

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 09/12/2013
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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 home health State licensure survey.</p> <p>Survey dates: September 10-12, 2013.</p> <p>Facility number: 012100</p> <p>Medicaid number: 200984210</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 238 Home Health Aide Only: 49 Personal Services Only: 7 Total: 294</p> <p>Sample: RR w/o HV: 4 RR w/HV: 2 Total: 6</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN September 16, 2013</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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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: Based on clinical record review, policy review, and interview, the agency failed to provide skilled nursing services in accordance with the plan of care for 3 of 6 clinical records reviewed with the potential to affect all the agency's patients receiving skilled nursing services. (#1, 3, and 6)</p> <p>Findings include</p> <p>1. Clinical record #1, start of care (SOC) 5/16/13, contained a Plan of Care (POC) dated 7/15-9/12/13 with orders for "skilled nurse (SN) frequency: every other week for Home Health Aide (HHA) sup visits. ... SN to develop individualized emergency plan with patient. SN to assess skin for breakdown every visit. SN to instruct patient to use prescribed assistive device when ambulating. SN to instruct the Patient/Caregiver to remove clutter from patient's path such as clothes, books, shoes, electrical cords, or other items that may cause patient to trip. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in</p>	N000522	Agency Director of Nursing will conduct an in-service on the importance of providing skilled nursing services in accordance with the plan of care. The in-service will discuss admission/re-certification requirements for patients without skilled needs. and the need for nurses to specify on the care plan what exactly the SN services are for and to make the clear distinction for whether or not the SN services are used for hands on care (and what kind) for the patient or for Home Health Aide supervision. The in service will also cover the importance obtaining specific orders for medication changes that deviate from the initial care plan from the supervising MD. In the future all incoming nurses, at the time of orientation will be instructed on the importance of the creation of the initial care plan for patients and to specify the nature of SN visits whether for hands on care, supervising a Home Health Aide/LPN and/or solely for re-certification purposes. In addition, incoming nurses will be oriented on the importance of communication to the supervising MD via the care plan and	10/20/2013			

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	<p>serious injury or causing severe pain or immobility." The clinical record failed to evidence the SN performed the duties listed on 7/24, 8/7, 8/21, and 9/4/13 when SN did HHA supervisory visits.</p> <p>A. On 9/11/13 at 12:40 PM, employee E indicated the agency writes the orders that way in order to get the pre-authorization from Medicare as they want to know the specifics of what the nurse will be doing when they go to the patients' homes.</p> <p>B. On 9/11/13 at 12:45 PM, employee D indicated this was a HHA case and the nurses are only going for supervisory visits, the other instructions for the nurse are meant for recert visits only.</p> <p>2. Clinical record #3, SOC 8/31/12, contained a POC dated 6/27-8/25/13 with orders for "SN to ... assess pain level and effectiveness of pain medications and current pain management therapy every visit. ... SN to assess caregiver filling medication box to determine if caregiver is preparing correctly."</p> <p>A. The Skilled Nurse Progress Note dated 7/1/13 states "SNV to administer B 12 injection. Injected in Pt L upper arm. No bleeding noted, pt tolerated well."</p>		<p>subsequent MD orders for any Medication changes or any pertinent alternations to the initial care plan or subsequent care plans throughout the treatment period. At the close of every chart, a Quality Assurance audit will be conducted on EVERY chart by our Quality assurance nurse to ensure that ALL disciplines and not just Skilled nursing services were performed in full accordance with the care plan and any deviations from the care plan were justified with a subsequent MD order addressing the change. In addition, ALL CHARTS that provided skilled services for more than one certification period will be audited at the close of the chart to ensure that changes to the care plan after creation of the initial care plan (justified with a subsequent MD order) and were still necessary in the next certification period were included in the care plan for the next certification period. The Agency Director of Nursing will be responsible for monitoring these corrective corrective actions to ensure the deficiency is corrected and will not recur.</p>		

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	<p>The clinical record failed to evidence an order for SN to administer the B 12 injection.</p> <p>B. On 9/11/13 at 1:30 PM, employee D indicated they do not know why the nurse gave the B 12 injection. The patient's family sets up and gives the patient their medications. At 2:20 PM employee D indicated the B 12 was probably due and the nurse got talked into administering it because at one point the agency was ordered to administer the B 12 injections.</p> <p>C. A physician order dated 8/14/13 states "Increase patient's Lasix to 40 mg daily from 20 mg for the next 3 days." A Skilled Nurse Progress Note dated 8/14/13 evidenced the nurse completed a head to toe assessment and administered Lasix 20 milligrams by mouth. The clinical record failed to evidence an order for this visit.</p> <p>On 9/11/13 at 1:50 PM, employee D indicated the nurse probably made the visit on 8/14 due to the order to increase the Lasix, but they did not have an order for an as needed visit.</p> <p>3. Clinical record #6, SOC 6/3/13, contained a POC dated 8/2-9/30/13 with orders for "SN Frequency: 5 times a</p>						

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	<p>week times 9 weeks 3 hours each visit. Sterile dressing change to LVAD site daily. ... SN to assess wound for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications."</p> <p>A. The Skilled Nursing Visit Notes page 1 has a section labeled "Skilled Procedure(s) Done" with first subject listed as "Wound Care: (see next page for details)." Page 2 contains a section titled "Skin Lesion/Open Wound" with subjects of wound assessment labeled "Type of wound/skin lesion, Location, Size (LxWxD), Stage (Pressure Ulcer), Tunneling, Surrounding Skin, Drainage/Amount, Drainage/Color, Odor, and Appearance of Wound Bed." Below is a section for narration labeled "Wound Care:." The record failed to evidence the Wound Care section on page 1 and the Skin Lesion/Open Wound section on page 2 was completed for visits: 8/5, 7, 8, 9, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30 and 9/2, 4, 5, and 6, 2013.</p> <p>B. The clinical record failed to evidence the SN changed the dressing as ordered on 8/15, 21, 26, and 27 and 9/4, 5, and 6, 2013.</p> <p>C. On 9/12/13 at 12:30 PM,</p>			

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	<p>employee D indicated this was not a wound; it was an insertion site and that is why the nurse was not charting an assessment. So the wording should not say wound.</p> <p>D. On 9/12/13 at 12:55 PM, employee J indicated the dressing was changed daily and assessed. If there was any redness or drainage they would chart it in the narrative notes and/or the wound section on page 2 under integumentary status, wound care section.</p> <p>4. The agency's policy titled "Clinical Documentation," #501A, states "1. All skilled services provided by Nursing or Therapy will be documented in the clinical record."</p> <p>5. The agency's policy titled "Plan of Care Implementation," #804A, states "2. The Plan of Care shall be completed in full to include: ... 1. Medications, treatments, and procedures."</p>				

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N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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 referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the frequency of visits was on the Plan of Care (POC) for Skilled Nurse (SN) visits for 1 of 6 clinical records reviewed with the potential to affect all the agency's patients. (#3)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Clinical record # 3, start of care 8/31/12, contained a Plan of Care dated 	N000524	Agency Director of Nursing will conduct an in-service to all nurses responsible for creating the care plans. The in- service will discuss the importance and requirement for the nurses creating the care plans to include the visit frequency on the care plan. The Director of Nursing will also reiterate to the nurses the importance of informing the patient the nursing visit frequency at the time of admission. Nurses will be informed of the importance of adhering to the frequency and	10/20/2013	

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	<p>6/27-8/25/13 with orders for "SN Frequency: every other week." The POC failed to evidence a duration for the SN visits.</p> <p>A. The Physician Order dated 7/31/13 states "start SN visits every other week according to medicaid PA approval starting week of 8/4/13." This order failed to include a duration for the SN visits.</p> <p>B. On 9/11/13 at 1:45 PM, employee D indicated the SN visits were ordered to begin 8/4 so the orders on the POC for SN every other week are only for HHA supervisory visits.</p> <p>2. The agency's undated policy titled "Plan of Care Implementation," #804A, states "2. The Plan of Care shall be completed in full to include: ... c. Type, frequency, and duration of all visits/services."</p>		<p>to document/obtain an MD order for any changes in the visit frequency. To ensure the deficiency does not occur, either the Director of Nursing or Quality Assurance Nurse will document the review of every Plan of Care within two weeks of the start of care/re-certification period (whichever applies) to make sure the visit frequency is included. Documented evidence will be in the form of a communication note signed/dated by the reviewing clinician and placed in the respective patient's chart. Further, a monthly audit will be conducted on at least 25% of discharged patients charts from the preceding month to ensure visit frequency was included in the care plan. The Agency Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>		

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N000600	<p>410 IAC 17-14-1(l)(3) Scope of Services Rule 14 Sec. 1(l)(3) If the home health agency issuing the proof of the aide's achievement of successful completion of a competency evaluation program is not the employing agency, the employing agency shall keep a copy of the competency evaluation documentation in the home health aide's employment file.</p> <p>Based on employee file review, policy review, and interview, the agency failed to ensure a copy of the Home Health Aide (HHA) competency test was in the employee file for 1 of 3 HHA files reviewed with the potential to affect all the patients receiving HHA services. (employee I)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Employee file I, date of hire 2/13/13, failed to evidence the agency had obtained a copy of the HHA competency test from the agency that trained and competency tested the aide. 2. On 9/12/13 at 10:40 AM, employee E indicated this aide was already a HHA at another agency and was on the state registry. At 11:45 AM, employee E indicated the previous agency said they could fax a copy over, but they needed the aide to approve it and pay for it first. 3. The agency's undated policy titled 	N000600	<p>All active home health aides on the agency's roster that were previously credentialed as Home Health Aides prior to employment at Divine Home Healthcare, Inc, and do not have a home health aide exam on file, will be required to take a Home Health Aide exam and score a 70% or better by the above-mentioned date of completion. Going forward, all incoming Home Health Aide candidates that do not possess and present a copy of their Home Health Aide exam (and with a score of 70% or better) will be required to take the exam to demonstrate competency of the written portion of the HHA Competency Evaluation Program. The candidate must attain a score of 70% or better for further consideration for employment as a Home Health Aide with the agency. The exam will be included in the candidate/employee's HR file. The Agency's Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	10/17/2013			

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	<p>"Personnel Records," #405A, states, "a. The personnel record for an employee will include, but not be limited to: ... c. Employment Information: Competency testing for home health aides."</p> <p>4. The agency's job description titled "Home Health Aide," states "Qualifications: Successful completion of a formal certification training program and/or a written skills test and competency evaluation."</p>			