

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157240	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2015
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NAME OF PROVIDER OR SUPPLIER CLINICAL HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 610 N HALLECK DEMOTTE, IN 46310
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G 000 Bldg. 00	This visit was for a home health federal recertification survey. This visit resulted in a partial extended survey. Survey date: February 25 - 27, 2015 Facility #: IN006009 Medicaid Vendor #: 100265900A Surveyor: Ingrid Miller, PHNS, RN Skilled unduplicated census: 163 Quality Review: Joyce Elder, MSN, BNS, RN March 4, 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. Based on observation, interview, and review of policy and procedures, the agency failed to ensure staff (G and I) had provided services in accordance to	G 121	1. All field staff will be re-instructed on infection control. A copy of the agency infection control and bag technique policy/procedure will be provided	03/25/2015

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>their own infection control polices in 2 of 6 home visit observations (#3 and #4) creating the potential to affect any patients cared for by Employee G, Registered Nurse, and Employee I, Physical Therapist.</p> <p>Findings</p> <p>1. At a home visit observation made on 2/26/15 at 5:15 PM to Patient #3 with Employee I, Physical Therapist, Employee I was observed to take a pulse oximeter out of his medical bag and use it on the patient's finger and then return the equipment without washing his hands or disinfecting the equipment.</p> <p>At 2/26/15 at 5:45 PM, Employee I indicated the equipment should be disinfected when returned to the bag and hands washed before entering the bag.</p> <p>2. At a home visit observation made on 2/27/15 at 11:30 AM to patient #4 with Employee G, Registered Nurse (RN), Employee G was observed to discard the used wound vac canister into the trash. She did not change her gloves or wash her hands after throwing this item into the trash. She then was observed to remove the patient's coccyx wound</p>		<p>to all field staff. Failure to adhere to agency policy/procedure will be grounds for disciplinary action which may include termination. All saline bottles will be one time use. Spray bottles for saline wash will be dated and disposed of after 28 days 2. Infection Control/Universal Precautions and Bloodborne Pathogens in-services are mandatory in the agency's hiring process and annual continuing education program. The Administrator/DON or qualified designee shall conduct unannounced home visits to observe staff performing appropriate procedures. 3.The Administrator/DON is responsible for overseeing these corrective actions to ensure that this deficiency is corrected and does not reoccur</p>	

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	<p>dressings. She removed her gloves and washed her hands. She poured normal saline from an already opened 1000 milliliter sterile normal saline bottle with an expiration date of 12/15 onto gauze pads by touching the lip of the bottle onto the gauze pads. There was no date or time of when this normal saline had been opened or the initials of whomever had opened it. She cleansed the wound. She discarded the gloves she was wearing and applied new gloves without washing or disinfecting her hands before applying the wound dressing.</p> <p>a. On 2/27/15 at 11:50 AM, Employee G indicated the bottle of saline had been opened and did not have the initials of who had opened it or the date and time of opening. She indicated the bottle had been opened two weeks ago. She indicated hands should be washed after gloves removed.</p> <p>b. On 2/27/15 at 2:35 PM, the administrator indicated the normal saline should have been signed and dated by whomever had opened it before its use with wound care at the visit observation above. She indicated hands should be washed after gloves are removed.</p>			

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	<p>4. The agency document titled "Universal Precautions" with no date stated, "Universal precautions means the prevention of disease transmission through the use of infection control practices with all patients ... This home care agency complies with the infection control practices required by the Indiana State Department of Health [ISDH], which were adopted by Indiana law, Indiana Occupational Safety and Health administration ... standards and Centers for Disease Control and Prevention [CDC] ... recommendations."</p> <p>5. The agency procedure titled "Infection Control - Hand Hygiene" with a date of 8/08 stated, "Indications for Hand - hygiene is required, but not limited to, the following home care patient activities [CDC 2002 guidelines] ... Decontaminate hands after removing gloves and or glove changes ... before entering or re - entering nursing bag."</p> <p>6. The agency policy titled "Exposure Control Plan: OSHA [Occupational Safety and Health Administration of the United States] ... Bags used by nurse, home health aides and other staff ... if additional items are needed after care has</p>			

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G 159 Bldg. 00	<p>started, wash hands before re - entering bag ... wash hands and return equipment to the bag."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on policy and clinical record review and interview, the agency failed to ensure the plan of care was signed by the physician in a timely manner for 3 of 12 records reviewed (#3, #8, #11).</p> <p>Findings</p>	G 159	<p>1. All staff will be re-instructed on the need for all verbal orders to be turned in promptly. Office staff will generate plan of cares timely and send to physician. 2. Follow-up on outstanding orders sent by mail, fax, hand delivered. A outstanding orders report will be generated weekly, if orders are not received with in 3 weeks</p>	03/20/2015			

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	<p>1. Clinical record #3, start of care (SOC) 12/18/14 - 2/15/15 and diagnosis of diabetes with neurological manifestations, included a plan of care for the certification period of 12/18/14 - 2/15/15. This plan of care was signed by the physician on 2/10/15.</p> <p>2. Clinical record #8, SOC 11/28/14 and diagnosis of breast cancer and after care of traumatic fracture of ankle, included a plan of care for the certification period of 11/28/14 - 1/26/15. This plan of care was signed by the physician on 1/11/15.</p> <p>On 2/27/15 at 4 PM, Employee B, Registered Nurse, indicated the plan of care had not been signed by the physician in a timely manner.</p> <p>3. Clinical record #11, SOC 10/7/14 and diagnosis of hypertensive heart with heart failure and congestive heart failure, included a plan of care for the certification period of 12/6/14 - 2/3/15. This plan of care was signed by the physician on 1/15/15.</p> <p>4. On 2/27/15 at 4:05 PM, Employee B indicated the physicians often signed the plans of care late.</p> <p>5. The agency policy titled "Plan of Care</p>		<p>or origination , a staff member will hand deliver to physician office to ensure a signature is obtained. 3. The Administrator/DON is responsible for overseeing these corrective actions to ensure that this deficiency is corrected and does not reoccur</p>				

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G 174 Bldg. 00	<p>- CMS 485 and Physician Orders" with a date of 9/10/01 stated, "Skilled nursing and other home health services will be in accordance with a plan of care ... Consultation with the physician on any modification in the plan of care will be documented and the physician's signature obtained according to state law."</p> <p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill.</p> <p>Based on clinical record and policy review and interview, the home health agency failed ensure the registered nurse utilized knowledge and specialized nursing skill to furnish those services requiring nursing skill for 1 of 2 home visits observed (# 4) with a registered nurse (g).</p> <p>Findings</p> <p>1. At a home visit observation made on</p>	G 174	1. All field staff will be re-instructed on infection control. A copy of the agency infection control and bag technique policy/procedure will be provided to all field staff. Failure to adhere to agency policy/procedure will be grounds for disciplinary action which may include termination.	03/25/2015

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	<p>2/27/15 at 11:30 AM to patient #4 with Employee G, Registered Nurse (RN), Employee G was observed to discard the used wound vac canister into the trash. She did not change her gloves or wash her hands after throwing this item into the trash. She then was observed to remove the patient's coccyx wound dressing. She removed her gloves and washed her hands. She poured normal saline from an already opened 1000 milliliter sterile normal saline bottle with an expiration date of 12/15 onto gauze pads by touching the lip of the bottle onto the gauze pads. There was no date or time of when this normal saline had been opened or the initials of whomever had opened it. She cleansed the wound. She discarded the gloves she was wearing and applied new gloves without washing or disinfecting her hands before applying the wound dressing.</p> <p>A. On 2/27/15 at 11:50 AM, Employee G indicated the bottle of saline had been opened and did not have the initials of who had opened it or the date and time of opening. She indicated the bottle had been opened two weeks ago. She indicated hands should be washed</p>		<p>All saline bottle will be one time use. Spray bottles for saline wash will be dated and disposed of after 28 days</p> <p>2. Infection Control/Universal Precautions and Bloodborne Pathogens in-services are mandatory in the agency's hiring process and annual continuing education program. The Administrator/DON or qualified designee shall conduct unannounced home visits to observe staff performing appropriate procedures.</p> <p>3. The Administrator/DON is responsible for overseeing these corrective actions to ensure that this deficiency is corrected and does not reoccur</p>	

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	<p>after gloves removed.</p> <p>B. On 2/27/15 at 2:35 PM, the administrator indicated the normal saline should have been signed and dated by whomever had opened it before its use with wound care at the visit observation above. She indicated hands should be washed after gloves are removed.</p> <p>3. The agency document titled "Universal Precautions" with no date stated, "Universal precautions means the prevention of disease transmission through the use of infection control practices with all patients ... This home care agency complies with the infection control practices required by the Indiana State Department of Health [ISDH], which were adopted by Indiana law, Indiana Occupational Safety and Health administration ... standards and Centers for Disease Control and Prevention [CDC] ... recommendations."</p> <p>4. The agency procedure titled "Infection Control - Hand Hygiene" with a date of 8/08 stated, "Indications for Hand - hygiene is required, but not limited to, the following home care patient activities [CDC 2002 guidelines] ... Decontaminate hands after removing gloves and or glove</p>				

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G 176 Bldg. 00	<p>changes ."</p> <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. Based on clinical record and agency policy/ procedure review and interview, the home health agency failed to ensure the registered nurse (J) prepared clinical and progress notes for 1 of 12 clinical records reviewed (#2).</p> <p>Findings</p> <p>1. Clinical record #2, start of care 8/25/14 with a diagnosis of Parkinson's Disease, included a plan of care for the certification period of 12/23/14 - 2/20/15 with orders for wound care. Employee J, Registered Nurse, failed to evidence the wound area had been cleansed prior to treating and dressing the wound at visits on 2/4/15 and 2/11/15. There was no order for cleansing on the order for the duoderm change ordered on the plan of care.</p> <p>a. A skilled nursing visit report on 2/4/15 at 9 AM showed that a duoderm dressing had been applied to the left buttocks wound. This visit note</p>			G 176	<p>1. all Nursing staff will receive copy of policy and procedure "Skin and Wound Cleansing" and be re-instructed on properly cleansing of wounds prior to applying a new dressing and on proper documentation of wounds. Failure to adhere to agency policy/procedure will be grounds for disciplinary action which may include termination. 2. The Administrator/DON and their designee will make in home spot checks to make sure policy are being followed. All nurses will have a spot check by 3/25/15 and then quarterly. A nurses note has been added this will be reviewed by a chart review of at least 10 % quarterly 3. The Administrator/DON will make sure policy are being followed and deficiency is corrected and does not reoccur.</p>		03/25/2015

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	<p>failed to evidence the area had been cleansed prior to the application of the duoderm. This visit was completed by Employee J.</p> <p>b. A skilled nursing visit report on 2/11/15 at 8:45 AM showed that a duoderm dressing had been applied to the left buttocks wound. The wound had not been cleansed. This visit was completed by Employee J.</p> <p>c. On 2/27/14 at 12:45 PM, the administrator indicated the wounds were to be cleansed as part of the wound care protocol that was a part of the agency's wound care policy / protocol. She indicated it was not necessary for the physician's order to state that cleansing would occur, but the agency protocol was to cleanse all wounds with soap and water or normal saline. She also indicated the nurse had failed to document the cleansing of the wound and that the cleansing of the wound had occurred.</p> <p>2. The agency protocol titled "Skin and Wound Cleansing" with no date stated, "Cleanse wounds initially and at each dressing change with soap and water and / normal saline unless otherwise specified by the physician ... after care ... document in patient's record a. procedure."</p>			

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G 224 Bldg. 00	<p>3. The agency policy titled "Clinical record" with no date stated, "The clinical record contains the documentation, which reflects the medical, nursing, and therapeutic care rendered to the patient."</p> <p>4. The agency policy titled "Nursing Services" with a revised date of 2009 stated, "Professional nursing service will be provided by a registered nurse and include ... preparing clinical and progress notes."</p> <p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse provided timely care instructions for the home health aide for 1 of 9 records (#1)</p>	G 224	1. All Nursing Staff will be re-instructed that the aid assignment sheet must be sign and dated for the date completed for admission and re-certification period. They will also update aid assignment sheets as patient	03/20/2015

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	<p>reviewed with orders for home health aide services and the agency failed to ensure the registered nurse (G) reviewed the aide care plan every 60 days for 1 of 1 closed records reviewed with aide services and longer than 60 days of home health aide service (# 9).</p> <p>Findings include</p> <p>1. Clinical record #1 evidenced a start of care (SOC) 1/16/15 and a plan of care for the certification period of 1/16/15 - 3/16/15 with orders for home health aide two times a week for 9 weeks. Aide visits occurred on 1/19/15, 1/23/15, 1/26/15, 1/30/15, 2/6/15, 2/9/15, 2/13/15, 2/16/15, 2/20/15, and 2/23/15. The written patient care instructions prepared for the aide by the registered nurse, Employee G, were not prepared by the registered nurse until 2/11/15.</p> <p>On 2/27/15 at 1 PM, the administrator indicated the Employee G, registered nurse, had signed and dated the aide care plan late.</p> <p>2. Clinical record #9 evidenced a SOC 3/4/14 and a plan of care for the certification period of 8/31/14 - 10/29/14 with home health aide services one time a week for 9 weeks. The home health aide made visits during this certification</p>		<p>condition changes with a new assignment sheet with a date and signature 2. The Administrator/DON or designee will do 100% chart audit to ensure compliance with the 60 day review rule. 3. The Administrator/DON or designee will do 10% of clinical record review to ensure continued compliance</p>				

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N 000 Bldg. 00	<p>period on 9/3/14, 9/10/14, 9/17/14, 9/24/15, 10/1/14. One aide care plan was reviewed on 6/30/14 by the registered nurse and was not reviewed by the registered nurse again until 10/15/14.</p> <p>On 2/27/15 at 10:15 AM, the administrator indicated the aide care plan was not reviewed every 60 days as needed.</p> <p>3. The agency policy titled "Care Planning Process" with a date of 2009 stated, "The patient care plan for the home health aide, home health aide assignment sheet: developed by a Registered Nurse ... prior to home health aide rendering care. Reviewed at least every 14 days during supervisory visit for skilled care and every 30 days for nonskilled care."</p> <p>This visit was for a state relicensure survey.</p> <p>Survey date: February 25 - 27, 2015</p> <p>Facility #: IN006009</p>	N 000		

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N 470 Bldg. 00	<p>Medicaid Vendor #: 100265900A</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Skilled unduplicated census: 163</p> <p>Quality Review: Joyce Elder, MSN, BNS, RN March 4, 2015</p> <p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, interview, and review of policy and procedures, the agency failed to ensure staff (G and I) had provided services in accordance to their own infection control polices in 2 of 6 home visit observations (#3 and #4) creating the potential to affect any patients cared for by Employee G, Registered Nurse, and Employee I, Physical Therapist.</p> <p>Findings</p> <p>1. At a home visit observation made on</p>	N 470	<p>1. All field staff will be re-instructed on infection control. A copy of the agency infection control and bag technique policy/procedure will be provided to all field staff. All saline bottle will be one time use. Spray bottles for saline wash will be dated and disposed of after 28 days Failure to adhere to agency policy/procedure will be grounds for disciplinary action which may include termination. 2. Infection Control/Universal Precautions and Bloodborne Pathogens in-services are mandatory in the agency's hiring process and annual continuing education</p>	03/25/2015			

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	<p>2/26/15 at 5:15 PM to Patient #3 with Employee I, Physical Therapist, Employee I was observed to take a pulse oximeter out of his medical bag and use it on the patient's finger and then return the equipment without washing his hands or disinfecting the equipment.</p> <p>At 2/26/15 at 5:45 PM, Employee I indicated the equipment should be disinfected when returned to the bag and hands washed before entering the bag.</p> <p>2. At a home visit observation made on 2/27/15 at 11:30 AM to patient #4 with Employee G, Registered Nurse (RN), Employee G was observed to discard the used wound vac canister into the trash. She did not change her gloves or wash her hands after throwing this item into the trash. She then was observed to remove the patient's coccyx wound dressing. She removed her gloves and washed her hands. She poured normal saline from an already opened 1000 milliliter sterile normal saline bottle with an expiration date of 12/15 onto gauze pads by touching the lip of the bottle onto the gauze pads. There was no date or time of when this normal saline had been opened or the initials of whomever had</p>		<p>program. The Administrator/DON or qualified designee shall conduct unannounced home visits to observe staff performing appropriate procedures. 3.The Administrator/DON is responsible for overseeing these corrective actions to ensure that this deficiency is corrected and does not reoccur</p>				

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	<p>opened it. She cleansed the wound. She discarded the gloves she was wearing and applied new gloves without washing or disinfecting her hands before applying the wound dressing.</p> <p>a. On 2/27/15 at 11:50 AM, Employee G indicated the bottle of saline had been opened and did not have the initials of who had opened it or the date and time of opening. She indicated the bottle had been opened two weeks ago. She indicated hands should be washed after gloves removed.</p> <p>b. On 2/27/15 at 2:35 PM, the administrator indicated the normal saline should have been signed and dated by whomever had opened it before its use with wound care at the visit observation above. She indicated hands should be washed after gloves are removed.</p> <p>4. The agency document titled "Universal Precautions" with no date stated, "Universal precautions means the prevention of disease transmission through the use of infection control practices with all patients ... This home care agency complies with the infection control practices required by the Indiana State Department of Health [ISDH],</p>			

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	<p>which were adopted by Indiana law, Indiana Occupational Safety and Health administration ... standards and Centers for Disease Control and Prevention [CDC] ... recommendations."</p> <p>5. The agency procedure titled "Infection Control - Hand Hygiene" with a date of 8/08 stated, "Indications for Hand - hygiene is required, but not limited to, the following home care patient activities [CDC 2002 guidelines] ... Decontaminate hands after removing gloves and or glove changes ... before entering or re - entering nursing bag."</p> <p>6. The agency policy titled "Exposure Control Plan: OSHA [Occupational Safety and Health Administration of the United States] ... Bags used by nurse, home health aides and other staff ... if additional items are needed after care has started, wash hands before re - entering bag ... wash hands and return equipment to the bag."</p>			

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N 524 Bldg. 00	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on policy and clinical record review and interview, the agency failed to ensure the plan of care was signed by the physician in a timely manner for 3 of 12 records reviewed (#3, #8, #11).</p> <p>Findings</p> <p>1. Clinical record #3, start of care (SOC) 12/18/14 - 2/15/15 and diagnosis of</p>			N 524	<p>1. All staff will be re-instructed on the need for all verbal orders to be turned in promptly. Office staff will generate plan of cares timely and send to physician. 2. Follow-up on outstanding orders sent by mail, fax, hand delivered. A outstanding orders report will be generated weekly, if orders are not received with in 3 weeks or origination , a staff member will hand deliver to physician office to</p>		03/20/2015

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	<p>diabetes with neurological manifestations, included a plan of care for the certification period of 12/18/14 - 2/15/15. This plan of care was signed by the physician on 2/10/15.</p> <p>2. Clinical record #8, SOC 11/28/14 and diagnosis of breast cancer and after care of traumatic fracture of ankle, included a plan of care for the certification period of 11/28/14 - 1/26/15. This plan of care was signed by the physician on 1/11/15.</p> <p>On 2/27/15 at 4 PM, Employee B, Registered Nurse, indicated the plan of care had not been signed by the physician in a timely manner.</p> <p>3. Clinical record #11, SOC 10/7/14 and diagnosis of hypertensive heart with heart failure and congestive heart failure, included a plan of care for the certification period of 12/6/14 - 2/3/15. This plan of care was signed by the physician on 1/15/15.</p> <p>4. On 2/27/15 at 4:05 PM, Employee B indicated the physicians often signed the plans of care late.</p> <p>5. The agency policy titled "Plan of Care - CMS 485 and Physician Orders" with a date of 9/10/01 stated, "Skilled nursing and other home health services will be in</p>		<p>ensure a signature is obtained. 3. The Administrator/DON is responsible for overseeing these corrective actions to ensure that this deficiency is corrected and does not reoccur</p>		

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N 544 Bldg. 00	<p>accordance with a plan of care ... Consultation with the physician on any modification in the plan of care will be documented and the physician's signature obtained according to state law."</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on clinical record and agency policy/ procedure review and interview, the home health agency failed to ensure the registered nurse (J) prepared clinical and progress notes for 1 of 12 clinical records reviewed (#2).</p> <p>Findings</p> <p>1. Clinical record #2, start of care 8/25/14 with a diagnosis of Parkinson's Disease, included a plan of care for the certification period of 12/23/14 - 2/20/15 with orders for wound care. Employee J, Registered Nurse, failed to evidence the wound area had been cleansed prior to treating and dressing the wound at visits on 2/4/15 and 2/11/15. There was no order for cleansing on the order for the duoderm change ordered on the plan of care.</p>	N 544	<p>1. All Nursing staff will receive a copy of policy and procedure "Skin and Wound Cleansing" and be re-instructed on property cleansing of wounds prior to applying a new dressing. All saline bottle will be one time use. Spray bottles for saline wash will be dated and disposed of after 28 days. Failure to adhere to agency policy/procedure will be grounds for disciplinary action which may include termination.</p> <p>2. The Administrator/DON and their designee will make in home spot checks to make sure policy are being followed. All nurse will have a spot check by 3/25/15 and then quarterly 3. The Administrator/DON will make sure policy are being followed and deficiency is corrected and does not reoccur.</p>	03/25/2015

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	<p>a. A skilled nursing visit report on 2/4/15 at 9 AM showed that a duoderm dressing had been applied to the left buttocks wound. This visit note failed to evidence the area had been cleansed prior to the application of the duoderm. This visit was completed by Employee J.</p> <p>b. A skilled nursing visit report on 2/11/15 at 8:45 AM showed that a duoderm dressing had been applied to the left buttocks wound. The wound had not been cleansed. This visit was completed by Employee J.</p> <p>c. On 2/27/14 at 12:45 PM, the administrator indicated the wounds were to be cleansed as part of the wound care protocol that was a part of the agency's wound care policy / protocol. She indicated it was not necessary for the physician's order to state that cleansing would occur, but the agency protocol was to cleanse all wounds with soap and water or normal saline. She also indicated the nurse had failed to document the cleansing of the wound and that the cleansing of the wound had occurred.</p> <p>2. The agency protocol titled "Skin and Wound Cleansing" with no date stated, "Cleanse wounds initially and at each</p>			
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N 550 Bldg. 00	<p>dressing change with soap and water and / normal saline unless otherwise specified by the physician ... after care ... document in patient's record a. procedure."</p> <p>3. The agency policy titled "Clinical record" with no date stated, "The clinical record contains the documentation, which reflects the medical, nursing, and therapeutic care rendered to the patient."</p> <p>4. The agency policy titled "Nursing Services" with a revised date of 2009 stated, "Professional nursing service will be provided by a registered nurse and include ... preparing clinical and progress notes."</p> <p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on policy and clinical record</p>	N 550	1. All Nursing Staff will be re-instructed that the Home	03/25/2015			

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	<p>review and interview, the agency failed to ensure the registered nurse provided timely care instructions for the home health aide for 1 of 9 records (#1) reviewed with orders for home health aide services and the agency failed to ensure the registered nurse (G) reviewed the aide care plan every 60 days for 1 of 1 closed records reviewed with aide services and longer than 60 days of home health aide service (# 9).</p> <p>Findings include</p> <p>1. Clinical record #1 evidenced a start of care (SOC) 1/16/15 and a plan of care for the certification period of 1/16/15 - 3/16/15 with orders for home health aide two times a week for 9 weeks. Aide visits occurred on 1/19/15, 1/23/15, 1/26/15, 1/30/15, 2/6/15, 2/9/15, 2/13/15, 2/16/15, 2/20/15, and 2/23/15. The written patient care instructions prepared for the aide by the registered nurse, Employee G, were not prepared by the registered nurse until 2/11/15.</p> <p>On 2/27/15 at 1 PM, the administrator indicated the Employee G, registered nurse, had signed and dated the aide care plan late.</p> <p>2. Clinical record #9 evidenced a SOC 3/4/14 and a plan of care for the</p>		<p>Health aide assignment sheet must be sign and dated for the date completed for admission and re-certification period. They will also update Home Health aide assignment sheets as patient condition changes with a new assignment sheet with a date and signature 2. The Administrator/DON or designee will do 100% chart audit to ensure compliance with the 60 day review rule. 3. The Administrator/DON or designee will do 10% of clinical record review to ensure continued compliance</p>				

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	<p>certification period of 8/31/14 - 10/29/14 with home health aide services one time a week for 9 weeks. The home health aide made visits during this certification period on 9/3/14, 9/10/14, 9/17/14, 9/24/15, 10/1/14. One aide care plan was reviewed on 6/30/14 by the registered nurse and was not reviewed by the registered nurse again until 10/15/14.</p> <p>On 2/27/15 at 10:15 AM, the administrator indicated the aide care plan was not reviewed every 60 days as needed.</p> <p>3. The agency policy titled "Care Planning Process" with a date of 2009 stated, "The patient care plan for the home health aide, home health aide assignment sheet: developed by a Registered Nurse ... prior to home health aide rendering care. Reviewed at least every 14 days during supervisory visit for skilled care and every 30 days for nonskilled care."</p>			