, 1.0 hr of education time each month. The Administrator will be responsible for monitoring this compliance</p>	12/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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G000218	<p>484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure an individual had been observed for the competent performance of all of the required tasks 1 (file F) of 2 home health aide files reviewed creating the potential to affect all of the agency's 6 current patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Personnel file F evidenced the individual had been hired on 8-21-13 to provide home health aide services on behalf of the agency. The file failed to evidence the individual had been observed for the competent performance of the appropriate and safe techniques in personal hygiene and grooming that include bed bath as required by 42 CFR 484.36 (a)(1)(ix)(A) and nail and skin care as required by 484.36 (a)(1)(ix)(D).</p>	G000218	G-0218Personnel File F: Employee's Skills Competency Checklist did not address the evaluation of a bed bath or nail care by observation. The aide will be evaluated for competency by the hospital's RN Educator in all areas required. The RN Educator was an LPN for 1 year, has been an RN for 6.5 years and has 4 years experience in Home Care. The HHA will utilize the Hospital's RN Educator for home health aide competency evaluation for the period identified in G-0000. Competency evaluations will be performed at hire and annually during anniversary month. While the RN educator will be responsible for the competency evaluations, the HHA Administrator will be responsible for monitoring this compliance. (Documentation Attached)	12/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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	<p>2. The Home Care Director, employee H, stated, on 12-5-13 at 11:55 AM, "We did not have anyone to do a bed bath on when we did her competency evaluation."</p> <p>3. The agency's April 2002 "Home Health Aide Job Requirements, Competency Evaluations and In-service Training" policy number 900.26 states, "The training program must address each of the following subject areas . . . bed bath . . . nail and skin care . . . safe transfer techniques and ambulation . . . Home health aides will successfully complete a competency evaluation, performed by a registered nurse, that addresses the areas listed above."</p>			

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G000236	<p>484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure clinical records included copies of written summary reports in 2 (#s 10 and 12) of 3 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 10, start of care 9-5-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes. The record evidenced skilled nursing (SN) services had been provided 1 to 2 times per week during the certification period 9-5-13 to 11-3-13 and every other week during the certification period 11-4-13 to 1-2-13. 2. Clinical record number 12, start of 	G000236	G-0236Written Summary of Care: Policy #900.77 addresses the Written Summary of Care guidelines. This policy and appropriate documentation guidelines will be reviewed by the Administrator with clinical staff during Monday Morning Staff Meeting. The Administrator will ensure clinical staff knowledge of appropriate entry of summary in the patient EHR. Completed written summary of care forwarded to physician on both clinical records. (Documentation Attached). The HHA Administrator will monitor continued compliance through the chart audit process.	12/23/2013			

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	<p>care 8-12-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes. The record evidenced SN had been provided 1 to 2 times per week during the certification periods 8-12-13 to 10-10-13 and 10-11-13 to 12-9-13.</p> <p>3. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p>				

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G000245	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. Based on administrative record and agency policy review and interview, the agency failed to ensure it had developed and maintained a quality assessment performance improvement (QAPI) program that included all aspects of the agency and used measurable outcomes to evaluate the effectiveness of the agency's program creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. The agency's May 2005 "Quality Monitoring/Performance Improvement" policy number 900.104 states, "Sullivan county community Hospital Home Health will monitor the quality of care delivery via chart review, patient surveys, physician surveys and OBQM/OBQI activities."</p> <p>A. The policy failed to to provide for the monitoring of all services provided by the agency and failed to include the objectives of the program.</p> <p>B. The policy failed to evidence details for data collection and</p>	G000245	G-0245The Performance Improvement Plan for the HHA is in the process of being updated. The update includes an entirely new comprehensive process for program evaluation. The new program allotts for program goals, identification of improvement needs, more specific and detailed measurements, aggregation and analysis of data to include a detailed chart auditing process. Tools to assist in the planning, implenetation and evaluation have been formulated as well as a program self-evaluation tool. Quarterly QAPI meetings will be held and the committee will be comprised of members from all disciplines. The Annual QAPI report will be presented to the Advisory Committee during it's annual meeting.The new program will be rolled out January 1, 2014.Performance improvement projects will include areas of concern identified during the survey process. As well as issues identified through the chart review process, patient satisfaction surveys, physician surveys, OBQM/OBQI reports, and infection control queries, incident reports and Customer Feedback process.The HHA Administrator will be responsible for monitoring	01/01/2014			

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	<p>performance improvement activities. The policy failed to provide for tracking performance improvement activities and measures to track and sustain the improvements.</p> <p>C. The policy failed to provide for the monitoring of infection control practices of agency staff. Areas of noncompliance with standard precautions were observed during home visits creating the potential for the spread of disease causing organisms among patients and staff. (see N 470).</p> <p>D. The policy failed to provide for an organized program for a quarterly review of both active and closed clinical records by all disciplines.</p> <p>1). The Home Care Director, employee H, indicated, on 12-5-13 at 12:30 PM, all clinical record audits were completed by the Director herself after the patient is discharged. She indicated there was no "quarterly record review" of a sample of both active and closed clinical records. The Director indicated the audit results were not reviewed in the aggregate at any time to identify potential areas for improvement. She stated, "We just address problems with each individual staff member when there is a problem with the chart."</p>		<p>the compliance with the Performance Improvement Plan. The Administrator is also responsible for coordinating Quarterly QAPI meetings and compiling the statistics for presentation.</p>				

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	<p>2). The Director indicated no clinical record audits had been completed by any of the therapists at any time.</p> <p>E. The policy failed to provide a definition of adverse events in order to track and analyze the events and implement preventive actions.</p> <p>1). The agency's "QAPI Report to Governing Body" for the period July through December 2012, identified there were 7 adverse events. The report states, "0 were true adverse events." The report identifies 5 of the events were caused by falls and that 3 of the patients were treated in the emergency room. The report states, "1 patient did fracture her arm . . . 1 patient tripped on the curb outside apartment and had a laceration to forearm." The report identifies 2 events were related to emergent care for wounds and 1 patient developed a stage 3 ulcer to the left hip.</p> <p>The agency's administrative records failed to evidence a system to track and analyze these events. The records failed to evidence a performance improvement project had been implemented. The report states, "Will continue to monitor in 2013."</p>						

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	<p>2). The agency's "QAPI Report to Governing Body" for the period January through July 2013" identifies 4 adverse events. The report states, "0 were true adverse events." The report identifies the events were injury caused by falls and that 1 patient fractured an arm, 1 a shoulder, and 1 a hip.</p> <p>a.) The agency's administrative records failed to evidence a system to track and analyze these events. The records failed to evidence a performance improvement project had been implemented. The report states, "Will continue to monitor in 2013."</p> <p>b.) The report identifies the agency's patient satisfaction survey score for explaining medication side effects was below the national average for the system used by the agency. The report states, "We will be working on improving that score . . . will continue to monitor this in 2013." The agency's administrative records failed to evidence a performance improvement project had been implemented.</p> <p>2. The agency's QAPI policy identified physician satisfaction surveys would be mailed annually to each physician that had a patient discharged from the agency and that "responses to the patient and</p>			

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	<p>satisfaction surveys will be compiled and analyzed for negative trends. A plan of corrective action will be established as a collaborative effort involving all staff/disciplines."</p> <p>The agency's administrative records failed to evidence any physician satisfaction surveys or a compilation of results of the surveys.</p> <p>3. The Home Care Director, employee H, and the hospital Clinical Director, employee K, indicated, on 12-5-13 at 12:50 PM, the agency's QAPI program was lacking. The hospital Clinical Director stated, "We plan to address this in 2014."</p>				

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G000250	<p>484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. Based on document review and interview, the agency failed to ensure an organized program for the review of active and closed clinical records had been implemented and that clinical record reviews had been completed by physical, occupational, and speech therapists representing the scope of the agency's program creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. The Home Care Director, employee H, indicated, on 12-5-13 at 12:30 PM, all clinical record audits were completed by the Director herself after the patient is discharged. She indicated there was no "quarterly record review" of a sample of both active and closed clinical records. The Director indicated the audit results were not reviewed in the aggregate at any time to identify potential areas for improvement. She stated, "We just address problems with each individual staff member when there is a problem with the chart." The Director indicated no</p>	G000250	G-0250Clinical Record Review: Policy #900.46 has been revised to indicate a more formal and thorough clinical record review process. The process accounts for review by therapists for those clients receiving therapy services and formalizes the process for reporting record review results to the QAPI committee and the need for action plans for those areas of opportunity. Updated audit tools and reporting records will be formulated and ready for use in January. The HHA Administrator will be responsible for monitoring compliance with this standard. (Documentation Attached).	01/01/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>clinical record audits had been completed by any of the therapists at any time.</p> <p>2. The CMS form 1572 completed by the agency during the survey identified the agency provided physical therapy, occupational therapy, and speech therapy services.</p>				

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G000321	<p>484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.</p> <p>Based on Indiana State Department of Health (ISDH) document review, agency policy review, and interview, the agency failed to ensure OASIS data had been transmitted within 30 days of completion in 26 (patients # 3, 4, 7, 9, 13, 14, 15, 17, 18, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, and 33) of 238 transmissions reviewed creating the potential to affect all of the agency's 34 current skilled patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 8-27-13 for patient number 3. The document evidenced the OASIS data had not been transmitted until 10-2-13 2. An ISDH document dated 11-22-13 evidenced the a start of care assessment had been completed on 5-8-13 for patient number 4. The document evidenced the OASIS data had not been transmitted until 6-11-13. 3. An ISDH document dated 11-22-13 	G000321	<p>G-0321OASIS Submission: The HHA Administrator has identified an isolated employee issue with timely documentation submission. The Administrator had counseled employee on 2 occasions and on 12/2/13 the employee was given a disciplinary action plan to improve document submission (Documentation Attached). It was also determined that implementation of a point of care program had caused a delay in submissions due to lack of employee training on the software's technical requirements for submission. All staff have been educated on the software requirements. Policy #900.75 has been revised to indicate the new internal process for OASIS completion within 48 hours. This is reasonable due to the point of care software. This timeframe allows for coding and auditing/changes to be completed to meet the condition of locking the OASIS within 7 days. The HHA Administrator will be responsible for monitoring compliance with timely submission through daily software reports. Daily tracking allows the Administrator to ensure timely completion. Compliance will also be monitored through the initial</p>	12/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
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	<p>evidenced a recertification assessment had been completed on 5-27-13 for patient number 7. The document evidenced the OASIS data had not been transmitted until 7-18-13.</p> <p>4. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 8-30-13 for patient number 9. The document evidenced the OASIS data had not been transmitted until 10-2-13.</p> <p>5. An ISDH document dated 11-22-13 evidenced a discharge assessment had been completed on 8-15-13 for patient number 13. The document evidenced the OASIS data had not been transmitted until 10-2-13.</p> <p>6. An ISDH document dated 11-22-13 evidenced a discharge assessment had been completed on 8-6-13 for patient number 14. The document evidenced the OASIS data had not been transmitted until 10-2-13.</p> <p>7. An ISDH document dated 11-22-13 evidenced a start of care assessment had been completed on 5-7-13 for patient number 15. The document evidenced the OASIS data had not been transmitted until 10-31-13.</p>		chart audit process.		

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	<p>The document evidenced a discharge assessment had been completed on 6-27-13 and had not been transmitted until 10-31-13.</p> <p>8. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 10-5-13 for patient number 17. The document evidenced the OASIS data had not been transmitted until 11-13-13.</p> <p>9. An ISDH document dated 11-22-13 evidenced a transfer assessment had been completed on 6-15-13 for patient number 18. The document evidenced the OASIS data had not been transmitted until 7-22-13.</p> <p>10. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 6-17-13 for patient number 19. The document evidenced the OASIS data had not been transmitted until 7-22-13.</p> <p>11. An ISDH document dated 11-22-13 evidenced a discharge assessment had been completed on 6-13-13 for patient number 20. The document evidenced the OASIS data had not been transmitted until 7-18-13.</p> <p>12. An ISDH document dated 11-22-13</p>						

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	<p>evidenced a recertification assessment had been completed on 5-17-13 for patient number 21. The document evidenced the OASIS data had not been transmitted until 7-22-13.</p> <p>13. An ISDH document dated 11-22-13 evidenced a start of care assessment had been completed on 5-3-13 for patient number 23. The document evidenced the OASIS data had not been transmitted until 6-11-13.</p> <p>14. An ISDH document dated 11-22-13 evidenced a resumption of care assessment had been completed on 6-22-13 for patient number 24. The document evidenced the OASIS data had not been transmitted until 7-31-13.</p> <p>15. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 8-7-13 for patient number 25. The document evidenced the OASIS data had not been transmitted until 9-10-13.</p> <p>16. An ISDH document dated 11-22-13 evidenced a start of care assessment had been completed on 6-12-13 for patient number 26. The document evidenced the OASIS data had not been transmitted until 7-18-13.</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>17. An ISDH document dated 11-22-13 evidenced a discharge assessment had been completed on 8-6-13 for patient number 27. The document evidenced the OASIS data had not been transmitted until 10-2-13.</p> <p>18. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 5-2-13 for patient number 28. The document evidenced the OASIS data had not been transmitted until 7-22-13.</p> <p>The document evidenced a discharge assessment had been completed on 6-7-13 and not transmitted until 7-18-13.</p> <p>19. An ISDH document dated 11-22-13 evidenced a discharge assessment had been completed on 6-27-13 for patient number 29. The document evidenced the OASIS data had not been transmitted until 8-13-13.</p> <p>20. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 6-14-13 for patient number 30. The document evidenced the OASIS data had not been transmitted until 7-31-13.</p> <p>The document evidenced a discharge assessment had been completed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>8-14-13 and not transmitted until 10-2-13.</p> <p>21. An ISDH document dated 11-22-13 evidenced a transfer assessment had been completed on 6-28-13 for patient number 31. The document evidenced the OASIS data had not been transmitted until 8-13-13.</p> <p>22. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 5-7-13 for patient number 32. The document evidenced the OASIS data had not been transmitted until 6-11-13.</p> <p>23. An ISDH document dated 11-22-13 evidenced a recertification assessment had been completed on 5-2-13 for patient number 33. The document evidenced the OASIS data had not been transmitted until 7-22-13.</p> <p>24. During the entrance conference, on 12-2-13 at 12:15 PM, the Home Care Director, employee H, acknowledged the agency has a problem with timely OASIS data transmission. The director stated, "It is one particular nurse."</p> <p>25. The agency's April 2002 "Initial and Comprehensive Assessment" policy number 900.75 states, "OASIS data will be transmitted to the state at least</p>				

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	monthly."			

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G000330	<p>484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary</p> <p>Based on clinical record and agency policy review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure comprehensive assessments were complete and accurately reflected the patients' status in 3 of 12 records reviewed creating the potential to affect all of the agency's 34 current patients (See G 335); by failing to ensure comprehensive assessments included a review of all medications in 1 of 12 records reviewed creating the potential to</p>	G000330	G-0330Comprehensive Assessments:Policy #900.75 was revised and reviewed with clinical staff. The definition of major decline or improvement was added to the policy. The importance of complete documentation of the patient's condition was discussed. The OASIS-C was reviewed and discussed with examples and sample situations given. Appropriate documentation requirements were discussed.Policy # 900.63 was revised and reviewed to indicate	12/23/2013

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>affect all of the agency's 34 current patients (See G 337); and by failing to ensure a policy was in place that specifies the agency's definition of a major decline or improvement in a patient's condition that would warrant an update of the comprehensive assessment creating the potential to affect all of the agency's 34 current patients (See G 338).</p> <p>The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients.</p>		<p>criteria for assigning nutritional status. The HHA Administrator will be responsible for monitoring compliance through the initial chart audit process. (Documentation Attached).</p>		

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G000335	<p>484.55(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments were complete and accurately reflected the patients' status in 3 (#s 5, 9, and 10) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 identified the patient began receiving services from the agency on 11-18-13 and had diagnoses of systemic sclerosis, rheumatoid arthritis, and Raynaud's Syndrome. The record included a start of care comprehensive assessment completed by the registered nurse (RN), employee I, on 11-18-13. The assessment identified the patient had lost more than 10 pounds in the last 3 months but had a "Good Nutritional Status" and was on a regular diet.</p> <p>A. A home visit was made to patient number 5 with the occupational therapist (OT), employee D, on 12-4-13 at 1:05</p>	G000335	G-0335Comprehensive Assessments:Policy #900.75 was revised and reviewed with clinical staff. The definition of major decline or improvement was added to the policy. The importance of complete and accurate documentation of the patient's condition was discussed. The OASIS-C was reviewed and discussed with examples and sample situations given. Appropriate documentation requirements were discussed.Policy # 900.63 was revised and reviewed to indicate criteria for assigning nutritional status.The HHA Administrator will be responsible for monitoring compliance through the initial chart audit process and the active chart process. (Documentation Attached)	12/23/2013			

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	<p>PM. Observation noted the patient to be very thin and emaciated. The patient indicated the patient's weight was approximately 88 pounds. The patient stated, "I should weigh about 110 pounds. I drink shakes with protein powder in them."</p> <p>B. The assessment failed to accurately reflect the patient's nutritional status.</p> <p>2. Employee E, a RN, indicated, on 12-3-13 at 3:55 PM, patient number 9 received dialysis treatments 3 times per week at a local dialysis clinic. A fax, obtained by the Home Care Director, employee H, on 12-3-13 at 3:55 PM, identified the patient had been on dialysis since 8-17-13.</p> <p>Clinical record number 9 included a recertification/resumption of care comprehensive assessment completed by employee J, a RN, on 10-24-13. The assessment failed to to include an assessment of the patient's condition related to the dialysis.</p> <p>3. Clinical record 10 included a skilled nurse (SN) visit note completed by the RN, employee H, on 10-1-13. The note states, "Pt [patient] reamins [sic] indecisive of dialysis, went to see surgeon for fistula placement with refusal at time</p>				

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	<p>of visit." A SN visit note competed by employee H on 10-18-13 states, "Pt has many questions regarding dialysis in home. Instructed pt on having a sterile field for peritoneal dialysis, et importance of having no pets in home."</p> <p>A. The record included a recertification comprehensive assessment completed by the RN, employee E, on 11-1-13. The assessment failed to include an assessment of the patient's status related to the patient's need for and refusal of dialysis treatments.</p> <p>B. The RN, employee B, stated, on 12-5-13 at 10 AM, "The patient is not yet on dialysis."</p> <p>4. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>5. The agency's April 2002 "Initial and Comprehensive Assessment" policy number 900.75 states, "A registered nurse will conduct and complete the comprehensive assessment."</p>			

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G000337	<p>484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record and agency policy review and interview, the agency failed to ensure comprehensive assessments included a review of all medications in 1 (# 9) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 9 included a resumption of care comprehensive assessment dated 8-16-13, a resumption of care/recertification comprehensive assessment dated 8-28-13, and a resumption of care comprehensive assessment dated 10-24-13. The medication reviews failed to include medications the patient received during incenter hemodialysis treatments. 2. The Home Care Director, employee H, obtained a list of medications from the dialysis facility on 12-3-13 at 3:55 PM. The list identified the patient had been on dialysis since 8-17-13 and that the patient 	G000337	G-0337Clinical Record #9 was updated to reflect dialysis meds on the day of survey finding.Drug Regimine Review: Policy #900.72 will be reviewed with clinical staff. The importance of care coordination was discussed and the need for the medication profile to reflect all meds, herbs, vitamins and nutritional supplements was discussed. The HHA Administrator will be responsible for ensuring compliance with this standard through the process of chart auditing, initial and active.	12/27/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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	<p>received acetaminophen 650 milligrams (mg) as needed, heparin lock solution 1000 units in each dialysis catheter port every treatment, 7400 units of EPO every treatment 3 times per week, Iron sucrose 50 mg 1 time per week, and Nitroglycerin 0.4 mg sublingual as needed for chest pain.</p> <p>3. The Home Care Director, employee H, indicated, on 12-3-13 at 3:55 PM, the medications administered to the patient during incenter hemodialysis treatments had not been included in the comprehensive assessment medication review.</p> <p>4. The agency's April 2002 "Initial and Comprehensive Assessment" policy number 900.75 states, "The comprehensive assessment includes a review of all medications the patient is currently using in order to identify any potential adverse effect and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy."</p> <p>5. The agency's February 2010 "Drug Regimen Review" policy number 900.72 states, "A drug regimen review will be conducted at admission, recertification,</p>			

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	resumption with med changes, and as needed on prescription and over the counter medications administered by any route."			

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G000338	<p>484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. Based on policy and procedure review and interview, the agency failed to have a policy in place that specifies the agency's definition of a major decline or improvement in a patient's condition that would warrant an update of the comprehensive assessment creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's policy and procedure manuals failed to include a policy that defines a major decline or improvement in a patient's condition that would warrant an update of the comprehensive assessment. 2. The hospital nursing director, employee K, stated, on 12-4-13 at 4:05 PM, "We don't have one." 	G000338	G-0338Policy #900.75 has been updated to include the agency's definition of a "major decline or improvement in health status." The clinical staff will be educated on teh policy revision at the staff meeting on 12/23/13. The HHA Administrator will be responsible for monitoring compliance through the formal chart audit process. (Documentation Attached).	12/23/2013	

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N000000	<p>This was a State home health re-licensure survey.</p> <p>Survey Dates: 12-2-13, 12-3-13, 12-4-13, and 12-5-13</p> <p>Facility #: 003248</p> <p>Medicaid Vendor #: 200387670</p> <p>Surveyor: Vicki Harmon, RN, PHNS</p> <p>Current Census:</p> <p>34 skilled patients 0 home health aide only patients 0 personal services patients</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN December 12, 2013</p>	N000000			

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N000446	<p>410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3)</p> <p>Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on personnel file and agency policy review and interview, the administrator failed to ensure annual performance evaluations had been completed at least annually in 3 (files B, D, and G) of 5 employee files reviewed of individuals employed for greater than 1 year and failed to ensure home health aides received at least 12 hours of inservice training in 1 (file A) of 1 home health aide file reviewed of aides employed for all of 2012 creating the potential to affect all of the agency's 34 current patients.</p> <p>Regarding annual performance evaluations:</p> <p>The findings include:</p> <p>1. Personnel file B evidenced the individual had been hired on 2-17-11 to provide skilled nursing services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 5-14-11.</p>	N000446	<p>N-0446 Annual Performance Evaluation: Hospital HR policy sets forth the requirement for annual staff performance evaluations. Personnel File B: The employee originally employed PRN on 2/17/11. She had a 90 day evaluation completed in 5/11. Employee then left the HHA and transferred to another department on 9/26/11 and thus no longer with the HHA for an annual evaluation. On 3/11/13 employee again began PRN status in Home Health and became full time on 11/25/13. Employee will have a 90 day eval completed in 2/14 and an annual performance evaluation completed in 11/14 and annually thereafter. (Documentation Attached) Personnel File D: The employee is an OT and had an annual evaluation completed by the Rehab Services Director in 1/13. The HHA Administrator will immediately complete a performance evaluation and the employee will have an annual evaluation completed in 12/14</p>	12/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
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	<p>2. Personnel file D evidenced the individual had been hired on 5-31-02 to provide occupational therapy services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 4-15-11.</p> <p>3. Personnel file G evidenced the individual had been hired on 3-19-07 to provide physical therapy assistant services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 3-27-12.</p> <p>4. The Home Care Director, employee H, indicated, on 12-5-13 at 2 PM, the personnel files were not up-to-date.</p> <p>5. The agency's April 2002 "Personnel Files" policy states, "Files contain complete information as listed on the Personnel File Checklist Form. Files are kept current by entering relevant employment information as listed on the checklist. Notification is sent to staff members by the Director, or designee, as current data is required - such as CPR Certification, license renewal."</p> <p>Regarding home health aide inservice training:</p>		<p>and annually thereafter. (Documentation Attached)Personnel File G: The employee has had a performance evaluation completed annually with the last evaluation completed in 3/13. The employee will have an evaluation completed in 3/14 and continue annually thereafter. (Documentation Attached)Home Health Aide Education Requirements: Home Health Policy #900.39 indicates the the Home Health Aide's requirement for a minimum 12 hours of inservice education per year. Personnel File A: Employee had 14 hours of continuing education in 2012. (Documentation Attached). The HHA Administrator will be responsible for completing annual performance evaluations for all HHA staff. Human Resource Director/Designee will inform HHA Administrator when evaluations are due.HHA Administrator is responsible for ensuring each aide has the minimum education requirements annually.</p>		

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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A evidenced the individual had been hired on 12-8-08 to provide aide services on behalf of the agency. The file failed to evidence the individual had completed 12 hours of in-service training in 2012. 2. The agency's April 2002 "Education and Staff Development" policy number 900.39 states, "Certified home health aides are required to attend a minimum of 12 hours of inservice education per year." 			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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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
N000451	<p>410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence.</p> <p>Based on administrative record and personnel file review and interview, the agency failed to ensure the individual authorized to act in the absence of the administrator was qualified creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records identified employee E had been authorized to act in the absence of the agency's administrator. 2. Personnel file E identified the individual is a registered nurse. The file failed to evidence the individual possessed any supervisory or administrative experience or experience in health service administration or health services finance as required by 410 IAC 17-9-2. 3. A letter to the agency from the Indiana State Department of Health dated 	N000451	N-0451Authorized Individual:The HHA informed ISDH of Administrative changes by mail on 10/30/13. On 11/20/13, the Hospital CNO contacted a "Bobbie" at the ISDH to inquire about receipt of changes. Was informed she would have "Samantha" call back the next day. On 11/21/13 "Samantha" from the ISDH returned call. Samantha informed CNO that letter dated 11/13/13 had been mailed to HHA informing need for additional info for Alternate Designee. Samantha emailed copy of letter to CNO. CNO emailed Samantha updated resume for designee on 11/26/13. HHA Administrator received letter dated 12/5/13 from the ISDH informing that Alternate could not qualify and requests a new designee be submitted. On 12/11/13 a new application for Alternate designee was submitted and a letter dated 12/12/13 approving new designee was received by HHA Administrator. (Documentation Attached).The HHA Administrator/Alternate will ensure the continued presence of	12/12/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>11-13-13 identified the agency had been informed employee E did not meet the qualifications for alternate administrator.</p> <p>3. Employee E indicated, on 12-5-13 at 11:10 AM, her supervisory experience consisted of having been a unit charge nurse at a local hospital and case management of home health clients.</p>		authorized individuals approved by the ISDH.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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N000454	<p>410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to:</p> <ol style="list-style-type: none"> (1) respond to an emergency; (2) provide guidance to staff; (3) answer questions; and (4) resolve issues; <p>within a reasonable amount of time, given the emergency or issue that has been raised.</p> <p>Based on administrative record and personnel file review and interview, the agency failed to ensure the individual authorized to act in the absence of the supervising nurse was qualified creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's administrative records identified employee E had been authorized to act in the absence of the agency's supervising nurse. 2. Personnel file E identified the individual is a registered nurse. The file failed to evidence the individual possessed any supervisory or administrative experience. 3. A letter to the agency from the Indiana 	N000454	<p>N-0454Authorized Individual:The HHA informed ISDH of Administrative changes by mail on 10/30/13. On 11/20/13, the Hospital CNO contacted a "Bobbie" at the ISDH to inquire about receipt of changes. Was informed she would have "Samantha" call back the next day. On 11/21/13 "Samantha" from the ISDH returned call. Samantha informed CNO that letter dated 11/13/13 had been mailed to HHA informing need for additional info for Alternate Designee. Samantha emailed copy of letter to CNO. CNO emailed Samantha updated resume for designee on 11/26/13. HHA Administrator received letter dated 12/5/13 from the ISDH informing that Alternate could not qualify and requests a new designee be submitted. On 12/11/13 a new application for Alternate designee was submitted and a letter dated 12/12/13</p>	12/12/2013

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>State Department of Health dated 11-13-13 identifies the agency had been informed employee E did not meet the qualifications for alternate supervising nurse.</p> <p>4. Employee E indicated, on 12-5-13 at 11:10 AM, her supervisory experience consisted of having been a unit charge nurse at a local hospital and case management of home health clients.</p>		<p>approving new designee was received by HHA Administrator. (Documentation Attached). The HHA Administrator/Alternate will ensure the continued presence of authorized individuals approved by the ISDH.</p>		

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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N000456	<p>410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure it had developed and maintained a quality assessment performance improvement (QAPI) program that included all aspects of the agency and used measurable outcomes to evaluate the effectiveness of the agency's program creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. The agency's May 2005 "Quality Monitoring/Performance Improvement" policy number 900.104 states, "Sullivan county community Hospital Home Health will monitor the quality of care delivery via chart review, patient surveys, physician surveys and OBQM/OBQI activities."</p> <p>A. The policy failed to to provide for</p>	N000456	<p>N-0456Clinical Record Review: Policy #900.46 has been revised to indicate a more formal and thorough clinical record review process. The process accounts for review by therapists for those clients receiving therapy services and formalizes the process for reporting record review results to the QAPI committee and the need for action plans for those areas of opportunity. Updated audit tools and reporting records will be formulated and ready for use in January.The HHA Administrator will be responsible for monitoring compliance with this standard. (Documentation Attached).N-0456 The Performance Improvement Plan for the HHA is in the process of being updated. The update includes an entirely new comprehensive process for program evaluation. The new program allotts for program goals, identification of improvement needs, more specific and detailed measurements, aggregation and analysis of data to include a</p>	01/01/2014

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>the monitoring of all services provided by the agency and failed to include the objectives of the program.</p> <p>B. The policy failed to evidence details for data collection and performance improvement activities. The policy failed to provide for tracking performance improvement activities and measures to track and sustain the improvements.</p> <p>C. The policy failed to provide for the monitoring of infection control practices of agency staff. Areas of noncompliance with standard precautions were observed during home visits creating the potential for the spread of disease causing organisms among patients and staff. (see N 470).</p> <p>D. The policy failed to provide for an organized program for a quarterly review of both active and closed clinical records by all disciplines.</p> <p>1). The Home Care Director, employee H, indicated, on 12-5-13 at 12:30 PM, all clinical record audits were completed by the Director herself after the patient is discharged. She indicated there was no "quarterly record review" of a sample of both active and closed clinical records. The Director indicated the audit</p>		<p>detailed chart auditing process. Tools to assist in the planning, impenetation and evaluation have been formulated as well as a program self-evaluation tool. Quarterly QAPI meetings will be held and the committee will be comprised of members from all disciplines. The Annual QAPI report will be presented to the Advisory Committee during it's annual meeting. The new program will be rolled out January 1, 2014. Performance improvement projects will include areas of concern identified during the survey process. As well as issues identified through the chart review process, patient satisfaction surveys, physician surveys, OBQM/OBQI reports, and infection control queries, incident reports and Customer Feedback process. The HHA Administrator will be responsible for monitoring the compliance with the Performance Improvement Plan. The Administrator is also responsible for coordinating Quarterly QAPI meetings and compiling the statistics for presentation.</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>results were not reviewed in the aggregate at any time to identify potential areas for improvement. She stated, "We just address problems with each individual staff member when there is a problem with the chart."</p> <p>2). The Director indicated no clinical record audits had been completed by any of the therapists at any time.</p> <p>E. The policy failed to provide a definition of adverse events in order to track and analyze the events and implement preventive actions.</p> <p>1). The agency's "QAPI Report to Governing Body" for the period July through December 2012, identified there were 7 adverse events. The report states, "0 were true adverse events." The report identifies 5 of the events were caused by falls and that 3 of the patients were treated in the emergency room. The report states, "1 patient did fracture her arm . . . 1 patient tripped on the curb outside apartment and had a laceration to forearm." The report identifies 2 events were related to emergent care for wounds and 1 patient developed a stage 3 ulcer to the left hip.</p> <p>The agency's administrative records failed to evidence a system to</p>			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>track and analyze these events. The records failed to evidence a performance improvement project had been implemented. The report states, "Will continue to monitor in 2013."</p> <p>2). The agency's "QAPI Report to Governing Body" for the period January through July 2013" identifies 4 adverse events. The report states, "0 were true adverse events." The report identifies the events were injury caused by falls and that 1 patient fractured an arm, 1 a shoulder, and 1 a hip.</p> <p>a.) The agency's administrative records failed to evidence a system to track and analyze these events. The records failed to evidence a performance improvement project had been implemented. The report states, "Will continue to monitor in 2013."</p> <p>b.) The report identifies the agency's patient satisfaction survey score for explaining medication side effects was below the national average for the system used by the agency. The report states, "We will be working on improving that score . . . will continue to monitor this in 2013." The agency's administrative records failed to evidence a performance improvement project had been implemented.</p>			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>2. The agency's QAPI policy identified physician satisfaction surveys would be mailed annually to each physician that had a patient discharged from the agency and that "responses to the patient and satisfaction surveys will be compiled and analyzed for negative trends. A plan of corrective action will be established as a collaborative effort involving all staff/disciplines."</p> <p>The agency's administrative records failed to evidence any physician satisfaction surveys or a compilation of results of the surveys.</p> <p>3. The Home Care Director, employee H, and the hospital Clinical Director, employee K, indicated, on 12-5-13 at 12:50 PM, the agency's QAPI program was lacking. The hospital Clinical Director stated, "We plan to address this in 2014."</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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N000458	<p>410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ol style="list-style-type: none"> (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. <p>Based on personnel file and agency policy review and interview, the agency failed to ensure personnel files included annual performance evaluations in 3 (files B, D, and G) of 5 employee files reviewed of individuals employed for greater than 1 year creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file B evidenced the individual had been hired on 2-17-11 to provide skilled nursing services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 5-14-11. 	N000458	N-0458 Annual Performance Evaluation Hospital HR policy sets forth the requirement for annual staff performance evaluations. Personnel File B: The employee originally employed PRN on 2/17/11. She had a 90 day evaluation completed in 5/11. Employee then left the HHA and transferred to another department on 9/26/11 and thus no longer with the HHA for an annual evaluation. On 3/11/13 employee again began PRN status in Home Health and became full time on 11/25/13. Employee will have a 90 day eval completed in 2/14 and an annual performance evaluation completed in 11/14 and annually thereafter. (Documentation	12/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>2. Personnel file D evidenced the individual had been hired on 5-31-02 to provide occupational therapy services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 4-15-11.</p> <p>3. Personnel file G evidenced the individual had been hired on 3-19-07 to provide physical therapy assistant services on behalf of the agency. The file evidenced the most recent performance evaluation had been completed on 3-27-12.</p> <p>4. The Home Care Director, employee H, indicated, on 12-5-13 at 2 PM, the personnel files were not up-to-date.</p> <p>5. The agency's April 2002 "Personnel Files" policy states, "Files contain complete information as listed on the Personnel File Checklist Form. Files are kept current by entering relevant employment information as listed on the checklist. Notification is sent to staff members by the Director, or designee, as current data is required - such as CPR Certification, license renewal."</p>		<p>Attached) Personnel File D: The employee is an OT and had an annual evaluation completed by the Rehab Services Director in 1/13. The HHA Administrator will immediately complete a performance evaluation and the employee will have an annual evaluation completed in 12/14 and annually thereafter. (Documentation Attached) Personnel File G: The employee has had a performance evaluation completed annually with the last evaluation completed in 3/13. The employee will have an evaluation completed in 3/14 and continue annually thereafter. (Documentation Attached)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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N000464	<p>410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:</p> <p>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.</p> <p>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.</p> <p>(3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii) completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest radiograph to exclude a diagnosis of tuberculosis.</p> <p>(4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).</p> <p>(5) Any person having a positive finding on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.</p> <p>Based on personnel file and agency policy review and interview, the agency failed to ensure all employees had an annual tuberculosis (TB) Mantoux skin test or screening in 1 (file A) of 5 personnel files reviewed of individuals that had been employed by the agency for greater than 1 year creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Personnel file A evidenced the individual had been hired on 12-8-08 to provide home health aide services on behalf of the agency. The file failed to evidence a TB skin test or screening had been completed since 9-24-12. 2. The Home Care Director, employee K, indicated, on 12-5-13 at 2 PM, she was aware the individual had not had a TB test for over 1 year. 	N000464	<p>N-0464Annual TB TestingHospital Employee Health Policy #250.05/245.143 indicates the need for annual TB testing during the employees anniversaty month. Personnel File A: Employee's last TB test completed prior to anniversary month causing a miscalculation for next test. Employee has completed TB test in 12/13 and will do so annually thereafter. (Documentation Attached)The Employee Health Nurse is responsible for ensuring annual employee health requirements are met. The EH Nurse will monitor compliance.</p>	12/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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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
	3. The agency's April 2002 "Personnel Files" policy number 250.05/245.143 states, "Each year during the employee's anniversary month, the employee must complete annual medical screening. 1. Request for annual screening shall be forwarded to the employee who is responsible for completing annual employee health requirements. 1.1 Tuberculin skin test of TB Health Screening form."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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N000470	<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 and agency policy and document review and interview the agency failed to ensure its staff provided care in accordance with the agency's infection control policies and procedures in 4 (patients # 1, 2, 5, and 9) of 6 home visit observations completed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The agency's May 2005 "Surveillance, Prevention, and Control of Infection" policy number 900.105 states, "Standard Precautions will be observed routinely regarding all patients, procedures and equipment when there is a potential for exposure to blood and other body fluids." 2. The Centers for Disease Control "Standards Precautions" states, "IV. Standard Precautions . . . IV.A. Hand Hygiene. IV.A.1. During the delivery of healthcare, avoid unnecessary touching of surfaces in close proximity to the patient to prevent both contamination of clean 	N000470	<p>N-0470 A- The Infection Control Preventist/Employee Health Nurse will inservice all clinical staff 12/19/13 on the CDC's Standard Precautions measures and Hand Hygiene. This inservice is mandatory for all clinical staff. B- All agency staff will also be inserviced on Infection Control Prevention Measures through Healthstream's "Infection Control" education module with competency testing completed. The Healthstream module will be assigned by the Administrator for completion by 12/23/13 and will occur annually thereafter. The HHA adopted hospital Infection Control Policies # 245.39 and #245.175. C- The Administrator revised policy 900.105 to reflect appropriate equipment cleaning measures. The policy originally stated only "visibly soiled" instruments/equipment were to be disinfected prior to being returned to the bag. This policy now states "All instruments and/or equipment" are to be cleaned prior to being returned to the bag. The Administrator will inservice clinical staff on the revisions to policy 900.105 and proper equipment cleaning and</p>	12/23/2013

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	<p>hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces . . .</p> <p>Perform hand hygiene: IV.A.3.a. Before having direct contact with patients.</p> <p>IV.A.3.b. After contact with blood, body fluids or excretions, mucous membranes, nonintact skin, or wound dressings.</p> <p>IV.A.3.c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure or lifting a patient).</p> <p>IV.3.d. If hands will be moving from a contaminated-body site to a clean-body site during patient care. IV.A.3.e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. IV.A.3.f. After removing gloves . . . IV.F.5. Include multi-use electronic equipment in policies and procedures for preventing contamination and for cleaning and disinfection, especially those items that are used by patients, those used during delivery of patient care, and mobile devices that are moved in and out of patient rooms frequently . . . IV.B. Personal protective equipment (PPE) . . . IV.B.2. Gloves. IV.B.2.a. Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin . . . could occur.</p>		<p>bag technique at the Monday Morning Staff Meeting 12/23/13. The Administrator will ensure compliance with Standard Precautions and Infection Control Prevention through quarterly supervisory visits per clinician with the first visits being conducted in January 2014.</p>		

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	<p>3. A home visit was made to patient number 1 on 12-4-13 at 1:30 PM with employee B, a registered nurse (RN). The employee was observed to place her stethoscope, blood pressure cuff and pulse oximeter on the patient's bed. After using the equipment on the patient, the RN replaced it in her bag without cleaning it. The RN assessed the patient and failed to cleanse her hands after removing her gloves after completing the assessment. The RN failed to cleanse her hands after removing her gloves during the dressing change to the patient's abdomen. The employee was observed to place the wound vacuum tubing connector on the patient's bed and not on a clean field. The employee was not observed to cleanse her hands after leaving the patient's room and entering another room to obtain more supplies.</p> <p>4. A home visit was made to patient number 2 on 12-2-13 at 1:20 PM with employee E, a RN. The RN was observed to perform a clean dressing change to the patient's right knee incision. The RN washed her hands, donned clean gloves, then retrieved the supplies for the dressing change from a supply in the patient's home. The RN removed the old dressing, removed her gloves and washed her hands. The RN took the patient's temperature and a pulse oximetry reading.</p>						

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	<p>The RN replaced the thermometer and pulse oximeter into her nursing bag without cleaning them. The RN took the patient's blood pressure and then placed the stethoscope around her neck. She replaced the blood pressure cuff into her nursing bag without cleaning it. The RN removed the stethoscope from around her neck and listened to the patient's lungs and checked for bowel sounds. The RN then replaced the stethoscope back into her nursing bag without cleaning it.</p> <p>The RN washed her hands and donned clean gloves and cleansed the incision with a Hibiclens soaked gauze. The RN removed her gloves and, without cleansing her hands, retrieved more supplies from her nursing bag. The RN then donned clean gloves and cut the Xeroform dressing to size using scissors. The RN replaced the scissors into her bag without cleaning them. The RN then changed her gloves without cleansing her hands and completed the dressing change.</p> <p>5. A home visit was made to patient number 5 on 12-3-13 at 1:05 PM with the occupational therapist (OT), employee D. The OT took the patient's blood pressure and replaced the cuff into her bag without cleaning it. The OT replaced the stethoscope and only the cleaned the bell of the stethoscope and failed to clean the</p>			

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	<p>tubing portion.</p> <p>The OT took the patient's temperature using a thermometer with a disposable plastic sheath. Without wearing gloves, the OT removed the thermometer from the patient's mouth, removed the sheath, and disposed of it. The OT failed to cleanse her hands after removing the thermometer and the protective sheath. The OT replaced the thermometer into her bag without cleaning it.</p> <p>6. A home visit was made to patient number 9 on 12-4-13 at 10:30 AM with employee F, a home health aide. The aide was observed to provide a bath to the patient. The aide assisted the patient to ambulate a few steps from the wheelchair to sit on the toilet with the lid closed. The aide took the patient's temperature and blood pressure. The patient's temperature was 99 degrees and the patient stated, "I have had diarrhea this morning." The aide replaced the thermometer and blood pressure cuff into her bag without cleaning it.</p> <p>The aide washed her hands, donned clean gloves, and washed the patient's upper body. The aide removed the patient's shoes and socks, assisted the patient to stand, and removed the patient's pants and a soiled Depends. The aide</p>						

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	<p>changed her gloves without cleansing her hands. The aide completed the bath and assisted the patient back to the wheelchair.</p> <p>7. The home visit observations were presented to the Home Care Director, employee H on 12-5-13 at 11:15 AM. The director indicated the employees had not followed the agency's infection control policies and procedures.</p>				

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N000472	<p>410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures.</p> <p>Based on administrative record and agency policy review and interview, the agency failed to ensure it had developed and maintained a quality assessment performance improvement (QAPI) program that included all aspects of the agency and used measurable outcomes to evaluate the effectiveness of the agency's program creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. The agency's May 2005 "Quality Monitoring/Performance Improvement" policy number 900.104 states, "Sullivan county community Hospital Home Health will monitor the quality of care delivery via chart review, patient surveys, physician surveys and OBQM/OBQI activities."</p>	N000472	N-0472Clinical Record Review: Policy #900.46 has been revised to indicate a more formal and thorough clinical record review process. The process accounts for review by therapists for those clients receiving therapy services and formalizes the process for reporting record review results to the QAPI committee and the need for action plans for those areas of opportunity. Updated audit tools and reporting records will be formulated and ready for use in January. The HHA Administrator will be responsible for monitoring compliance with this standard. (Documentation Attached).N-0472The Performance Improvement Plan for the HHA is in the process of being updated. The update includes an entirely new comprehensive process for program evaluation. The new program allotts for program goals,	01/01/2014	

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	<p>A. The policy failed to to provide for the monitoring of all services provided by the agency and failed to include the objectives of the program.</p> <p>B. The policy failed to evidence details for data collection and performance improvement activities. The policy failed to provide for tracking performance improvement activities and measures to track and sustain the improvements.</p> <p>C. The policy failed to provide for the monitoring of infection control practices of agency staff. Areas of noncompliance with standard precautions were observed during home visits creating the potential for the spread of disease causing organisms among patients and staff. (see N 470).</p> <p>D. The policy failed to provide for an organized program for a quarterly review of both active and closed clinical records by all disciplines.</p> <p>1). The Home Care Director, employee H, indicated, on 12-5-13 at 12:30 PM, all clinical record audits were completed by the Director herself after the patient is discharged. She indicated there was no "quarterly record review" of a</p>		<p>identification of improvement needs, more specific and detailed measurements, aggregation and analysis of data to include a detailed chart auditing process. Tools to assist in the planning, impenetation and evaluation have been formulated as well as a program self-evaluation tool. Quarterly QAPI meetings will be held and the committee will be comprised of members from all disciplines. The Annual QAPI report will be presented to the Advisory Committee during it's annual meeting. The new program will be rolled out January 1, 2014. Performance improvement projects will include areas of concern identified during the survey process. As well as issues identified through the chart review process, patient satisfaction surveys, physician surveys, OBQM/OBQI reports, and infection control queries, incident reports and Customer Feedback process. The HHA Administrator will be responsible for monitoring the compliance with the Performance Improvement Plan. The Administrator is also responsible for coordinating Quarterly QAPI meetings and compiling the statistics for presentation.</p>		

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	<p>sample of both active and closed clinical records. The Director indicated the audit results were not reviewed in the aggregate at any time to identify potential areas for improvement. She stated, "We just address problems with each individual staff member when there is a problem with the chart."</p> <p>2). The Director indicated no clinical record audits had been completed by any of the therapists at any time.</p> <p>E. The policy failed to provide a definition of adverse events in order to track and analyze the events and implement preventive actions.</p> <p>1). The agency's "QAPI Report to Governing Body" for the period July through December 2012, identified there were 7 adverse events. The report states, "0 were true adverse events." The report identifies 5 of the events were caused by falls and that 3 of the patients were treated in the emergency room. The report states,"1 patient did fracture her arm . . . 1 patient tripped on the curb outside apartment and had a laceration to forearm." The report identifies 2 events were related to emergent care for wounds and 1 patient developed a stage 3 ulcer to the left hip.</p>						

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	<p>The agency's administrative records failed to evidence a system to track and analyze these events. The records failed to evidence a performance improvement project had been implemented. The report states, "Will continue to monitor in 2013."</p> <p>2). The agency's "QAPI Report to Governing Body" for the period January through July 2013" identifies 4 adverse events. The report states, "0 were true adverse events." The report identifies the events were injury caused by falls and that 1 patient fractured an arm, 1 a shoulder, and 1 a hip.</p> <p>a.) The agency's administrative records failed to evidence a system to track and analyze these events. The records failed to evidence a performance improvement project had been implemented. The report states, "Will continue to monitor in 2013."</p> <p>b.) The report identifies the agency's patient satisfaction survey score for explaining medication side effects was below the national average for the system used by the agency. The report states, "We will be working on improving that score . . . will continue to monitor this in 2013." The agency's administrative records failed to evidence a performance</p>				

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	<p>improvement project had been implemented.</p> <p>2. The agency's QAPI policy identified physician satisfaction surveys would be mailed annually to each physician that had a patient discharged from the agency and that "responses to the patient and satisfaction surveys will be compiled and analyzed for negative trends. A plan of corrective action will be established as a collaborative effort involving all staff/disciplines."</p> <p>The agency's administrative records failed to evidence any physician satisfaction surveys or a compilation of results of the surveys.</p> <p>3. The Home Care Director, employee H, and the hospital Clinical Director, employee K, indicated, on 12-5-13 at 12:50 PM, the agency's QAPI program was lacking. The hospital Clinical Director stated, "We plan to address this in 2014."</p>				

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N000484	<p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure failed to ensure coordination of care among disciplines had occurred in 1 (# 9) of 1 record reviewed of patients that received services from more than 1 discipline and had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical record number 9 evidenced SN, home health aide, and physical and occupational therapy had been provided to the patient during the certification periods 7-1-13 to 8-29-13, 8-30-13 to 10-28-13, and 10-29-13 to 12-27-13. The record failed to evidence planned case conferences had been held at least every 60 days per the agency's own policy. 2. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when 	N000484	N-0484Coordination of Care: Case Conferences had been held per policy but documentation was maintained in a Case Conference Log with no formal documentation in the patient chart. Home Health Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy #900.101 has been revised to indicate coordination of care among disciplines and providers. The "Care Plan Update Note" will be filed in the patients chart. (Documentation Attached)The HHA Administrator is responsible for ensuring Case Conferences are held according to policy. The presence of Care Plan Update Forms will be monitored by the Administrator through the chart audit process.	12/23/2013	

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	asked on 12-5-13 at 11:15 AM. 3. The agency's April 2002 "Coordination of Services/Case Management" policy number 900.98 states, "Essential components of service coordination/case management include the following: . . . Communicating in planned and spontaneous case conferences to evaluate progress and consider revision to interventions and goals to meet changing needs. Planned case conferences will be held at least every 60 days for care planning and evaluation."			

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N000486	<p>410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure it had maintained communication with other service providers in 2 (#s 5 and 9) of 2 records reviewed of patients that received services from other care providers creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a start of care comprehensive assessment dated 11-18-13 that states, "SUPPORTIVE ASSISTANCE Names of Organizations Providing Assistance: Choice [a payer source] HMK [homemaker]."</p> <p>A. During a home visit to patient number 5, on 12-3-13 at 1:05 PM, the patient indicated another home health agency provided assistance with bathing, dressing, meal preparation, and housekeeping. The patient indicated staff from the other home health agency "soak my feet every day in vinegar and then apply triple antibiotic ointment."</p>	N000486	N-0486Clinical Record #9 was updated to reflect dialysis meds on the day of survey finding.Drug Regimine Review: Policy #900.72 will be reviewed with clinical staff. The importance of care coordination was discussed and the need for the medication profile to reflect all meds, herbs, vitamins and nutritional supplements was discussed. Clinical Record #5 was updated to reflect coordination of care. Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy #900.101 has been revised to indicate coordination of care among disciplines and providers. The "Care Plan Update Note" will be filed in the patients chart. (Documentation Attached)Coordination of Care: Case Conferences had been held per policy but documentation was maintained in a Case Conference Log with no formal documentation in the patient chart.The HHA	12/23/2013			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>B. The clinical record failed to evidence any communication and/or coordination with the other home health agency providing services to the patient.</p> <p>2. Clinical record number 9 included a recertification comprehensive assessment dated 8-28-13 that identifies the patient had a "R upper chest dialysis cath site" and listed "renal failure [with] dialysis." The record also included a resumption of care comprehensive assessment dated 8-16-13 that identified the patient "has renal failure on dialysis."</p> <p>A. During a home visit to patient number 9, on 12-4-13 at 10:30 AM, the patient indicated dialysis treatment were provided 3 times per week for 4 hours each treatment.</p> <p>B. The clinical record failed to evidence any communication and/or coordination with the dialysis facility that provided the patient's incenter hemodialysis treatments.</p> <p>3. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>4. The agency's April 2002 "Coordination</p>		<p>Administrator is responsible for ensuring Case Conferences are held according to policy and that care coordination occurs and is documented appropriately in the patient record. The presence of Care Plan Update Forms will be monitored by the Administrator through the chart audit process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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	of Services/Case Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis. The coordination may be achieved by phone calls of on site conferences and should be documented in the patient's record. All services will be listed on the patient's plan of care (CMS 485)."			

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N000518	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on clinical record and agency policy review and interview, the agency failed to ensure patients had been informed of the agency's policy regarding advance directives in 12 (#s 1 through 12) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Clinical records numbered 1 through 12 failed to evidence the agency had provided the patients with information concerning the agency's own policies regarding advance directives. 2. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM. 3. The agency's April 2002 "Advance 	N000518	N-0518 The "Patient Information Guide" was reviewed and does contain the HHA's policy on Advanced Directives. The guide also includes the ISDH's "Advance Directives: Your Right To Decide". Upon admission the guide is reviewed with the patient and/or legal representative and acknowledgement of such is documented by signature on the Admission Agreement/Consent For Care Form. This form has been revised by the HHA Administrator to reflect receipt of the Patient Information Guide by the patient/legal representative. The Administrator will inservice the clinical staff on the form change. The Administrator will be responsible for monitor the acknowledgement of receipt of Advance Directive information through the initial chart audit process.	12/20/2013	

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	Directive" policy number 900.95 states, "The agency will provide each adult individual, during the initial visit, written information describing the individual's rights under state statutes and court decisions to accept or refuse medical or surgical treatment and to formulate advance directives. The information will also include the agency's policies regarding the right to make health care decisions, including the right to accept or refuse treatment and formulate advance directives . . . The agency does not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. Nor will the agency discriminate against a patient based on the specific content of an advance directive."				

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N000522	<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 podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure services and procedures had been provided as ordered by the physician in 3 (#s 1, 2, & 8) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Clinical record number 1 included an addendum to the plan of care established by the physician for the certification period 10-12-13 to 12-10-13 dated 11-13-13. The addendum to the plan of care identified a negative pressure wound therapy vacuum dressing change was to be performed 3 times per week and the pressure maintained at 125 mm/Hg (millimeters of mercury) continuously. <p>Skilled nurse (SN) visit notes dated 11-25-13, 11-27-13, and 11-29-13, failed to evidence the nurse had re-applied the wound vacuum at 125 mm/Hg per the physician's order.</p> <ol style="list-style-type: none"> Clinical record number 2 included a 	N000522	N-0522Per the HHA Administrator, SN visit notes for Clinical Record #1 dated 11/25/13, 11/27/13, and 11/29/13 were reviewed with the case manager and the need to document the wound vac pressure setting was discussed. Clinical Record #2: The POC and SN visit notes were reviewed by the Administrator with the case manager. The administrator discussed with employee the importance of following the POC and the appropriate process to make addendums/adjustments to the POC through physician contact and orders. Clinical Record# 8: SN visit frequency reviewed by Administrator and noted verbal order dated 11/21/13 for missed SN visit per patient/family request. Additional visit offered and declined by patient/family. (Document Attached). Acceptance of Patients, POC and Medication Supervision Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and	12/23/2013			

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	<p>plan of care established by the physician for the certification period 11-23-13 to 1-21-13. The plan of care states, "Keep inc [incision] clean & dry. Cleanse site w [with] /betadine, cover w/xeroform, apply 4 x 4, secure w/foam tape."</p> <p>SN visit notes, dated 11-25-13 and 11-27-13, evidenced the SN used Hibiclens to cleanse the incision. The plan of care failed to include an order for the Hibiclens.</p> <p>3. Clinical record number 8 included a plan of care established by the physician for the certification period 11-11-13 to 01-09-14. The plan of care identified SN visits were to be provided 1 time per week for 2 weeks then every other week and that occupational therapy (OT) visits were to be provided 2 times per week for 1 week then 2 times per week for 4 weeks.</p> <p>A. The record failed to evidence any SN visits had been provided the week of 11-17-13 (week # 2).</p> <p>B. The record evidenced only 1 OT visit had been provided the week of 11-17-13 (week # 2).</p> <p>4. The Home Care Director, employee H, was unable to provide any additional</p>		<p>medications, as well as therapy services and frequency/durations. Discipline visits are tracked weekly for compliance with frequencies. Orders are obtained as needed. The HHA Administrator will review the policy with all clinical staff and the Administrator will be responsible for ensuring compliance with the POC through the chart audit process.</p>		

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	<p>documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>5. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."</p>			

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N000524	<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> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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>Based on clinical record and agency policy review and interview, the agency failed to ensure plans of care included all services required, all medications, and specific therapy orders in 3 (#s 5, 9, & 11) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 included a</p>	N000524	N-0524Coordination of CareHome Health Policy #900.98 outlines the process for Coordination of care between service providers and disciplines. A case conference "Care Plan Update Form" will be initiated to document patient progress/decline and show coordination of care between disciplines and providers as well as communication of care to attending physician. Policy #900.101 has been revised to indicate coordination of care	12/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>plan of care established by the physician for the certification period 11-18-13 to 01-16-14. The plan of care failed to include home health services being provided to the patient by another home health agency.</p> <p>A. The record included a start of care comprehensive assessment dated 11-18-13 that states, "Names of organizations providing assistance: Choice [payor source] HMK [homemaker]."</p> <p>B. During a home visit to patient number 5, on 12-3-13 at 1:05 PM, the patient indicated an individual from another home health agency provided total assistance with activities of daily living, such as dressing, bathing, and combing hair, and meal preparation and housekeeping.</p> <p>C. The Home Care Director, employee H, indicated, on 12-3-13 at 2:30 PM, the patient did receive home health aide services from another agency and that the services had not been included on the plan of care.</p> <p>2. Clinical record number 9 included plans of care established by the physician for the certification periods 7-1-13 to 8-29-13, 8-30-13 to 10-28-13, and</p>		<p>among disciplines and providers. (Documentation Attached)The HHA Administrator is responsible for ensuring Case Conferences are held according to policy. The presence of Care Plan Update Forms will be monitored by the Administrator through the chart audit process. Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. The HHA Administrator will review the policy with all clinical staff and ensure compliance with the POC through the chart audit process. N-0524Clinical Record #9 was updated to reflect dialysis meds on the day of survey finding.Drug Regimine Review: Policy #900.72 will be reviewed with clinical staff. The importance of care coordination was discussed and the need for the medication profile to reflect all meds, herbs, vitamins and nutritional supplements was discussed. Clinical Record #11 ST eval was reviewed for the presence of modalities and noted modalities present for aphasia but eval also included a therapy diagnosis of dysphagia. There were no modalities present for dysphagia. Upon interview of ST it was found that family requested</p>	

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>10-29-13 to 12-27-13. The plans of care failed to evidence medications being administered to the patient during dialysis treatments 3 times per week.</p> <p>A. The Home Care Director, employee H, indicated, on 12-3-13 at 4 PM, the plans of care did not include medications being administered to the patient during dialysis treatments.</p> <p>B. The Home Care Director obtained a list of medications from the dialysis facility on 12-3-13 at 3:55 PM. The list identified the patient had been on dialysis since 8-17-13 and that the patient received acetaminophen 650 milligrams (mg) as needed, heparin lock solution 1000 units in each dialysis catheter port every treatment, 7400 units of EPO every treatment 3 times per week, Iron sucrose 50 mg 1 time per week, and Nitroglycerin 0.4 mg sublingual as needed for chest pain.</p> <p>C. The record included orders for physical therapy services dated 10-31-13. The orders failed to specify how many weeks the therapy services would be provided.</p> <p>3. Clinical record 11 included orders for speech therapy services dated 11-13-13. The orders failed to include the specific</p>		no treatment for dysphagia due to prior treatment. (Documentation Attached) The HHA Administrator will be responsible for ensuring compliance with this standard through the process of chart auditing, initial and active.				

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	<p>procedures the speech language pathologist planned to use to treat the patient.</p> <p>4. The Home Care Director, employee H, stated, on 12-5-13 at 11:15 AM, "We have told the therapist not to use a range for the duration of visits." The Director indicated the orders for the speech therapy did not include the specific procedures to be used.</p> <p>5. The agency's April 2002 "Plan of Care" policy number 900.86 states, "The plan of care covers all pertinent diagnoses, including . . . types of services and equipment required . . . medications and treatments."</p> <p>6. The agency's April 2002 "Coordination of Service/Case Management" policy number 900.98 states, "Coordination of care provided by other organizations serving the patient is done on an ongoing basis . . . All services will be listed on the patient's plan of care (CMS 485)."</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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N000529	<p>410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the:</p> <p>(A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months.</p> <p>Based on clinical record review and interview, the agency failed to ensure written summary reports had been sent to the physician at least every two (2) months in 2 (#s 10 and 12) of 3 records reviewed of patients that had been on service for longer than 2 months creating the potential to affect all of the agency's patients receiving services longer than 60 days.</p> <p>The findings include:</p> <p>1. Clinical record number 10, start of care 9-5-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced skilled nursing (SN) services had been provided 1 to 2 times per week during the certification period 9-5-13 to 11-3-13 and every other week during the certification period 11-4-13 to 1-2-13.</p> <p>2. Clinical record number 12, start of</p>	N000529	n-0529 Written Summary of Care: Policy #900.77 addresses the Written Summary of Care guidelines. This policy and appropriate documentation guidelines will be reviewed by the Administrator with clinical staff during Monday Morning Staff Meeting. Update written summary for both patients sent to physician (documentation attached). The Administrator will ensure clinical staff knowledge of appropriate entry of summary in the patient EHR. The HHA Administrator will monitor continued compliance through the chart audit process.	12/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>care 8-12-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes had been sent to the physician. The record evidenced SN had been provided 1 to 2 times per week during the certification periods 8-12-13 to 10-10-13 and 10-11-13 to 12-9-13.</p> <p>3. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013	
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N000537	<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: Based on clinical record and agency policy review and interview, the agency failed to ensure skilled nursing services and procedures had been provided as ordered by the physician in 3 (#s 1, 2, & 8) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included an addendum to the plan of care established by the physician for the certification period 10-12-13 to 12-10-13 dated 11-13-13. The addendum to the plan of care identified a negative pressure wound therapy vacuum dressing change was to be performed 3 times per week and the pressure maintained at 125 mm/Hg (millimeters of mercury) continuously.</p> <p>Skilled nurse (SN) visit notes dated 11-25-13, 11-27-13, and 11-29-13, failed to evidence the nurse had re-applied the wound vacuum at 125 mm/Hg per the physician's order.</p>	N000537	<p>N-0537Per the HHA Administrator, SN visit notes for Clinical Record #1 dated 11/25/13, 11/27/13, and 11/29/13 were reviewed with the case manager and the need to document the wound vac pressure setting was discussed. Clinical Record #2: The POC and SN visit notes were reviewed by the Administrator with the case manager. The administrator discussed with employee the importance of following the POC and the appropriate process to make addendums/adjustments to the POC through physician contact and orders. Clinical Record# 8: SN visit frequency reviewed by Administrator and noted verbal order dated 11/21/13 for missed SN visit per patient/family request. Additional visit offered and declined by patient/family. (Document Attached). Acceptance of Patients, POC and Medication Supervision Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and</p>	12/23/2013			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>2. Clinical record number 2 included a plan of care established by the physician for the certification period 11-23-13 to 1-21-13. The plan of care states, "Keep inc [incision] clean & dry. Cleanse site w [with] /betadine, cover w/xeroform, apply 4 x 4, secure w/foam tape."</p> <p>SN visit notes, dated 11-25-13 and 11-27-13, evidenced the SN used Hibiclens to cleanse the incision. The plan of care failed to include an order for the Hibiclens.</p> <p>3. Clinical record number 8 included a plan of care established by the physician for the certification period 11-11-13 to 01-09-14. The plan of care identified SN visits were to be provided 1 time per week for 2 weeks then every other week and that occupational therapy (OT) visits were to be provided 2 times per week for 1 week then 2 times per week for 4 weeks.</p> <p>The record failed to evidence any SN visits had been provided the week of 11-17-13 (week # 2).</p> <p>4. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p>		<p>medications, as well as therapy services and frequency/durations. Discipline visits are tracked weekly for compliance with frequencies. Orders are obtained as needed. The HHA Administrator will review the policy with all clinical staff and the Administrator will be responsible for ensuring compliance with the POC through the chart audit process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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	5. The agency's April 2002 "Plan of Care" policy number 900.86 states, "A plan of care is developed by the physician, case manager, and interdisciplinary team members; care provided to that patient is in accordance with the plan of care and any additions or modifications must be approved by the physician."			

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N000542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse initiated revisions to the plan of care to address identified nutritional needs in 1 (# 5) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 5 identified the patient began receiving services from the agency on 11-18-13 and had diagnoses of systemic sclerosis, rheumatoid arthritis, and Raynaud's Syndrome. The record included a start of care comprehensive assessment completed by the registered nurse (RN), employee I, on 11-18-13. The assessment identified the patient had lost more than 10 pounds in the last 3 months but had a "Good Nutritional Status" and was on a regular diet.</p> <p>A. A home visit was made to patient number 5 with the occupational therapist (OT), employee D, on 12-4-13 at 1:05</p>	N000542	N-0542 Policy #900.25 and #900.114 reviewed with clinical staff at staff meeting. Revision to POC was discussed. Policy #900.63 was reviewed and revised per the Administrator to provide criteria for implementation of nutritional interventions and consultation with Registered Dietician. This policy was reviewed with clinical staff by the Administrator. The POC and the presence of or need for revision will be monitored by the HHA Administrator through the formal chart audit process. Issues and/or trends will be identified and a plan/recommendation will be implemented. The results of chart audits will be reviewed quarterly at the QAPI quarterly meeting. (Documentation Attached)	12/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2013
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	<p>PM. Observation noted the patient to be very thin and emaciated. The patient indicated the patient's weight was approximately 88 pounds. The patient stated, "I should weigh about 110 pounds. I drink shakes with protein powder in them."</p> <p>B. The record failed to evidence the patient's nutritional status had been communicated to the physician and the plan of care revised to address the patient's compromised nutritional status.</p> <p>2. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p> <p>3. The agency's April 2002 "Clinical Staff Functions" policy number 900.25 states, "Professional nursing service is provided by a registered nurse (RN) . . . Skilled nursing services may include, but are not limited to: . . . Developing and revising the plan of care in collaborations with . . . the patient's physician."</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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N000545	<p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) coordinated with the physician regarding medication changes in 1 (# 1) of 12 records reviewed creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 1 included a hospital "Discharge Instructions" dated 11-12-13. The instructions state, "STOP taking these medicines: bisoprolol-Hydrochlorothiazide 5 mg-6.25 mg 1 tables once a day by mouth. Comment: BP low in the hospital, so please check with PCP [primary care provider] prior to restarting."</p> <p>The record failed to evidence the RN had coordinated with the patient's physician regarding the medication change.</p>	N000545	N-0545Acceptance of Patients, POC and Medication Supervision: Policy #900.86 "Plan of Care" outlines the policy/procedure for the POC. The policy addresses the need to ensure services and procedures are provided according to physician order, that the POC includes all services and medications, as well as therapy services and frequency/durations. The HHA Administrator will review the policy with all clinical staff and the HHA Administrator will be responsible for ensuring compliance with the POC through the initial chart audit process.	12/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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	<p>2. The Home Care Director was unable to provide any additional documentation/information when asked on 12-2-13 at 3:40 PM and on 12-5-13 at 11:15 AM.</p> <p>3. The agency's April 2002 "Clinical Staff Functions" policy number 900.25 states, "Professional nursing services is provided by a registered nurse . . . Skilled nursing services may include, but are not limited to: . . . Coordinating services with other disciplines and facilities, as indicated."</p>			

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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N000570	<p>410 IAC 17-14-1(d) Scope of Services Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may:</p> <p>(1) direct the activities of any therapy assistant; or (2) delegate duties and tasks to other individuals as appropriate.</p> <p>Based on clinical record and agency policy review, interview, and review of the Indiana State Practice Act, the agency failed to ensure services provided by the physical therapy assistant (PTA) had been supervised in accordance with agency policy and the Indiana Practice Act in 6 (#s 3, 4, 5, 7, 8, & 9) of 6 records reviewed of patients that received services from the PTA creating the potential to affect all of the agency's 6 current patients that receive physical therapy services.</p> <p>The findings include:</p> <p>1. 844 IAC 6-1-2 (g) states, "'Direct supervision' means that the supervising physical therapist or physician at all times shall be available and under all circumstances shall be absolutely responsible for the direction and the actions of the person supervised when services are performed by the physical therapist's assistant . . . unless the supervising physical therapist of physician is on the premises to provide constant supervision, the physical</p>	N000570	N-0570PTA Supervision: Policy #900.25 and #900.70 were reviewed by the HHA Administrator. They were noted to be significantly redundant in nature. Policy #900.25 was revised to include the 5 day window to complete therapy evaluation and to clarify client re-evaluation to occur at the 13th visit and again at the 19th visit. Supervision of the PTA will occur according to regulation and can be completed daily by telephone call. Calls are to be logged on form which was reviewed during survey. Policy #900.70 has been retired. The HHA Administrator will be responsible for monitoring compliance through the formal Active chart audit process. PT, OT, ST will be required to participate in the chart audit process and review compliance with standards. (Documentation Attached)	12/27/2013	

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>therapist's assistant shall consult with the supervising physical therapist of physician at least once each working day to review all patients' treatments."</p> <p>2. The agency's April 2002 "Client Home Health Care Visit Protocol for Rehabilitation Services" policy number 900.70 states, "When the patient is seen by the pts [physical therapy assistant], progress notes will be co-signed by the physical therapist . . . The P.T.A. shall consult with the supervising physical therapist or physician at least once each working day to review all client's treatment . . . The consultation may be in person, by telephone, so long as there is interactive communication concerning client care."</p> <p>3. Clinical record number 3 evidenced physical therapy services had been provided 1 to 2 times per week during the certification period 7-2-13 to 8-30-13. The record evidenced the physical therapy assistant (PTA), employee L, had provided services to the patient on 7-12-13, 7-18-13, 7-25-13, 8-2-13, and 8-9-13.</p> <p>A. The visit notes dated 7-12-13, 7-18-13, 7-25-13, 8-2-13, and 8-9-13 failed to evidenced a co-signature by the physical therapist responsible for the</p>						

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>4. Clinical record number 4 evidenced physical therapy services had been provided 1 to 3 times per week during the certification period 3-1-13 to 4-29-13. The record evidenced the PTA, employee L, had provided services to the patient on 3-5-13, 3-7-13, 3-12-13, 3-13-13-, 3-15-13, 3-19-13, and 3-27-13.</p> <p>A. The visit notes dated 3-5-13, 3-7-13, 3-12-13, 3-13-13-, 3-15-13, 3-19-13, and 3-27-13 failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>5. Clinical record number 5 evidenced physical therapy services had been provided 1 to 2 times per week during the certification period 11-18-13 to 1-16-13. The record evidenced the PTA, employee L, had provided services to the patient on</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>11-25-13 and 11-26-13.</p> <p>A. The visit notes dated 11-25-13 and 11-26-13 failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>6. Clinical record number 7 evidenced physical therapy services had been provided 1 to 2 times per week during the certification period 9-25-13 to 11-23-13. The record evidenced the PTA, employee L, had provided services to the patient on 10-15-13, 10-16-13, 10-23-13, .10-25-13, 10-30-13, 11-1-13, and 11-7-13.</p> <p>A. The visit notes, dated .10-25-13, 10-30-13, 11-1-13, and 11-7-13, failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>7. Clinical record number 8 evidenced physical therapy services had been</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	<p>provided 1 to 2 times per week during the certification period 11-11-13 to 01-09-14. The record evidenced the PTA, employee L, had provided services to the patient on 11-22-13 and 11-25-13.</p> <p>A. The visit notes, dated 11-22-13 and 11-25-13, failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's treatments.</p> <p>8. Clinical record number 9 evidenced physical therapy services had been provided 2 to 3 times per week starting 10-31-13. The record evidenced the PTA, employee L, had provided services to the patient on 11-8-13, 11-15-13, 11-18-13, and 11-20-13.</p> <p>A. The visit notes, dated 11-8-13, 11-15-13, 11-18-13, and 11-20-13, failed to evidence a co-signature by the physical therapist responsible for the supervision of the services.</p> <p>B. The record failed to evidence the PTA had consulted with the supervising physical therapist to review the patient's</p>				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882		
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	treatments. 9. The PTA, employee L, indicated, on 12-4-13 at 10 AM, she did speak with the supervising physical therapist per telephone every day. The PTA stated, "We don't talk about every patient I saw that day, only about new evaluations or problems."				

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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N000586	<p>410 IAC 17-14-1(h) Scope of Services Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas:</p> <p>(1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff.</p> <p>(2) Observing, reporting, and documenting patient status and the care or service furnished.</p> <p>(3) Reading and recording temperature, pulse, and respiration.</p> <p>(4) Basic infection control procedures and universal precautions.</p> <p>(5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</p> <p>(6) Maintaining a clean, safe, and healthy environment.</p> <p>(7) Recognizing emergencies and knowledge of emergency procedures.</p> <p>(8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property.</p> <p>(9) Appropriate and safe techniques in personal hygiene and grooming that include the following:</p> <p>(A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene.</p>						

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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH				STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882			
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	<p>(F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform.</p> <p>Based on personnel file and agency policy review, the agency failed to ensure home health aides received at least 12 hours of inservice training in 1 (file A) of 1 home health aide file reviewed of aides employed for all of 2012 creating the potential to affect all of the agency's 6 current patients that receive home health aide services.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Personnel file A evidenced the individual had been hired on 12-8-08 to provide aide services on behalf of the agency. The file failed to evidence the individual had completed 12 hours of in-service training in 2012. The agency's April 2002 "Education and Staff Development" policy number 900.39 states, "Certified home health aides are required to attend a minimum of 12 hours of inservice education per year." 	N000586	N-0586Home Health Aide Education Requirements: Home Health Policy #900.39 indicates the the Home Health Aide's requirement for a minimum 12 hours of inservice education per year. Personnel File A: Employee had 14 hours of continuing education in 2012. (Documentation Attached).The HHA Administrator is responsible for ensuring staff education requirements are met. The Administrator tracks education hours and ensures each aide has at a minimum, 1.0 hr of education time each month. The Administrator will be responsible for monitoring this compliance	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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N000596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file and agency policy review and interview, the agency failed to ensure an individual had been observed for the competent performance of all of the required tasks 1 (file F) of 2 home health aide files reviewed creating the potential to affect all of the agency's 6 current patients that receive home health aide services.</p> <p>The findings include:</p> <p>1. Personnel file F evidenced the individual had been hired on 8-21-13 to provide home health aide services on behalf of the agency. The file failed to evidence the individual had been observed for the competent performance of the appropriate and safe techniques in personal hygiene and grooming that include bed bath as required by 42 CFR 484.36 (a)(1)(ix)(A) and nail and skin care as required by 484.36 (a)(1)(ix)(D).</p>	N000596	N-0596Personnel File F: Employee's Skills Competency Checklist did not address the evaluation of a bed bath or nail care by observation. The aide will be evaluated for competency by the hospital's RN Educator in all areas required. The RN Educator was an LPN for 1 year, has been an RN for 6.5 years and has 4 years experience in Home Care. The HHA will utilize the Hospital's RN Educator for home health aide competency evaluation for a period of 2 years. Competency evaluations will be performed at hire and annually during anniversary month. While the RN educator will be responsible for the competency evaluations, the HHA Administrator will be responsible for monitoring this compliance. (Documentation Attached)	12/19/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157542	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER SULLIVAN COUNTY COMMUNITY HOSPITAL HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 817 N SECTION ST STE A SULLIVAN, IN 47882
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	<p>2. The agency's April 2002 "Home Health Aide Job Requirements, Competency Evaluations and In-service Training" policy number 900.26 states, "The training program must address each of the following subject areas . . . bed bath . . . nail and skin care . . . safe transfer techniques and ambulation . . . Home health aides will successfully complete a competency evaluation, performed by a registered nurse, that addresses the areas listed above."</p>			

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N000608	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review and interview, the agency failed to ensure clinical records included copies of written summary reports in 2 (#s 10 and 12) of 3 records reviewed of patients that had been on service for longer than 60 days creating the potential to affect all of the agency's 34 current patients.</p> <p>The findings include:</p> <p>1. Clinical record number 10, start of care 9-5-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes. The record</p>	N000608	N-0608Written Summary of Care: Policy #900.77 addresses the Written Summary of Care guidelines. This policy and appropriate documentation guidelines will be reviewed by the Administrator with clinical staff during Monday Morning Staff Meeting. Both patients had an updated written summary completed and forwarded to the appropriate physician. The Administrator will ensure clinical staff knowledge of appropriate entry of summary in the patient EHR. The HHA Administrator will monitor continued compliance through the chart audit process. Documentation Attached	12/23/2013			

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	<p>evidenced skilled nursing (SN) services had been provided 1 to 2 times per week during the certification period 9-5-13 to 11-3-13 and every other week during the certification period 11-4-13 to 1-2-13.</p> <p>2. Clinical record number 12, start of care 8-12-13, failed to evidence a written summary report that included a compilation of the pertinent factors of clinical and progress notes. The record evidenced SN had been provided 1 to 2 times per week during the certification periods 8-12-13 to 10-10-13 and 10-11-13 to 12-9-13.</p> <p>3. The Home Care Director, employee H, was unable to provide any additional documentation and/or information when asked on 12-5-13 at 11:15 AM.</p>				