STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157581	A. BUILDING 00 B. WING	03/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED HOME HEALTHCARE INC	1947 HARDER CT STE B SCHERERVILLE, IN 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000 Bldg. 00	This was a revisit survey for the Federal recertification survey conducted on 2-3-2015 to 2-10-2015. Survey Dates: 3-19-15 and 3-20-15 Facility #: 011121 Medicaid Vendor#: 200839240 Surveyor: Tameka Warren, RN, BSN, PHNS Four conditions and sixteen standards were found to be corrected and two standards were recited during this survey. Quality Review: Joyce Elder, MSN, BSN, RN April 1, 2015	G 000		
G 121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.	G 121	The Administrator and Director of Nursingand	04/17/2015

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Based on observation, interview, and review of policy and procedures, the agency failed to ensure staff had provided services in accordance to their own infection control polices in 1 of 1 home visit observation with patient #4 creating the potential to affect any patients cared for employee A. Findings: 1. Home visit observation made on 3/20/15 at 9:15 AM to patient #4, with employee A, Registered Nurse. The RN was observed placing nursing bag on patient's ottoman without barrier. The RN placed a personal binder on top of patient's table and personal items (Bible) without barrier. The RN placed a coat on patient's floor without a barrier. 2. Interview with employee C, director of nursing (DON) and employee B, Quality Assurance (QA) registered nurse, on 3/20/15 at 12:10 PM indicated that employee A, registered nurse, should have used a barrier for bag and equipment during home visit to patient #4's home. 3. The agency's policy titled "Bag Technique", dated May 2010, states,		Quality Assurance Nurse have reviewed the standard, 484.12(c), Compliancewith Accepted Professional Standards and Principles, and agency policy on BagTechnique. The Administrator, Director of Nursing,and Quality Assurance Nurse have also discussed with employee A individuallyabout the home visit findings and observations, reviewing the standards andprinciples with agency policy. Employee A has verbalized	

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	"Purpose: To describe the procedure for maintaining a clean nursing bag and preventing cross contamination ... 5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to bag... ."		understanding as EmployeeA was shown a video on proper bag technique, and was also shown a demonstrationof bag technique by the Director of Nursing, and Employee A has also performeda return demonstration during the discussion. The Director of Nursing also supervised ahome visit with Employee A observing proper bag technique in a patient's homeon 4/6/15, and has been observed to use proper bag technique with use of properbarriers for nursing bag and equipment used for	

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			patient care during thevisit. The Director of Nursing and QualityAssurance Nurse will further in-service field staff on April 17, 2015, goingover and reviewing the standard and bag technique with return demonstration byall staff on an individual basis. The Administrator, Director of Nursing,and Quality Assurance Nurse will be responsible for the maintenance andmonitoring the compliance in accordance with policies and proceduresimplemente	

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			d for control of communicable disease by requiring field employeesperform a yearly return demonstration individually of bag technique observingstandard precautions.	
G 158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on observation, clinical record review and interview, the agency failed to ensure the plan of care (POC) was followed by the registered nurse providing services for 2 of 4 clinical record reviewed (#1 and 4). Findings: 1. Home visit observation made on 3/20/15 at 9:00 AM to patient #4, with	G 158	The Administrator, Director of Nursing,and Quality Assurance Nurse have reviewed the standard, 484.18, Acceptance ofPatients, Plan of Care, and Medical Supervision that care follows a writtenplan of care established and periodically reviewed by a doctor of medicine,osteopathy, podiatric medicine. TheAdministrator, Director of Nursing, and Quality Assurance Nurse have furtherdiscussed with employee A individually who was directly associated with the clinicalrecord findings and home visit during the revisit survey reviewing the	04/17/2015

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	Employee A, registered nurse. During this visit the patient's feet were not assessed. A. Interview on 3/20/15 at 10:15 AM, patient #4 stated, "[employee A], registered nurse, has never touched or checked the feet during any visits. B. Clinical Record #4 (SOC 3/7/15, Certification Period 3/7/15-5/5/15), included a plan of care that states, " ... SN [skilled nurse] is to assess pt.'s [patient's] physical and mental status ... SN to assess/instruct on diabetic management to include: nail, skin & foot care ... ." C. Interview on 3/20/2015 at 12:35 PM, employee C, administrator, employee D, the director of nursing, DON, and employee B, quality assurance registered nurse, agreed patient #4's feet should have been assessed at this home visit observation and at all previous skilled nursing visits with patient #4. 2. Clinical record # 1, start of care 12/13/14, included a POC for the certification period of 2/11/15 - 4/11/15		standardto ensure this deficiency may not recur with the employee as care services ofthe agency are to be provided in accordance with the patient's plan of carethat is established and reviewed by the physician. After discussion with Employee A,clinical notes after the re-visit survey have been reviewed and Employee A hasdocumented appropriately to reflect the patient's plan of care; assessment offeet and foot care, see Addendum 1. Review of patient's vital sign parameterswere reviewed, and Employee A informed the physician on 3/21/2015 notifyingphysician of the patient's increased heart rate as documented by acommunication note, see Addendum 2. The Administrator, Director of Nursing,and Quality Assurance Nurse will further in-service agency staff on April 17,2015 that care services are to follow a written plan of care established,reviewed, and signed by a physician in accordance with the standard. TheQuality Assurance Nurse will audit 10% of clinical records quarterly through02-2016 for compliance and to monitor these corrective actions, to ensure thisdeficiency is corrected and will not recur. All findings will be reported tothe Director of Nursing and is responsible that this deficiency is correctedand compliance maintained.	

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	that stated, " ... SN to inform physician if ... symptomatic heart rate greater than 100 or less than 60 beats/min ... ." A. Home visit observation made on 3/20/15 at 9:00 AM to patient #1 with Employee A, registered nurse. During this visit the patient's heart rate was observed being 110. The record failed to evidence the physician was informed of the out of range heart rate. B. Interview on 3/20/15 at 12:35 PM with employee C, administrator, employee D, DON, and employee B, QA registered nurse, each agreed the registered nurse, employee A, should follow the POC and inform the physician of the elevated out of range heart rate of patient #1 during home visit observation. Employee C, administrator, stated she would notify the physician of the elevated out of range heart rate.			
N 000 Bldg. 00	This was a revisit survey for the State re-licensure survey conducted on 2-3-2015 to 2-10-2015.	N 000		

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	Survey Dates: 3-19-15 and 3-20-15 Facility #: 011121 Medicaid Vendor#: 200839240 Surveyor: Tameka Warren, RN, BSN, PHNS Eight deficiencies were found corrected and two deficiencies were recited during this survey. Quality Review: Joyce Elder, MSN, BSN, RN April 1, 2015			
N 470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, interview, and review of policy and procedures, the agency failed to ensure staff had provided services in accordance to their own infection control polices in 1 of 1 home visit observation with patient #4 creating the potential to affect any patients cared for employee A. Findings: 1. Home visit observation made on	N 470	The Administrator and Director of Nursingand Quality Assurance Nurse have reviewed the rule, 410 IAC 7-12-1(m), Home Health agencyadministration/ management that policies and procedures shall be written andimplemented for the control of communicable diseases in compliance withapplicable federal and state laws, and also reviewing agencypolicy on Bag Technique. The Administrator, Director of Nursing,and Quality Assurance Nurse have also	04/17/2015

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	3/20/15 at 9:15 AM to patient #4, with employee A, Registered Nurse. The RN was observed placing nursing bag on patient's ottoman without barrier. The RN placed a personal binder on top of patient's table and personal items (Bible) without barrier. The RN placed a coat on patient's floor without a barrier. 2. Interview with employee C, director of nursing (DON) and employee B, Quality Assurance (QA) registered nurse, on 3/20/15 at 12:10 PM indicated that employee A, registered nurse, should have used a barrier for bag and equipment during home visit to patient #4's home. 3. The agency's policy titled "Bag Technique", dated May 2010, states, "Purpose: To describe the procedure for maintaining a clean nursing bag and preventing cross contamination ... 5. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to bag... ."		discussed with employee A individuallyabout the home visit findings and observations, reviewing the standards andprinciples with agency policy. Employee A has verbalized understanding as EmployeeA was shown a video on proper bag technique, and was also shown a demonstrationof bag technique by the Director of Nursing, and Employee A has also performeda return demonstration during the discussion. The Director of Nursing also supervised ahome visit with Employee A observing proper bag technique in a patient's homeon 4/6/15, and has been observed to use proper bag technique with use of properbarriers for nursing bag and equipment used for patient care during thevisit. The Director of Nursing and QualityAssurance Nurse will further in-service field staff on April 17, 2015, goingover and reviewing the rule and bag technique with return demonstration by allstaff on an individual basis. The Administrator, Director of Nursing,and Quality Assurance Nurse will be responsible for the maintenance andmonitoring the compliance in accordance with policies and proceduresimplemented for control of communicable disease by requiring field employeesperform a yearly return demonstration individually of bag technique observingstandard	

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			precautions.	
N 522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on observation, clinical record review and interview, the agency failed to ensure the plan of care (POC) was followed by the registered nurse providing services for 2 of 4 clinical record reviewed (#1 and 4). Findings: 1. Home visit observation made on 3/20/15 at 9:00 AM to patient #4, with Employee A, registered nurse. During this visit the patient's feet were not assessed. A. Interview on 3/20/15 at 10:15 AM, patient #4 stated, "[employee A], registered nurse, has never touched or checked the feet during any visits. B. Clinical Record #4 (SOC 3/7/15, Certification Period 3/7/15-	N 522	The Administrator, Director of Nursing,and Quality Assurance Nurse have reviewed the Rule, 410 IAC 17-13-1(a), Patient Care,that medical care shall follow a written medical plan of care established andperiodically reviewed by the physician, dentist, chiropractor, optometrist, orpodiatrist. The Administrator, Director of Nursing,and Quality Assurance Nurse have further discussed with Employee A individuallywho was directly associated with the clinical record findings and home visitduring the revisit survey reviewing the standard to ensure this deficiency maynot recur with the employee as care services of the agency are to be providedin accordance with the patient's plan of care that is established and reviewedby the physician. After discussion with Employee A,clinical notes after the revisit survey have been reviewed and Employee A hasdocumented appropriately to reflect the patient's plan of care; assessment offeet and foot care, see Addendum 1. Review of patient's vital sign parameterswere reviewed, and	04/17/2015

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	5/5/15), included a plan of care that states, " ... SN [skilled nurse] is to assess pt.'s [patient's] physical and mental status ... SN to assess/instruct on diabetic management to include: nail, skin & foot care ... ." C. Interview on 3/20/2015 at 12:35 PM, employee C, administrator, employee D, the director of nursing, DON, and employee B, quality assurance registered nurse, agreed patient #4's feet should have been assessed at this home visit observation and at all previous skilled nursing visits with patient #4. 2. Clinical record # 1, start of care 12/13/14, included a POC for the certification period of 2/11/15 - 4/11/15 that stated, " ... SN to inform physician if ... symptomatic heart rate greater than 100 or less than 60 beats/min ... ." A. Home visit observation made on 3/20/15 at 9:00 AM to patient #1 with Employee A, registered nurse. During this visit the patient's heart rate was observed being 110. The record failed to evidence the physician was informed of the out of range heart rate.		Employee A informed the physician on 3/21/2015 notifyingphysician of the patient's increased heart rate as documented by acommunication note, see Addendum 2. The Administrator, Director of Nursing,and Quality Assurance Nurse will further in-service agency staff on April 17,2015 that care services are to follow a written plan of care established,reviewed, and signed by a physician in accordance with the standard. TheQuality Assurance Nurse will audit 10% of clinical records quarterly through02-2016 for compliance and to monitor these corrective actions, to ensure thisdeficiency is corrected and will not recur. All findings will be reported tothe Director of Nursing and is responsible that this deficiency is correctedand compliance maintained.	

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	B. Interview on 3/20/15 at 12:35 PM with employee C, administrator, employee D, DON, and employee B, QA registered nurse, each agreed the registered nurse, employee A, should follow the POC and inform the physician of the elevated out of range heart rate of patient #1 during home visit observation. Employee C, administrator, stated she would notify the physician of the elevated out of range heart rate.			