

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K016		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2013									
NAME OF PROVIDER OR SUPPLIER NEW HOPE HOME CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4023 N ROSEWOOD AVE MUNCIE, IN 47304											
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G000000	<p>This visit was a home health federal recertification survey.</p> <p>Facility #: 003962</p> <p>Survey Dates: 10/22, 10/23, 10/24, and 10/28/13</p> <p>Medicaid #: 200466330</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor Shannon Pietraszewski, RN, PH Nurse Surveyor in Training</p> <p>Census by Service Type</p> <table> <tr> <td>Skilled Patients</td> <td>7</td> </tr> <tr> <td>Home Health Aide Only Patients</td> <td>26</td> </tr> <tr> <td>Personal Service Only Patients</td> <td>1</td> </tr> <tr> <td>Total</td> <td>34</td> </tr> </table> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>October 30, 2013</p>			Skilled Patients	7	Home Health Aide Only Patients	26	Personal Service Only Patients	1	Total	34	G000000			
Skilled Patients	7														
Home Health Aide Only Patients	26														
Personal Service Only Patients	1														
Total	34														

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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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 observation, interview, and clinical record review, the agency failed to ensure the Advance Directives dated "Revised June 2013" were complete when given to the patients in 7 of 7 clinical records (1, 2, 3, 4, 5, 7, 8) reviewed of patients who were receiving services in June 2013 and 5 of 5 home visits (1, 2, 3, 4, 5) conducted with the potential to affect all 34 patients.</p> <p>Findings:</p> <p>1. On 10/22/13 at 11:30 AM, the Admission Packet was reviewed. The document "Indiana State Department of Health Advance Directive" Revised June 2013 failed to evidence pages 2, 4, 6, and 8.</p>	G000110	All Advanced directives that were revised on June 2013 were replaced in each client home with a completed copy of Advanced Directives. Office staff will double check forms when printing both sides and Skilled Nurse will ensure upon admissions that all forms are complete. All client admission packets were replaced with completed Advanced Directives. 10% of clinical records will be audited quarterly for completeness of forms. Director will be responsible for monitoring corrections and ensure future compliance.	10/25/2013	

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	<p>2. Clinical record 1, start of care (SOC) 3/2/09, with physician orders for 8/8/13 through 10/06/13, evidenced acceptance of the new Advance Directives on 8/6/13.</p> <p>On 10/23/13 at 8:32 AM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>3. Clinical record 2, SOC 9/1/05, with physician orders for 9/13/13 through 11/11/13, evidenced acceptance of the new Advance Directives on 7/9/13.</p> <p>On 10/23/13 at 1:30 PM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>4. Clinical record 3, SOC 1/18/12 , with physician orders for 9/9/13 through 11/7/13, evidenced acceptance of the new Advance Directives on 7/9/13.</p> <p>On 10/23/13 at 9:50 AM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>5. Clinical record 4, start of care SOC</p>				

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	<p>8/23/07, with physician orders for 7/21/13 through 9/18/13, evidenced acceptance of the new Advance Directives on 7/19/13.</p> <p>On 10/23/13 at 10:55 AM during the home visit, the confidential file in the home was not able to be found.</p> <p>6. Clinical record 5, SOC 7/26/13, with physician orders for 7/26/13 through 9/23/13, evidenced acceptance of the new Advance Directives on 7/26/13.</p> <p>On 10/24/13 at 8:32 AM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>7. Clinical record 7, SOC 10/18/10, with physician orders for 8/3/13 through 10/1/13, evidenced acceptance of the new Advance Directives on 7/30/13.</p> <p>8. Clinical record 8, SOC 5/23/12, with physician orders for 9/15/13 through 11/13/13, evidenced acceptance of the new Advance Directives on 7/9/13.</p> <p>9. On 10/25/13, Employee A, Director of Nursing, indicated only one side of the two sided Advance Directives had been copied and only one side had been given to the patients.</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 policy review, observation, and interview, the agency failed to ensure a Registered Nurse and Home Health Aides followed the professional standards of universal precautions and the policy for hand washing for 4 of 5 patients observed for Activities of Daily Living with the potential to affect all patients of the agency. (#1, #3, #4, and #5)</p> <p>The Findings included:</p> <p>1. Observations during the 10/23/2013 home visit from 8:43 a.m. to 9:40 p.m. revealed Employee #M, Home Health Aide, dried his hands with a community hand towel after washing them, removed a disposable pad from under Patient #1, and placed the pad in the trash can without wearing gloves. Employee #M removed Patient #1's shirt and lifted the patient out of the bed with the employee's left arm under Patient #1's head and the right arm under Patient #1's knees and</p>	G000121	The Director of Nursing has inservice all field staff on Universal Precautions and the policy for proper hand washing. The Supervisory Nurse will monitor and reinforce proper Universal Precautions during each supervisory visit and other random visits the nurse may make to the client home. The Director will be responsible for monitoring the corrections and for ensuring the deficiency does not happen again.	11/01/2013			

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	<p>placed him in the shower chair without barriers or gloves. Employee #M did not wash his hands or apply gloves in between removing the patient's 4 x 4 gauze around the feeding tube on the patient's abdomen and prior to rinsing the patient's hair. Employee #A, Director of Nursing, put on gloves and washed the patient's hair without washing her hands after her arrival to the home. Employee M washed the patient's back and then the peri area with the same washcloth in a continuous motion. After the shower, Employee #M removed his gloves, returned the patient to his bedroom, and dried him off without washing hands or applying new gloves. Employee #M did not wash his hands and/or apply new gloves in between drying the floor with a towel from the bathroom to the bedroom to shaving the patient. After putting clothes on the patient, Employee #M washed his hands but continued to dry them off with the community towel. Employee #M did not wash his hands after applying 4 x 4 gauze around the feeding tube site, and did not have gloves on when removing a disposable pad from the wheel chair or a cloth pad from the</p>			

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	<p>patient's bed. Employee #M indicated there were no paper towels in the bathroom for him to use and he did not know where to obtain a clean hand towel for his use.</p> <p>2. Observation during 10/23/2013 home visit from 9:50 a.m. to 10:40 a.m. revealed Employee #G did not wash her hands and/or apply new gloves in between Patient #3's shower and assistance with oral care. Employee #G applied a new pair of gloves before applying denture adhesive to Patient #3's partial denture plate but did not wash her hands before applying the gloves.</p> <p>3. Observation during 10/23/2013 home visit from 10:55 a.m. to 1150 a.m. revealed Employee #F washed her hands prior to removing Patient #4's clothes and partially dried her hands by wiping them on her jeans. Employee #F did not wash her hands or change gloves after Employee #F removed an incontinence pad from the patient's underwear. Employee #F used her gloved left hand to clean the patient's rectum after the patient used the bathroom. Employee #F</p>				

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	<p>continued to wear the same gloves when washing Patient #4's hair, face, and body. Employee #F did not change wash cloths after washing the patient's buttocks and prior to washing lower extremities and groin area. Employee #F continued to wear the same gloves while brushing Patient #F's teeth. Employee #F picked up the patient's dirty clothing from the floor and placed them against her stomach until she put the dirty clothes in the utility room.</p> <p>4. Observation during 10/24/2013 home visit from 8:35 a.m. to 10:00 a.m. revealed Employee #P did wear gloves while shaving Patient #5. Oral care was provided without hand washing or wearing gloves. Employee #P placed Patient #5 into the shower and rinsed the patient without wearing gloves. Employee #P applied gloves and took his left hand and wiped over the patient's buttocks. Using the same gloves, Employee #P washed the patient's hair. Employee #P then washed the patient starting with the shoulders, face, chest, back, buttocks, groin and the lower legs last, using the same gloves and wash</p>			

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	<p>cloth. Employee #A indicated the staff had been educated on universal precautions and infection control.</p> <p>5. A policy titled "Standard Infection Control Procedures For Home Care" approved 11/5/07 states, "1. Wash hands before and after client care and after removing gloves. ... Gloves should be worn for any known or anticipated contact with blood, body fluids, tissue, mucous membrane and non-intact skin. Change gloves and wash hands between client contacts."</p> <p>6. On 10/25/13 at 1 PM, Employee A, the Director of Nursing, indicated all the home health aides have been instructed and have been competency tested on the proper use of gloves and proper order in giving baths.</p>				

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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 review and interview, the agency failed to ensure visits and treatments were completed as ordered on the plan of care for 6 of 10 clinical records reviewed creating the potential for treatment omission and patient harm affecting all 37 patients of the agency. (3, 4, 5, 6, 7 and 9)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care (SOC) 1/18/12, evidenced physician orders for the certification period 9/9/13 through 11/7/13 for home health aide services 1 to 3 hours a visit, 1 to 3 times a day, 5 to 7 days a week for 60 days. The home health aide (HHA) was to assist with all personal care needs, including bathing. The "HHA Assignment Sheet" evidenced the patient was to shower each visit. The clinical record failed to evidence a shower was performed on 9/9/13, 9/10/13, 9/12/13, 9/15/13, 9/16/13, 9/19/13 , 9/22/13, 9/23/13, 9/24/13, 9/29/13, 10/3/13, 10/6/13, 10/7/13, 10/11/13, and 10/13/13.</p>	G000158	<p>Director of Nursing corrected Physician Plan of care to reflect each discipline and the specific treatment and pay source. Corrections made with new physician order (telephone order). reflecting accurate ranges. Staff was inserviced on completing flow sheets correctly and accurately, per individual client orders. Director of Nursing ensured each home had updated home health aide assignment sheet. All staff and clients where instructed on knowing where admission folder/assignment sheet is at in each home. To prevent deficiency from reoccurring in the future 10% of all clinical records will be audited quarterly. Director of Nursing corrected current Plan of Care's with physicians orders correcting ranges of each discipline. Director will be responsible for monitoring these corrective actions and ensure future compliance.</p>	11/22/2013			

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	<p>On 10/25/13 at 12:55 PM, Employee A, the Director of Nursing, indicated the shower had not been completed as ordered.</p> <p>2. Clinical record 4, SOC 8/23/07, evidence physician orders for the certification period 7/21/13 through 9/18/13 for home health aide services 10 hours a day, 3 to 5 visits a day, 5 to 7 days a week for 60 days. Hours were not to exceed 61 hours a week. The record evidenced the hours for week 2 exceeded the ordered hours by 20, the hours for week 3 exceeded hours by 30, the hours for week 4 exceeded hours by 36, the hours for week 5 exceeded hours by 30, the hours for week 6 exceeded hours by 30, the hours for week 7 exceeded hours by 21, the hours for week 8 exceeded hours by 28 hours, and the hours for week 9 exceeded hours by 30 hours.</p> <p>On 10/25/13 at 12:55 PM, Employee A indicated the hours were over.</p> <p>3. Clinical record 5, SOC 7/26/13 included a plan of care for the certification period 7/26/13 to 9/23/2013 with orders for the patient to receive home health aide services one to three times a day, four to six times a week, for 60 days.</p>			

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	<p>A. The clinical record failed to evidence the patient received home health aide services at least four times during weeks 1 and 10. The plan of care failed to evidence an order for respite care but the patient clinical record evidenced the patient received 4 hours of respite services on 9/5/13, 9/10/13, and 9/13/13; 6 hours of respite care on 9/6/13; 2.5 hours of respite care on 9/7/13; and 4.25 hours of respite care on 9/11/13.</p> <p>B. On 10/25/13 at 4:00 PM, Employee A, Director of Nursing, indicated Patient 5 was receiving respite services and she thought the frequency was based on per week rather than by certification period.</p> <p>4. Clinical record 6, SOC 12/3/10, included a plan of care for the certification period 7/20/13 through 9/17/13, with orders for the patient to receive skilled nursing services up to 10 hours a visit; two to four times a day; 5 to 7 days a week for 60 days.</p> <p>A. The clinical record indicated the patient received skilled nursing services for only 2 days on weeks 1 and 10.</p> <p>B. Nursing notes dated 7/21/13, 7/27/13, 7/28/13, 8/2/13, 8/4/13, 8/5/13,</p>			
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	<p>8/6/13, 8/11/13, and 8/18/13 indicated Employee J, Licensed Practical Nurse, administered " OTC [over the counter] vitamin, antacid ... & [and] decongestant " between the working hours of 9:00 a.m. to 5:00 p.m. The plan of care failed to evidence the patient was to receive these medications.</p> <p>5. Clinical record 7, SOC 10/18/10, included a plan of care for the certification period 8/3/13 to 10/1/13 with orders for skilled nursing up to 8 hours a visit, 1 to 2 visits a day, 5 to 7 days a week for 60 days to do a straight in/out cath 3 to 5 times a day and perform Range of Motion (ROM) with each limb each day. The clinical record fails to evidence the registered nurse performed the in/out cath more then 2 times a day on any given day a month, and the registered nurse did not performed the ROM at any time.</p> <p>6. Clinical record 9, SOC 8/19/12, included a plan of care for the certification period 2/15/13 to 4/15/13 with orders for the patient to receive home health aide services up to 23 hours per visit, 3 to 5 times a day, 5 -7 days a week for 9 weeks and skilled nursing services one to two hours a visit, one to three times per day, 5 - 7 days per week for 9 weeks.</p>						

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	The clinical record indicated the patient received home health aide and skilled nursing services for three days during week #1 and one day of home health aide and skilled nursing services on week 10.			

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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			
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 medical record review, observation, and interview, the agency failed to ensure the medications were accurate on the Plan of Care for 2 of 5 home visits. (Patient 1 and 5)</p> <p>Findings include:</p> <p>1. Review of Patient 1's medications on the 10/7/2013 to 12/5/2013 Plan of Care, indicated the resident was receiving Nexium powder 40 mg daily (for the stomach), Xopenex 1 vial daily (for lung congestion), and Risperidone 0.5 mg 1 tab at bedtime (for behaviors).</p> <p>A. Review of Patient 1 ' s medications on 10/23/13 at 8:45 AM, the spouse indicated the pharmacy would not pay for the Xopenex. The spouse</p>	G000159	<p>Skilled Nurse was inservice on medication verification for correctness and will ask to see all medications on reassessment to verify if any changes have been made and reinforce with clients to notify of any med changes. Skilled Nurse will also reinforce this on supervisory visits.10% of all clinical records will be audited quarterly to ensure Plan of Care medications are accurate.The Director will be responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.</p>	10/25/2013			

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	<p>indicated the resident was receiving Brovana 15 mcg (micrograms) every morning and at 8:00 p.m., Budesonide 0.5 mg/2 ml (milliliters) with Ipratropine Bromide 0.5 mg/3 mg and Albuterol Sulfate 0.083% at 12:00 noon, and Albuterol Sulfate 0.083% at 4:00 p.m. The spouse indicated the patient received Nexium 30 mg daily, and the prescription was filled on 8/9/13. The spouse indicated the spouse administered the Risperidone 0.5 mg as needed.</p> <p>B. Employee A indicated on 10/23/13 at 8:45 AM she did not look at the medications during comprehensive reassessments. Employee A indicated she would ask the family if there were changes in the medications and to call the office and inform her if there was any changes after doctor appointments.</p> <p>2. Review of Patient 5's medications on the 9/26/2013 to 11/24/13 Plan of Care indicated the patient was receiving Seroquel 100 mg (milligram) tabs 3 tabs (300 mg total) PO (by mouth) QHS (every bedtime), Thioridazine HCl 50 mg tabs take 1-2 tabs PO QHS PRN (as needed)</p>			

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	<p>for sleep, Xanax 0.25 mg tabs take ½ -1 tab PO TID (three times a day) PRN for anxiety, Fish Oil Multi-Omega 3-6-9 800 mg PO daily, and BiPap QHS"</p> <p>A. Review of Patient 5's medications during the home visit on 10/24/13 at 8:35 AM, the spouse indicated the patient had stopped taking the Seroquel 100 mg (milligrams) tabs at bedtime, Xanax 0.25 mg, and fish oil 800 mg vitamins and stopped using the bi-pap machine for a couple of months. The spouse indicated the patient was receiving 100 mg of Thioridazine HCI three times a day. The pill bottle indicated the Thioridazine HCI was filled by the pharmacy on 9/10/13.</p> <p>B. Employee #A indicated on 10/24/13 at 8:35 AM the family would tell her there were no changes in medications when she would come to the home for comprehensive reassessments.</p>				

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G000230	<p>484.36(d)(3) SUPERVISION</p> <p>If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the registered nurse (RN) conducted home health aide (HHA) supervisory visits when the home health aide was performing care for 3 of 3 records reviewed of patients receiving home health aide only services with the potential to affect all 27 home health aide only patients. (1, 4, and 5)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 3/2/09, evidenced physician orders for 8/8/13 through 10/06/13 for HHA only services. The record evidenced RN supervisory visits 10/2/13, 9/8/13, and 8/21/13 with the aide present but without observing care.</p> <p>2. Clinical record 4, SOC 8/23/07,</p>	G000230	Supervisory Nurse will make all supervisory visits to non skilled clients when the aide is providing care and the nurse will observe the aid giving care.10% of all clinical records will be audited quarterly to ensure supervisory visits reflect the supervisory nurse observing aide giving care to non skilled clients.The Director of nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	10/25/2013	

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	<p>evidenced physician orders for 7/21/13 through 9/18/13 for HHA only services. The record evidenced RN supervisory visits 9/11/13, 8/14/13, and 7/19/13 with the aide present but without observing care.</p> <p>3. Clinical record 5, SOC 7/26/13, evidenced physician orders for 7/26/13 to 9/23/13 for HHA only services. The record evidenced RN supervisory visits 9/18/13 and 10/16/13 with the aide present but without observing care.</p> <p>4. A policy titled "Home Health Aide Services", adopted 11/6/07, states, "The Registered Nurse will provide supervision of the Home Health Aide services. ... For those patients who are not receiving skilled nursing care, the Registered Nurse must make a supervisory visit to the patient's home at least every thirty (30) days, and the Aide must be present and providing care during the supervisory visit at least once every 62 days."</p>			

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N000000	<p>This visit was a home health state licensure survey.</p> <p>Facility #: 003962</p> <p>Survey Dates: 10/22, 10/23, 10/24, and 10/28/13</p> <p>Medicaid #: 200466330</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor Shannon Pietraszewski, RN, PH Nurse Surveyor in Training</p> <p>Census by Service Type</p> <table> <tr> <td>Skilled Patients</td> <td>7</td> </tr> <tr> <td>Home Health Aide Only Patients</td> <td>26</td> </tr> <tr> <td>Personal Service Only Patients</td> <td>1</td> </tr> <tr> <td>Total</td> <td>34</td> </tr> </table> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>October 30, 2013</p>	Skilled Patients	7	Home Health Aide Only Patients	26	Personal Service Only Patients	1	Total	34	N000000			
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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 policy review, observation, and interview, the agency failed to ensure a Registered Nurse and Home Health Aides followed the professional standards of universal precautions and the policy for hand washing for 4 of 5 patients observed for Activities of Daily Living with the potential to affect all patients of the agency. (#1, #3, #4, and #5)</p> <p>The Findings included:</p> <p>1. Observations during the 10/23/2013 home visit from 8:43 a.m. to 9:40 p.m. revealed Employee #M, Home Health Aide, dried his hands with a community hand towel after washing them, removed a disposable pad from under Patient #1, and placed the pad in the trash can without wearing gloves. Employee #M removed Patient #1's shirt and lifted the patient out of the bed with the employee's left arm under Patient #1's head and the right arm under Patient #1's knees and</p>	N000470	The Director of Nursing has in-serviced all staff on Universal Precautions and the policy for proper hand washing. The Supervisory Nurse will monitor and reinforce proper Universal Precautions during each supervisory visit and other random visits the nurse may make to the client home. The Director will be responsible for monitoring the corrections and for ensuring the deficiency does not happen again.	11/01/2013			

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	<p>placed him in the shower chair without barriers or gloves. Employee #M did not wash his hands or apply gloves in between removing the patient's 4 x 4 gauze around the feeding tube on the patient's abdomen and prior to rinsing the patient's hair. Employee #A, Director of Nursing, put on gloves and washed the patient's hair without washing her hands after her arrival to the home. Employee M washed the patient's back and then the peri area with the same washcloth in a continuous motion. After the shower, Employee #M removed his gloves, returned the patient to his bedroom, and dried him off without washing hands or applying new gloves. Employee #M did not wash his hands and/or apply new gloves in between drying the floor with a towel from the bathroom to the bedroom to shaving the patient. After putting clothes on the patient, Employee #M washed his hands but continued to dry them off with the community towel. Employee #M did not wash his hands after applying 4 x 4 gauze around the feeding tube site, and did not have gloves on when removing a disposable pad from the wheel chair or a cloth pad from the</p>			

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	<p>patient's bed. Employee #M indicated there were no paper towels in the bathroom for him to use and he did not know where to obtain a clean hand towel for his use.</p> <p>2. Observation during 10/23/2013 home visit from 9:50 a.m. to 10:40 a.m. revealed Employee #G did not wash her hands and/or apply new gloves in between Patient #3's shower and assistance with oral care. Employee #G applied a new pair of gloves before applying denture adhesive to Patient #3's partial denture plate but did not wash her hands before applying the gloves.</p> <p>3. Observation during 10/23/2013 home visit from 10:55 a.m. to 1150 a.m. revealed Employee #F washed her hands prior to removing Patient #4's clothes and partially dried her hands by wiping them on her jeans. Employee #F did not wash her hands or change gloves after Employee #F removed an incontinence pad from the patient's underwear. Employee #F used her gloved left hand to clean the patient's rectum after the patient used the bathroom. Employee #F</p>						

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	<p>continued to wear the same gloves when washing Patient #4's hair, face, and body. Employee #F did not change wash cloths after washing the patient's buttocks and prior to washing lower extremities and groin area. Employee #F continued to wear the same gloves while brushing Patient #F's teeth. Employee #F picked up the patient's dirty clothing from the floor and placed them against her stomach until she put the dirty clothes in the utility room.</p> <p>4. Observation during 10/24/2013 home visit from 8:35 a.m. to 10:00 a.m. revealed Employee #P did wear gloves while shaving Patient #5. Oral care was provided without hand washing or wearing gloves. Employee #P placed Patient #5 into the shower and rinsed the patient without wearing gloves. Employee #P applied gloves and took his left hand and wiped over the patient's buttocks. Using the same gloves, Employee #P washed the patient's hair. Employee #P then washed the patient starting with the shoulders, face, chest, back, buttocks, groin and the lower legs last, using the same gloves and wash</p>			

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	<p>cloth. Employee #A indicated the staff had been educated on universal precautions and infection control.</p> <p>5. A policy titled "Standard Infection Control Procedures For Home Care" approved 11/5/07 states, "1. Wash hands before and after client care and after removing gloves. ... Gloves should be worn for any known or anticipated contact with blood, body fluids, tissue, mucous membrane and non-intact skin. Change gloves and wash hands between client contacts."</p> <p>6. On 10/25/13 at 1 PM, Employee A, the Director of Nursing, indicated all the home health aides have been instructed and have been competency tested on the proper use of gloves and proper order in giving baths.</p>				

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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 observation, interview, and clinical record review, the agency failed to ensure the Advance Directives dated "Revised June 2013" were complete when given to the patients in 7 of 7 clinical records (1, 2, 3, 4, 5, 7, 8) reviewed of patients who were receiving services in June 2013 and 5 of 5 home visits (1, 2, 3, 4, 5) conducted with the potential to affect all 34 patients.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 10/22/13 at 11:30 AM, the Admission Packet was reviewed. The document "Indiana State Department of Health Advance Directive" Revised June 2013 failed to evidence pages 2, 4, 6, and 8. Clinical record 1, start of care (SOC) 3/2/09, with physician orders for 8/8/13 through 10/06/13, evidenced acceptance 	N000518	All Advanced Directives that were revised on June 2013 were replaced in each client home with a completed copy of Advanced Directives. The office staff will double check forms for completeness when copying two sided. Skilled Nurse will ensure upon admission that all forms are complete. All client admission packets were replaced with completed Advanced Directives. 10% of all clinical records will be audited quarterly for completeness of forms in clinical records. The Director will be responsible for monitoring corrections and to ensure future compliance.	10/25/2013			

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	<p>of the new Advance Directives on 8/6/13.</p> <p>On 10/23/13 at 8:32 AM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>3. Clinical record 2, SOC 9/1/05, with physician orders for 9/13/13 through 11/11/13, evidenced acceptance of the new Advance Directives on 7/9/13.</p> <p>On 10/23/13 at 1:30 PM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>4. Clinical record 3, SOC 1/18/12 , with physician orders for 9/9/13 through 11/7/13, evidenced acceptance of the new Advance Directives on 7/9/13.</p> <p>On 10/23/13 at 9:50 AM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>5. Clinical record 4, start of care SOC 8/23/07, with physician orders for 7/21/13 through 9/18/13, evidenced acceptance of the new Advance Directives on 7/19/13.</p>						

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	<p>On 10/23/13 at 10:55 AM during the home visit, the confidential file in the home was not able to be found.</p> <p>6. Clinical record 5, SOC 7/26/13, with physician orders for 7/26/13 through 9/23/13, evidenced acceptance of the new Advance Directives on 7/26/13.</p> <p>On 10/24/13 at 8:32 AM during the home visit, the confidential file in the home evidenced the incomplete "Indiana State Department of Health Advance Directive."</p> <p>7. Clinical record 7, SOC 10/18/10, with physician orders for 8/3/13 through 10/1/13, evidenced acceptance of the new Advance Directives on 7/30/13.</p> <p>8. Clinical record 8, SOC 5/23/12, with physician orders for 9/15/13 through 11/13/13, evidenced acceptance of the new Advance Directives on 7/9/13.</p> <p>9. On 10/25/13, Employee A, Director of Nursing, indicated only one side of the two sided Advance Directives had been copied and only one side had been given to the patients.</p>						

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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 review and interview, the agency failed to ensure visits and treatments were completed as ordered on the plan of care for 6 of 10 clinical records reviewed creating the potential for treatment omission and patient harm affecting all 37 patients of the agency. (3, 4, 5, 6, 7 and 9)</p> <p>Findings:</p> <p>1. Clinical record 3, start of care (SOC) 1/18/12, evidenced physician orders for the certification period 9/9/13 through 11/7/13 for home health aide services 1 to 3 hours a visit, 1 to 3 times a day, 5 to 7 days a week for 60 days. The home health aide (HHA) was to assist with all personal care needs, including bathing. The "HHA Assignment Sheet" evidenced the patient was to shower each visit. The clinical record failed to evidence a shower was performed on 9/9/13, 9/10/13, 9/12/13, 9/15/13, 9/16/13, 9/19/13 , 9/22/13, 9/23/13, 9/24/13, 9/29/13, 10/3/13, 10/6/13, 10/7/13, 10/11/13, and 10/13/13.</p>	N000522	<p>Director of Nursing corrected Physician Plan of care to reflect each discipline and the specific treatment and pay source. Corrections made with new physician order (telephone order). reflecting accurate ranges. Staff was inserviced on completing flow sheets correctly and accurately, per individual client orders. Director of Nursing ensured each home had updated home health aide assignment sheet. All staff and clients were instructed on knowing where admission folder/assignment sheet is at in each home. To prevent deficiency from reoccurring in the future 10% of all clinical records will be audited quarterly. Director of Nursing corrected current Plan of Care's with physicians orders correcting ranges of each discipline. Director will be responsible for monitoring these corrective actions and ensure future compliance.</p>	11/22/2013			

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	<p>On 10/25/13 at 12:55 PM, Employee A, the Director of Nursing, indicated the shower had not been completed as ordered.</p> <p>2. Clinical record 4, SOC 8/23/07, evidence physician orders for the certification period 7/21/3 through 9/18/13 for home health aide services 10 hours a day, 3 to 5 visits a day, 5 to 7 days a week for 60 days. Hours were not to exceed 61 hours a week. The record evidenced the hours for week 2 exceeded the ordered hours by 20, the hours for week 3 exceeded hours by 30, the hours for week 4 exceeded hours by 36, the hours for week 5 exceeded hours by 30, the hours for week 6 exceeded hours by 30, the hours for week 7 exceeded hours by 21, the hours for week 8 exceeded hours by 28 hours, and the hours for week 9 exceeded hours by 30 hours.</p> <p>On 10/25/13 at 12:55 PM, Employee A indicated the hours were over.</p> <p>3. Clinical record 5, SOC 7/26/13 included a plan of care for the certification period 7/26/13 to 9/23/2013 with orders for the patient to receive home health aide services one to three times a day, four to six times a week, for 60 days.</p>			

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	<p>A. The clinical record failed to evidence the patient received home health aide services at least four times during weeks 1 and 10. The plan of care failed to evidence an order for respite care but the patient clinical record evidenced the patient received 4 hours of respite services on 9/5/13, 9/10/13, and 9/13/13; 6 hours of respite care on 9/6/13; 2.5 hours of respite care on 9/7/13; and 4.25 hours of respite care on 9/11/13.</p> <p>B. On 10/25/13 at 4:00 PM, Employee A, Director of Nursing, indicated Patient 5 was receiving respite services and she thought the frequency was based on per week rather than by certification period.</p> <p>4. Clinical record 6, SOC 12/3/10, included a plan of care for the certification period 7/20/13 through 9/17/13, with orders for the patient to receive skilled nursing services up to 10 hours a visit; two to four times a day; 5 to 7 days a week for 60 days.</p> <p>A. The clinical record indicated the patient received skilled nursing services for only 2 days on weeks 1 and 10.</p> <p>B. Nursing notes dated 7/21/13, 7/27/13, 7/28/13, 8/2/13, 8/4/13, 8/5/13, 8/6/13, 8/11/13, and 8/18/13 indicated</p>				

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	<p>Employee J, Licensed Practical Nurse, administered " OTC [over the counter] vitamin, antacid ... & [and] decongestant " between the working hours of 9:00 a.m. to 5:00 p.m. The plan of care failed to evidence the patient was to receive these medications.</p> <p>5. Clinical record 7, SOC 10/18/10, included a plan of care for the certification period 8/3/13 to 10/1/13 with orders for skilled nursing up to 8 hours a visit, 1 to 2 visits a day, 5 to 7 days a week for 60 days to do a straight in/out cath 3 to 5 times a day and perform Range of Motion (ROM) with each limb each day. The clinical record fails to evidence the registered nurse performed the in/out cath more then 2 times a day on any given day a month, and the registered nurse did not performed the ROM at any time.</p> <p>6. Clinical record 9, SOC 8/19/12, included a plan of care for the certification period 2/15/13 to 4/15/13 with orders for the patient to receive home health aide services up to 23 hours per visit, 3 to 5 times a day, 5 -7 days a week for 9 weeks and skilled nursing services one to two hours a visit, one to three times per day, 5 - 7 days per week for 9 weeks.</p> <p>The clinical record indicated the</p>						

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	patient received home health aide and skilled nursing services for three days during week #1 and one day of home health aide and skilled nursing services on week 10.				

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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 medical record review, observation, and interview, the agency failed to ensure the medications were accurate on the Plan of Care for 2 of 5 home visits. (Patient 1 and 5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Patient 1's medications on the 10/7/2013 to 12/5/2013 Plan of Care, 	N000524	Skilled Nursing was inservice on medication verification for correctness. Nurse will ask to see all Med bottles on reassessment and reinforce to client to notify agency with any medication changes. Skilled Nurse will also reinforce this on supervisory visits. 10% of medical records will be audited quarterly to ensure Plan of Care medications are accurate. The Director will be responsible for monitoring these corrective actions to ensure deficiency is corrected and to	10/25/2013			

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	<p>indicated the resident was receiving Nexium powder 40 mg daily (for the stomach), Xopenex 1 vial daily (for lung congestion), and Risperidone 0.5 mg 1 tab at bedtime (for behaviors).</p> <p>A. Review of Patient 1 ' s medications on 10/23/13 at 8:45 AM, the spouse indicated the pharmacy would not pay for the Xopenex. The spouse indicated the resident was receiving Brovana 15 mcg (micrograms) every morning and at 8:00 p.m., Budesonide 0.5 mg/2 ml (milliliters) with Ipratropine Bromide 0.5 mg/3 mg and Albuterol Sulfate 0.083% at 12:00 noon, and Albuterol Sulfate 0.083% at 4:00 p.m. The spouse indicated the patient received Nexium 30 mg daily, and the prescription was filled on 8/9/13. The spouse indicated the spouse administered the Risperidone 0.5 mg as needed.</p> <p>B. Employee A indicated on 10/23/13 at 8:45 AM she did not look at the medications during comprehensive reassessments. Employee A indicated she would ask the family if there were changes in the medications and to call the</p>		prevent any further errors.				

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	<p>office and inform her if there was any changes after doctor appointments.</p> <p>2. Review of Patient 5's medications on the 9/26/2013 to 11/24/13 Plan of Care indicated the patient was receiving Seroquel 100 mg (milligram) tabs 3 tabs (300 mg total) PO (by mouth) QHS (every bedtime), Thioridazine HCI 50 mg tabs take 1-2 tabs PO QHS PRN (as needed) for sleep, Xanax 0.25 mg tabs take ½ -1 tab PO TID (three times a day) PRN for anxiety, Fish Oil Multi-Omega 3-6-9 800 mg PO daily, and BiPap QHS"</p> <p>A. Review of Patient 5's medications during the home visit on 10/24/13 at 8:35 AM, the spouse indicated the patient had stopped taking the Seroquel 100 mg (milligrams) tabs at bedtime, Xanax 0.25 mg, and fish oil 800 mg vitamins and stopped using the bi-pap machine for a couple of months. The spouse indicated the patient was receiving 100 mg of Thioridazine HCI three times a day. The pill bottle indicated the Thioridazine HCI was filled by the pharmacy on 9/10/13.</p> <p>B. Employee #A indicated on 10/24/13 at 8:35 AM the family would</p>						

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	tell her there were no changes in medications when she would come to the home for comprehensive reassessments.				