

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157442	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806
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G000000	<p>This was a revisit for the extended Federal home health agency complaint survey completed on August 26, 2014.</p> <p>Complaint #: IN00152278- Substantiated: Federal deficiencies related to the allegation were cited. Unrelated deficiencies were also cited.</p> <p>Survey Date: October 9, 2014</p> <p>Facility #: 008749</p> <p>Medicaid Vendor #: 20065690A</p> <p>Surveyor: Miriam Bennett, RN, PHNS</p> <p>Three (3) Conditions of Participation and fourteen (14) standard level deficiencies were found corrected during this survey. Three standard level deficiencies were recited.</p> <p>Quality review: Joyce Elder, MSN, BSN, RN October 14, 2014</p>	G000000		
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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.</p> <p>Based on home visit observation, document review, and interview, the agency failed to ensure staff followed agency policy for infection control in 1 of 1 observations, creating the potential to affect all the agency's patients. (Employee D)</p> <p>Findings include</p> <p>1. During home visit observation with patient #4 on 10/9/14 at 9:30 AM, employee D, a Home Health Aide, was observed providing a shower to the patient. Employee D washed patient's buttocks and rectal area, rinsed patient, then proceeded to begin drying patient, applying lotion to skin, and dressing patient. Employee D failed to remove gloves and perform hand hygiene after having washed patient's buttocks and rectal area and prior to drying, applying lotion, and dressing patient.</p> <p>2. During interview on 10/9/14 at 11:00</p>	G000121	<p>G-0121The direct care staff (nurses and home health aides) has been in-serviced on agency policy #8.001 Infection Control (revised September 2014). In-service specifically includes re-training on bathing techniques and pericare. Annual re-training process on infection control has been revised to include return demonstration on bathing techniques. Employee D referred to direct supervisor for coach and counsel. Direct care staff will continue to be monitored on supervisory visits for compliance with agency policy and procedures regarding infection control and re-trained annually. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	11/15/2014

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G000158	<p>AM, employee B indicated infection control was covered during the inservices after the last survey.</p> <p>3. The agency's document titled "HHA Bath/Shower Check Off" states, "15) Assists client out of shower/tub. 16) Removes gloves and wash hands. 17) Washes hands and don gloves. [17]) Assists client in drying off. 18) Assists client with dressing."</p> <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 provided as ordered on the plan of care (POC) for 2 of 3 clinical records reviewed and the physician was notified of missed visits for 1 of 3 clinical records reviewed creating the potential to affect all the agency's patients. (#s 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record 2, start of care date (SOC) 9/17/14, contained a POC with orders for Skilled Nurse 4 hours, 2</p>	G000158	<p>G-0158 The nursing staff has been in-serviced on agency policies #2.012 Client 60 Day Summaries and #2.010 Client Plan of Care (revised September 2014). In-service specifically includes: -re-training on process of notifying physician of missed visits -reviewing missed visits in daily census meeting -adding a note to the client's plan of care to reflect changes due to client request -reviewing visit notes weekly to ensure "non-billable" items are clearly marked on the visit note. 10% of all clinical records will be</p>	11/15/2014

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	<p>mornings per week times 60 days. The record failed to evidence 4 hours of care were provided on 9/24, 10/1, and 10/2/14.</p> <p>A. The Nursing Flow Sheet dated 9/24/14 evidenced the nurse provided care from 8:00 AM-11:40 AM.</p> <p>B. The Nursing Flow Sheet dated 10/1/14 evidenced the nurse provided care from 8:00 AM-11:00 AM.</p> <p>C. The Nursing Flow Sheet dated 10/2/14 evidenced the nurse provided care from 8:00 AM-11:15 AM.</p> <p>D. During interview on 10/8/14 at 1:30 PM, employee A indicated the primary caregiver lets the nurses leave when they are finished providing care because they don't need to stay.</p> <p>2. Clinical record #3, SOC 8/30/14 contained a POC with orders for Home Health Aide 2 hours, 4 times per week times 60 days.</p> <p>A. The record evidenced a Missed Visit/Shift Report dated 9/13/14. This form failed to evidence the physician was notified of the missed visit.</p> <p>B. During interview on 10/8/14 at</p>		<p>audited quarterly for compliance with agency policies #2.012 and #2.010.</p> <p>The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G000159	<p>2:55 PM, employee B indicated the process was changed to notify the physicians weekly of missed visits, also on the next 60 day summaries, and the nurse completed the form but it looks like it did not get placed in the fax pile to notify the physician.</p> <p>C. The record evidenced 5 visits were provided the week of 8/31-9/6/14 and 9/21-27/14. The record failed to evidence any orders to increase the visits.</p> <p>3. The agency's policy titled "Client Plan of Care" # 2.010 revised September, 2014, states, "2. The client plan of care: ... b. includes the following: ... ix. Frequency of needed services, ... 3. Changes in the plan of treatment are documented through written and signed physician orders."</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</p>			

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	<p>against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on observation, interview, and review of policy, the agency failed to ensure Medical Plans of Care (POC) included all durable medical equipment (DME) used by the patient for 1 of 1 home visit observation creating the potential to affect all the agency's patients. (#4)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. During home visit observation with patient #4 on 10/9/14 at 9:30 AM, DME observed in the home included a wheel chair, shower chair, and gait belt. The POC failed to evidence the wheel chair and shower chair. 2. During interview on 10/9/14 at 10:30 AM, employee D indicated the shower chair is used for all residents in this home, but it gets cleaned after each shower. 3. The agency's policy titled "Client Plan of Care," # 2.010, revised September, 2014, states "2. The client plan of care: ... b. includes the following: ... xiv. Medical supplies/appliances necessary (DME)." 	G000159	G-159 The Clinical Manager has in-serviced the nursing staff on agency policy # 2.010 Client Plan of Care (revised September 2014). In-service specifically includes re-training on the process of including all DME on the client's plan of care. Case Manager assigned to patient #4 referred to supervisor for coach and counsel. 10% of all clinical records will be reviewed quarterly for compliance with agency policy #2.010. Agency will continue random home observation visits (implemented September 2014) for compliance with this policy. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/15/2014

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N000000	<p>This was a revisit for the state home health agency complaint survey completed on August 26, 2014.</p> <p>Complaint #: IN00152278- Substantiated: State deficiencies related to the allegation were cited.</p> <p>Survey Date: October 9, 2014</p> <p>Facility #: 008749</p> <p>Medicaid Vendor #: 20065690A</p> <p>Surveyor: Miriam Bennett, RN, PHNS</p> <p>Two (2) deficiencies were found corrected during this survey. One deficiency was recited.</p> <p>Quality review: Joyce Elder, MSN, BSN, RN October 14, 2014</p>	N000000		
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</p>			

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	<p>and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure visits were provided as ordered on the plan of care (POC) for 2 of 3 clinical records reviewed and the physician was notified of missed visits for 1 of 3 clinical records reviewed creating the potential to affect all the agency's patients. (#s 2, and 3)</p> <p>Findings include</p> <p>1. Clinical record 2, start of care date (SOC) 9/17/14, contained a POC with orders for Skilled Nurse 4 hours, 2 mornings per week times 60 days. The record failed to evidence 4 hours of care were provided on 9/24, 10/1, and 10/2/14.</p> <p>A. The Nursing Flow Sheet dated 9/24/14 evidenced the nurse provided care from 8:00 AM-11:40 AM.</p> <p>B. The Nursing Flow Sheet dated 10/1/14 evidenced the nurse provided care from 8:00 AM-11:00 AM.</p> <p>C. The Nursing Flow Sheet dated 10/2/14 evidenced the nurse provided</p>	N000522	<p>N-0522</p> <p>The nursing staff has been in-serviced on agency policies #2.012 Client 60 Day Summaries and #2.010 Client Plan of Care (revised September 2014). In-service specifically includes:</p> <ul style="list-style-type: none"> -re-training on process of notifying physician of missed visits -reviewing missed visits in daily census meeting -adding a note to the client's plan of care to reflect changes due to client request -reviewing visit notes weekly to ensure "non-billable" items are clearly marked on the visit note. 10% of all clinical records will be audited quarterly for compliance with agency policies #2.012 and #2.010. <p>The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	11/15/2014

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	<p>care from 8:00 AM-11:15 AM.</p> <p>D. During interview on 10/8/14 at 1:30 PM, employee A indicated the primary caregiver lets the nurses leave when they are finished providing care because they don't need to stay.</p> <p>2. Clinical record #3, SOC 8/30/14 contained a POC with orders for Home Health Aide 2 hours, 4 times per week times 60 days.</p> <p>A. The record evidenced a Missed Visit/Shift Report dated 9/13/14. This form failed to evidence the physician was notified of the missed visit.</p> <p>B. During interview on 10/8/14 at 2:55 PM, employee B indicated the process was changed to notify the physicians weekly of missed visits, also on the next 60 day summaries, and the nurse completed the form but it looks like it did not get placed in the fax pile to notify the physician.</p> <p>C. The record evidenced 5 visits were provided the week of 8/31-9/6/14 and 9/21-27/14. The record failed to evidence any orders to increase the visits.</p> <p>3. The agency's policy titled "Client Plan of Care" # 2.010 revised September,</p>			

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	2014, states, "2. The client plan of care: ... b. includes the following: ... ix. Frequency of needed services, ... 3. Changes in the plan of treatment are documented through written and signed physician orders."				