

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953
--	---

(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
--------------------	--	---------------	---	----------------------

G0000	<p>This was an initial Home Health Medicaid certification survey. This was a partial extended survey.</p> <p>Survey Dates: 2/21/12 to 2/23/12. Partial Extended Dates: 2/23/12.</p> <p>Facility Number: 012691</p> <p>Surveyors: Miriam Bennett, RN, BSN, Public Health Nurse Surveyor Susan Sparks, RN, Public Health Nurse Surveyor Tonya Tucker, RN, Public Health Nurse Surveyor</p> <p>Census Service Type: Skilled: 11 Home Health Aide Only: 0 Personal Care Only: 0 Total: 11</p> <p>Sample: RR w/HV: 4 RR w/o HV: 11 Total: 11</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN February 29, 2012</p>	G0000		
-------	--	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, interview, and personnel file and policy review, the agency failed to ensure staff followed infection control guidelines when providing care in 1 of 4 home visits with the registered nurse (employee B) with the potential to affect all the patients the employees cared for. (patient #4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 2/22/12 at 10:15 am, employee B was observed during home visit with patient #4 and was performing PICC (Peripherally Inserted Central Catheter) dressing change and cap replacement using sterile technique. Sterility was broken during procedure when employee twice adjusted mask with sterile gloves. Employee did not stop to obtain new sterile gloves. While cleaning the exit site, employee used a back and forth motion to clean the exit site (not a circular pattern starting with the needle insertion site). After changing line caps, employee did not flush the catheter. Employee B's personnel file contained 	G0121	G121 The Agency failed to be in compliance with accepted professional standards. A request for assistance to correct this deficiency was accepted by a qualified registered nurse from another agency, Sheila Cochran. In order to ascertain the competency standards of our nursing staff, on 03/16/2012 Sheila Cochran RN delivered to them instructions covering the proper procedures of sterility, infection control, and PICC Line Dressing. Additionally, a descriptive account for this particular deficiency was reviewed. An oral skill test followed to establish acceptable competency. Another training session is scheduled 04/18/2012 which shall be followed by two additional sessions to ensure the nursing staff is fully cognizant of their responsibility regarding sterile procedures and infection control. The DON is assigned the responsibility of supervising and monitoring randomly selected cases to assure compliance with standards. Procedural guidelines and policies will be entered in our QA as a practical reference and also as a monitoring tool.	03/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>a skilled nursing checklist which listed "current experience" in sterile dressing change and Central Line Care, but did not document a competency demonstration.</p> <p>3. The agency's policy "PICC Line Dressing Change" states, "Cleaning exit site starting at exit site and moving outward in a circular fashion, maintaining strict aseptic technique."</p> <p>4. On 2/23/12 at 2:25 PM, employee B indicated sterile technique was not maintained during procedure when employee B adjusted mask.</p> <p>3. Agency policy #B-405 titled "Infection Control/Exposure Control Plan" states, "Patient infection control procedures include ... changing gloves as necessary during the delivery of patient care, and after handling soiled or contaminated areas."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
G0133	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.</p> <p>Based on interview, the administrator failed to maintain liaison among the governing body for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>On 2/21/12 at 10:45 am, the administrator, employee A, indicated she had not been involved in Governing Body meetings.</p>	G0133	<p>The Agency's Administrator failed to maintain liaison with the Governing Body that may have resulting consequences for all patients of the Agency. On 03/09/2012 a documented meeting was organized and conducted via the Administrator and the Governing Body. At this meeting, the Administrator delegated certain responsibilities to each member of the Governing Body so as to facilitate improved efficiency, better notification, an enhanced organization. The positive effect of these actions will lead to better coordination of policies and procedures throughout the agency, and the opportunity to develop improved patient care. A follow-up meeting of the Governing Body is scheduled for 04/06/12, and then annually there after.</p>	03/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
G0135	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, ensures the accuracy of public information materials and activities.</p> <p>Based on interview and review of documents, the agency failed to ensure the accuracy of public information material for 1 of 1 agency brochure reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency brochure states the agency is Medicare/Medicaid Certified and offers the following services: CNA's (Certified Nursing Assistants), Physical & Occupational Therapy, Speech Therapy, Homemaking Service, and Companionship. Documentation supplied by the agency to the Indiana State Department of Health identified the agency provided Home Health Aide and Skilled Nurse Services. During interview on 2/23/12 at 12:15 PM, employee A indicated the brochures reflect the agency's plans for future services. The agency has decided to not become Medicare certified at this time. 	G0135	<p>G135 Agency has failed to insure the accuracy of its public information Brochure. Brochures that had been placed in different locations throughout the city were collected. Each Brochure was corrected by striking through erroneous or incorrect text before being returned to its former placement. Additionally, a correction of the Master Copy was made by our print vendor, Jiffy Print. A new Brochure is in the process of development with the availability expected in May 2012. The contained text of the new Brochure will more accurately explain our mission, our qualifications and our offered services. The Administrator is responsible for the deficiency, to ensure no future erroneous materials are placed in the community.</p>	03/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
G0136	<p>484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, implements an effective budgeting and accounting system.</p> <p>Based on interview, the administrator failed to implement an effective budget and accounting system for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>On 2/21/12 at 10:45 am, the administrator, employee A, indicated she had not been involved in the budget because the owner does the budget.</p>	G0136	<p>G136 The Administrator failed to coordinate with the owner an acceptable Budget and Accounting system for the agency. On 03/05/2012 this deficiency was corrected with the joint cooperation of the Administrator and the Owner. Employing Quick Books, the accounting system of the agency, under its Planning & Budgeting preference, a new budget was developed covering the calendar period of March 2012 to December 2012. The Budget will be reviewed at the end of each month and timely corrections to the forecasts will be made using actual financial data. The Administrator along with the Owner are responsible for this deficiency.</p>	03/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
G0158	<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, the agency failed to ensure treatments were provided as ordered on the plan of care in 3 of 11 records reviewed with the potential to affect all the agency's patients. (#1, 4, and 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care date 1/5/12, included a plan of care for the certification period 1/5/12 thru 3/4/12 with orders for the Home Health Aide to assist with Activities of Daily Living; encourage patient as able; exercises as instructed by physical therapy, occupational therapy, skilled nursing; light housekeeping; meal preparation; personal care; skin care; and transfers. The Aide Visit Record dated 2/6/12 signed employee G failed to evidence the aide provided any of the ordered care. 2. Clinical record #4, start of care 2/2/12, included a Home Health Certification and Plan of Care the certification period 2/2-4/1/12 with orders for "Wound treatment ... 3x [times] weekly." On 	G0158	<p>Based on clinical record review, the Agency failed to ensure treatments were provided as order on the plan of care. On 03/09/12, all HHA's were in-serviced on policies and procedures contained in our Home Health Assignment and in our Home Health Aide Care Plans, and the proper documentation in the Daily Visit Notes. HHA's are instructed to follow a plan of care as directed or outlined by the case RN. HHA's were instructed to report any changes in client care directly to the DON and case RN to update the plan of care. To ensure the information in each visit note is entered correctly and completely, the DON will audit all incoming visit notes to ensure compliance with clients plan of care prior to filing. On 03/09/12 the nursing staff was in-serviced on the importance of documenting all timely information related to Wound Care. SN will use Wound Sheet once weekly to document measurements. SN Daily Visit Note will contain all other pertinent entries of the wound, dressing changes etc. An RN delegated an important clinical</p>	03/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2/10/12 and 2/13/12, employee E, under the section titled "Wound / Ostomy Care," failed to document the dressing was changed.</p> <p>Employee E noted on 2/15/12, under the section titled "Wound / Ostomy Care," "See wound sheet." There record failed to evidence a wound sheet.</p> <p>3. Clinical record #10, start of care 11/16/11, included a plan of care for the certification period 1/15/12 thru 3/14/12 with orders for the skilled nurse (SN) to assess / monitor / evaluate vital signs with SN visits 1 - 2 times a week for 9 weeks. The Aide Care Plan indicated the nurse had delegated the aide to perform Temperature, Pulse, Respirations, Blood Pressure, and Weight weekly.</p> <p>Aide Visit Records dated 11/25/11, 12/1/11, 12/8/11, and 12/15/11 completed by employee C only took the patient's blood pressures and not the other vital signs or weight.</p>		<p>procedure to an HHA who lacked the skill level to accurately perform the assignment. On 02/24/12, all HHA's were in-serviced on the proper process of understanding, performing, and recording Vital Signs. Using a pseudo client, each HHA was competency tested by the DON to establish their skill level. All HHA's qualified. Plans are in place to repeat these evaluations each month for the next three months. All new hires will be tested to evaluate their competency with this clinical procedure. delegating this important clinical procedure to an aide that lacked the competency to perform such task, was an erroneous decision by the Nurse. On 02/24/12 all aides were in-serviced on guidelines for measuring, recording and reporting vital signs. HHA's were competency tested and demonstrated on a pseudo client to accurately perform each vital sign. The DON will monitor all aide documentation to ensure proper care is given and recorded consistently with care plans. To prevent a reoccurrence in the future, all new hires will be tested to demonstrate their ability to accurately this procedure.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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
G0175	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.</p> <p>Based on clinical record review and policy review, the registered nurse failed to notify the physician timely to prevent a potential major drug interaction for 1 of 11 records reviewed with the potential to affect all the agency's 11 patients. (#3)</p> <p>Findings include:</p> <p>1. Clinical record #3, start of care date 2/4/12, evidenced a comprehensive adult nursing assessment completed on 2/4/12 that identified problems were found during medication review and that the physician was notified within one calendar day. The nurse indicated the physician was aware of drug interactions on the medication profile. A fax transmission log report to the doctor regarding the drug interactions was dated 2/7/12.</p> <p>2. Agency policy titled "Medication Profile" #C-700 states, "The clinician shall promptly report any identified problems to the physician."</p>			G0175	<p>G 175 Agency failed to notify physician in a timely manner about a patient drug interaction. On 03/16/2012 a meeting of the Nursing Staff convened for the purpose of detailing guidelines regarding drug interactions as referenced in our " Medication Profile Policy". The procedure to follow will be to notify the Physician STAT of a drug interaction. If the interaction manifests after hours normal office hours or on weekends, a message will be left on the attending physician's call service.</p> <p>Immediately complete a Care Conference Note and file in the client's chart. Verify a follow up of your call by sending a FAX and filing a copy of the transmittal in the client's chart. Responsibility for this deficiency rests with the DON who will monitor charts for the next eight weeks to assure notification policies are being adhered to. A copy of these guidelines will be placed in the QA and used as a monitoring tool.</p>		03/16/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
G0212	<p>484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.</p> <p>Based on policy review, personnel record review, and clinical record review, the agency failed to ensure the Home Health Aides had been competency tested to take blood pressures for 2 of 2 home health aide files reviewed with the potential to affect all the agency's patients that received home health aide services. (C and G)</p> <p>Findings include:</p> <p>1. The agency's policy titled "Competency Evaluation of Home Care Staff" under Home Health Aide Competency section states, "Skills competency is evaluated by observing the aide with client or "pseudo" client (not a manikin). A Home Health Aide will not be permitted to provide Home Health Aide services until evidence of adequate training and/or competency has been determined by the designated professional in the agency." The policy also lists a note of "subject area with an [asterisk] must be evaluated after observation of the Home Health Aide's performance of the tasks with a client." The policy indicated</p>	G0212	<p>G 212 The Agency failed to ensure all individuals providing health care services completed a competency evaluation program. The DON together with the Administrator who at this time, serves as Human Resource Coordinator, developed a Competency Evaluations Program to guarantee the competency of its providers. On 02/24/2012, and under the scrutiny of the program developers, each HHA was required to demonstrate using a pseudo client, their understanding and skill of Vital Signs, personal care including bathing, bed baths, oral hygiene, nail and skin care, emphasis on bed sores, toileting, safe transfer techniques and ambulation, together with ROM and client positioning. All HHA's satisfied acceptable standards. All new hires will be skill tested in a similar manner. The Administrator will audit employee files on a monthly basis to ensure compliance to these standards are being met.</p>	02/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the areas included bed bath; sponge, tub, or shower bath; shampoo in sink, tub or bed; nail and skin care; oral hygiene; toileting and elimination; safe transfer techniques and ambulation; normal range of motion (ROM) and positioning; and reading and recording temperature, pulse, and respiration.</p> <p>2. Personnel record C included a "Certified Home Health / Hospice Aide Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 11/18/11. The file failed to evidence the aide had been competency tested to perform blood pressure checks.</p> <p>Clinical record #10, start of care date of 11/16/11, included an Aide Care Plan that identified the aide was assigned to do temperature, pulse, respirations, blood pressure, and weight weekly. Four "Aide Visit Records" dated 11/25/11, 12/1/11, 12/8/11, and 12/15/11 identified employee C took the patient's blood pressure.</p> <p>3. Personnel record G included a "Certified Home Health / Hospice Aide Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 1/5/12. The file failed to evidence the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>aide had been competency tested to perform blood pressure checks.</p> <p>4. Clinical record #11, start of care date 11/29/11, included an Aide Care Plan that identified the aide was to do blood pressure every visit and weekly.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
G0218	<p>484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI</p> <p>The subject areas listed at paragraphs (a)(1) (iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.</p> <p>Based on policy review, personnel record review, and clinical record review, the agency failed to ensure the Home Health Aides had been competency tested to take blood pressures for 2 of 2 home health aide files reviewed with the potential to affect all the agency's patients that received home health aide services. (C and G)</p> <p>Findings include:</p> <p>1. The agency's policy titled "Competency Evaluation of Home Care Staff" under Home Health Aide Competency section states, "Skills competency is evaluated by observing the aide with client or "pseudo" client (not a manikin). A Home Health Aide will not be permitted to provide Home Health Aide services until evidence of adequate training and/or competency has been determined by the designated professional in the agency." The policy also lists a</p>	G0218	<p>The Agency failed to meet standards of competency and in-service training. On 02/24/2012 a rigorous competency evaluation program of all HHA's was launched. Using a pseudo client, competency evaluations were made under the supervision of the DON and the Human Resource Coordinator. Many nursing related skills were evaluated. A special emphasis was made regarding Vital Signs, especially blood pressure tests. All HHA's have mastered these important clinical studies. HHA's have a much keener understanding of their duties and a much sharper awareness of their importance.</p> <p>All new hires will be tested in a similar manner. The Administrator or an appointed designee will be responsible for assessing the personal files of all HHA's for competency compliance.</p>	02/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>note of "subject area with an [asterisk] must be evaluated after observation of the Home Health Aide's performance of the tasks with a client." The policy indicated the areas included bed bath; sponge, tub, or shower bath; shampoo in sink, tub or bed; nail and skin care; oral hygiene; toileting and elimination; safe transfer techniques and ambulation; normal range of motion (ROM) and positioning; and reading and recording temperature, pulse, and respiration.</p> <p>2. Personnel record C included a "Certified Home Health / Hospice Aide Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 11/18/11. The file failed to evidence the aide had been competency tested to perform blood pressure checks.</p> <p>Clinical record #10, start of care date of 11/16/11, included an Aide Care Plan that identified the aide was assigned to do temperature, pulse, respirations, blood pressure, and weight weekly. Four "Aide Visit Records" dated 11/25/11, 12/1/11, 12/8/11, and 12/15/11 identified employee C took the patient's blood pressure.</p> <p>3. Personnel record G included a "Certified Home Health / Hospice Aide</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 1/5/12. The file failed to evidence the aide had been competency tested to perform blood pressure checks.</p> <p>4. Clinical record #11, start of care date 11/29/11, included an Aide Care Plan that identified the aide was to do blood pressure every visit and weekly.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
G0229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days in 1 of 11 records reviewed of patients who received skilled and home health aide services for longer than 14 days (#2).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Home Health Aide Supervision", policy number C-340, states, "When skilled services are being provided to a client, a Registered Nurse / Therapist must make a supervisory visit to the client's residence at least every two (2) weeks to assess relationships and determine whether goals are being met. Supervisory visits are to be documented in the client's chart on the Home Health Aide Supervision Form." 2. Clinical Record #2, start of care 1/5/12, evidenced the patient received skilled and home health aide services. The record failed to evidence a Home Health Aide supervisory visit had been completed between the dates of 1/20/12 	G0229	<p>G229 The Agency failed to ensure registered nurse completed a supervisory visit. Nursing staff had in-service discussing the agencies policies and procedures regarding supervisory visits. Episode calendars will be pre-assigned in advance for each client, this calendar will reflect all scheduled supervisory visit due dates, along with re-certifications, and discharges. Revised calendars will ensure agency is completing each task in a timely manner. DON is responsible for this deficiency and implementing, each calendar is completed and assigned to RN. DON will monitor for the next eight weeks to assure calendars are met and within compliance standards.</p>	03/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
N0445	<p>and 2/9/12.</p> <p>410 IAC 17-12-1(c)(2) Home health agency administration/management Rule 12 Sec. 1(c)(2) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (2) Maintain ongoing liaison among the governing body and the staff.</p> <p>Based on interview, the administrator failed to maintain liaison among the governing body for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>On 2/21/12 at 10:45 am, the administrator, employee A, indicated she had not been involved in Governing Body meetings.</p>	N0445	<p>Administrator has failed to maintain liaison among the Governing Body. Administrator has read and understands Governing Body Policy. Administrator has conducted a meeting of the governing Body 03/09/2012. At this meeting, certain responsibilities were delegated to each member. The sharing of these responsibilities will permit the Administrator to better coordinate policies and activities with the Professional Advisory Board and other agency personnel. An additional meeting of the Governing Body is scheduled for April 6th, then annually thereafter to ensure Administrator is communicating among the Governing Body members. Administrator is responsible for this plan of correction.</p>	03/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0447	<p>410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities.</p> <p>Based on interview and review of documents, the agency failed to ensure the accuracy of public information material for 1 of 1 agency brochure reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Agency brochure states the agency is Medicare/Medicaid Certified and offers the following services: CNA's (Certified Nursing Assistants), Physical & Occupational Therapy, Speech Therapy, Homemaking Service, and Companionship. Documentation supplied by the agency to the Indiana State Department of Health identified the agency provided Home Health Aide and Skilled Nurse Services. During interview on 2/23/12 at 12:15 PM, employee A indicated the brochures reflect the agency's plans for future services. The agency has decided to not become Medicare certified at this time. 	N0447	. Agency has failed to insure the accuracy of its public information Brochure. Brochures that had been placed in different locations throughout the city were collected. Each Brochure was corrected by striking through erroneous or incorrect text before being returned to its former placement. Additionally, a correction of the Master Copy was made by our print vendor, Jiffy Print. A new Brochure is in the process of development with the availability expected in May 2012. The contained text of the new Brochure will more accurately explain our mission, our qualifications and our offered services. The Administrator is responsible for the deficiency, to ensure no future erroneous materials are placed in the community.	03/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0448	<p>410 IAC 17-12-1(c)(5) Home health agency administration/management Rule 12 Sec. 1(c)(5) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (5) Implement a budgeting and accounting system.</p> <p>Based on interview, the administrator failed to implement an effective budget and accounting system for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>On 2/21/12 at 10:45 am, the administrator, employee A, indicated she had not been involved in the budget because the owner does the budget.</p>	N0448	<p>The Administrator failed to coordinate with the owner an acceptable Budget and Accounting system for the agency. On 03/05/2012 this deficiency was corrected with the joint cooperation of the Administrator and the Owner. Employing Quick Books, the accounting system of the agency, under its Planning & Budgeting preference, a new budget was developed covering the calendar period of March 2012 to December 2012. The Budget will be reviewed at the end of each month and timely corrections to the forecasts will be made using actual financial data. The Administrator along with the Owner are responsible for this deficiency.</p>	03/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0462	<p>410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review, the agency failed to ensure employee physical exam forms indicated employees would not spread infectious or communicable diseases for 3 of 8 personnel files reviewed with the potential to affect all the agency's 11 patients. (C, E, and G)</p> <p>Findings include:</p> <p>Personnel files for employees C, E, and G evidenced physical exams dated 11/14/11, 12/16/11, and 1/7/12 respectively. The exams identified the employees were fit to work but did not state the employees were free from communicable disease.</p>	N0462	<p>N 462 Agency has failed to ensure employee physical exam forms indicated employees would not spread infectious or communicable diseases. All pre-employment physicals must include a clinical opinion that the employee is free of all communicable disease. Although Ambucare told us that this is a routine observation on each physical examination, we emphasized the fact that a notation of this requirement must be entered on each Pre-Employment Examination form. Simultaneously, the two existing employee examination forms in questions that did not contain this notation were returned back to Ambucare. The forms were later and returned to us with the proper entry. Administrator or appointed designee will be responsible for this deficiency. Administrator will audit all staff files once a month for compliance of these physicals. Administrator will ensure all new hires physical will state " free from communicable disease" .</p>	03/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0470	<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 personnel file and policy review, the agency failed to ensure staff followed infection control guidelines when providing care in 1 of 4 home visits with the registered nurse (employee B) with the potential to affect all the patients the employees cared for. (patient #4)</p> <p>Findings include:</p> <p>1. On 2/22/12 at 10:15 am, employee B was observed during home visit with patient #4 and was performing PICC (Peripherally Inserted Central Catheter) dressing change and cap replacement using sterile technique. Sterility was broken during procedure when employee twice adjusted mask with sterile gloves. Employee did not stop to obtain new sterile gloves. While cleaning the exit site, employee used a back and forth motion to clean the exit site (not a circular pattern starting with the needle insertion site). After changing line caps, employee did not flush the catheter.</p>	N0470	<p>The Agency failed to be in compliance with accepted professional standards. A request for assistance to correct this deficiency was accepted by a qualified registered nurse from another agency, Sheila Cochran. In order to ascertain the competency standards of our nursing staff, on 03/16/2012 Sheila Cochran RN delivered to them instructions covering the proper procedures of sterility, infection control, and PICC Line Dressing. Additionally, a descriptive account for this particular deficiency was reviewed. An oral skill test followed to establish acceptable competency. Another training session is scheduled 04/18/2012 which shall be followed by two additional sessions to ensure the nursing staff is fully cognizant of their responsibility regarding sterile procedures and infection control. The DON is assigned the responsibility of supervising and monitoring randomly selected cases to assure compliance with standards. Procedural guidelines and policies will be entered in our QA as a practical reference and also as a monitoring tool.</p>	03/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2. Employee B's personnel file contained a skilled nursing checklist which listed "current experience" in sterile dressing change and Central Line Care, but did not document a competency demonstration.</p> <p>3. The agency's policy "PICC Line Dressing Change" states, "Cleaning exit site starting at exit site and moving outward in a circular fashion, maintaining strict aseptic technique."</p> <p>4. On 2/23/12 at 2:25 PM, employee B indicated sterile technique was not maintained during procedure when employee B adjusted mask.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
N0522	<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:</p> <p>Based on clinical record review, the agency failed to ensure treatments were provided as ordered on the plan of care in 3 of 11 records reviewed with the potential to affect all the agency's patients. (#1, 4, and 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1, start of care date 1/5/12, included a plan of care for the certification period 1/5/12 thru 3/4/12 with orders for the Home Health Aide to assist with Activities of Daily Living; encourage patient as able; exercises as instructed by physical therapy, occupational therapy, skilled nursing; light housekeeping; meal preparation; personal care; skin care; and transfers. The Aide Visit Record dated 2/6/12 signed employee G failed to evidence the aide provided any of the ordered care. 2. Clinical record #4, start of care 2/2/12, included a Home Health Certification and Plan of Care the certification period 2/2-4/1/12 with orders for "Wound treatment ... 3x [times] weekly." On 	N0522	<p>Based on clinical record review, the Agency failed to ensure treatments were provided as order on the plan of care. On 03/09/12, all HHA's were in-serviced on policies and procedures contained in our Home Health Assignment and in our Home Health Aide Care Plans, and the proper documentation in the Daily Visit Notes. HHA's are instructed to follow a plan of care as directed or outlined by the case RN. HHA's were instructed to report any changes in client care directly to the DON and case RN to update the plan of care. To ensure the information in each visit note is entered correctly and completely, the DON will audit all incoming visit notes to ensure compliance with clients plan of care prior to filing. On 03/09/12 the nursing staff was in-serviced on the importance of documenting all timely information related to Wound Care. SN will use Wound Sheet once weekly to document measurements. SN Daily Visit Note will contain all other pertinent entries of the wound, dressing changes etc. An RN delegated an important clinical</p>	03/09/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2/10/12 and 2/13/12, employee E, under the section titled "Wound / Ostomy Care," failed to document the dressing was changed.</p> <p>Employee E noted on 2/15/12, under the section titled "Wound / Ostomy Care," "See wound sheet." There record failed to evidence a wound sheet.</p> <p>3. Clinical record #10, start of care 11/16/11, included a plan of care for the certification period 1/15/12 thru 3/14/12 with orders for the skilled nurse (SN) to assess / monitor / evaluate vital signs with SN visits 1 - 2 times a week for 9 weeks. The Aide Care Plan indicated the nurse had delegated the aide to perform Temperature, Pulse, Respirations, Blood Pressure, and Weight weekly.</p> <p>Aide Visit Records dated 11/25/11, 12/1/11, 12/8/11, and 12/15/11 completed by employee C only took the patient's blood pressures and not the other vital signs or weight.</p>		<p>procedure to an HHA who lacked the skill level to accurately perform the assignment. On 02/24/12, all HHA's were in-serviced on the proper process of understanding, performing, and recording Vital Signs. Using a pseudo client, each HHA was competency tested by the DON to establish their skill level. All HHA's qualified. Plans are in place to repeat these evaluations each month for the next three months. All new hires will be tested to evaluate their competency with this clinical procedure. delegating this important clinical procedure to an aide that lacked the competency to perform such task, was an erroneous decision by the Nurse. On 02/24/12 all aides were in-serviced on guidelines for measuring, recording and reporting vital signs. HHA's were competency tested and demonstrated on a pseudo client to accurately perform each vital sign. The DON will monitor all aide documentation to ensure proper care is given and recorded consistently with care plans. To prevent a reoccurrence in the future, all new hires will be tested to demonstrate their ability to accurately this procedure.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0543	<p>410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures.</p> <p>Based on clinical record review and policy review, the registered nurse failed to notify the physician timely to prevent a potential major drug interaction for 1 of 11 records reviewed with the potential to affect all the agency's 11 patients. (#3)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #3, start of care date 2/4/12, evidenced a comprehensive adult nursing assessment completed on 2/4/12 that identified problems were found during medication review and that the physician was notified within one calendar day. The nurse indicated the physician was aware of drug interactions on the medication profile. A fax transmission log report to the doctor regarding the drug interactions was dated 2/7/12. 2. Agency policy titled "Medication Profile" #C-700 states, "The clinician shall promptly report any identified 	N0543	<p>Agency failed to notify physician in a timely manner about a patient drug interaction. On 03/16/2012 a meeting of the Nursing Staff convened for the purpose of detailing guidelines regarding drug interactions as referenced in our " Medication Profile Policy". The procedure to follow will be to notify the Physician STAT of a drug interaction. If the interaction manifests after hours normal office hours or on weekends, a message will be left on the attending physician's call service. Immediately complete a Care Conference Note and file in the client's chart. Verify a follow up of your call by sending a FAX and filing a copy of the transmittal in the client's chart. Responsibility for this deficiency rests with the DON who will monitor charts for the next eight weeks to assure notification policies are being adhered to. A copy of these guidelines will be placed in the QA and used as a monitoring tool.</p>	03/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	problems to the physician."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0596	<p>410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and</p> <p>Based on policy review, personnel record review, and clinical record review, the agency failed to ensure the Home Health Aides had been competency tested to take blood pressures for 2 of 2 home health aide files reviewed with the potential to affect all the agency's patients that received home health aide services. (C and G)</p> <p>Findings include:</p> <p>1. The agency's policy titled "Competency Evaluation of Home Care Staff" under Home Health Aide Competency section states, "Skills competency is evaluated by observing the aide with client or "pseudo" client (not a manikin). A Home Health Aide will not be permitted to provide Home Health Aide services until evidence of adequate training and/or competency has been determined by the designated professional in the agency." The policy also lists a</p>	N0596	<p>The Agency failed to ensure all individuals providing health care servies completed a competency evaluation program. The DON together with the Administrator who at this time, serves as Human Resource Coordinator, developed a Competency Evaluations Program to guarantee the competency of its providers. On 02/24/2012, and under the scrutiny of the program developers, each HHA was required to demonstrate using a pseudo client, their understanding and skill of Vital Signs, personal care including bathing, bed baths, oral hygiene, nail and skin care, emphasis on bed sores, toileting, safe transfer techniques and ambulation, together with ROM and client positioning. All HHA's satisfied acceptable standards. All new hires will be skill tested in a similar manner. The Administrator will audit employee files on a monthly basis to ensure compliance to these standards are being met.</p>	02/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>note of "subject area with an [asterisk] must be evaluated after observation of the Home Health Aide's performance of the tasks with a client." The policy indicated the areas included bed bath; sponge, tub, or shower bath; shampoo in sink, tub or bed; nail and skin care; oral hygiene; toileting and elimination; safe transfer techniques and ambulation; normal range of motion (ROM) and positioning; and reading and recording temperature, pulse, and respiration.</p> <p>2. Personnel record C included a "Certified Home Health / Hospice Aide Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 11/18/11. The file failed to evidence the aide had been competency tested to perform blood pressure checks.</p> <p>Clinical record #10, start of care date of 11/16/11, included an Aide Care Plan that identified the aide was assigned to do temperature, pulse, respirations, blood pressure, and weight weekly. Four "Aide Visit Records" dated 11/25/11, 12/1/11, 12/8/11, and 12/15/11 identified employee C took the patient's blood pressure.</p> <p>3. Personnel record G included a "Certified Home Health / Hospice Aide</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 1/5/12. The file failed to evidence the aide had been competency tested to perform blood pressure checks.</p> <p>4. Clinical record #11, start of care date 11/29/11, included an Aide Care Plan that identified the aide was to do blood pressure every visit and weekly.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0603	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide may not be assigned to perform additional tasks not included in the original competency evaluation until he or she has successfully been evaluated as competent in that task.</p> <p>Based on personnel record review and clinical record review, the agency failed to ensure the Home Health Aides was not assigned tasks for which she had not been competency tested for 1 of 2 home health aide files reviewed with the potential to affect all the agency's patients that received home health aide services. (C)</p> <p>Findings include:</p> <p>1. Personnel record C included a "Certified Home Health / Hospice Aide Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 11/18/11. The file failed to evidence the aide had been competency tested to perform blood pressure checks.</p> <p>Clinical record #10, start of care date of 11/16/11, included an Aide Care Plan that identified the aide was assigned to do temperature, pulse, respirations, blood pressure, and weight weekly. Four "Aide Visit Records" dated 11/25/11, 12/1/11, 12/8/11, and 12/15/11 identified employee C took the patient's blood</p>	N0603	<p>The Agency failed to meet standards of competency and in-service training. On 02/24/2012 a rigorous competency evaluation program of all HHA's was launched. Using a pseudo client, competency evaluations were made under the supervision of the DON and the Human Resource Coordinator. Many nursing related skills were evaluated. A special emphasis was made regarding Vital Signs, especially blood pressure tests. All HHA's have mastered these important clinical studies. HHA's have a much keener understanding of their duties and a much sharper awareness of their importance. All new hires will be tested in a similar manner. The Administrator or an appointed designee will be responsible for assessing the personal files of all HHA's for competency compliance.</p>	02/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>pressure.</p> <p>3. Personnel record G included a "Certified Home Health / Hospice Aide Check List" titled "Demonstration of Skills" which indicated the aide was competency tested for all competencies on 1/5/12. The file failed to evidence the aide had been competency tested to perform blood pressure checks.</p> <p>4. Clinical record #11, start of care date 11/29/11, included an Aide Care Plan that identified the aide was to do blood pressure every visit and weekly.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012	
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953			
(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			
N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed a supervisory visit of the home health aide every 14 days as required by agency policy in 1 of 11 records reviewed of patients who received skilled and home health aide services for longer than 14 days (#2).</p> <p>Findings include:</p> <p>1. Facility policy titled "Home Health Aide Supervision", policy number C-340, states, "When skilled services are being provided to a client, a Registered Nurse / Therapist must make a supervisory visit to the client's residence at least every two (2) weeks to assess relationships and determine whether goals are being met. Supervisory visits are to be documented in the client's chart on the Home Health Aide Supervision Form."</p> <p>2. Clinical Record #2, start of care 1/5/12, evidenced the patient received</p>	N0606	<p>The Agency failed to ensure registered nurse completed a supervisory visit. Nursing staff had in-service discussing the agencies policies and procedures regarding supervisory visits. Episode calendars will be pre-assigned in advance for each client, this calendar will reflect all scheduled supervisory visit due dates, along with re-certifications, and discharges. Revised calendars will ensure agency is completing each task in a timely manner. DON is responsible for this deficiency and implementing, each calendar is completed and assigned to RN. DON will monitor for the next eight weeks to assure calendars are met and within compliance standards.</p>	03/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/23/2012
NAME OF PROVIDER OR SUPPLIER NEW HORIZONS HOME HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 303 E 5TH STREET MARION, IN 46953		
(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	
	skilled and home health aide services. The record failed to evidence a Home Health Aide supervisory visit had been completed between the dates of 1/20/12 and 2/9/12.				