

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151503	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/28/2013
NAME OF PROVIDER OR SUPPLIER VISITING NURSE & HOSPICE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5910 HOMESTEAD RD FORT WAYNE, IN 46814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0000	<p>This was a Hospice state licensure survey.</p> <p>Survey Dates: January 22, 23, 24, 25, and 28, 2013</p> <p>Facility Number: 005120</p> <p>Medicaid Number: 200141410</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN January 29, 2013</p>	S0000			

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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S0555	<p>418.56(e)(2) COORDINATION OF SERVICES [The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to-] (2) Ensure that the care and services are provided in accordance with the plan of care. Based on clinical record review, interview, and policy review, the hospice failed to ensure all Home Hospice Aide (HHA) visits were made as ordered on the plan of care and the hospice followed their own policy for documentation of missed visits for 1 of 16 clinical records reviewed, with the potential to affect all the hospice's patients receiving HHA services. (#8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Clinical record #8, SOC date 12/17/12, contained a Team Care Plan dated 12/17/12 with physician orders for HHA 2-3 times per week week for 13 weeks. The clinical record failed to evidence the HHA visits were conducted the week of 12/17-12/22/12 and failed to document the reason and how the patient's needs were met. The first HHA visit was conducted on 12/27/12. On 1/25/13 at 3:08 PM, employee O indicated the first week of visits by the HHA were missed because they were not 	S0555	<p>S 0555. The Vice President of Clinical Services inserviced the Home Health Aide Supervisor on 1/31/2013 regarding the tracking of Home Health Aide Visit orders with the new Visit Order Tracking Tool and the guide for tracking Home Health Aide Frequency Orders to ensure all visits are made according to the Plan of Care, and if not made, documentation of changes and communication to involved individuals will be documented in the patients electronic record. The Home Health Aide Supervisor began use of the Visit Order Tracking Tool on 2/1/2013 and will inservice Home Health Aides on 2/5/2013 on the guide for tracking Home Health Aide Frequency Orders. The Vice President of Clinical Services will meet with the Home Health Aide supervisor monthly to review the Visit Order Tracking Tool and audit these records monthly for three months for evidence that the Home Health Aide visits are made according to the plan of care. Thereafter, random audits will be conducted every three months as part of the quarterly agency's peer audit review</p>	02/05/2013
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	<p>sent a task request to schedule an aide for the patient.</p> <p>3. On 1/28/13 at 9:10 AM, employee J provided a procedure titled "Visit Cancellations and Missed Visits," revised 12-2009, and indicated this is the hospice's current procedure used for missed or canceled visits. The procedure states "Document all pertinent details in a clinical note, including: the date and type of visit missed, a reason why the visit was missed, make sure to connect the clinical note to the staff member who is recording the missed visit. Type in the missed visit information including discipline, date of visit(s) missed, reason missed, and how patient needs were met."</p> <p>5. During interview on 1/25/13 at 2:50 PM, employee H indicated they did not see a reason for the missed visits.</p>		process.		