

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2013
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NAME OF PROVIDER OR SUPPLIER HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
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G000000	<p>This was a Home Health Medicaid recertification survey.</p> <p>Survey Dates: October 11, 15, 16, and 17, 2013</p> <p>Facility Number: 004219</p> <p>Medicaid Number: 200889890B</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 25 Home Health Aide Only: 5 Personal Service Only: 0 Total: 30</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 22, 2013</p>	G000000	N 0000HomePointe HealthCare acknowledges a survey was completed on 10/17/13 by Miriam Bennett	

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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G000121	<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 staff followed infection control practices for 1 of 5 home visit observations with the potential to affect all the agency's patients. (#3)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation on 10/15/13 at 12:15 PM, employee C was observed performing cough assist for patient #3. After donning clean gloves, employee C leaned over and placed both gloved hands on the floor to ensure the machine was plugged in. The employee failed to change gloves after removing hands from the floor and prior to suctioning the patient's tracheostomy. 2. On 10/15/13 at 1:35 PM, employee G indicated the Registered Nurse should have changed gloves once they touched the floor and prior to suctioning the tracheostomy. 3. The agency's undated policy titled "Standard Precautions-Tier One," #B-403 	G000121	<p>G 0121Action:All staff was inserviced on "clean technique in the home". The inservice re-educated staff on proper hand washing and glove hygiene before, during and after patient contact. In addition, policy and procedure B-304 Infection Prevention/Control was reviewed with all staff members.Responsible Party:Clinical Case Manger/Director will monitor adherence to inservice and policy.Time frame:Inservice was distributed on 10/18/2013.Evaluation/Follow-up: Clinical Case Manger/Director will monitor staff during supervisory visits, annual mandatory competency testing and new employee orientation.</p>	10/18/2013

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	states, "2. Hands are washed ... when indicated to prevent transfer of microorganisms between other clients or the environment."				

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G000158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care in 3 of 10 records reviewed creating the potential to affect all the agency's patients. (#4, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #4 included a plan of care established by the physician for the certification period 8/23 to 10/20/13 with orders for Skilled Nursing (SN) shifts 7-9 hours a day 4-6 days a week times 60 days.</p> <p>A. The record failed to evidence 4 visits were provided the weeks of 9/2-9/8/13 and 9/16-9/22/13 and failed to evidence the physician was notified of any missed visits.</p> <p>B. A SN visit note dated 9/6/13 evidenced 14.5 hours of care were provided, The record failed to evidence an order was obtained for increased hours.</p> <p>2. Clinical record #7 included a plan of</p>	G000158	<p>G 0158Action:A reweiv and monitoring of hours provided in accordance with the plan of care will be conducted weekly. In addition, all staff was instructed to notify the scheduler of any changes in their scheduled daily shifts/hours. Physicians will be notified of variances to the plan of care via a "missed visit" form. An order will be sent to the physician for approval for any hours that exceed the plan of care.Responsible Party:DirectorTime frame:Initiated 10/21/13 during weekly meetings Evaluation/Follow-up:To be monitored at weekly meetings and quarterly with 10% of charts reviewed by Clinical Manager/Director</p>	10/21/2013			

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	<p>care established by the physician for the certification period 8/6 to 10/4/13 with orders for SN 8-12 hours a day 5-7 days a week times 60 days.</p> <p>A. The record failed to evidence 5 visits were provided the weeks of 8/6-8/11/13 and 9/2-9/8/13 and failed to evidence the physician was notified of any missed visits.</p> <p>B. SN visit note dated 9/15/13 failed to evidence 8 hours of care were provided. The record failed to evidence an order was obtained to decrease hours.</p> <p>C. SN visit note dated 9/30/13 failed to evidence 8 hours of care were provided. The record failed to evidence an order was obtained to decrease hours.</p> <p>3. Clinical record #8 included a plan of care established by the physician for the certification period 8/14 to 10/12/13 with orders for SN 5-8 hours a day 4-6 days a week times 60 days.</p> <p>A. The record failed to evidence 4 visits were provided the week of 9/2-9/8/13 and failed to evidence the physician was informed of any missed visits.</p> <p>B. SN visit note dated 10/7/13</p>			

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	<p>evidenced 10.5 hours of care were provided. The record failed to evidence an order was obtained to increase hours.</p> <p>4. On 10/17/13 at 1:20 PM, employee G indicated the 10.5 hours on 10/7 for record 8 is only for identifying pay for the nurse, but the care shift had ended around 5:15 PM and the nurse accompanied the mother to the emergency room with the patient due to the mother only spoke Spanish.</p> <p>5. The agency's undated policy titled "Clinical Documentation," #C-680 states, "2. ... Actual time of the client visit will be included in each note. ... 5. Documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within fourteen (14) days after the care has been provided. 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period.</p>			

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N000000	<p>This was a Home Health state license survey.</p> <p>Survey Dates: October 11, 15, 16, and 17, 2013</p> <p>Facility Number: 004219</p> <p>Medicaid Number: 200889890B</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 25 Home Health Aide Only: 5 Personal Service Only: 0 Total: 30</p> <p>Sample: RR w/HV: 5 RR w/o HV: 5 Total: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 22, 2013</p>	N000000	N 0000HomePointe HealthCare acknowledges a survey was completed on 10/17/13 by Miriam Bennett	

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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> <p>Based on observation, policy review, and interview, the agency failed to ensure staff followed infection control practices for 1 of 5 home visit observations with the potential to affect all the agency's patients. (#3)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation on 10/15/13 at 12:15 PM, employee C was observed performing cough assist for patient #3. After donning clean gloves, employee C leaned over and placed both gloved hands on the floor to ensure the machine was plugged in. The employee failed to change gloves after removing hands from the floor and prior to suctioning the patient's tracheostomy. 2. On 10/15/13 at 1:35 PM, employee G indicated the Registered Nurse should have changed gloves once they touched the floor and prior to suctioning the tracheostomy. 3. The agency's undated policy titled 	N000470	<p>N 0470 Action:All staff was inserviced on "clean technique in the home". The inservice re-educated staff on proper hand washing and glove hygiene before, during and after patient contact. In addition, policy and procedure B-304 Infection Prevention/Control was reviewed with all staff members.Responsible Party:Clinical Case Manger/Director will monitor adherence to inservice and policy.Time frame:Inservice was distributed on 10/18/2013.Evaluation/Follow-up: Clinical Case Manger/Director will monitor staff during supervisory visits, annual mandatory competency testing and new employee oreintation.</p>	10/18/2013	

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	"Standard Precautions-Tier One," #B-403 states, "2. Hands are washed ... when indicated to prevent transfer of microorganisms between other clients or the environment."			

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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 ensure visits were made as ordered on the plan of care in 3 of 10 records reviewed creating the potential to affect all the agency's patients. (#4, 7, and 8)</p> <p>Findings include:</p> <p>1. Clinical record #4 included a plan of care established by the physician for the certification period 8/23 to 10/20/13 with orders for Skilled Nursing (SN) shifts 7-9 hours a day 4-6 days a week times 60 days.</p> <p>A. The record failed to evidence 4 visits were provided the weeks of 9/2-9/8/13 and 9/16-9/22/13 and failed to evidence the physician was notified of any missed visits.</p> <p>B. A SN visit note dated 9/6/13 evidenced 14.5 hours of care were provided, The record failed to evidence an order was obtained for increased hours.</p> <p>2. Clinical record #7 included a plan of</p>	N000522	<p>N 0522Action:A reweiv and monitoring of hours provided in accordance with the plan of care will be conducted weekly. In addition, all staff was instructed to notify the scheduler of any changes in their scheduled daily shifts/hours. Physicians will be notified of variances to the plan of care via a "missed visit" form. An order will be sent to the physician for approval for any hours that exceed the plan of care.Responsible Party:DirectorTime frame:Initiated 10/21/13 during weekly meetings Evaluation/Follow-up:To be monitored at weekly meetings and quarterly with 10% of charts reviewed by Clinical Manager/Director</p>	10/21/2013			

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	<p>care established by the physician for the certification period 8/6 to 10/4/13 with orders for SN 8-12 hours a day 5-7 days a week times 60 days.</p> <p>A. The record failed to evidence 5 visits were provided the weeks of 8/6-8/11/13 and 9/2-9/8/13 and failed to evidence the physician was notified of any missed visits.</p> <p>B. SN visit note dated 9/15/13 failed to evidence 8 hours of care were provided. The record failed to evidence an order was obtained to decrease hours.</p> <p>C. SN visit note dated 9/30/13 failed to evidence 8 hours of care were provided. The record failed to evidence an order was obtained to decrease hours.</p> <p>3. Clinical record #8 included a plan of care established by the physician for the certification period 8/14 to 10/12/13 with orders for SN 5-8 hours a day 4-6 days a week times 60 days.</p> <p>A. The record failed to evidence 4 visits were provided the week of 9/2-9/8/13 and failed to evidence the physician was informed of any missed visits.</p> <p>B. SN visit note dated 10/7/13</p>			

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	<p>evidenced 10.5 hours of care were provided. The record failed to evidence an order was obtained to increase hours.</p> <p>4. On 10/17/13 at 1:20 PM, employee G indicated the 10.5 hours on 10/7 for record 8 is only for identifying pay for the nurse, but the care shift had ended around 5:15 PM and the nurse accompanied the mother to the emergency room with the patient due to the mother only spoke Spanish.</p> <p>5. The agency's undated policy titled "Clinical Documentation," #C-680 states, "2. ... Actual time of the client visit will be included in each note. ... 5. Documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within fourteen (14) days after the care has been provided. 6. Services not provided and the reason for the missed visits will be documented and reported to the physician within current certification period.</p>			

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N000606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) made an on-site visit to the patient's home no less frequently than every 30 days as required by agency policy in 2 of 3 patient records reviewed of patients who had home health aide (HHA) only services creating the potential to affect all the agency's patients receiving HHA services for longer than 30 days. (#5 and 9)</p> <p>Findings include</p> <p>1. The agency's undated policy titled "Home Health Aide Supervision" #C-340 states, "When Home Health Aide services are being furnished to a client, who does not require the skilled service of a nurse or therapist, the Registered Nurse ... must make a supervisory visit to the client's residence at least once every 30 days."</p> <p>2. Clinical record #5, start of care (SOC) date 9/3/09, included a plan of care with physician orders for HHA services 3-5</p>	N000606	<p>N 0606Action:Clinical Case Manger will contact client/client family at 20 days to schedule each 30 day visit. In addition, a reminder card will be given at each supervisory visit to the client/client family to aid in the scheduling of the next 30 day visit. An ongoing supervisory calendar will be maintained by the Clinical Case Manager.Responsible Party:Clinical Case Manager and DirectorTime frame:started supervisory visit calendar 10/18/13 Evaluation/Follow-up:Wi ll be monitored at weekly staff meetings to ensure 30 day visits are scheduled. All Home Health Aide charts will be audited quarterly to ensure process is compliant with regulations.</p>	10/18/2013			

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	<p>days a week, 8 to 10 hours a day. The record failed to evidence supervisory visits were made within the 30 day time frame between 8/2/13 to 9/3/13.</p> <p>3. Clinical record #9, SOC date 10/29/11, included a plan of care with physician orders for respite HHA visits average 60 hours a month. The record failed to evidence supervisory visits were made within the 30 day time frame between 8/26-9/27/13.</p> <p>4. On 10/16/13 at 2:20 PM, employee H indicated the supervisory visits should be at least every 30 days.</p>			