

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157627	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/02/2015
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NAME OF PROVIDER OR SUPPLIER  INTERIM HEALTHCARE OF FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 310 E DUPONT RD STE 1 FORT WAYNE, IN 46825
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G 000  Bldg. 00	<p>This was a federal complaint investigation survey.</p> <p>Complaint IN00163896- Substantiated: Federal deficiencies related to the allegation are cited.</p> <p>Survey Date: April 2, 2015</p> <p>Facility #: 003294</p> <p>Medicaid #: 200396990A</p>	G 000		
G 101  Bldg. 00	<p>484.10 PATIENT RIGHTS</p> <p>The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p> <p>Based on clinical record review, policy review, agency document review, and interview, the agency failed to ensure all staff followed the patient rights to be free from verbal abuse as required by agency policy for 1 of 4 records reviewed. (#3)</p> <p>Findings include</p>	G 101	Employee G, a REgistered Nurse was suspended on 9/22/14 pending results of investigation. She was terminated on 10/3/14 after investigation. Administrator will re-educate all agency staff on patient's rights and the importance of protecting and promoting those rights.	05/01/2015

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.

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	<p>1. The agency complaint log evidenced a complaint filed on 9/22/14 concerning patient #3, with allegations of verbal abuse to the patient by employee G, a registered nurse. This complaint alleged employee D, a registered nurse, had witnessed employee G responding to the patient in an elevated voice when the patient asked employee G to leave, stating "I refuse to leave until I've talked to [employee D], I've been in a bad mood all day and [patient's] been in a bad mood also. [Patient] keeps telling me to leave [patient] alone. [Patient] has been a pain and I would cuss if I could." Employee D reported that employee G kept saying how terrible the patient was, using an elevated voice."</p> <p>A. This complaint was investigated by the agency with a phone call to the patient's family member on 9/22/14- family requested that employee G be removed from this patient's care. Agency scheduled appointment with employee G on 9/26/14.</p> <p>B. The agency Case Conference/Investigation took place on 9/26/14 at 9:00 AM with employees G (registered nurse), B (Nurse Supervisor), and A (administrator). The conference stated "[Employee G] was then asked about verbal abuse allegations made and</p>			

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G 170 Bldg. 00	<p>[employee G] denied being verbally abusive toward patient. [Employee G] was made aware that [employee G] was being pulled from patient's home at family's request. ... It was discussed with [employee G] that [her] behavior has been questioned recently."</p> <p>C. The agency Case Conference dated 10/3/14 took place at the patient's residence with employee A, B, patient #3 and their family. This report states "When asked if the patient felt that [employee G] was ever abusive towards [patient] while providing care, [patient] responded "no but she could sometimes become verbal." Patient's family interjected "didn't she call you an [bad word]?" Patient answered "yes." ... Patient also stated [they] felt she wouldn't listen to [patient]. ... Patient stated, "she gave me my 11 AM pills at 8:30 am even after I told her it was too early."</p> <p>2. The agency's undated policy titled "Statement of Patient's/Clients Rights," no number, states "11. Be free from verbal, physical and psychological abuse and to be treated with dignity."</p> <p>484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.</p>			
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	<p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) provided medications at ordered times in accordance with the plan of care (POC) for 1 of 4 clinical records reviewed.</p> <p>Findings include</p> <p>1. Clinical record # 3, contained a POC dated 9/14-11/13/14 with orders for skilled nurse (SN) 6-8 hours a day, 1-2 times a day, 5-7 days a week per Medicaid pre-authorization, SN to perform assessment every shift, monitor vital signs, and administer medications as ordered per medication profile.</p> <p>A. Medications listed on the POC to be given at 11:00 AM included Phenytoin (Dilantin) Extended Release 100 milligram (mg)/capsule, 2 capsules daily at 11:00, Levetiracetam (Keppra) 1000 mg/tablet, 2 tablets orally every morning, 1 every evening, and Nexium 40 mg/tablet, 1 tablet orally daily at 11:00.</p> <p>B. The Medication Sheet dated 9/20-9/26/14 evidenced the 11:00 AM medications to be given were Multivitamin 1 tablet, Dilantin 100 mg/tablet 2 tablets daily, Levetiracetam 1000 mg/tablet 2 tablets, and Nexium 40 mg/tablet 1 tablet. The Medication Sheet</p>	G 170	Employee G, Registered nurse was terminated 10/3/14. The Administrator will re-educate all nurses on medication agency's administration policy including the "Five Rights" of medication administration. Administrator will also re-educate all nurses on correctly following the orders on the patient's (MD) signed Plan of Care and correct documentation procedure for any variances in medication administration times.	05/01/2015

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	<p>evidenced the 11:00 AM medications were administered at 8:00 AM on 9/22/14 by employee G (RN).</p> <p>2. During interview on 4/2/15 at 1:10 PM, employee C, licensed practical nurse, indicated they have provided care to patient # 3, including administering medications. Employee C indicated if a patient or family request medications be given at times other than prescribed or ordered, they tell them the medications are to be given per agency policy 1 hour before or 1 hour after the ordered times. Employee C indicated if a patient or family are insistent on administering medications at other times, they contact their supervisor first and then document the insistence and steps taken.</p> <p>3. During interview on 4/2/15 at 11:50 AM, employee A indicated if a nurse receives orders to give medications at another time other than when they are ordered, they are to write in the narrative notes. Employee A indicated often families will request medications be given at different times, but the nurses will document this on the medication sheets notes area.</p> <p>4. During interview on 4/2/15 at 12:00 PM, employee B, supervising nurse, indicated employee G was used to giving</p>			

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N 000  Bldg. 00	<p>all the 11:00 AM medications right away because she would start her shift at 11:00, but 9/22 she started shift at 8:00 AM. Employee B indicated employee G was very task oriented and probably just gave the medications early by mistake or habit.</p> <p>5. The agency's policy titled "Medications," no number, dated 8/27/04, states, "Interim HealthCare ensures that they have the right patient, right drug, right dose, right route, and right time prior to administering any medication. ... Procedure ... 3. An employee administering any medication performs the five rights of medication/treatment administration."</p> <p>This was a state home health complaint investigation survey.</p> <p>Complaint IN00163896- Substantiated: deficiencies related to the allegation are cited.</p> <p>Survey Date: April 2, 2015</p> <p>Facility #: 003294</p>	N 000		

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N 512 Bldg. 00	<p>Medicaid #: 200396990A</p> <p>410 IAC 17-12-3(b)(4) Patient Rights Rule 12 Sec. 3(b)(4) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (4) The patient has the right to be as follows: (A) Free from verbal, physical, and psychological abuse. (B) Treated with dignity.</p> <p>Based on clinical record review, policy review, agency document review, and interview, the agency failed to ensure all staff followed the patient rights to be free from verbal abuse for 1 of 4 records reviewed. (#3)</p> <p>Findings include</p> <p>1. The agency complaint log evidenced a complaint filed on 9/22/14 concerning patient #3, with allegations of verbal abuse to the patient by employee G, a registered nurse. This complaint alleged employee D, a registered nurse, had witnessed employee G responding to the patient in an elevated voice when the patient asked employee G to leave, stating "I refuse to leave until I've talked to [employee D], I've been in a bad mood all day and [patient's] been in a bad mood</p>	N 512	Employee G, a Registered Nurse was suspended on 9/22/14 pending results of investigation. She was terminated on 10/3/14 after investigation completed. Administrator will re-educate all agency staff on patient's rights and the importance of protecting and promoting those rights.	05/01/2015

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	<p>also. [Patient] keeps telling me to leave [patient] alone. [Patient] has been a pain and I would cuss if I could." Employee D reported that employee G kept saying how terrible the patient was, using an elevated voice."</p> <p>A. This complaint was investigated by the agency with a phone call to the patient's family member on 9/22/14- family requested that employee G be removed from this patient's care. Agency scheduled appointment with employee G on 9/26/14.</p> <p>B. The agency Case Conference/Investigation took place on 9/26/14 at 9:00 AM with employees G (registered nurse), B (Nurse Supervisor), and A (administrator). The conference stated "[Employee G] was then asked about verbal abuse allegations made and [employee G] denied being verbally abusive toward patient. [Employee G] was made aware that [employee G] was being pulled from patient's home at family's request. ... It was discussed with [employee G] that [her] behavior has been questioned recently."</p> <p>C. The agency Case Conference dated 10/3/14 took place at the patient's residence with employee A, B, patient #3 and their family. This report states</p>			

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N 537 Bldg. 00	<p>"When asked if the patient felt that [employee G] was ever abusive towards [patient] while providing care, [patient] responded "no but she could sometimes become verbal." Patient's family interjected "didn't she call you an [bad word]?" Patient answered "yes." ... Patient also stated [they] felt she wouldn't listen to [patient]. ... Patient stated, "she gave me my 11 AM pills at 8:30 am even after I told her it was too early."</p> <p>2. The agency's undated policy titled "Statement of Patient's/Clients Rights," no number, states "11. Be free from verbal, physical and psychological abuse and to be treated with dignity."</p> <p>410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) provided medications at ordered times in accordance with the plan of care (POC) for 1 of 4 clinical records reviewed.</p>	N 537	Employee G, Registered Nurse was terminated on 10/3/14. The Administrator will re-educate all nurses on medication, agency's administration policy including the "Five Rights" of medication administration. Administrator will also re-educate all nurses on correctly following the orders on	05/01/2015

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	<p>Findings include</p> <p>1. Clinical record # 3, contained a POC dated 9/14-11/13/14 with orders for skilled nurse (SN) 6-8 hours a day, 1-2 times a day, 5-7 days a week per Medicaid pre-authorization, SN to perform assessment every shift, monitor vital signs, and administer medications as ordered per medication profile.</p> <p>A. Medications listed on the POC to be given at 11:00 AM included Phenytoin (Dilantin) Extended Release 100 milligram (mg)/capsule, 2 capsules daily at 11:00, Levetiracetam (Keppra) 1000 mg/tablet, 2 tablets orally every morning, 1 every evening, and Nexium 40 mg/tablet, 1 tablet orally daily at 11:00.</p> <p>B. The Medication Sheet dated 9/20-9/26/14 evidenced the 11:00 AM medications to be given were Multivitamin 1 tablet, Dilantin 100 mg/tablet 2 tablets daily, Levetiracetam 1000 mg/tablet 2 tablets, and Nexium 40 mg/tablet 1 tablet. The Medication Sheet evidenced the 11:00 AM medications were administered at 8:00 AM on 9/22/14 by employee G (RN).</p> <p>2. During interview on 4/2/15 at 1:10 PM, employee C, licensed practical nurse, indicated they have provided care</p>		the patient's (MD) signed Plan of Care and correct documentation procedure for any variances in medication times.		

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	<p>to patient # 3, including administering medications. Employee C indicated if a patient or family request medications be given at times other than prescribed or ordered, they tell them the medications are to be given per agency policy 1 hour before or 1 hour after the ordered times. Employee C indicated if a patient or family are insistent on administering medications at other times, they contact their supervisor first and then document the insistence and steps taken.</p> <p>3. During interview on 4/2/15 at 11:50 AM, employee A indicated if a nurse receives orders to give medications at another time other than when they are ordered, they are to write in the narrative notes. Employee A indicated often families will request medications be given at different times, but the nurses will document this on the medication sheets notes area.</p> <p>4. During interview on 4/2/15 at 12:00 PM, employee B, supervising nurse, indicated employee G was used to giving all the 11:00 AM medications right away because she would start her shift at 11:00, but 9/22 she started shift at 8:00 AM. Employee B indicated employee G was very task oriented and probably just gave the medications early by mistake or habit.</p>			

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	5. The agency's policy titled "Medications," no number, dated 8/27/04, states, "Interim HealthCare ensures that they have the right patient, right drug, right dose, right route, and right time prior to administering any medication. ... Procedure ... 3. An employee administering any medication performs the five rights of medication/treatment administration."				