

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 10/09/2014
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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 revisit for the state licensure survey completed on August 6-26, 2014.</p> <p>Survey Date: October 9, 2014</p> <p>Facility #: 008749</p> <p>Medicaid Vendor #: 20065690A</p> <p>Surveyor: Miriam Bennett, RN, PHNS</p> <p>Thirteen previously cited deficiencies were found corrected during this survey. Three deficiencies were recited.</p> <p>Quality review: Joyce Elder, MSN, BSN, RN October 14, 2014</p>	N000000		
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>	N000470	The direct care staff (nurses and	11/15/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Based on home visit observation, document review, and interview, the agency failed to ensure staff followed agency policy for infection control in 1 of 1 observations, creating the potential to affect all the agency's patients. (Employee D)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation with patient #4 on 10/9/14 at 9:30 AM, employee D, a Home Health Aide, was observed providing a shower to the patient. Employee D washed patient's buttocks and rectal area, rinsed patient, then proceeded to begin drying patient, applying lotion to skin, and dressing patient. Employee D failed to remove gloves and perform hand hygiene after having washed patient's buttocks and rectal area and prior to drying, applying lotion, and dressing patient. 2. During interview on 10/9/14 at 11:00 AM, employee B indicated infection control was covered during the inservices after the last survey. 3. The agency's document titled "HHA Bath/Shower Check Off" states, "15) Assists client out of shower/tub. 16) Removes gloves and wash hands. 17) Washes hands and don gloves. [17]" 		<p>home healthaides) has been in-serviced on agency policy #8.001 Infection Control (revised September 2014). In-service specifically includes re-training on bathing techniques and pericare. Annual re-training process on infection control has been revised to include return demonstration on bathing techniques. Employee D referred to direct supervisor for coach and counsel. Direct care staff will continue to be monitored on supervisory visits for compliance with agency policy and procedures regarding infection control and re-trained annually. 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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N000522	<p>Assists client in drying off. 18) Assists client with dressing."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure visits were provided as ordered on the plan of care (POC) for 2 of 3 clinical records reviewed and the physician was notified of missed visits for 1 of 3 clinical records reviewed creating the potential to affect all the agency's patients. (#s 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record 2, start of care date (SOC) 9/17/14, contained a POC with orders for Skilled Nurse 4 hours, 2 mornings per week times 60 days. The record failed to evidence 4 hours of care were provided on 9/24, 10/1, and 10/2/14.</p> <p>A. The Nursing Flow Sheet dated</p>	N000522	<p>N-522 The nursing staff has been in-serviced on agency policies #2.012Client 60 Day Summaries and #2.010 Client Plan of Care (revised September2014). In-service specifically includes: -re-training on process of notifying physician of missed visits -reviewing missed visits in daily census meeting -adding a note to the client's plan of care to reflect changes due to client request -reviewing visit notes weekly to ensure "non-billable" items are clearly marked on the visit note. 10% of all clinical records will be audited quarterly for compliance with agency policies #2.012 and #2.010. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	11/15/2014

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	<p>9/24/14 evidenced the nurse provided care from 8:00 AM-11:40 AM.</p> <p>B. The Nursing Flow Sheet dated 10/1/14 evidenced the nurse provided care from 8:00 AM-11:00 AM.</p> <p>C. The Nursing Flow Sheet dated 10/2/14 evidenced the nurse provided care from 8:00 AM-11:15 AM.</p> <p>D. During interview on 10/8/14 at 1:30 PM, employee A indicated the primary caregiver lets the nurses leave when they are finished providing care because they don't need to stay.</p> <p>2. Clinical record #3, SOC 8/30/14 contained a POC with orders for Home Health Aide 2 hours, 4 times per week times 60 days.</p> <p>A. The record evidenced a Missed Visit/Shift Report dated 9/13/14. This form failed to evidence the physician was notified of the missed visit.</p> <p>B. During interview on 10/8/14 at 2:55 PM, employee B indicated the process was changed to notify the physicians weekly of missed visits, also on the next 60 day summaries, and the nurse completed the form but it looks like it did not get placed in the fax pile to</p>						

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N000524	<p>notify the physician.</p> <p>C. The record evidenced 5 visits were provided the week of 8/31-9/6/14 and 9/21-27/14. The record failed to evidence any orders to increase the visits.</p> <p>3. The agency's policy titled "Client Plan of Care" # 2.010 revised September, 2014, states, "2. The client plan of care: ... b. includes the following: ... ix. Frequency of needed services, ... 3. Changes in the plan of treatment are documented through written and signed physician orders."</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.</p>			

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	<p>(vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on observation, interview, and review of policy, the agency failed to ensure Medical Plans of Care (POC) included all durable medical equipment (DME) used by the patient for 1 of 1 home visit observation creating the potential to affect all the agency's patients. (#4)</p> <p>Findings include</p> <p>1. During home visit observation with patient #4 on 10/9/14 at 9:30 AM, DME observed in the home included a wheel chair, shower chair, and gait belt. The POC failed to evidence the wheel chair and shower chair.</p> <p>2. During interview on 10/9/14 at 10:30 AM, employee D indicated the shower chair is used for all residents in this home, but it gets cleaned after each shower.</p> <p>3. The agency's policy titled "Client Plan</p>	N000524	N-0524The Clinical Manager has in-serviced the nursingstaff on agency policy # 2.010 Client Plan of Care (revised September 2014).In-service specifically includes re-training on the process of including allDME on the client's plan of care. CaseManager assigned to patient #4 referred to supervisor for coach and counsel.10% of all clinical records will be reviewed quarterly for compliance with agency policy #2.010. Agency will continue random home observation visits (implementedSeptember 2014) for compliance with this policy.The Clinical Manager will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	11/15/2014

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	of Care," # 2.010, revised September, 2014, states "2. The client plan of care: ... b. includes the following: ... xiv. Medical supplies/appliances necessary (DME)."				