

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/22/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0000  Bldg. 00	<p>This was a State Home Health relicensure survey.</p> <p>Survey Dates: June 16, 17, 18, 19, and 22, 2015</p> <p>Facility #: 005248</p> <p>Medicaid Vendor #: 100272270</p> <p>QR: JE 6/24/15</p>	N 0000		
N 0522  Bldg. 00	<p>410 IAC 17-13-1(a) Patient Care</p> <p>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 and interview, the agency failed to ensure visits were made as ordered on the plan of care for 3 of 16 active patient records reviewed. (#5, 6, and 13)</p> <p>Findings include:</p> <p>1. Clinical record #5, start of care 6/5/15, contained a Home Health Certification</p>	N 0522	<p>The clinical manager or designee will educate clinical staffwith regard to Agency Policy related to this standard. Additional education regarding documentation of missedvisits, attempts to reschedule visits and physician notification will beprovided to all staff as well. The clinical manager or designee will perform a 10% audit ofcurrent census to evaluate if the ordered frequency is being followed, with propriate physician notification</p>	07/22/2015

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/22/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and Plan of Care for certification period 6/5 to 8/3/15 with orders for skilled nursing services 1 time week 1 and 3 times a week for 2 weeks. The record failed to evidence a third skilled nursing visit was conducted week 3.</p> <p>On 6/22/15 at 9:52 AM, employee H (clinical manager) indicated during week 3 of the certification period, skilled nursing visits were conducted on 6/15 and 6/19/15 by the registered nurse.</p> <p>2. Clinical record #6, start of care 5/29/15, contained a Home Health Certification and Plan of Care for certification period 5/29 to 7/27/15 with orders to include physical therapy services 1 time per week for 4 weeks beginning the second week of the certification period. The record failed to evidence a physical therapy visit was conducted week 3.</p> <p>A. The record contained a document dated 6/11/15 titled "Case Communication Report" stating, "Order Cancellation Missed Visit Call several times no answer at phone and no return call. Patient not seen. Dr. [doctor] notified."</p> <p>B. On 6/22/15 at 10:05 AM, employee H (clinical manager) indicated</p>		<p>when necessary. These audits will continue until there are two consecutive months with less than 5% error rate.</p> <p>The education will be provided to all staff no later than July 22, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/22/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0524 Bldg. 00	<p>there was no physical therapy visit conducted week 3 and was unable to locate documentation of contact to the patient for re-scheduling of the visit.</p> <p>3. Clinical record #13, start of care 6/8/15, contained a Home Health Certification and Plan of Care for certification period 6/8 to 8/6/15 with orders to include home health aide services 1 time week 1 and 2 times per week for 2 weeks. The record failed to evidence a second home health aide visit was conducted week 2.</p> <p>On 6/22/15 at 1:45 PM, employee H (clinical manager) indicated being unable to locate documentation of a second home health aide visit for week 2.</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.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/22/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included accurate dates in 2 of 20 clinical records reviewed. (#6 and #18)</p> <p>Findings include:</p> <p>1. Clinical record #6, start of care 5/29/15, evidenced a Home Health Certification and Plan of Care for certification period 5/29 to 7/27/15 that stated, "23. Nurse's signature and Date of Verbal SOC [start of care] ... 05/28/15."</p> <p>2. Clinical record #18, start of care 5/31/15, evidenced a Home Health Certification and plan of care for certification period 5/31 to 7/29/15 stating, "23. Nurse's signature and Date of Verbal SOC ... 5/29/15."</p> <p>On 6/22/15 at 2:13 PM, employee H</p>	N 0524	<p>The clinical manager or designee will educate clinical staff with regard to Agency Policy related to this Standard. The Quality Assurance staff will monitor that the actual start of care date and the physician's verbal start of care date are entered appropriately. Clinical Manager or designee will provide education to all staff no later than July 22, 2015</p>	07/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/22/2015	
NAME OF PROVIDER OR SUPPLIER  SAINT JOSEPH VNA HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	(clinical manager) indicated 5/29/15 was the referral date.  3. The agency policy with a revision date of December 2013 titled "Physicians Orders" states, "Policy: ... Physician's oral/verbal orders are entered in Orders or in Meds, and signed and dated with the date of verbal order receipt by the registered nurse or therapist responsible for furnishing or supervising ordered services. ... Verbal orders: ... A. Process ... B. Verbal/Oral Orders: 1. Physician's oral/verbal orders: a. The clinician enters in orders, including therapy and social work plans of care established after the Start of Care. b. The registered nurse or therapist responsible for furnishing or supervising the ordered services sign and dates when they received the verbal order."						