

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K035	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
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NAME OF PROVIDER OR SUPPLIER TRINITY HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3502 STELLHORN FORT WAYNE, IN 46815
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G000000	<p>This was a Home Health Medicaid recertification survey.</p> <p>Survey Dates: May 12-14, 2014</p> <p>Facility Number: 011096</p> <p>Medicaid Number: 200898530</p> <p>Surveyors: Miriam Bennett, RN, BSN, PHNS Nina Koch, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 39 Home Health Aide Only: 7 Personal Service Only: 0 Total: 46</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 16, 2014</p>	G000000		

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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G000110	<p>484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives.</p> <p>The HHA 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 HHA 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>Based on clinical record review, observation, and document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 3 of 5 records reviewed (#3, 4, 5) with the potential to affect all the agency's 46 active patients.</p> <p>Findings include</p> <ol style="list-style-type: none"> 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). 2. Clinical record #3, SOC 11/9/2013, failed to evidence an updated July 1, 	G000110	<p>Administrator has inserviced office staff on current Advanced Directives. Case Managers have replaced outdated Advanced Directives for existing clients during supervisory visits. Admission folders for new clients have been corrected with current Advanced Directive policy and all old policies have been destroyed. Case Managers will have ongoing responsibility to ensure admissions folders contain updated policies. Administrator will bi-annually review admission policies for possible updates from the state and/or federal government.</p>	05/30/2014

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	<p>2013, version of the Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 5/14/14 at 9:30 AM, the home admission folder was observed during a home visit for patient #3. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>3. Clinical record #4, SOC 3/24/2014, failed to evidence an updated version of the Indiana Advanced Directives document, revised July 1, 2013 . The patient signed that the document was received on the SOC date.</p> <p>On 5/14/14 at 12:15 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>4. Clinical record #5, SOC 4/14/2014, 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> <p>On 5/14/14 at 2:45 PM, the home admission folder was observed in the</p>						

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G000121	<p>home for patient #5. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, policy review, and interview, the agency failed to ensure all staff followed infection control policies and procedures for 3 of 5 home visit observations with the potential to affect all the agency's 46 patients. (#1, 2, and 4)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During interview on 5/14/14 at 1:35 PM, employee A indicated they clean their equipment once a week unless it is visibly soiled, then they clean it with Clorox bleach wipes. 2. During interview on 5/14/14 at 4:25 PM, employee A indicated there are no paper towels in the home of patient #2. 3. The agency's policy titled "Nursing Bag," dated August 2002, # N-120, states "The inside of the bag and its 	G000121	<p>DON held a nursing inservice to review agency's infection control policy and procedures, including proper hand washing technique, cleaning equipment before returning to nursing bag, washing hands before removing equipment from bag, and ensuring bags are placed on clean, dry surface when in client's home. All nursing bags have been cleaned and paper towels (should the home not have clean hand towels) have been added to the bags. In addition, nurses will carry protective barriers for their bags while in the client's home. DON is responsible for ensuring proper infection control is being followed. Nursing bags will be inspected on a quarterly basis by the DON.</p>	06/30/2014

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G000159	<p>contents are considered clean. Therefore: Hand washing must occur before entering the bag for any reason. All items removed from the bag should be cleaned before returning to the bag. ... When in a client's home, place the bag on a clean and dry surface. If there is no suitable place in the home, take only those items into the home that are needed for the visit."</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review, observation, policy review, and interview, the agency failed to ensure the plan of care (POC) included all durable medical equipment (DME) used by the patient for 1 of 5 (#3) observations, included a start of care date for 1 of 10 records reviewed (#3), and contained updates to treatments that were ordered by the physician for 1 of 10 clinical records reviewed (#2) with the potential to affect all the agency's 46 patients.</p>	G000159	The DON held a nursing inservice to review POC procedures to ensure that all POC's are completed in full. The inservice included review of the policy to include all durable medical equipment on POC, start of care dates on POC, and ALL updates ordered by the physician are included on the POC. In addition, current charts have been reviewed for compliance. Review of the agency's new software system was included in the inservice to alleviate the omission of start of care dates on the POC.	06/30/2014

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	<p>Findings include</p> <p>1. Clinical record #3, start of care (SOC) 2/18/14, contained a POC dated 4/14-6/12/14 with orders for home health aide (HHA) 2 hours a day Sunday through Saturday. The SOC date section failed to contain a date.</p> <p>2. The agency's undated policy titled "Plan of Care," # C-580, states, "2. The Plan of Care shall be completed in full to include: ... l. Medications, treatments, and procedures, m. Medical supplies and equipment required. ... t. Other appropriate items, ... 9. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>3. The agency's undated policy titled "Physician Orders," # C-635 states, "All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician. ... 8. ... In the event the change are medication changes, the nurse can review the prescription medication bottles and document those changes on the patient's medication record in the home and in the clinical chart in the office. At the time of recertification, those changes should be incorporated to the Plan of Care sent to the physician for signature."</p>		<p>The DON is responsible for ensuring compliance with the agency's policies, #C-580 (Plan of Care) and #C-635 (Physician's Orders). Charts will be reviewed quarterly for quality assurance audits. These specific items are listed on the audit form.</p>	

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G000173	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) updated and revised the plan of care in 1 of 5 records reviewed (#2) creating the potential to affect all the agency's 46 patients receiving skilled nursing (SN) services.</p> <p>Findings include</p> <p>1. Clinical record #2, start of care (SOC) 2/20/12, contained a Plan of Care (POC) for the certification period 2/10/14 to 4/10/14 with orders for SN to include dressing changes for decubitus care in AM daily, and Saturday / Sunday 1 hour visits for decubitus care. The record failed to evidence specific orders for drugs or treatments to be used for the decubitus care and failed to identify the anatomic location of any existing decubitus ulcers requiring treatment.</p> <p>A. A SN visit note dated 3/9/2014 evidenced the nurse applied hydrocortisone cream to the patient's rectal area when the patient complained of discomfort. The record failed to evidence the SN contacted the patient's</p>	G000173	The Administrator/Director of Nursing has inserviced nursing staff on POC documentation. All patient records have been reviewed and cross-checked by case managers to ensure POC's contain necessary updates including physician orders for over the counter medications, and patient anatomical location for dressing changes. This practice has been highlighted on the patient chart audit forms. The Administrator is responsible for ensuring that proper updates to the POC are completed and will be reviewed ongoing, quarterly at quality assurance meetings.	06/30/2014

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N000000	<p>physician to obtain an order for the cream and had updated the plan of care to include the hydrocortisone cream.</p> <p>B. During interview on 5/12/2014 at 3:15 PM, employee A indicated the hydrocortisone was 1% topical cream and that, since this is available over the counter, they did not believe that an order was needed for the medication.</p> <p>This was a Home Health state license survey.</p> <p>Survey Dates: May 12-14, 2014</p> <p>Facility Number: 011096</p> <p>Medicaid Number: 200898530</p> <p>Surveyors: Miriam Bennett, RN, BSN, PHNS Nina Koch, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 39 Home Health Aide Only: 7 Personal Service Only: 0 Total: 46</p>	N000000		

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N000470	<p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN May 16, 2014</p> <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 all staff followed infection control policies and procedures for 3 of 5 home visit observations with the potential to affect all the agency's 46 patients. (#1, 2, and 4)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During interview on 5/14/14 at 1:35 PM, employee A indicated they clean their equipment once a week unless it is visibly soiled, then they clean it with Clorox bleach wipes. 2. During interview on 5/14/14 at 4:25 PM, employee A indicated there are no paper towels in the home of patient #2. 	N000470	DON held a nursing inservice to review agency's infection control policy and procedures, including proper hand washing technique, cleaning equipment before returning to nursing bag, washing hands before removing equipment from bag, and ensuring bags are placed on clean, dry surface when in client's home. All nursing bags have been cleaned and paper towels (should the home not have clean hand towels) have been added to the bags. In addition, nurses will carry protective barriers for their bags while in the client's home. DON is responsible for ensuring proper infection control is being followed. Nursing bags will be inspected on a quarterly basis by the DON.	06/30/2014

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N000518	<p>3. The agency's policy titled "Nursing Bag," dated August 2002, # N-120, states "The inside of the bag and its contents are considered clean. Therefore: Hand washing must occur before entering the bag for any reason. All items removed from the bag should be cleaned before returning to the bag. ... When in a client's home, place the bag on a clean and dry surface. If there is no suitable place in the home, take only those items into the home that are needed for the visit."</p> <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 clinical record review, observation, and document review, the agency failed to ensure patients were provided the current Advanced Directives, including a description of applicable State law, in 3 of 5 records reviewed (#3, 4, 5) with the potential to affect all the agency's 46 active patients.</p>	N000518	<p>Administrator has inserviced office staff on current Advanced Directives. Case Managers have replaced outdated Advanced Directives for existing clients during supervisory visits. Admission folders for new clients have been corrected with current Advanced Directive policy and all old policies have been destroyed. Case Managers will have</p>	05/30/2014

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	<p>Findings include</p> <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 #3, SOC 11/9/2013, failed to evidence an updated July 1, 2013, version of the Indiana Advanced Directives document. The patient signed that the document was received on the SOC date.</p> <p>On 5/14/14 at 9:30 AM, the home admission folder was observed during a home visit for patient #3. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</p> <p>3. Clinical record #4, SOC 3/24/2014, failed to evidence an updated version of the Indiana Advanced Directives document, revised July 1, 2013 . The patient signed that the document was received on the SOC date.</p> <p>On 5/14/14 at 12:15 PM, the home admission folder was observed during a home visit for patient #4. The folder failed to evidence the Indiana Advanced</p>		ongoing responsibility to ensure admissions folders contain updated policies. Administrator will bi-annually review admission policies for possible updates from the state and/or federal government.				

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N000524	<p>Directives document revised July 1, 2013.</p> <p>4. Clinical record #5, SOC 4/14/2014, 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> <p>On 5/14/14 at 2:45 PM, the home admission folder was observed in the home for patient #5. The folder failed to evidence the Indiana Advanced Directives document revised July 1, 2013.</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. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or</p>						

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	<p>referral.</p> <p>(xii) Therapy modalities specifying length of treatment.</p> <p>(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 (POC) included a duration of visits for 7 of 10 clinical records reviewed (#2, 3, 5, 6, 7, 8, and 10), included a start of care date for 1 of 10 records reviewed (#3), included all durable medical equipment (DME) used by the patient for 1 of 5 (#3) observations, and contained updates to treatments that were ordered by the physician for 1 of 10 clinical records reviewed (#2) with the potential to affect all the agency's 46 patients.</p> <p>Findings include</p> <p>Related to duration of visits</p> <p>1. Clinical record #2, start of care date (SOC) 2/20/12, contained a POC dated 4/11-6/9/14 with orders for Home Health Aide (HHA) 5 hours AM visit, 2 hours mid-afternoon visit, 4 hours evening visit for 60 day certification period and Skilled Nurse (SN) visits, 2 hour in AM for bowel program 3 times a week. The SN visits failed to evidence a duration of services.</p> <p>2. Clinical record #3, SOC 2/18/14,</p>	N000524	<p>The DON held a nursing inservice to review POC procedures to ensure that all POC's are completed in full. The inservice included review of the policy to include all durable medical equipment on POC, duration and start of care dates on POC, and ALL updates ordered by the physician are included on the POC. In addition, current charts have been reviewed for compliance. Review of the agency's new software system was included in the inservice to alleviate the omission of start of care dates on the POC. The DON is responsible for ensuring compliance with the agency's policies, #C-580 (Plan of Care) and #C-635 (Physician's Orders). Charts will be reviewed quarterly for quality assurance audits. These specific items are listed on the audit form.</p>	06/30/2014			

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	<p>contained a POC dated 4/14-6/12/14 with orders for HHA 2 hours a day Sunday through Saturday. The HHA visits failed to evidence a duration of services and the SOC date section failed to contain a date.</p> <p>3. Clinical record #5, SOC 11/9/13, contained a POC dated 2/18-4/18/14 with orders for HHA 4 hours, 4 times a week. The HHA visits failed to evidence a duration of services.</p> <p>4. Clinical record #6, SOC 10/29/12, contained a POC dated 10/29-12/27/12 with orders for HHA visit 9:00 AM to 12:00 PM Tuesday and Thursdays only. The HHA visits failed to evidence a duration of services.</p> <p>5. Clinical record #7, SOC 2/12/13, contained a POC dated 2/7-4/7/14 with orders for HHA for 2 hours daily Sunday - Saturday and SN 2 visits per week. The HHA and SN visits failed to evidence a duration of services.</p> <p>6. Clinical record #8, SOC 8/4/11, contained a POC dated 3/21-5/19/14 with orders for HHA for 2 hours 3 times per week and SN weekly. The HHA and SN visits failed to evidence a duration of services.</p> <p>7. Clinical record #10, SOC 7/5/10,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K035	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
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	<p>contained a POC dated 2/7-4/7/14 with orders for HHA visits 3 times a week for 2 hours each visit. The HHA visits failed to evidence a duration of services.</p> <p>8. During interview on 5/14/14 at 10:35 AM, employee A, administrator, indicated the durations should say 60 days, but they were missed with entry of the plan of care on some due to the new computer system.</p> <p>9. The agency's undated policy titled "Plan of Care," # C-580, states, "2. The Plan of Care shall be completed in full to include: ... 1. Medications, treatments, and procedures, m. Medical supplies and equipment required, 2. The Plan of Care shall be completed in full to include: ... c. Type, frequency, and duration of all visits/services, ... t. Other appropriate items ... 9. Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care."</p> <p>10. The agency's undated policy titled "Physician Orders," # C-635 states, "All medications and treatments, that are part of the patient's plan of care, must be ordered by the physician. ... 8. ... In the event the change are medication changes, the nurse can review the prescription medication bottles and document those changes on the patient's medication</p>			

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N000542	<p>record in the home and in the clinical chart in the office. At the time of recertification, those changes should be incorporated to the Plan of Care sent to the physician for signature."</p> <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. Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurse (RN) updated and revised the plan of care in 1 of 5 records reviewed (#2) creating the potential to affect all the agency's 46 patients receiving skilled nursing (SN) services.</p> <p>Findings include</p> <p>1. Clinical record #2, start of care (SOC) 2/20/12, contained a Plan of Care (POC) for the certification period 2/10/14 to 4/10/14 with orders for SN to include dressing changes for decubitus care in AM daily, and Saturday / Sunday 1 hour visits for decubitus care. The record failed to evidence specific orders for drugs or treatments to be used for the decubitus care and failed to identify the</p>	N000542	The Administrator/Director of Nursing has inserviced nursing staff on POC documentation. All patient records have been reviewed and cross-checked by case managers to ensure POC's contain necessary updates including physician orders for over the counter medications, and patient anatomical location for dressing changes. This practice has been highlighted on the patient chart audit forms. The Administrator is responsible for ensuring that proper updates to the POC are completed and will be reviewed ongoing, quarterly at quality assurance meetings.	06/30/2014

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	<p>anatomic location of any existing decubitus ulcers requiring treatment.</p> <p>A. A SN visit note dated 3/9/2014 evidenced the nurse applied hydrocortisone cream to the patient's rectal area when the patient complained of discomfort. The record failed to evidence the SN contacted the patient's physician to obtain an order for the cream and had updated the plan of care to include the hydrocortisone cream.</p> <p>B. During interview on 5/12/2014 at 3:15 PM, employee A indicated the hydrocortisone was 1% topical cream and that, since this is available over the counter, they did not believe that an order was needed for the medication.</p>				