

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157630	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/31/2013
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NAME OF PROVIDER OR SUPPLIER  DIVINE HOME HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5215 N BEND DR FORT WAYNE, IN 46804
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N000000	<p>This was a state Home Health Agency complaint investigation.</p> <p>Complaint #: IN00131630-Substantiated: State deficiencies related to the allegation are cited. State deficiencies unrelated to the allegation are also cited.</p> <p>Survey date: July 31, 2013</p> <p>Facility #: 012100</p> <p>Medicaid #: 200984210</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p>	N000000		

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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N000488	<p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on document review, policy review, and interview, the agency failed to ensure they had developed and implemented a 5-day notice of discharge for 1 of 2 discharge records reviewed with the potential to affect all patients who are discharged.</p>	N000488	N488 Current Discharge policy will be modified to explicitly state that the agency must give the patient notice to discharge at least 5 calendar days before services are stopped. Current Discharge policy will be amended to require the discharging clinician to provide proof to the Agency Director of Nursing that a	08/30/2013			

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	<p>Findings include</p> <p>1. The agency's undated policy titled "Client Discharge Process" states, "2. Client's needs for continuing care to meet physical and psychological needs are identified and clients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Clients are informed of the reason for discharge and anticipated needs for services after discharge. 3. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan. ... A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family. ... 9. To avoid charges 'abandonment' at the time of discharge agency documentation will include the following: a. Evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge the client from the agency. ... c. If there are unmet need and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated. ... Discharge Criteria: 1.</p>		<p>discharge notice was provided and signed off by the patient before the discharge visit can be scheduled. Agency Director of Nursing will hold an in service for all agency nurses to re-train staff on Agency Discharge Procedures, to include the above-mentioned changes in the Agency's discharge policy.. Going forward, all new/incoming agency nurses will be trained/informed on the agency discharge procedures as part of their initial orientation program. In addition, employees will attend an in-service on Agency discharge procedures at least once annually. The Agency Administrator and Director of Nursing collectively 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>Criteria for discharge may include, but are not limited to the following: ... c. Client is non-compliant with the established plan of care." The Client Discharge Process policy failed to evidence the agency developed and implemented a five day notice of discharge.</p> <p>2. Clinical record #3 failed to evidence five days written discharge notice was given. A communication note dated 6/18/13 at 2:10 PM states, "(Phone call between [patient] &amp; [employee B] [Employee B] called and spoke with patient [patient] regarding past concerns with different HHAs [home health aides] in home and the current issues that are starting to develop again with the new HHAs. ... DON explained that we will work with any agency patient wishes, but we will need to terminate services as of Friday 6/21/13. Patient became nasty with DON and told her to 'FORGET IT' and then the patient hung up on DON." The clinical record failed to evidence a 5 day notice of discharge letter was sent to the patient. A physician order dated 6/20/13 states "patient discharged from agency due to non-compliance."</p> <p>3. On 7/31/13 at 2:15 PM, employee B indicated the discharge process is begun with Start of care. If goals are met, the agency gives a five day notice of</p>						

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	<p>discharge. If discharged for other reasons such as insurance does not approve, then the agency discharges with in five days. If the issue is non-compliance, the agency just discharges the patient.</p> <p>4. On 7/31/13 at 3:20 PM, employee A indicated the agency does do a five day notice of discharge, but it is not in the policy or in the patients' rights and was an oversight.</p>			

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N000506	<p>410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice.</p> <p>Based on document review, policy review, and interview, the agency failed to ensure the patient was informed of a reasonable discharge notice for 1 of 2 discharge records reviewed with the potential to affect all patients who are discharged.</p> <p>Findings include</p> <p>1. The agency's undated policy titled "Client Discharge Process" states, "2. Client's needs for continuing care to meet physical and psychological needs are identified and clients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Clients are informed of the reason for discharge and anticipated needs for services after discharge. 3. The physician will be involved in the discharge plan and</p>	N000506	N506 Current Discharge policy will be modified to explicitly state that the agency must give the patient notice to discharge at least 5 calendar days before services are stopped. Current Discharge policy will be amended to require the discharging clinician to provide proof to the Agency Director of Nursing that a discharge notice was provided and signed off by the patient before the discharge visit can be scheduled (perpetual). Agency Director of Nursing will hold an in service for all agency nurses to re-train staff on Agency Discharge Procedures, to include the above-mentioned changes in the Agency's discharge policy.. Going forward, all new/incoming agency nurses will be trained/informed on the agency discharge procedures as part of their initial orientation program. In addition, employees will attend an in-service on Agency discharge procedures at least once annually. The Agency	08/30/2013	

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	<p>specific ongoing care needs will be identified and addressed as part of the plan. ... A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family. ... 9. To avoid charges 'abandonment' at the time of discharge agency documentation will include the following: a. Evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge the client from the agency. ... c. If there are unmet need and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated. ... Discharge Criteria: 1. Criteria for discharge may include, but are not limited to the following: ... c. Client is non-compliant with the established plan of care." The Client Discharge Process policy failed to evidence the agency developed and implemented a five day notice of discharge.</p> <p>2. Clinical record #3 failed to evidence five days written discharge notice was given. A communication note dated 6/18/13 at 2:10 PM states, "(Phone call between [patient] &amp; [employee B] [Employee B] called and spoke with</p>		<p>Administrator and Director of Nursing collectively 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>patient [patient] regarding past concerns with different HHAs [home health aides] in home and the current issues that are starting to develop again with the new HHAs. ... DON explained that we will work with any agency patient wishes, but we will need to terminate services as of Friday 6/21/13. Patient became nasty with DON and told her to 'FORGET IT' and then the patient hung up on DON." The clinical record failed to evidence a 5 day notice of discharge letter was sent to the patient. A physician order dated 6/20/13 states "patient discharged from agency due to non-compliance."</p> <p>3. On 7/31/13 at 2:15 PM, employee B indicated the discharge process is begun with Start of care. If goals are met, the agency gives a five day notice of discharge. If discharged for other reasons such as insurance does not approve, then the agency discharges with in five days. If the issue is non-compliance, the agency just discharges the patient.</p> <p>4. On 7/31/13 at 3:20 PM, employee A indicated the agency does do a five day notice of discharge, but it is not in the policy or in the patients' rights and was an oversight.</p>						

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N000514	<p>410 IAC 17-12-3(c) Patient Rights 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 document review, policy review, and interview, the agency failed to ensure the existence, documentation, and resolution of complaints was evidenced for 1 of 1 agency with the potential to affect all the agency's patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>The agency's complaint log book failed to evidence any complaints were documented and only contained the policy and blank complaint intake sheets.</li> <li>During interview on 7/31/13 at 9:30 AM, employee A indicated he is in charge of handling complaints but the agency does not consider a complaint formal until</li> </ol>	N000514	N514 Agency Administrator will conduct an in-service for all employees on Agency Complaint Policy. In-service will include content on properly communicating all issues and complaints via the use of the complaint logbook and the forms inside the logbook. Employees will be taught on how to fill out the forms from the initial reporting of the complaint, up to and including the resolution of the complaint by Agency staff. Going forward, agency will inform all new/incoming employees as part of orientation/new hire process, about the Agency protocols of filing a complaint and proper procedures on following through with the complaint to the point of resolution. Instruction will include the use of the complaint logbook and the forms located inside the complaint logbook. The agency's	08/30/2013	

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	<p>the same issue has been raised three times and it does not get placed in the complaint log until then.</p> <p>3. During interview on 7/31/13 at 11:05 AM, employee A indicated the agency has not had any formal complaints written on paper, they are verbal and resolution would be in the specific patients' charts.</p> <p>4. The agency's admission packet was reviewed and contained an undated document titled "Patient's Rights and Responsibilities" which states, "As a Patient You have the Right to: ... Have Divine Home Healthcare, Inc. investigate complaints and document both the existence of the complaint and the resolution of the complaint made by you or your family or your legal representative regarding any of the following: Treatment or care that is (or fails to be) furnished, The lack of respect for your property by anyone furnishing services on behalf of Divine."</p> <p>5. The agency's undated policy titled "Filing Grievances/Complaints" states, "2. Grievances and/or complaints may be submitted orally or in writing. The client or the person filing the grievance or complaint in behalf of the client must sign written complaints or grievances. 3. The Administrator or Nurse Supervisor has</p>		Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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	<p>the responsibility to address the grievance and/or complaint investigation. 4. Upon receipt of a written grievance and/or complaint, Nurse Supervisor will investigate the allegations and determine the findings within 5 working days of receiving the grievance and/or complaint. If the complaint is substantiated, it is recorded in the Grievance/Complaint log. 6. The administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. 7. The client, or person filing the grievance and/or complaint in behalf of the client, will be informed of the actions that will be taken to correct any identified problems. The administrator, or his designee will make such report orally, within 3 working days of the filing of the grievance or complaint with the facility. A written summary of the report will also be provided to the client if the complaint is substantiated. 8. Should the client not be satisfied with the result of the investigation, or recommended actions, he or she may file a written complaint to the local ombudsman office or to the state survey and certification agency."</p>				