

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/24/2013
NAME OF PROVIDER OR SUPPLIER  FORTE HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 808 A SOUTH HUNTINGTON STREET SYRACUSE, IN 46567		
(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	
G000000	<p>This was a home health federal complaint investigation survey.</p> <p>Complaint IN00136604 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Date: October 24, 2013</p> <p>Facility #: 012779</p> <p>Medicaid #: 201068710A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 28, 2013</p>	G000000			

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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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.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure home health aide services were provided as ordered in 1 of 4 records reviewed creating the potential to affect all 44 of the agency's patients. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 5/20/13, included a plan of care established by the physician for certification period 7/15 to 9/12/13 with orders for "HHA [home health aide] care - 10-12 hours per day, 5-6 days per week for a total of 60 hours per week to be determined by the agency and coordinated with the member and family to provide the most efficient schedule of care to meet the member's medical needs. "</p> <p>A. A document dated 4/22/13 titled "Nursing plan of care" states, "Frequency of care: 60 [hours] wk [week] HHA."</p> <p>B. The record evidenced home health aide services were provided on July 15, 16, 17, and 18, 2013, and totaled 42 hours</p>	G000158	The deficiency addressed in G 158 is pertaining to services from the previous certification period, and a client who is no longer receiving services through Forte HHC, and therefore cannot be corrected at this time. The facility is conducting a review of all current patients' weekly Summary of Hours sheet against the Plan of Care and other physician orders. Institution of new practice: To prevent this deficiency from recurring, Forte HHC Office Assistant will create a Family Correspondence file for each patient, in order to document all communications with patient and/or family. Institution of new form: Office Assistant will create a Missed Visit Log for each patient to document any missed visits and reasons for any decrease in weekly hours provided to the patient by home health aide services. Office Assistant will maintain Missed Visit Log weekly, and will provide a summary report to the Nursing Supervisor each week. This will be an ongoing practice. Forte Home Health Care Nursing Supervisor will be responsible for implementation this correction. These documents will	11/25/2013			

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	<p>for week 1.</p> <p>C. The record evidenced home health aide services were provided on August 19, 20, 21, 22 and 23, 2013, and totaled 49 hours for week 6.</p> <p>D. The record evidenced home health aide services were provided on August 26, 27, 28, 29 and 30, 2013, and totaled 50 hours for week 7.</p> <p>E. The record evidenced home health aide services were provided on September 2, 3, 4, 5 and 6, 2013, and totaled 49 hours for week 8.</p> <p>F. The record failed to evidence documentation for the missed hours or visits.</p> <p>2. On 10/24/13 at 3:08 PM, employee C indicated there was no documentation of the missed visits or reason for the decrease in weekly hours provided to the patient by home health aide services.</p> <p>3. The agency policy with a review date of 1/10/12 titled "4.5 Compliance &amp; Implementation" states, "Services will be provided in compliance with the health care provider 's order, plan of care, and needs of the family and client. ... ."</p>		be completed by November 13, 2013, and will be fully implemented by November 25, 2013.		

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G000159	<p><b>484.18(a)</b> <b>PLAN OF CARE</b> 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 against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record review and interview, the agency failed to ensure the plan of care identified the registered nurse had obtained a verbal order from the physician for services to be provided prior to the certification period beginning in 1 of 4 records reviewed creating the potential to affect all of the agency's current 44 patients. (#4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Clinical record #4, start of care of 4/22/13, evidenced a plan of care for certification period 9/21 to 11/19/13 that failed to evidence the registered nurse had obtained a verbal order for services to be provided prior to the beginning of the certification period.</li> <li>2. On 10/24/13 at 11:45 AM, employee C indicated the plan of care should have</li> </ol>	G000159	To correct this deficiency, on October 24, 2013, when the deficiency was noted, Forte HHC Nursing Supervisor reviewed and signed verbal order from physician for plan of care for certification period 9/21/13 to 11/19/13. Forte HHC Office Assistant is reviewing all current patient charts to ensure that no other patients are affected by this deficiency, verifying that all orders have been signed by both the ordering physician and nurse who received the order. A review of the policy on Verbal Orders was conducted by the Administrator and Nurse Supervisor. To prevent this deficiency from recurring in the future, the Administrator of Forte Home Health Care will institute a change to the Verbal Order Policy to specify that the nurse sign the Verbal Order at the time it is received. Policy will be updated by 11/13/13. All office staff and will receive a copy of the updated policy by 11/25/13, and policy will be implemented at that	11/25/2013	

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	been signed by the registered nurse before sending it to the physician.		time. Training conducted on 11/7/13 for office staff, instructing them to review all verbal orders for nurse signature prior to submission to ordering physician. Administrator of Forte HHC to be responsible for implementation of this policy update. All current patients' orders will be audited quarterly by office assistant. Results of this audit will be submitted to and reviewed by Professional Advisory Committee quarterly, indefinitely. Will be implemented by 11/25/13.		

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G000339	<p>484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on clinical record review and interview, the agency failed to ensure the comprehensive assessment was updated and revised during the last 5 days of the certification period in 1 of 4 records reviewed creating the potential to affect all 44 of the agency's patients. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 5/20/13 and discharge date of 9/11/13, contained a physicians plan of care for certification period 7/15 to 9/12/13. A one page document signed by the registered nurse and dated 7/15/13 titled "Supervisor and Reassessment Visit" states, "Patient Medical Status: no change Patient medications: no change Fall Risk Assessment: no change Comprehensive Assessment: no change Nursing Plan of care: no change." The record failed to evidence a comprehensive assessment, with the collection of data,</p>	G000339	<p>Clinical record addressed in this deficiency cannot be corrected as assessment mentioned took place on 7/15/13. New assessment documentation of this this patient is not possible as patient is no longer receiving services through Forte HHC. Current patient charts were reviewed for assessment documentation. It was noted that new Comprehensive Assessment documentation forms are needed in order to more accurately document each assessment. Institution of new forms: To prevent the deficiency from recurring, Forte Corporate Office Manager is creating a new Comprehensive Nursing Assessment Form which will be completed by November 13, 2013, to ensure that each comprehensive assessment is documented thoroughly. Forte HHC will implement the use of this form by November 25, 2013. Completion of comprehensive assessments will be tracked on client calendar and will be reviewed monthly at staff</p>	11/25/2013
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	<p>had been completed.</p> <p>2. On 10/24/13 at 1:58 PM, employee C indicated the form dated 7/15/13 titled "Supervisory and Reassessment Visit" was the comprehensive assessment for the new certification period.</p>		<p>meetings, indefinitely. Forte Home Health Care Nursing Supervisor will be responsible for implementation of this correction. This correction will be fully implemented by November 25, 2013.</p>		

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G000341	<p>484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on clinical record review and interview, the agency failed to ensure the comprehensive assessment was updated and revised at discharge in 1 of 2 discharge records reviewed creating the potential to affect all discharged patients. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, discharge date of 9/11/13, included a one page document signed by the registered nurse and dated 9/7/13 titled "Supervisor and Reassessment Visit" states, "Patient Medical Status: no change Patient medications: no change Fall Risk Assessment: no change Comprehensive Assessment: no change Nursing Plan of care: no change." The record failed to evidence a discharge assessment, with the collection of data, had been completed.</p> <p>2. On 10/24/13 at 2:20 PM, employee C indicated the document dated 9/7/13 titled "Supervisory and Reassessment Visit" was the discharge assessment.</p>	G000341	<p>Clinical record addressed in this deficiency cannot be corrected as assessment mentioned occurred on 9/11/13, and patient is no longer receiving services through Forte HHC. Implementation of new form: To prevent the deficiency from recurring, Forte Home Health Care Office Assistant will create a new Discharge Nursing Assessment Form by November 13, 2013. This form will be fully implemented to use by November 25, 2013. Nursing Supervisor will review Discharge Assessment of each patient who is discharged from care, within one week of completion of Discharge Assessment. Forte Home Health Care Nursing Supervisor will be responsible for implementation of this correction. This correction will be fully implemented by November 25, 2013.</p>	11/25/2013			

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N000000	<p>This was a home health state complaint investigation survey.</p> <p>Complaint IN00136604 - Substantiated: State deficiencies related to the allegation are cited. Unrelated deficiencies are cited.</p> <p>Survey Date: October 24, 2013</p> <p>Facility #: 012779</p> <p>Medicaid #: 201068710A</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 28, 2013</p>	N000000			

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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 home health aide services were provided as ordered in 1 of 4 records reviewed creating the potential to affect all 44 of the agency's patients. (#1)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 5/20/13, included a plan of care established by the physician for certification period 7/15 to 9/12/13 with orders for "HHA [home health aide] care - 10-12 hours per day, 5-6 days per week for a total of 60 hours per week to be determined by the agency and coordinated with the member and family to provide the most efficient schedule of care to meet the member's medical needs. "</p> <p>A. A document dated 4/22/13 titled "Nursing plan of care" states, "Frequency of care: 60 [hours] wk [week] HHA."</p> <p>B. The record evidenced home health aide services were provided on July 15, 16, 17, and 18, 2013, and totaled 42 hours</p>	N000522	<p>The deficiency addressed is pertaining to services from a previous certification period, for a client who no longer receives services through Forte HHC, and therefore cannot be corrected at this time. The facility is conducting a review of all current patients' weekly Summary of Hours sheet against the Plan of Care and other physician orders. Institution of new practice: To prevent this deficiency from recurring, Forte HHC Office Assistant will create a Family Correspondence file for each patient, in order to document all communications with patient and/or family. Institution of new form: Office Assistant will create a Missed Visit Log for each patient to document any missed visits and reasons for any decrease in weekly hours provided to the patient by home health aide services. Office Assistant will maintain Missed Visit Log weekly, and will provide a summary report to the Nursing Supervisor each week. This will be an ongoing practice. Forte Home Health Care Nursing Supervisor will be responsible for implementation of this correction. These documents will be created</p>	11/25/2013			

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	<p>for week 1.</p> <p>C. The record evidenced home health aide services were provided on August 19, 20, 21, 22 and 23, 2013, and totaled 49 hours for week 6.</p> <p>D. The record evidenced home health aide services were provided on August 26, 27, 28, 29 and 30, 2013, and totaled 50 hours for week 7.</p> <p>E. The record evidenced home health aide services were provided on September 2, 3, 4, 5 and 6, 2013, and totaled 49 hours for week 8.</p> <p>F. The record failed to evidence documentation for the missed hours or visits.</p> <p>2. On 10/24/13 at 3:08 PM, employee C indicated there was no documentation of the missed visits or reason for the decrease in weekly hours provided to the patient by home health aide services.</p> <p>3. The agency policy with a review date of 1/10/12 titled "4.5 Compliance &amp; Implementation" states, "Services will be provided in compliance with the health care provider 's order, plan of care, and needs of the family and client. ... ."</p>		by November 13, 2013, and will be fully implemented by November 25, 2013.		

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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"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record review and interview, the agency failed to ensure the plan of care identified the registered nurse had obtained a verbal order from the physician for services to be provided prior to the certification period beginning in 1 of 4 records reviewed creating the potential to affect all of the agency's current 44 patients. (#4)</p> <p>Findings include:</p>	N000524	To correct this deficiency, on October 24, 2013, when the deficiency was noted, Forte HHC Nursing Supervisor reviewed and signed verbal order from physician for plan of care for certification period 9/21/13 to 11/19/13. Forte HHC Office Assistant is reviewing all current patient charts to ensure that no other patients are affected by this deficiency, verifying that all orders have been signed by both the ordering physician and nurse who received the order. A review of the	11/25/2013			

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	<p>1. Clinical record #4, start of care of 4/22/13, evidenced a plan of care for certification period 9/21 to 11/19/13 that failed to evidence the registered nurse had obtained a verbal order for services to be provided prior to the beginning of the certification period.</p> <p>2. On 10/24/13 at 11:45 AM, employee C indicated the plan of care should have been signed by the registered nurse before sending it to the physician.</p>		<p>policy on Verbal Orders was conducted by the Administrator and Nurse Supervisor. To prevent this deficiency from recurring in the future, the Administrator of Forte Home Health Care will institute a change to the Verbal Order Policy to specify that the nurse sign the Verbal Order at the time it is received. Policy will be updated by 11/13/13. All office staff and will receive a copy of the updated policy by 11/25/13, and policy will be implemented at that time. Training conducted on 11/7/13 for office staff, instructing them to review all verbal orders for nurse signature prior to submission to ordering physician. Administrator of Forte HHC to be responsible for implementation of this policy update. All current patients' orders will be audited quarterly by office assistant. Results of this audit will be submitted to and reviewed by Professional Advisory Committee quarterly, indefinitely. Will be implemented by 11/25/13.</p>		