

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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N000000	<p>This was a Home Health state licensure survey.</p> <p>Survey Dates: August 6, 15, 18, 19, 20, 22, 25, and 26, 2014</p> <p>Facility Number: IN008749</p> <p>Medicaid Number: 200065690A</p> <p>Surveyors: Miriam Bennett, RN, BSN, PHNS Tonya Tucker, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 59 Home Health Aide Only: 182 Personal Care Only: 39 Total: 280</p> <p>Sample: RR w/HV: 5 RR w/o HV: 8 Total: 13</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 10, 2014</p>	N000000		
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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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N000470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure staff implemented agency policy for infection control in 3 of 5 observations. (Employees B, C, and E)</p> <p>Findings include:</p> <p>1. During home visit observation with patient #5 on 8/19/14 at 1:30 PM, employee C, a Home Health Aide (HHA), was observed providing a shower to the patient. Employee C donned two pair of gloves, one pair over the other, and was observed washing the patient's perineal area with a wash cloth. The employee rinsed the patient and then proceeded to wash the patient's hair with same gloves. Employee C continued to care to patient with same pair of gloves through drying the patient with a towel. Employee C then removed the first pair of gloves and used the second pair to continue care through removing dirty towels from bathroom. Employee C removed the second pair of gloves, failed</p>	N000470	The nursing staff has in serviced the direct care staff ( home health aides and nurses) on agency policy # 8001 Infection Control, #2026 Coordination of Care with Outside agencies and agency policy # 7003 Home Health Aide Services. In service includes training on infection control, equipment cleaning and bathing techniques. Direct care staff will be monitored on supervisory visits for compliance with agency policy and procedures regarding infection control and retrained annually. 10% of all clinical records will be audited quarterly for evidence that the direct care staff provides care in accordance with agency policy. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	09/25/2014

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	<p>to wash hands or use hand gel, then donned a new pair of gloves.</p> <p>A. Employee C was observed cleaning the toilet with a toilet brush then proceeded to clean the bathroom sink but failed to change gloves and wash hands in between the toilet and sink.</p> <p>B. During interview on 8/19/14 at 1:45 PM, employee C indicated wearing 2 pairs of gloves simultaneously so that when they remove the first pair, they do not have to leave the patient alone to go grab another pair.</p> <p>2. During home visit observation on 8/18/14 at 10:20 AM, employee E, a licensed practical nurse, was observed assessing patient #9 with thermometer, blood pressure cuff, pulse oximeter, and stethoscope. Employee E failed to clean the stethoscope, pulse oximeter, and blood pressure cuff before and after use and placed equipment into the nursing bag and the stethoscope around neck. At 10:50 AM, employee E indicated they were off to see the next patient.</p> <p>3. During home visit observation with patient #16 on 8/19/14 at 9:00 AM, employee B, a HHA, was observed providing a sponge bath to the patient. Employee B donned gloves; washed</p>			

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	<p>patient's face, arms, chest, back, legs, and feet; changed to a third wash cloth; proceeded to wash the patient's buttocks and rectal area; and moved to the perineal area then back to the buttocks and rectal area again. Employee B proceeded to rinse the same wash cloth with water and used it to rinse the patient's arms, chest, back and legs. Employee B failed to change gloves and wash cloth after washing patient's buttock and rectal and perineal areas. The employee dried patient using the same pair of gloves and failed to change the gloves until after the patient was dressed.</p> <p>A. Employee B provided hair care to the patient with a hair brush marked with another patient's name on it. During interview on 8/19/14 at 9:20 AM, employee B indicated each resident in the group home has their own bucket of supplies, the brush is the other patient's brush, but employee B indicated they just use that brush on everyone.</p> <p>B. The supply bucket being used for patient #9 was not marked with any name, had approximately 7 deodorant sticks in it, and none were marked with any names.</p> <p>4. During interview on 8/18/14 at 1:25 PM, employee L indicated the agency has</p>			

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	<p>inserviced and inserviced on infection control.</p> <p>5. During interview on 8/19/14 at 10:05 AM, employee L indicated the group home has to do the monitoring of marking patient supplies.</p> <p>6. The agency's policy titled "Risk Management," # 8.001, reviewed 4/4/14 states, "1. All Community Home Health Care staff will follow infection control procedures. ... 4. Universal precautions will be consistently used for all clients. ... Procedure 1. Gloves should be worn when there is any chance of contact with body fluids, mucous membranes, or skin lesions which contain visible blood. ... 3. Effective hand washing techniques should be carried out before and after any client contact or procedures, before meal preparation, after handling soiled contaminated materials, and after going to the toilet. ... 11. Environmental infection control procedures include, but are not limited to, the following: g. Keep clean and dirty items separate, h. Maintain the maintenance and cleaning schedule for all client equipment and supplies."</p> <p>7. The agency's policy titled "Coordination of Client Care with Outside Agencies," # 2.026, reviewed</p>			

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	<p>4/4/14 states, "To assure the highest quality and continuity of care Community Home Health care will work closely with all outside agencies in the client's home. Procedure 1. Upon admission and throughout the service agreement, CHHC employees will assess the use of outside agencies by the client. 2. If outside agencies are being utilized, CHHC employees will determine the type and duration of service. 3. as the client's situation warrants, CHHC will notify these outside agencies of changes in client condition and services so that all services may be coordinated appropriately to best meet the needs of the client. 4. Any coordination of services will be documented in the client's medical record."</p> <p>8. The agency's policy titled "Home Health Aide Services," # 7.003, reviewed 4/4/13 states, "2. Home Health Aides are carefully trained in: ... b. observation, reporting, and documentation of client status and the care or service provided, ... d. basic infection control procedures, ... f. maintenance of a clean, safe, healthy environment, ... i. appropriate and safe techniques in personal hygiene and grooming that include: i. bed bath, ii. sponge, tub, or shower bath, iii. shampoo, sink, tub, or bed, iv. nail and skin care, v. oral hygiene, vi. toileting</p>			

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N000484	<p>and elimination, ... 1. adequate nutrition and fluid intake."</p> <p>410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record review, policy review, and interview, the agency failed to ensure all personnel providing services maintained effective communications to assure that their efforts appropriately complemented one another and supported the objectives of the patient's care in 1 of 13 clinical records reviewed creating the potential to affect all 280 of the agency's patients. (#6)</p> <p>Findings include:</p> <p>1. Clinical record #6, start of care 5/7/14, contained physician plan of care for certification period 5/7 to 7/5/14 with orders for skilled nursing services 3 times</p>	N000484	The Administrator has revised agency policy #3.011 Physician Telephone Orders to ensure all personnel providing services maintain effective communications to ensure that their efforts appropriately complement one another and support the objectives of the patients care. The Clinical Manager has implemented a revised process for reviewing clinical documentation on a weekly basis to ensure effective communications and coordination of care. (Weekly QA audit) The Administrator and Clinical Manager have in serviced the nursing staff on the revised process and policy. 10% of all clinical records will be audited quarterly for evidence that	09/25/2014

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	<p>daily for 60 days to assess vital signs, assess medication compliance/effectiveness, assess cardio/pulmonary status, monitor blood sugars and administer insulin as ordered by the physician and medications to include Levimir 42 Units twice daily and Humulog sliding scale. The record contained a physician plan of care for certification period 7/6 to 9/3/14 with orders for skilled nursing services 4 times daily for 60 days to assess vital signs, assess medication compliance/effectiveness, assess cardio/pulmonary status, monitor blood sugars and administer insulin as ordered by the physician and medications to include Levimir 42 Units twice daily and Humulog sliding scale.</p> <p>A. The record evidenced a document titled "Care Coordination" stating, "Care Coordination Note Coordination of care with : skilled nurse Communicated via: Other 'In office' Area/problem discussed Medication issue Details: 0 [no] Levimir available for a.m. dose. Nurse @ [at] [patient physician's name] office notified. Spoke [with] [nurse's name]. NO's [new orders] received from 6/26/14 appt. [appointment]. 1) Levirmir 40 U [units] BID [twice daily]. 2) Humalog SQ [Subcutaneous] BID 5 U @ breakfast et [and] lunch. 3) Humalog 10 U QD [every</p>		<p>effective communications and care coordination is documented in the clinical record or case conference notes. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>day] @ dinner. 4) continue [with] current sliding scale orders. ... Person completing form: Signature/Title [employee J, licensed practical nurse] Date 6/27/14 ... ." The record failed to evidenced the licensed practical nurse notified the registered nurse prior to calling the physician, failed to evidence the licensed practical nurse wrote an order for medication change on a physician's telephone order form, and failed to evidence the licensed practical nurse communicated with the casemanager to ensure effective communication regarding physicians orders.</p> <p>On 8/26/14 at 11:34 AM, employee J indicated conducting a visit on 6/27/14, realizing there was no levimir to administer for the AM dose, the employee notified the physicians office and spoke to the physician's nurse, obtained the new order from the 6/26/14 appointment, documented this on a "Care Coordination note", and then finished conducting the visit. The employee indicated the patient's casemanager (employee M, registered nurse) was not aware of the medication change.</p> <p>B. The record evidenced a document titled "Current medications" stating, "Levimir 30 units bid [twice daily] subq</p>			

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	<p>[subcutaneous] AM and hs [at bedtime] 05/07/2014 ... humulog 1 unit subq (121-150), 2 units (151-200), 3 units (201-250), 4 units (251-300), 6 units (301-350), and greater than 350 call dr [doctor] /nurse 03/01/2014 ... 'Reviewed [employee J, licensed practical nurse] 7/8/14'."</p> <p>C. The record evidenced a document titled "Current medications" stating, "Levimir 30 units bid [twice daily] subq [subcutaneous] AM and hs [at bedtime] 05/07/2014 ... humulog 1 unit subq (121-150), 2 units (151-200), 3 units (201-250), 4 units (251-300), 6 units (301-350), and greater than 350 call dr/nurse 03/01/2014 ... 'Updated + [and] Reviewed 8/21/14 [employee O, registered nurse]'."</p> <p>2. The agency policy with a review date of 4/4/13 titled "Policy 3.011 - Physician Telephone orders" states, "POLICY Community Home Health care obtains verbal and written orders from physicians for all licensed nurses to obtain physician telephone (verbal) orders for those clients with medical plans of care as needed. PURPOSE 1. to ensure accurate and uniform order taking. 2. to ensure effective communications with client, client's family ... and other staff regarding physicians orders. PROCEDURE 1.</p>						

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N000494	<p>physician's telephone order (short order form or computer -generated order form is used. ... 11. LPN's [licensed practical nurses] who obtain verbal physician orders must discuss client status with RN [registered nurse] prior to calling physician. Physician telephone orders form is then co-signed by RN. "</p> <p>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. Based on clinical record review, agency policy review, and interview, the agency</p>	N000494	The Administrator has revised the policy #2008 Client Nursing Assessment to comply with	09/25/2014

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	<p>failed to ensure the patient was provided a written notice of the patient's rights in advance of furnishing care to the patient or doing the initial evaluation visit before the initiation of treatment in 1 of 13 records reviewed creating the potential to affect all new patients of the agency. (#11)</p> <p>Findings include:</p> <p>1. Clinical record #11, start of care date 2/17/14, evidenced a document titled "Comprehensive Adult Nursing Assessment" dated 2/15/14 and signed by employee H (director of nursing).</p> <p>The record evidenced a document signed and dated by the patient's caregiver on 3/19/14 (more than a month after the start of care) titled "Admission Service Agreement" stating, "Consent for Care I hereby consent and authorize this organization, its agency, and associates to provided care and treatment to me in my home per program policies and/or as prescribed by my physician. A representative of this organization has explained my plan of care and all my questions have been answered satisfactorily. ... Notice of Services to be Provided You have requested, your physician has ordered, and/or your payor has approved the following home health</p>		<p>federal regulations concerning the initial assessment visit. The Clinical Manager has revised the admission paperwork review process to ensure that all pertinent documents, including a written notice of the patient's rights, are signed at the time of admission. The new process will require a medical records review and checklist prior to setting up the new chart. The Administrator has in serviced the nursing staff on the revised policy # 2008 Client Nursing Assessment and the current policy #2028 Admission Service Agreement to ensure the patient is provided with a written notice of the patient's rights in advance of furnishing care. 10% of all clinical records will be audited quarterly for evidence that the patient is provided with a written notice of the patient's rights in advance of furnishing care. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>services effective: '2-17-14' ... Liability for Payment I certify that all information given by me to the organization is correct to the best of my knowledge. I further understand that services provided to me by this organization will be billed to the following: Medicaid Waiver 'Respite' Client is not responsible for amounts not paid by medicare, medicaid and medicaid waiver. Medicaid clients are responsible for paying spenddowns. ... Advance Directive for Health Care I have received an explanation and written information regarding advance directives from the organization. ... Receipt of Handbook and Acknowledgement I have received a copy of the Community Home Health Care Handbook and an explanation of its policies, procedures and practices; including but not limited to: Patient/Client Rights and Responsibilities, client satisfaction and complaints, agency standards, and the retention, disclosure, accessibility and protection of clinical records.. I understand what I have read and what was explained to me and agree to the terms and conditions stated above. Additionally, I understand that I my terminate this agreement at any time. .... "</p> <p>2. The agency policy with a review date of 4/4/13 titled "Admission Service Agreement" states, "POLICY</p>			

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N000514	<p>Community Home Health Care informs all clients of their responsibilities regarding the payment of deductibles, co-payments, and any amounts due after payments of benefits by any and all third party payors. PURPOSE To comply with federal regulations concerning condition of participation : Patient Rights. ... PROCEDURE 1. The admitting RN [registered nurse] informs all Medicare and Medicaid clients that they are not responsible for any amounts not paid by Medicare and Medicaid. ... "</p> <p>3. On 8/25/14 at 10:44 AM, employee A (alternate administrator) indicated the admission service agreement is signed on admission.</p> <p>4. On 8/25/14 at 10:46 AM, employee H indicated the Admission Service Agreement was not signed on the date of the patient's admission to the agency.</p>				

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	<p><b>Patient Rights</b> Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure all client complaints / concerns were investigated and resolved for 1 complaint evidenced within a clinical record and the complaint was filed in the agency's administrative files for 1 of 1 complaint found in a clinical record creating the potential to affect all the agency's 280 patients. (#12)</p> <p>Findings include</p> <p>1. Clinical record #12 was reviewed on 8/18/14. The record evidenced a Universal / Communication Record noted as a Client Concern and dated 4/3/14 at 4:30 PM. The Universal / Communication Record failed to evidence any follow up was conducted.</p>	N000514	The Administrator has revised agency policy # 2025 Client Concerns to include a revised process for investigating and resolving client complaints. All complaints will be copied to the Administrator and entered into the complaint log to ensure appropriate follow up. The Administrator has in serviced the management staff on the revised policy. The complaint log will be reviewed weekly with the management staff to ensure appropriate follow up and resolution. Results will be reported quarterly as part of our UR/QA review. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	09/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>2. During interview on 8/18/14 at 3:15 PM, employee L indicated they handle the complaints which are called directly to them and they get investigated and placed in the complaint log. Employee L indicated they were not aware of the Concern dated 4/3/14, it was a scheduling issue, and they will have to check with scheduling or human resources to see if it was resolved or not, but a case manager wrote it. Employee L indicated client concerns go to them or the alternate administrator but if it is a nursing complaint / concern, then it might go to scheduling, but client concerns should not go in the patient records.</p> <p>3. During interview on 8/19/14 at 10:05 AM, employee L indicated scheduling and human resources could not find any evidence of the concern dated 4/3/14 having been resolved.</p> <p>4. The agency's policy titled "Client Concerns," # 2.025, reviewed 4/4/13 states, "b. Encourage clients to contact the Administrator and/or Director of Clinical Services to discuss client concerns ... e. Give information regarding expressed client concerns to the Director of Clinical Services. 2. The Director of Clinical Services: a. Reviews the completed Client Concerns forms, b. Initials problems-solving</p>			

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	<p>process to deal with client concerns: i. Informs the client that the client's concern has been received, ii. Plans appropriate corrective action, iii. Implements a corrective action plan, iv. Evaluates the implemented corrective action plan to determine if the client concern has been alleviated, v. Informs client that the client's concern has been investigated and corrective action has been implemented, as necessary, either verbally or in writing, as appropriate; if verbally, document on the concern form, vi. Gives information regarding the expressed client concern to the Administrator, as necessary. 3. Client concerns are communicated to involved individuals, as appropriate. 4. Completed and reviewed Client Concern forms are filed in the agency's administrative files."</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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N000518	<p>410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on admission packet review, clinical record review, home visit observation, policy review, and interview, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, for 13 of 13 clinical records reviewed creating the potential to affect all the agency's 280 patients. (#1-13)</p> <p>Findings include</p>	N000518	<p>The agency has informed and distributed the current State of Indiana Advanced Directives document, revised July 2013, to all of its clients via client newsletter and direct mail. Nursing staff will review Advance Directives information, including a description of applicable state law and any applicable updates with the patient on supervisory visits. The Clinical Manager has revised the admission paperwork review process to ensure that all pertinent documents, including a current version of the State of</p>	09/25/2014

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806		
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	<p>1. The information given to the patients failed to include the updated state of Indiana advanced directives document, revised July 1, 2013, in the admission folder that was distributed to the patients at the start of care (SOC).</p> <p>2. Clinical record #4, SOC 10/3/12, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 8/19/14 at 12:45 PM, the home admission folder was observed during a home visit for patient 4. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>3. Clinical record #5, SOC 3/14/13, failed to evidence an updated Indiana Advanced Directives document, revised July 2013.</p> <p>On 8/19/14 at 9:00 AM, the home admission folder was observed during a home visit for patient 5. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>4. Clinical record #6, SOC 5/7/14, failed to evidence an updated Indiana Advanced Directives document, revised July 2013,</p>		<p>Indiana Advanced Directives Document, are signed at the time of admission. The new process will require a medical records review and checklist prior to setting up the new chart. 10% of all clinical records will be audited quarterly for evidence that the Registered Nurse has reviewed advance directives information, including a description of applicable state law and any applicable updates with the patient on supervisory visits. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>was given to the patient. The patient signed that the document was received on the SOC date.</p> <p>5. Clinical record #7, SOC 1/28/13, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was given to the patient.</p> <p>6. Clinical record #8, SOC 4/12/12, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was given to the patient.</p> <p>7. Clinical record #9, SOC 9/20/12, failed to evidence an updated July 1, 2013, version of the Indiana Advanced Directives document.</p> <p>On 8/18/14 at 10:20 AM, the home admission folder was observed during a home visit for patient #9. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>8. Clinical record #10, SOC 5/21/11, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was given to the patient.</p> <p>9. Clinical record #11, SOC 2/17/14, failed to evidence an updated Indiana Advanced Directives document, revised</p>			

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	<p>July 2013, was given to the patient.</p> <p>10. Clinical record #12, SOC 4/25/11, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was given to the patient.</p> <p>11. Clinical record #13, SOC 1/25/13 , failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was given to the patient.</p> <p>12. Clinical record #14, SOC 1/15/13, failed to evidence an updated version of the Indiana Advanced Directives document, revised July 1, 2013.</p> <p>On 8/18/14 at 11:45 AM, the home admission folder was observed during a home visit for patient #14. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>13. Clinical record #15, SOC 8/8/12, failed to evidence an updated Indiana Advanced Directives document, revised July 2013, was given to the patient.</p> <p>14. Clinical record #16, SOC 12/13/13, failed to evidence an updated Indiana Advanced Directives document, revised July 2013. The patient signed that the document was received on the SOC date.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>On 8/19/14 at 9:00 AM, the home admission folder was observed during a home visit for patient 16. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>15. During interview on 8/18/14 at 9:50 AM, employee A indicated the admission packet is current with what is given to patients on admission.</p> <p>16. During interview on 8/18/14 at 1:20 PM, employee L indicated the agency only has the May 2004 Advance Directives packet and have just now learned about the updated one revised July 2013 so they will have to replace the old ones.</p> <p>17. The agency's policy titled "Advance Directives," # 2.023, reviewed 4/4/13 states, "CHHC ensures compliance with the requirements of state law regarding advance directives and informs all adult individuals those complaint concerning the advance directive requirements may be filed with the Indiana State Department of Health."</p> <p>18. The agency's undated document titled "Patient Rights," states, "(e) The home health agency must inform and</p>			

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N000520	<p>distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on clinical record review, agency policy review, and interview, the agency failed to ensure patients were accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence in 1 of 13 records reviewed creating the potential to affect all 280 of the agency's current patients.</p>	N000520	The Administrator has revised the policy Acceptance of Patients #2001 to include the documentation of requests to delay the start of care. The request must be documented in the clinical record as well as a notation that the physician was notified of and approves the patient request for a delayed start of care. The decision will be noted on the initial referral form and also documented on the	09/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806			
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	<p>(#11)</p> <p>Findings include:</p> <p>1. Clinical record #11 contained a plan of care for certification period 2/17/14 to 4/17/14 stating, "Start of Care Date 02/17/2014 ... Principal Diagnosis Paraplegia ... 21. Orders for Discipline and Treatments 02/17/2014 Respite HHA [home health aide] for 1 hr [hour] in a.m. Mon. [Monday] through Fri [Friday] and 1 hr p.m. Mon and Fri per Medicaid Waiver x [times] 60 days. ... 23. Nurse's Signature and Date of Verbal SOC [start of care] where applicable: [signature of employee H, director of nursing] '1-16-14.'" The record failed to evidence the reason for a 32 day delay in services or that the physician had been notified the delay.</p> <p>On 8/25/14 at 10:55 AM, employee H indicated the physician was not notified about the delay in services to be provided to this patient and was unable to locate documentation of the patient's notification of the delay. The employee indicated the insurance approval for the requested services was received by the agency on 2/5/14 but was unable to locate documentation to determine why the initial visit did not occur until 2/15/14.</p>		<p>medical plan of care (POC). The Administrator has in serviced the nursing staff on the revised policy # 2001 Acceptance of Patients 10% of all clinical records will be audited quarterly for evidence that the clinical record includes documentation of requests to delay the start of care where applicable. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>2. The agency policy with a review date of 4/4/13 titled "Policy 2.001 - Acceptance of clients for home health care services" states, "POLICY Acceptance of clients who request home health care services is based on a reasonable expectation the client's medical, nursing and social needs can be adequately met by community home health care staff members in the client's place of residence. PURPOSE 1. To establish specific admission criteria for acceptance of clients who request home health care services. 2. To assess client referrals for appropriateness of clients admissions to the agency. PROCEDURE 1. Client referrals are documented on an intake sheet. 2. The CHHC registered nurse assess the client referral for appropriateness for admission to service ... 3. The registered nurse: a. contacts the prospective client's family by telephone or in person for a nursing and in home assessment regarding the applicant's need for home health care services. ... e. decides if the prospective client should be accepted or not accepted for admission to the agency f. informs the prospective client or family of the decision to accept or not accept the prospective client for admission to the home health care agency. ... ."</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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N000522	<p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure treatments and visits were conducted as ordered on the plan of care (POC), and failed to ensure the physician was notified of missed visits for 6 of 13 clinical records reviewed creating the potential to affect all the agency's 280 patients. (# 6, 8, 11, 14, 15, and 16)</p> <p>Findings include</p> <p>1. Clinical record #6, SOC date 5/7/14, contained a POC dated 5/7-7/5/14 with orders for HHA 2 hours daily in the AM and 2 hours daily in the PM for 60 days per Medicaid Code 50 and SN 3 times daily for 60 days per Medicaid Code 50. An order dated 6/4/14 evidenced the SN was to cleanse right wrist with soap and water, pack wet/dry with normal saline twice a day, and cover with gauze.</p>	N000522	The Administrator has revised the policy #2012 Client 60 day summaries to state that missed visits will be faxed to the physician weekly and noted on the POC. The Administrator has in serviced the nursing staff on the revised policy to ensure that "all missed visits will be documented on the 60 day summary and the physician will be notified weekly." The Administrator has revised agency policy# 2.010 Client Plan of Care to require a copy of the medical plan of care be kept in the home. The Administrator has also revised agency policy #2.028 Coordination of Care with Outside Agencies to include a revised process for collecting medication administration sheets shared with outside agencies. The Administrator has in serviced the nursing staff on revised agency policies #2.028 and #2.010. 10% of all clinical records will be audited quarterly for evidence that	09/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806		
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	<p>A. The record evidenced SN visits were conducted 4 times a day on June 1, 2, 3, 8, 9, 13, 14, 15, 16, 17, 18, 22, 24, 27, 28, 29, and July 4 and 5, 2014. The record failed to evidence an order to increase SN visits and failed to evidence the physician was notified of a need to increase visits.</p> <p>B. The SN visit notes failed to evidence the right wrist dressing change was changed twice on 6/5, 6/6, and 6/12/14 as ordered and failed to evidence the physician was notified.</p> <p>C. The record failed to evidence HHA visits were conducted twice daily on June 16, 17, 18, 23, 24, 25, 26, 27, 29, 30, and July 1, 2, 3, and 4, 2014. The record failed to evidence any missed visit sheets were completed for these dates, failed to evidence an order to change or stop the visits, and failed to evidence the physician was notified of missed visits.</p> <p>D. During interview on 8/20/14 at 11:40 AM, employee A indicated they did not see any orders to increase the SN visits to 4 times daily and the only reason the visits increased was due to being a code 50 (if the patient goes to the hospital for a certain amount of time and needs more care, then the agency can increase</p>		<p>the physician was notified of any missed visits and the missed visits are documented on the POC. Audit will include a randomly selected home observation visit to monitor compliance with keeping a copy of the Plan of Care in the home. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806			
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	<p>the visits when they return, if needed) - but the plan of care still says 3 times a day, and that is the order.</p> <p>2. Clinical record #11, SOC date 2/17/14, contained a POC dated 2/17-4/17/14 with orders for HHA 1 hour in the AM Monday through Friday and 1 hour in the PM Monday through Friday for 60 days, not to exceed 20 hours per month.</p> <p>A. Missed Visit/Shift reports failed to evidence the physician was notified of missed or canceled visits by the patient for 2/21/14 evening, 2/24/14, 3/13/14 evening, 3/7/14 evening, 3/12/14 and 3/14/14 evening, 3/17/14 and 3/21/14 evening, 3/24/14 evening, 3/28/14 evening, 4/7/14 evening, 4/11/14 evening, and 4/14/14, each sheet noting reason as Other: Not to exceed 20 hours per week.</p> <p>B. During interview on 8/25/14 at 10:55 AM, employee A indicated the physician was not notified of the missed visits.</p> <p>3. Clinical record #14, SOC 1/15/13, contained a POC dated 5/9-7/7/14 with orders for skilled nursing (SN) 4 visits daily, 7 days per week per Medicaid PA x 60 days. SN for peg tube feedings, Jevity</p>						

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	<p>1.2 (1 to 1 1/2 can) with 200 to 300 cc flush; monitor peg tube site; SN for medication administration per peg tube; assess medication effectiveness; and assess neuro status and cardiopulmonary status. Head to toe assessment each visit. Home Health Aide (HHA) for 5 hours, 7 days a week per Medicaid PA x 60 days. The record failed to evidence a fourth SN visit was conducted on 5/9, 5/29, 6/5, 6/25, and 6/27/14.</p> <p>A. The record failed to evidence missed visit reports were completed and the physician was notified of the missed visits for 5/9, 5/29, 6/25, and 6/27/14.</p> <p>B. During interview on 8/6/14 at 11:56 AM, employee K indicated there should not be any missed visits in this chart; they don't miss visits with this patient.</p> <p>C. During interview on 8/6/14 at 2:03 PM, employee A indicated missed visits are unusual for this patient; the agency never cancels.</p> <p>D. During interview on 8/6/14 at 2:00 PM, employee K indicated the agency cannot find the documents for the SN visits. The visits were made, but billing cannot locate them. They can only assume they are mis-filed in another</p>						

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	<p>patient's chart.</p> <p>E. The record evidenced a document titled "Visit/Shift Report form" dated 6/25/14 for SN visit at 4:00 PM evidenced the reason states "Client canceled the visit/shift." The form failed to evidence the name of the employee who faxed the information and failed to identify the name of the physician it was faxed to. The form dated 6/26/14 states "Date Faxed" [Blank], "Doctor" [Blank], and "Initials" [Blank]. During interview on 8/6/14 at 2:37 PM, employee K indicated this form was probably just filled out now because there was not a missed visit form in the chart and most likely the physician was not notified of the missed visit.</p> <p>4. Clinical record #15, SOC date 8/8/12, contained a POC dated 6/9-8/7/14 with orders for HHA 1 hour 7 days per week per Medicaid PA x 60 days. The record failed to evidence a HHA visit was conducted on 7/16/14, failed to evidence a missed visit form was completed, and failed to evidence the physician was notified of the missed visit.</p> <p>5. Clinical record #16, SOC date 12/13/13, contained a POC dated 6/11-8/9/14 with orders for HHA for personal care 1 hour in A.M., 7 days per</p>			

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	<p>week per Medicaid PA x 60 days. SN QID (4 times daily) 7 times per week per Medicaid PA x 60 days. SN to administer to client tube feeding of Nutren 2.0 twice daily and Pulmonary Nutren 1 can twice daily.</p> <p>A. The record failed to evidence a fourth SN visit was conducted on 6/12, 6/30, 7/11, 7/20, and 7/23/14 and failed to evidence a third and fourth visit was conducted on 6/17, 7/21, and 7/24/14. The clinical record failed to evidence missed visit notes were completed and the physician was notified.</p> <p>B. The record failed to evidence HHA visits were conducted on 6/16 and 6/17/14. The clinical record failed to evidence missed visit notes were completed and the physician was notified.</p> <p>C. On 8/6/14 at 3:50 PM, the agency failed to provide nurses' notes or missed visit forms for one SN visit on 6/12, 6/30, 7/11, 7/20, 7/21, and 7/23/14, failed to provide nurses' notes or missed visit forms for two SN visits on 6/17 and 7/24/14, and failed to provide HHA notes or missed visit forms for 6/16 and 6/17/14.</p> <p>D. Employee time sheet logs for</p>			

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	<p>patient #16 were provided for 6/1-8/2/14. The time sheet log failed to evidence the HHA visit was staffed on 6/17/14. The clinical record failed to evidence a missed visit note was completed and the physician was notified.</p> <p>E. During interview on 8/6/14 at 11:55 AM, employee L indicated missed visit forms were kept in the charts with the disciplines that missed the visits.</p> <p>F. During interview on 8/6/14 at 3:50 PM, employee A indicated patient #16 lives in a group home and the medication administration sheets for June and July have not been brought into the office as of today.</p> <p>6. During interview on 8/6/14 at 2:45 PM, employee K (alternate director of nursing), indicated the missed visits were to be incorporated into the 60 day summary on the plan of care.</p> <p>7. During interview on 8/6/14 at 3:00 PM, employee L (administrator) indicated the current policy indicates to document the missed visit in writing, notify the physician and place a copy in the chart. Employee L indicated the physicians have not been notified of missed visits since the change of administration in October of 2013, but</p>				

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	<p>the current forms for missed visits are processed and placed in charts on the date noted in the upper right hand corner.</p> <p>8. The agency's policy titled "Client 60-Day Summaries," # 2.012, reviewed 4/4/13, states, "4. All missed visits will be documented in writing and sent to the physician."</p> <p>9. The agency's policy titled "Client Plan of Care," # 2.010, reviewed 4/4/13, states "7. ... Treatments shall be administered by appropriate agency staff only as ordered by the physician. 8. Accountability a. Director of Clinical Services will be directly responsible for compliance with the above."</p> <p>10. Clinical record #8, SOC date 4/12/12, contained a POC dated 7/31-9/28/14 with orders for skilled nursing 4 times per day, 7 days per Medicaid PA for 60 days for in/out catheters, assess for signs and symptoms of urinary tract infection, assess neuro status, assess cardiopulmonary status, assess GI status, and assess skin integrity.</p> <p>A. The record evidenced a document dated 8/5/14 titled "Missed visit/shift report" stating, "Type of visit: SNV [skilled nursing visit] The reason for the missed visit/shift was: Client canceled</p>			

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N000524	<p>the visit/shift."</p> <p>B. The record evidenced a document dated 8/12/14 titled "Missed visit/shift report" stating, "Type of visit: SNV The reason for the missed visit/shift was: Client canceled the visit/shift."</p> <p>C. On 8/26/14 at 1:50 PM, employee A (alternate administrator) indicated the physician was not notified of the 8/5/14 missed visit and the missed visit form dated 8/12/14 was faxed to the physician on 8/21/14, after survey entrance.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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.</p>						

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	<p>(x) Any safety measures to protect against injury.</p> <p>(xi) Instructions for timely discharge or referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(xiii) Any other appropriate items.</p> <p>Based on clinical record review, observation, and policy review, the agency failed to ensure Medical Plans of Care (POC) included all durable medical equipment (DME) used by the patient for 5 of 5 home visit observations creating the potential to affect all the agency's 280 patients. (#4, 5, 9, 14, and 16)</p> <p>Findings include</p> <p>1. Clinical record #4, start of care (SOC) date 10/3/12, contained a POC dated 7/25-9/22/14 with DME listed as wheelchair, Hoyer lift, shower chair, prone stander, feeding pump, and Gtube supplies. During home visit observation on 8/19/14 at 12:45 PM, the patient was observed lying in a hospital bed with an overlay mattress. The bed with an overlay mattress was not listed on the plan of care.</p> <p>2. Clinical record #5, SOC date 3/14/13, contained a POC dated 7/7-9/4/14 with DME listed as walker, wheelchair, and shower chair. During home visit observation on 8/19/14 at 1:30 PM, DME</p>	N000524	<p>The Administrator has in serviced the nursing staff on agency policy # 2.010 Plan of Care and reviewed current process which requires the Registered Nurse to include all DME items in the home on the medical plan of care (POC). RN Case Managers will review and update DME items on supervisory visits and document any changes on the supervisory visit note. 10% of all clinical records will be audited quarterly for evidence that the POC includes all durable medical equipment used by the patient. Audit will include a home visit observation selected at random to monitor compliance with this policy. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	09/25/2014

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	<p>observed in home included bedside commode, slide board, hospital bed, and prosthetic leg. These items were not included on the plan of care.</p> <p>3. Clinical record #9, SOC date 9/20/12, contained a POC dated 7/3-9/10/14 with DME listed as hospital bed, wheel chair, shower chair, and Gtube supplies. During home visit observation on 8/18/14 at 10:20 AM, other DME observed in home included an overlay mattress. This was not included on the plan of care.</p> <p>4. Clinical record #14, SOC date 1/5/13, contained a POC dated 7/8-9/5/14 with DME listed as wheelchair, hospital bed, bedside commode, Hoyer lift, shower bench, tube feeding supplies, and syringes. During home visit observation on 8/18/14 at 11:45 AM, other DME observed in home included a toilet riser. This item was not included on the plan of care.</p> <p>5. Clinical record #16, SOC date 3/14/13, contained a POC dated 8/10-10/8/14 with DME listed as Gtube supplies. During home visit observation on 8/19/14 at 9:00 AM, DME observed in home included hospital bed and shower chair. These items were not included on the plan of care.</p>			

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N000537	<p>6. The agency's policy titled "Client Plan of Care," # 2.010, reviewed 4/4/13 states, "2. The client plan of care: ... b. includes the following: ... xiv. Medical supplies/appliances necessary. ... 8. Accountability a. Director of Clinical Services will be directly responsible for compliance with the above."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure the nurses provided care as ordered on the physician plan of care for 1 of 13 clinical records reviewed creating the potential to affect all the agency's patients. (# 6)</p> <p>Findings include</p> <p>1. Clinical record #6, start of care date 5/7/14, contained a Plan of Care dated 5/7-7/5/14 with orders for Home Health Aide (HHA) 2 hours daily in the AM and 2 hours daily in the PM for 60 days per Medicaid Code 50 and skilled nursing (SN) 3 times daily for 60 days per Medicaid Code 50. SN to assess vital</p>	N000537	The Administrator has revised agency policy #2.010 Plan of Care to require that a copy of the plan of care is kept in the clients home folder to ensure that the nurses provide care as ordered. The Administrator has updated the nursing staff on revised policy #2.010 Plan of Care. The Clinical Manager has implemented a weekly QA audit to ensure the nurses provided care as ordered on the physician plan of care. The Clinical Manager has in serviced the nursing staff on the revised process. The Administrator has updated the agency nursing protocol resources and in serviced the nursing staff on the updated protocols. 10% of all clinical records will be audited quarterly for evidence that the	09/25/2014

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	<p>signs, assess medication compliance/effectiveness, assess cardio/pulmonary status, and monitor blood sugars and administer insulin as ordered by physician. An order dated 6/4/14 evidenced the SN to cleanse right wrist with soap and water, pack wet/dry with normal saline twice a day, and cover with gauze.</p> <p>A. The record failed to evidence a third SN was conducted on 5/7, 5/8, and 5/9/14.</p> <p>B. The SN visit note dated 5/30/14 9:22 PM failed to evidence the blood sugar (BS) value.</p> <p>C. The SN visit note dated 6/12/14 9:06 PM failed to evidence the BS was checked by the nurse and states it was "taken per house caregiver." The SN visit note failed to evidence the BS value.</p> <p>D. The SN visit note dated 6/3/14 3:45 PM failed to evidence the BS was checked.</p> <p>E. The SN visit notes dated 6/3/14 3:45 PM, 6/27/14 9:33 PM, and 6/29/14 4:12 PM, failed to evidence the BS was checked.</p> <p>F. The SN visit note dated 7/4/14 at</p>		nurses provided care as ordered on the plan of care and in accordance with agency approved protocols. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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	<p>7:06 AM evidenced the BS was 74, patient in bed sleeping, gave orange juice, held 5 units Humalog, patient declined breakfast, signs and symptoms of hypoglycemia. The SN visit note failed to evidence a re-check was done per policy and failed to evidence the nurse called the physician to coordinate care and notify of patient's symptoms.</p> <p>G. The SN visit note dated 7/5/14 at 12:05 PM evidenced the patient's BS was 62, the nurse gave 5 units of Humalog but no coverage, client was eating lunch. The SN visit note failed to evidence a re-check of the BS per policy.</p> <p>H. During interview on 8/20/14 at 11:30 AM, employee A indicated they would expect the nurses would call the physician for a BS of 62 and not give the Humalog if the orders were under the sliding scale range.</p> <p>I. During interview on 8/26/14 at 10:25 AM, employee M indicated if a BS was below 70 the agency uses the sliding scale, nursing judgment is typically to not give the insulin but patient #6 has not had any signs or symptoms of hypoglycemia. If the patient were exhibiting symptoms they would call the physician and follow up if the agency could reach the physician.</p>			

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	<p>J. The SN visit notes failed to evidence the right wrist dressing change was changed twice on 6/5, 6/6, and 6/12/14 as ordered.</p> <p>K. The SN visit notes failed to evidence the right wrist wound was measured weekly. The record failed to evidence the wound was measured the weeks of 5/7-5/10, 5/11-5/17, 5/18-5/22, 6/1-6/7, 6/15-6/21, and 6/29-7/5/14.</p> <p>2. During interview on 8/20/14 at 11:40 AM, employee A indicated the SN services were to be performed three times per day.</p> <p>3. During interview on 8/20/14 at 1:45 PM, employee A indicated the wounds should be measured weekly.</p> <p>4. The agency's undated protocol titled "Wound Management Protocols," states, "Wound Measurement ... The wound should be measured at its greatest length and breadth using the sterile measuring ruler in the dressing packet. The depth of the wound is measured using a sterile probe using a clock with the head of the patient as a guide being at 12 o'clock."</p>			

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N000541	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on clinical record review and interview, the agency failed to ensure the registered nurse reevaluated the patient's needs at least every 60 days for 1 of 13 clinical records reviewed, creating the potential to affect all the agency's 280 patients. (#9)</p> <p>Findings include</p> <p>1. Clinical record #9, start of care date 9/20/12, contained a plan of care dated 7/13-9/10/14. The record failed to evidence a the registered nurse reevaluated the patient's needs for the current certification period.</p> <p>2. During interview on 8/20/14 at 1:50 PM, employee A indicated the recertification was transmitted through Outcome Assessment Information Set on 7/8/14 but the agency cannot locate the paperwork anywhere.</p>	N000541	The Clinical Manager has revised the process for submitting paperwork to the nursing office for OASIS submission. All paperwork will be scanned daily when received in the office. The Clinical Manager has in serviced the staff on the new process. The Clinical Manager has also implemented a weekly QA audit to ensure the nurses reevaluate the patients' needs at least every 60 days. 10% of all clinical records will be audited quarterly for evidence that the nurses reevaluate the patients'needs at least every 60 days. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	09/25/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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N000542	<p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse revised the plan of care in 1 of 13 records reviewed creating the potential to affect all the agency's 280 patients. (6)</p> <p>Findings include:</p> <p>1. Clinical record #6, start of care 5/7/14, contained physician plan of care for certification period 5/7 to 7/5/14 with orders for skilled nursing services 3 times daily for 60 days to assess vital signs, assess medication compliance/effectiveness, assess cardio/pulmonary status, monitor blood sugars and administer insulin as ordered by the physician and medications to include Levimir 42 Units twice daily and Humulog sliding scale. The record contained a physician plan of care for certification period 7/6 to 9/3/14 with</p>	N000542	<p>The Administrator has in serviced the nursing staff on agency policy #2.004 Client Case Management to ensure compliance with POC updates and supervisory visits. The Clinical Manager has implemented a weekly QA audit to ensure compliance with POC updates and supervisory visits. 10% of all clinical records will be audited quarterly for evidence that the nurses reevaluate the patients' needs at least every 60 days and documents updates on the POC The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	09/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>orders for skilled nursing services 4 times daily for 60 days to assess vital signs, assess medication compliance/effectiveness, assess cardio/pulmonary status, monitor blood sugars and administer insulin as ordered by the physician and medications to include Levimir 42 Units twice daily and Humulog sliding scale. The record failed to evidence the registered nurse updated the plan of care to include changes in medication orders.</p> <p>A. On 8/26/14 at 11:40 AM, employee J indicated the medication change should have been updated on the medication profile during the review on 7/8/14.</p> <p>B. On 8/26/14 at 10:43 AM, employee M (case manager) indicated the medication change should have been updated on the plan of care for recertification on 7/4/14 but was not aware of the change since it was written as a progress note and not as a physician's order.</p> <p>C The record identified the patient had diagnoses of Congestive Heart Failure (CHF), Chronic Kidney Disease (CKD) stage 4, Insulin Dependent Diabetes Mellitus, and Pulmonary Embolism. The record evidenced the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>patient was hospitalized from 5/22-5/30/14 with admission diagnoses of COPD, CHF, and Volume Overload and a final discharge diagnosis of Volume Overload. The hospital discharge instructions dated 5/30/14 evidenced the patient diet should be limit salt intake to 1500 milligrams daily, do not add salt to food, and do not eat food made with a lot of salt, and do not eat food made with a lot of salt, and to weigh self each morning and tell the physician if they gain 3 pounds or more in one day, or 5 pounds in a week. The record failed to evidence the POC was updated to reflect diet change from regular diet, watch sugar intake, and failed to assign follow up of the weights to the Skilled Nurse (SN).</p> <p>1.) A. During interview on 8/22/14 at 8:50 AM, employee A indicated the nurses should be documenting the weight daily as instructed, especially since the patient went in for fluid overload. At 8:55 AM, employee A indicated the case managers should review hospital discharge instructions and update any changes.</p> <p>2.) During interview on 8/22/14 at 9:00 AM, employee H indicated the agency should have the SN monitor the weights.</p> <p>3. The agency's policy titled "Client Case</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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N000550	<p>Management," # 2.004, reviewed 4/4/13 states, "4. The Registered Nurse makes subsequent home health care visits at least once every two weeks. In these visits, the nurse: ... d. Revises and implements the client plan of care based on the nursing assessment, the attending physician's orders, and the client's participation."</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.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) completed the Aide Care Plans (ACP) as ordered and accurately, differentiated which tasks were to be completed by which aide on which shift, and reviewed the ACP at least every 60 days for 4 of 8 clinical records reviewed of patients receiving HHA services creating the potential to affect all the agency's 182</p>	N000550	The Administrator has in serviced the nursing staff on the Assignment and Duties of the Home Health Aide (Agency policy #7003) The Clinical Manager has in serviced the Home Health Aides on the Assignment and Duties of the Home Health Aide (Agency policy # 7003), and agency policy #3.002 Charting The Clinical Manager has implemented a weekly QA audit to review the aide charting for	09/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806		
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	<p>patients receiving HHA services. (#6, 9, 10 and 12)</p> <p>Findings include</p> <p>1. The agency's policy titled "Home Health Aide Services," # 7.003, reviewed 4/4/13 states, "2. Home Health Aides are carefully trained in: ... b. observation, reporting, and documentation of client status and the care or service provided, ... d. basic infection control procedures, ... f. maintenance of a clean, safe, healthy environment, ... i. appropriate and safe techniques in personal hygiene and grooming that include: i. bed bath, ii. sponge, tub, or shower bath, iii. shampoo, sink, tub, or bed, iv. nail and skin care, v. oral hygiene, vi. toileting and elimination, ... 1. adequate nutrition and fluid intake. ... 3. CHHC Registered Nurse gives written instructions (Home Health Aide Assignment Sheet) for client care to the Home Health Aide, as appropriate. 4. The duties of the Home Health Aide include the following: a. performance of simple procedures as extensions of therapy, b. client personal care, c. client ambulation and exercise, d. household services essential to health care at home, e. assistance with client medications that are ordinarily self-administered, f. reporting of changes in client conditions</p>		<p>compliance with the assignment sheet. 10% of all clinical records will be audited quarterly for evidence that the registered nurse completed the assignment sheet as ordered and accurately and reviews the assignment sheet at least every 60 days. 10% of all clinical records will be audited quarterly for evidence that the home health aide charting is completed in compliance with the aide assignment sheet. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>and client needs, g. completion of appropriate client clinical records. 5. CHHC Registered Nurse: a. closely supervises the Home Health Aide to ensure the Aide's competence in providing home health care."</p> <p>2. Clinical record #6, start of care (SOC) 5/7/14, contained a plan of care (POC) dated 5/7-7/5/14 with diagnoses Congestive Heart Failure, Chronic Kidney Disease stage 4, Insulin Dependent Diabetes Mellitus, and Pulmonary Embolism with orders for Home Health Aide (HHA) 2 hours daily in the AM and 2 hours daily in the PM for 60 days per Medicaid Code 50, and skilled nursing (SN) 3 times daily for 60 days per Medicaid Code 50. HHA to provide personal care including bathing, grooming, good skin care, incontinent care, assist with transfers, and provide for safety per Medicaid.</p> <p>A. The HHA assignment sheet dated 5/7/14 for AM prepared by the registered nurse (RN) assigned the following duties to be completed each visit: Bath as needed, Skin intact, Assist with dressing, Deodorant, Shampoo, record last bowel movement date, incontinent care, Universal precautions, chair transfer as needed, medication remind/assist, encourage fluids, and report any red open</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>areas of skin to office nurse. The section titled "Client Diagnosis" failed to evidence clinical diagnoses and states "patient unable to do personal care d/t [due to] decreased mobility, decreased endurance, and increased shortness of breath (SOB)."</p> <p>B. The HHA assignment sheet for PM prepared by the registered nurse (RN) assigned the following duties to be completed each visit: Bath per request, Skin intact, Assist with dressing, Dentures, record last bowel movement date, incontinent care as needed, bed and chair transfer as needed, and medication remind/assist, and report any red open areas of skin to office nurse. The section titled "Client Diagnosis" failed to evidence clinical diagnoses and states "Patient unable to do personal care d/t decreased mobility, decreased endurance, and SOB."</p> <p>C. The HHA assignment sheets for AM and PM failed to evidence the registered nurse (RN) reviewed them on 7/8/14. Both are signed by employee J, a licensed practical nurse, not the registered nurse.</p> <p>D. During interview on 8/26/14 at 10:10 AM, employee A indicated if a task is circled on the HHA assignment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>sheets, that means the task is assigned to be completed by the HHA.</p> <p>E. During interview on 8/26/14 at 10:30 AM, employee M , RN, indicated they should have put monitor fluids, not encourage fluids on the HHA care plan.</p> <p>F. During interview on 8/26/14 at 11:49 AM, employee J indicated they signed the update on 7/8/14 for the HHA care plans for patient #6, but it should have been an RN.</p> <p>3. Clinical record #9, SOC date 9/20/12, contained a POC dated 7/13-9/10/14 with orders for HHA 1 hour in the AM and 1 hour in the PM, 7 days a week per Medicaid PA x 60 days. HHA for personal care: bathing, grooming, skin care, incontinent care, assist with transfer, provide safety. Both the AM and PM assignment sheets were the same, indicating all activities were to be provided twice a day.</p> <p>A. The HHA assignment sheet for AM prepared by the RN assigned the following duties to be completed each visit: Bath, Skin intact, Assist with dressing, Deodorant, Shampoo, Hair Care, Lotion/Massage, record last bowel movement date, incontinent care, Universal precautions, transfer activities,</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>and report any red open areas of skin to office nurse.</p> <p>B. The HHA assignment sheet for PM prepared by the RN assigned the following duties to be completed each visit: Bath, Skin intact, Assist with dressing, Deodorant, Shampoo, Hair Care, record last bowel movement date, incontinent care, Universal precautions, transfer activities, and range of motion as time allows, and report any red open areas of skin to office nurse.</p> <p>C. The HHA Charting does not differentiate whether the tasks were completed in the AM or PM for each sheet.</p> <p>D. The two HHA Charting sheets dated 8/11-8/15/14, 8/4-8/8/14, and 7/21-7/25/14 failed to evidence the HHA provided hair care and range of motion and lotion/massage was provided twice each day Monday through Friday.</p> <p>E. The HHA Charting sheet dated 8/10/14 failed to evidence hair care was provided.</p> <p>F. The two HHA Charting sheets dated 7/28-8/1/14 failed to evidence the HHA provided hair care and range of motion, lotion/massage was provided</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>twice each day, and shampoo was only provided once each day, Monday through Friday.</p> <p>G. The HHA Charting sheet dated 8/2/14 failed to evidence hair care, deodorant, shampoo, and lotion/massage was provided.</p> <p>H. The second HHA Charting sheet dated 8/2/14 failed to evidence range of motion was provided.</p> <p>I. The HHA Charting sheet dated 7/26/14 failed to evidence lotion/massage was provided.</p> <p>J. The two HHA Charting sheets dated 7/13-7/19 failed to evidence shampoo and hair care were provided each shift Monday through Friday .</p> <p>K. During interview on 8/19/14 at 12:00 PM, employee A indicated the aides need to be identifying if the tasks are being done in the AM or the PM.</p> <p>4. Clinical record #10, SOC date 5/21/11, contained a POC dated 6/29-8/27/14 with orders for HHA 2 hours per day, 7 days a week for 60 days. HHA for total care all activities of daily living: bathing, grooming, dressing, incontinent care both bowel and bladder,</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>monitor/maintain skin integrity; Vaseline to skin after bath daily, safety in home, stand by assist with ambulation, active range of motion (ROM) all extremities, provide continuous supervision for client due to cognitive function.</p> <p>A. The HHA assignment sheet dated 5/5/14 was created and signed by the RN. The assignment sheet failed to evidence the RN reviewed it before 6/29/14 and evidenced it was reviewed and signed on 7/1/14 by the licensed practical nurse, employee J, not the RN.</p> <p>B. The HHA assignment sheet states the following tasks to be performed with each visit: bath, skin intact, complete dressing, shaving, deodorant, brush teeth, hair care, lotion/massage, last bowel movement date, universal precautions, meal/snack prep with Carnation shake each AM and special pudding in fridge. Incontinence care and ambulation, chair or bed transfer as needed. The sheet failed to evidence the HHA was assigned to ROM each visit.</p> <p>5. Clinical record #12, SOC dated 4/25/11, contained a POC dated 4/9-6/7/14 with orders for HHA 3 times a week for 2 hours per visit x 60 days. HHA for personal care to include: bathing, grooming, incontinent care a</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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N000553	<p>needed, skin care, and ROM as tolerated, and provide for safety, assist with transfers as needed.</p> <p>The HHA initial assignment sheet was created by employee H, RN, on 8/13/13. The sheet evidenced a Licensed Practical Nurse reviewed on 10/15/13 and employee H co-signed. The sheet failed to evidence it had been reviewed since 12/10/13.</p> <p>410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/26/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806			
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	<p>agency policies.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the licensed practical nurse furnished services in accordance with agency policy in 1 of 13 clinical records reviewed creating the potential to affect all 280 of the agency's patients. (#6)</p> <p>Findings include:</p> <p>1. Clinical record #6, start of care 5/7/14, contained a physician plan of care for certification period 5/7 to 7/5/14 with orders for skilled nursing services 3 times daily for 60 days to assess vital signs, assess medication compliance / effectiveness, assess cardio / pulmonary status, monitor blood sugars, and administer insulin as ordered by the physician. The record contained a physician plan of care for certification period 7/6 to 9/3/14 with orders for skilled nursing services 4 times daily for 60 days to assess vital signs, assess medication compliance / effectiveness, assess cardio / pulmonary status, monitor blood sugars and administer insulin as ordered by the physician.</p> <p>A. The record evidenced a document titled "Care Coordination" stating, "Care Coordination Note Coordination of care with : skilled nurse Communicated via:</p>	N000553	The Administrator has revised agency policy 3.011 Physician Telephone Orders to ensure that the Registered Nurse obtains verbal orders in accordance with agency policy and federal regulations. The Administrator has updated the nursing staff on the revised policy #3001. 10% of all clinical records will be audited quarterly for evidence that the registered nurse obtains orders in accordance with agency policy and state and federal regulations. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	09/25/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>Other 'In office' Area/problem discussed Medication issue Details: 0 [no] Levimir available for a.m. dose. Nurse @ [at] [patient physician's name] office notified. Spoke [with] [nurse's name]. NO's [new orders] received from 6/26/14 appt. [appointment]. 1) Levirmir 40 U [units] BID [twice daily]. 2) Humalog SQ [Subcutaneous] BID 5 U @ breakfast et [and] lunch. 3) Humalog 10 U QD [every day] @ dinner. 4) continue [with] current sliding scale orders. ... Person completing form: Signature/Title [employee J, licensed practical nurse] Date 6/27/14 ... ." The record failed to evidenced the licensed practical nurse notified the registered nurse prior to calling the physician, failed to evidence the licensed practical nurse wrote an order for medication change on a physician's telephone order form, and failed to evidence the licensed practical nurse communicated with the case manager to ensure effective communication regarding physicians orders.</p> <p>B. On 8/26/14 at 11:34 AM, employee J, licensed practical nurse, indicated conducting a visit on 6/27/14, realizing there was no levimir to administer for the AM dose, notified the physician's office and spoke to the physician's nurse, obtained the new order</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/26/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>from the 6/26/14 appointment, documented this on a "Care Coordination note", and then finished conducting the visit. The employee indicated the patient's case manager (employee M, registered nurse) was not aware of the medication change.</p> <p>2. The agency policy with a review date of 4/4/13 titled "Policy 3.011 - Physician Telephone orders" states, "POLICY Community Home Health care obtains verbal and written orders from physicians for all licensed nurses to obtain physician telephone (verbal) orders for those clients with medical plans of care as needed. PURPOSE 1. to ensure accurate and uniform order taking. 2. to ensure effective communications with client, client's family ... and other staff regarding physicians orders. PROCEDURE 1. physician's telephone order (short order form or computer -generated order form is used. ... 11. LPN's [licensed practical nurses] who obtain verbal physician orders must discuss client status with RN [registered nurse] prior to calling physician. Physician telephone orders form is then co-signed by RN."</p>			

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N000559	<p>410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist, chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse.</p> <p>Based on document, clinical record, and policy review, the agency failed to ensure the licensed practical nurse consulted the registered nurse regarding the patient's need for medication before consulting the physician for 1 of 13 records reviewed. (# 6)</p> <p>Findings include</p> <p>1. Clinical record #6, start of care 5/7/14, contained physician plan of care for certification period 5/7 to 7/5/14 with orders for medications to include Levimir 42 Units twice daily and Humulog sliding scale. The record contained a physician plan of care for certification period 7/6 to 9/3/14 with orders for skilled nursing services 4 times daily for 60 days to administer insulin as ordered by the physician and medications to include Levimir 42 Units twice daily and Humulog sliding scale.</p>	N000559	The Administrator has revised agency policy # 3011 Physician Telephone Orders to comply with the federal regulations regarding the duties of the licensed practical nurse. The Administrator has in serviced the nursing staff on revised agency policy 3011 Physicians Telephone Orders 10% of all clinical records will be audited quarterly forevidence that the Registered Nurse obtains orders for medication changes and updates the plan of care with any changes. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	09/25/2014

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	<p>A. The record evidenced a document titled "Care Coordination" stating, "Care Coordination Note Coordination of care with : skilled nurse Communicated via: Other 'In office' Area/problem discussed Medication issue Details: 0 [no] Levimir available for a.m. dose. Nurse @ [at] [patient physician's name] office notified. Spoke [with] [nurse's name]. NO's [new orders] received from 6/26/14 appt. [appointment]. 1) Levimir 40 U [units] BID [twice daily]. 2) Humalog SQ [Subcutaneous] BID 5 U @ breakfast et [and] lunch. 3) Humalog 10 U QD [every day] @ dinner. 4) continue [with] current sliding scale orders. ... Person completing form: Signature/Title [employee J, licensed practical nurse] Date 6/27/14 ... ." The record failed to evidenced the licensed practical nurse notified the registered nurse prior to calling the physician, failed to evidence the licensed practical nurse wrote an order for medication change on a physician's telephone order form, and failed to evidence the licensed practical nurse communicated with the case manager to ensure effective communication regarding physicians orders.</p> <p>B. On 8/26/14 at 11:34 AM, employee J indicated conducting a visit on 6/27/14, realizing there was no</p>			

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	<p>Levimir to administer for the AM dose. The employee notified the physicians office and spoke to the physician's nurse, obtained the new order from the 6/26/14 appointment, documented this on a "Care Coordination note", and then finished conducting the visit. The employee indicated the patient's case manager (employee M, registered nurse) was not aware of the medication change.</p> <p>2. The agency policy with a review date of 4/4/13 titled "Policy 3.011 - Physician Telephone orders" states, "POLICY Community Home Health care obtains verbal and written orders from physicians for all licensed nurses to obtain physician telephone (verbal) orders for those clients with medical plans of care as needed. PURPOSE 1. to ensure accurate and uniform order taking. 2. to ensure effective communications with client, client's family ... and other staff regarding physicians orders. PROCEDURE 1. physician's telephone order (short order form or computer -generated order form is used. ... 11. LPN's [licensed practical nurses] who obtain verbal physician orders must discuss client status with RN [registered nurse] prior to calling physician. Physician telephone orders form is then co-signed by RN. " (Note: This policy is not congruent with Federal regulations.)</p>			

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N000606	<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 (RN) supervised the Home Health Aide (HHA) every two weeks as required by agency policy for 2 of 3 clinical records reviewed of patients receiving skilled nursing (SN) and HHA services for longer than 14 days creating the potential to affect all the agency's patients who receive HHA services with skilled services for longer than 30 days. (#s 6 and 16 )</p> <p>Findings include</p> <p>1. Clinical record #6, start of care (SOC) 5/7/14, contained a plan of care (POC) dated 5/7-7/5/14 with orders for HHA 2 hours daily in the AM and 2 hours daily in the PM for 60 days per Medicaid Code 50 and SN 3 times daily for 60 days per Medicaid Code 50. An order dated 6/4/14 evidenced the SN to cleanse right wrist with soap and water, pack the</p>	N000606	<p>The Administrator has in serviced the nursing staff on agency policy #5035 to ensure the registered nurse makes an on-site visit to the patient's home at least every two weeks where applicable. The Clinical Manager has revised the process for assigning supervisory visits to ensure that the Registered Nurse makes a supervisory visit to the client's residence every 14 days or every 30 days in accordance with agency policy # 5.035, Home Health Aide Supervisory visits. Registered Nurses will discontinue the practice of "self-scheduling." The Clinical Manager has in serviced the nursing staff on the revised process including a review of agency policy #5.035 The Clinical Manager has implemented a weekly QA review for evidence that the Registered Nurse makes an on-site visit to the patient's home at least every 14 or 30 days where applicable. 10% of all clinical records will be audited quarterly for evidence that the</p>	09/25/2014

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	<p>wound with normal saline twice a day, and cover with gauze.</p> <p>A. A HHA supervisory visit was conducted on 5/19/14 and not again until 15 days later on 6/3/14.</p> <p>B. A HHA supervisory visit was conducted on 6/16/14 and not again until 17 days later on 7/3/14.</p> <p>2. Clinical record #16, start of care date 12/13/13, contained a plan of care dated 6/11-8/9/14 with orders for HHA for personal care 1 hour in A.M., 7 days per week per Medicaid PA x 60 days and SN 4 times daily 7 times per week per Medicaid PA x 60 days. SN was to administer to client tube feeding of Nutren 2.0 twice daily and Pulmonary Nutren 1 can twice daily.</p> <p>A. The record failed to evidence the SN conducted a HHA supervisory visit between 6/19 and 7/17/14.</p> <p>B. During interview on 8/6/14 at 3:30 PM, employee L indicated on 7/3/14 there was not an Aide supervisory visit completed and indicated the nurse must have forgotten to do it.</p> <p>3. The agency's policy titled "Home Health Aide Supervisory Visits," # 5.035,</p>		Registered Nurse makes an onsite visit to the patient's home at least every 14 or 30 days where applicable. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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N000608	<p>revised May, 2014, states, "1. Clients receiving skilled services (PT [physical therapy], OT [occupational therapy], SLP [speech language pathologist], MSW [master of social work], skilled nursing);</p> <p>A. Registered Nurse makes a Home Health Aide supervisory visit to the client residence at least every two weeks."</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel.</p>			

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	<p>Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.</p> <p>(5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.</p> <p>(6) A discharge summary.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the records containing pertinent current findings in accordance with accepted professional standards is maintained for every patient receiving home health services, were complete and contained accurate information, and documents were completed and signed for 8 of 13 clinical records reviewed, creating the potential to affect all the agency's clinical records. (#s 4, 6, 9, 11, 12, 14, 15, and 16)</p> <p>Findings include</p> <p>1. Clinical record #4, start of care (SOC) date 10/3/12, contained a plan of care (POC) dated 7/25-9/22/14. The record failed to evidence a drug regimen review and medication profile was completed and reviewed with a listing of current medications for recertification on 7/22/14.</p> <p>A. During interview on 8/20/14 at 10:30 AM, employee A indicated the medication profiles are reviewed with</p>	N000608	<p>The Administrator has reviewed and revised where applicable the agency policies listed below: #3.006 Review of Clinical Records #3.003 Clinical Records #3.002 Charting #2.012 60 Day Summaries #2.008 Client Nursing Assessment #7.003 Home Health Aide Services #8.001 Infection Control #2.026 Coordination of Client Care with Outside Agencies The Administrator, Clinical Manager and Nursing Staff has in-serviced the agency staff on the revised policies to ensure that the clinical record contains pertinent findings in accordance with accepted professional standards and to ensure that the record contains accurate information and the documents are completed and signed. The nursing staff will review every chart for patients currently receiving home health services for evidence that the clinical record contains pertinent current findings in accordance with accepted professional standards and to ensure that the record contains accurate information and the documents are completed and signed. The Administrator has reassigned Medical Records and QA</p>	09/25/2014

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	<p>assessment and supervisory visits and they had done it this way for years.</p> <p>B. On 8/20/14 at 10:45 AM, employee A indicated the medication profile was not reviewed on 7/22/14; the agency cannot locate any information or paperwork to prove otherwise.</p> <p>C. The Recertification/follow-up Assessment with Outcome Assessment and Information Set (OASIS) Elements dated 7/22/14 failed to evidence all information documented on the form; CMS Certification Number, Patient ID number, Start of Care date, and durable medical equipment (DME) and supplies. This form also failed to evidence documentation of date reviewed, entered, locked, and transmitted for the OASIS section.</p> <p>D. During interview on 8/20/14 at 10:35 AM, employee A indicated employee H does the OASIS information and marks their initials and date on the front of the forms to indicate the information has been sent.</p> <p>2. Clinical record #6, SOC 5/7/14, evidenced a resumption of care comprehensive assessment dated 5/30/14. This form also failed to evidence documentation of date reviewed,</p>		<p>responsibilities to the Alternate Administrator until a permanent replacement has been selected. The Clinical Manager has in serviced the nursing staff on the proper completion of agency clinical documentation including the skilled nursing visit note, comprehensive assessment, discharge comprehensive assessment, on call log and Plan of Care The nursing staff has in serviced the direct care staff (Licensed and Unlicensed) on agency policies # 8.001 Infection Control, #7.003 Home Health Aide Services, and #3.002 Charting. In service includes training on am and pm documentation and bathing techniques. 10% of all clinical records will be audited quarterly for evidence that patients receiving home health services for evidence that the clinical record contains pertinent current findings in accordance with accepted professional standards and to ensure that the record contains accurate information and the documents are completed and signed. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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	<p>entered, locked, and transmitted for the OASIS section.</p> <p>A. the Recertification/follow-up assessment dated 7/3/14 failed to evidence documentation of date reviewed, entered, locked, and transmitted for the OASIS section as of 8/26/14.</p> <p>B. The record failed to evidence the agency collected hospital discharge paperwork from 5/7/14 for review. During interview on 8/26/14 at 9:30 AM, employee A indicated this patient came home from the hospital on 5/7/14 when the agency started care.</p> <p>C. The record evidenced an order dated 6/21/14 for skilled nurse to do treatment once a day to right forearm fistula site, remove dressing, cleanse area with antibacterial normal saline wash, pat dry, pack wound with Kaltostat 2G, apply 2x4 gauze, and secure with tape, and initial and date dressing. This order failed to evidence who received the order and a physician signature as of 8/26/14.</p> <p>D. The Home Health Aide (HHA) assignment sheets dated 5/8, 5/11, 5/19, 5/20/, 5/21, 6/2, 6/3, 6/15, 6/17, 6/21, 6/28, 6/22, 7/13, 8/2, 8/10, and 8/16/14 failed to evidence if the care was</p>			

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	<p>provided in the AM or the PM.</p> <p>3. Clinical record #9, SOC 9/20/12, contained a POC dated 7/13-9/10/14. The record failed to evidence a Recertification Assessment was conducted between 7/8-7/12/14 for the current certification period.</p> <p>A. During interview on 8/20/14 at 1:50 PM, employee A indicated the recertification was transmitted through OASIS on 7/8/14 but the agency cannot locate the paperwork anywhere.</p> <p>B. Clinical record #9 POC dated 7/13-9/10/14 contained orders for HHA 1 hour in the AM and 1 hour in the PM, 7 days a week per Medicaid PA x 60 days. HHA for personal care of bathing, grooming, skin care, incontinent care, assist with transfer, provide safety. The HHA Charting does not differentiate whether the tasks were completed in the AM or PM for each sheet.</p> <p>4. Clinical record #11, SOC date 2/17/14, contained a POC dated 2/17-4/17/14 with orders for HHA 1 hour in the AM Monday through Friday and 1 hour in the PM Monday through Friday for 60 days, not to exceed 20 hours per month.</p>			

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	<p>A. Missed Visit/Shift reports failed to evidence the physician was notified of missed or canceled visits by the patient for 2/21/14 evening, 2/24/14, 3/13/14 evening, 3/7/14 evening, 3/12/14, 3/14/14 evening, 3/17/14, 3/21/14 evening, 3/24/14 evening, 3/28/14 evening, 4/7/14 evening, 4/11/14 evening, and 4/14/14, each sheet noting reason as Other: Not to exceed 20 hours per week.</p> <p>B. During interview on 8/25/14 at 10:45 AM, employee A indicated the missed visit sheets should say monthly not weekly and that was a mistake.</p> <p>C. During interview on 8/25/14 at 10:55 AM, employee A indicated the physician was not notified of the missed visits.</p> <p>5. Clinical record #12, SOC dated 4/25/11, contained a POC dated 4/9-6/7/14 with orders for HHA 3 times a week for 2 hours per visit x 60 days.</p> <p>A. The Current Medications list dated as printed 1/2/14 failed to evidence it had been reviewed since 2/10/14.</p> <p>B. The POC listed a medication two times - Neurontin 300 mg tablets by mouth every 8 hours.</p>			

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	<p>C. The discharge assessment dated 4/25/14 failed to evidence the last page was completed.</p> <p>D. The Discharge Summary sheet failed to evidence a summary of problems and goals was completed by the registered nurse on 4/25/14.</p> <p>6. Clinical record #14, SOC 1/15/13, contained a POC dated 5/9-7/7/14 with orders for SN 4 visits daily, 7 days per week per Medicaid PA x 60 days. SN for peg tube feedings, Jevity 1.2 (1 to 1 1/2 can) with 200 to 300 cc flush; monitor peg tube site; SN for medication administration per peg tube; assess medication effectiveness; assess neuro status and cardiopulmonary status; and Head to toe assessment each visit. HHA for 5 hours, 7 days a week per Medicaid PA x 60 days. The record failed to evidence a fourth SN visit was conducted on 5/9, 5/29, 6/5, 6/25, and 6/27/14.</p> <p>A. The record failed to evidence missed visit reports were completed for 5/9, 5/29, 6/5, 6/25, and 6/27/14.</p> <p>B. During interview on 8/6/14 at 11:56 AM, employee K indicated there should not be any missed visits in this chart; they don't miss visits with this patient.</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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	<p>C. During interview on 8/6/14 at 2:03 PM, employee A indicated missed visits are unusual for this patient; they never cancel.</p> <p>D. During interview on 8/6/14 at 2:00 PM, employee K indicated the agency cannot find the documents for the SN visits. The visits were made but billing cannot locate them, and they can only assume they are misfiled in another patient's chart.</p> <p>E. A Missed Visit/Shift Report form dated 6/25/14 for SN visit at 4:00 PM evidenced the reason was "Client canceled the visit/shift." This form failed to evidence a signature of who completed it and failed to evidence the name of the physician it had been faxed to on 6/26/14. During interview on 8/6/14 at 2:37 PM, employee K indicated this form was probably just filled out now because there was not a missed visit form in the chart and most likely the physician was not notified of the missed visit.</p> <p>F. During interview on 8/6/14 at 1:15 PM, employee K indicated that on patient #14 for the date 6/5/14, the HHA called to say the nurse did not show up for the 5:00 PM shift so this was covered by the on-call nurse and the family requested all</p>			

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	<p>dinner medications be given late. The on-call nurse covered the shift, but the SN visit note is missing. Employee K also indicated at 1:30 PM there was no way tell if the Jevity was given on 6/5 due to someone had circled the uncharted data on the medication/tube feeding sheet, and the initials of the person who documented are circled. At 1:39 PM, employee K indicated the corrective charting nurse circled the missing data and the nurse who covered the shift charted later and was told to go ahead and place their initials inside the circle.</p> <p>G. During interview on 8/6/14 at 1:45 PM, employee J indicated they did administer the Jevity on 6/5/14 for patient #14, and they apparently did not sign the medication/tube feeding sheet. When the corrective charting nurse circled the missing data, employee J was directed by employee H to sign inside the circle even though it would look as if the Jevity had been held for some reason or missed.</p> <p>7. Clinical record #15, SOC date 8/8/12, contained a POC dated 6/9-8/7/14 with orders for HHA 1 hour 7 days per week per Medicaid PA x 60 days. The clinical record evidenced comprehensive assessments were performed and on time. The record failed to evidence a HHA visit was conducted on 7/16/14, failed to</p>			

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	<p>evidence a missed visit form was completed, and failed to evidence the physician was notified of the missed visit.</p> <p>8. Clinical record #16, SOC date 12/13/13, contained a POC dated 6/11-8/9/14 with orders for HHA for personal care 1 hour in A.M., 7 days per week per Medicaid PA x 60 days. SN 4 times daily 7 times per week per Medicaid PA x 60 days. SN to administer to client tube feeding of Nutren 2.0 twice daily and Pulmonary Nutren 1 can twice daily.</p> <p>A. The record failed to evidence a fourth SN visit was conducted on 6/12, 6/30, 7/11, 7/20, and 7/23/14 and failed to evidence a third and fourth visit was conducted on 6/17, 7/21, and 7/24/14. The clinical record failed to evidence missed visit notes were completed and the physician was notified.</p> <p>B. The record failed to evidence the SN completed a HHA supervisory visit between 6/19 and 7/17/14.</p> <p>C. The record failed to evidence HHA visits were conducted on 6/16 and 6/17/14. The clinical record failed to evidence a missed visit note was completed and the physician was</p>			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOME HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806			
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	<p>notified.</p> <p>D. On 8/6/14 at 3:50 PM, the agency failed to provide nurses' notes or missed visit forms for one SN visit on 6/12, 6/30, 7/11, 7/20, 7/21, and 7/23/14, and failed to provide nurses' notes or missed visit forms for two SN visits on 6/17 and 7/24/14, and failed to provide HHA notes or missed visit forms for 6/16 and 6/17/14.</p> <p>E. Employee time sheet logs for patient #16 were provided for 6/1-8/2/14. The time sheet log failed to evidence the HHA visit was staffed on 6/17/14. The clinical record failed to evidence a missed visit note was completed and the physician was notified.</p> <p>F. During interview on 8/6/14 at 3:50 PM, employee A indicated patient #16 lives in a group home and the medication administration sheets for June and July have not been brought into the office yet as of today.</p> <p>9. During interview on 8/6/14 at 11:55 AM, employee L indicated missed visit forms are kept in the charts with the disciplines that missed the visits.</p> <p>10. During interview on 8/6/14 at 2:45 PM, employee K indicated as of June 1st,</p>						

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	<p>per the administrator, the missed visits were to be incorporated into the plans of care with 60 days summaries.</p> <p>11. During interview on 8/6/14 at 3:00 PM, employee L indicated the physicians have not been notified of missed visits since the change of administration in October of 2013.</p> <p>12. The agency's policy titled "Client 60-Day Summaries," # 2.012, reviewed 4/4/13, states, "4. All missed visits will be documented in writing and sent to the physician."</p> <p>13. The agency's policy titled "Client Clinical Record," # 3.003, reviewed 4/4/13 states, "1. Client records are maintained in accordance with accepted professional standards. 2. Client clinical records contain: a. Pertinent current and past findings, ... 3. A chart order of content is maintained for each client clinical record, following Policy and Procedure; Client clinical Record chart Order. 4. Clinical records of current clients are monitored for compliance with accepted professional/legal standards, following Policy and Procedures; Utilization Review. ... 6. Client clinical records are reviewed to ensure that established policies and procedures are followed in providing home health care</p>			

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	<p>services to determine the adequacy of plans of care and the appropriateness of continuing care, at such intervals as the severity of the client illness requires, but at least every 60 days."</p> <p>14. The agency's policy titled "Home Health Aide Services," # 7.003, reviewed 4/4/13 states, "2. Home Health Aides are carefully trained in: ... b. observation, reporting, and documentation of client status and the care or service provided, ... d. basic infection control procedures, ... f. maintenance of a clean, safe, healthy environment, ... i. appropriate and safe techniques in personal hygiene and grooming that include: i. bed bath, ii. sponge, tub, or shower bath, iii. shampoo, sink, tub, or bed, iv. nail and skin care, v. oral hygiene, vi. toileting and elimination, ... 1. adequate nutrition and fluid intake."</p> <p>15. Clinical record #8, SOC date 4/12/12, contained a POC dated 7/31-9/28/14 with orders for skilled nursing 4 times per day, 7 days a week per Medicaid PA for 60 days for in/out catheters, assess for signs and symptoms of urinary tract infection, assess neuro status, assess cardiopulmonary status, assess GI status, and assess skin integrity.</p> <p>The record evidenced a document</p>			

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	<p>dated 8/12/14 titled "Skilled Nursing Visit Note" signed by employee I (LPN-Licensed practical nurse) stating, "Date of visit 8/12/14 Time In 1115A Out [blank] Type of visit: SN NURSING ASSESSMENT AND OBSERVATION SIGNS/SYMPTOMS Cardiovascular [blank] ... Respiratory [blank] Digestive [blank] Genitourinary [blank] Skin [blank] Pain [blank] Musculoskeletal [blank] Neurosensory [blank] emotional status [blank] Vitals [blank] Interventions/Instructions [blank] Analysis/Interventions/Instructions/ Patient Response [blank] ... Signature/Date [employee I] 8/12/14 Patient Signature [blank]."</p> <p>16. Clinical record #11 contained a plan of care for certification period 2/17/14 to 4/17/14. The record evidenced a document titled "Patient Discharge Summary" stating, "Discharge Date '4/18/14' ... Summary of Care D/C [discharge] services after today."</p> <p>A. The record evidenced a document signed and dated by employee F (registered nurse) on 5/13/14 titled "'Discharge Summary' Comprehensive Adult Assessment" stating, "Date of Visit 5/12/14 ... PAIN Is patient experiencing pain? No ... SKIN CONDITION/WOUNDS 'Skin Intact'</p>			

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	<p>Skin (temperature, color, turgor) 'warm, pink ... good skin turgor' WNL ... CARDIOPULMONARY ... Blood Pressure sitting R 146/90 ... Temperature 98.4 Pulse: Radial 76 Heart Sounds: Regular Respirations 18 regular Breath Sounds: Clear Anterior: Right Upper Lower Posterior: Right Left Upper Lower O2 Saturation 96% ... SUMMARY CHECKLIST Medication Status: Medication regimen completed/reviewed No change ... Billable Supplies Recorded? Yes Care Coordination: Aide ... DISCHARGE PLANS Return to an independent level of care (self-care) Discussed with Patient: Yes ... SIGNATURE/DATES Patient/Caregiver (if applicable) 'didn't sign' Date '5/13/14' ... "</p> <p>B. On 8/25/14 at 11:04 AM, employee H (director of nursing) indicated the discharge comprehensive assessment is to be conducted at time of discharge from the agency. The employee indicated the last nursing assessment visit was conducted by employee F on 3/17/14.</p> <p>17. The agency policy with a review date of 4/4/13 titled "Policy 3.002 - Charting" states, "POLICY Community home health care staff and interdisciplinary team members document the client home</p>			

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	health care given during each home health care visit. PURPOSE 1. To document the home health care services given to clients. ... PROCEDURE 1. CHHC [Community home health care] staff and interdisciplinary team members document all client home health care on the day the service is rendered. ... 3. CHHC staff and interdisciplinary team members: a. document client home health care information on applicable form ... as appropriate b. document: ... xiii. Charting only for actual days of delivered home health care services."			