

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2014
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NAME OF PROVIDER OR SUPPLIER AM HOME HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 HOBSON ROAD, SUITE 104 FORT WAYNE, IN 46815
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N000000	This was a home health initial state licensure survey Survey dates: April 8 and 9, 2014 Facility Number: 013209 Surveyor: Miriam Bennett, RN, BSN, PHNS Census Service Type: Skilled: 3 Home Health Aide Only: 1 Personal Care Only: 0 Total: 4 Sample: RR w/HV: 3 RR w/o HV: 4 Total: 4 Quality Review: Joyce Elder, MSN, BSN, RN April 11, 2014 410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications.	N000000		
N000458				

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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N000466	<p>(3) A copy of limited criminal history pursuant to IC 16-27-2.</p> <p>(4) A copy of current license, certification, or registration.</p> <p>(5) Annual performance evaluations.</p> <p>Based on employee file review and policy review, the agency failed to ensure employee files contained a job description for 1 of 5 files reviewed (E) with the potential to affect all the agency's patients.</p> <p>Findings include</p> <p>1. Employee file E failed to evidence a job description.</p> <p>2. The agency's undated policy titled "Personnel Policies and Records," #1.26 states, "Personnel records shall contain the following: 1. documentation that indicates receipt of orientation and job description." 410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the:</p> <p>(1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k).</p> <p>Based on employee file review, policy review, and interview, the agency failed to ensure medical information was kept separate and confidential from personnel information for 5 of 5 employee files reviewed with the</p>	N000458	The Administrator has inserviced the Staffing Coordinator that all employee files must contain a written job description as evidenced by 410 IAC17-12-1(f) and also by AM Home Health Care's Policies and Procedures Manual. Employees files have been updated to include current job descriptions. The Administrator will be responsible for monitoring the above corrective action to ensure this type of deficiency is corrected and will not recur in the future.	04/10/2014
		N000466	The Administrator has inserviced the Staffing Coordinator that all employee medical files must be keep in a separate folder or file and clearly marked as "confidential" and treated as a confidential medical record as	

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N000488	<p>potential to affect all the agency's employees. (A, B, C, D, and E)</p> <p>Findings include</p> <ol style="list-style-type: none"> 1. Employee file A contained an envelope marked "Confidential" that included a criminal history, chest x-ray, and physical. 2. Employee file B contained an envelope marked "Confidential" that included a criminal history and Mantoux record. 3. Employee file C contained an envelope marked "Confidential" that included a criminal history, physical, and Mantoux record. 4. Employee file D contained an envelope marked "Confidential" that included a criminal history, chest x-ray, and physical. 5. Employee file E contained an envelope marked "Confidential" that included a criminal history, chest x-ray, and physical. 6. On 4/8/14 at 1:10 PM, employee C indicated they think the home health packet the owner ordered does say the medical information needs to be separate and confidential. 7. The agency's undated policy titled "Personnel Policies and Records," #1.26 states, "Personnel records shall contain the following: ... 3. Records of a health nature, including Mantoux results or chest x-ray results, which are filed separately and marked confidential." <p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy</p>		evidenced by 410 IAC17-12-1(f) and also by AM Home Health Care's Policies and Procedures Manual. All employee files have been corrected and all medical files are in a separate folder and marked confidential. The Administrator will be responsible for monitoring the above corrective action to ensure this type of deficiency is corrected and will not recur in the future.	

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	<p>requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances:</p> <p>(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.</p> <p>(2) The patient refuses the home health agency's services.</p> <p>(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or</p> <p>(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on policy review and interview, the agency failed to ensure the discharge policy included information that the agency would continue, in good faith, to attempt to provide services during the 5 day period of discharge for 1 of 1 discharge policy with the potential to affect all patients who are discharged from the agency.</p> <p>Findings include</p> <p>1. The agency's undated policy titled</p>	N000488	The Administrator has amended AM Home Health Care's Policy #2.17 "Discharge/Transfer Policy" to reflect compliance with 410 IAC 17-12-2(i) and (j) that the agency would continue, in good faith, to attempt to provide services during the 5 day period of discharge as evidenced by the revised policy statement that " All effort by the agency will be made to accommodate and staff the client/patient during the 5 day discharge period."	04/10/2014

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N000518	<p>"Discharge/Transfer Policy," # 2.17 failed to evidence the agency would continue, in good faith, to attempt to provide services during the 5 day period of discharge.</p> <p>2. On 4/8/14 at 2:15 PM, employee C indicated the five day coverage in good faith is not in the policy. 410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.</p> <p>Based on admission packet review, observation, policy review, and interview, the agency failed to ensure the current Advance Directives packets were received by the patients upon admission to the agency for 3 of 3 home visit admission packet observations with the potential to affect all the agency's patients. (#1, 2, and 3)</p> <p>Findings include</p> <p>1. The agency's admission packet reviewed contained the Indiana State Department of Health Advance Directives packet revised May 2004. The packet failed to evidence the current revised Advance Directives dated July 2013.</p> <p>2. On 4/8/14 at 1:50 PM, employee C</p>	N000518	<p>No future monitoring will be required as AM Home Health Care's Policy #2.17 has been changed to immediately reflect the appropriate revision.</p> <p>The updated and most current copy of Indiana's Advanced Directives has been printed and replaced in all New Patient Admission Packets for future admissions and new copies have been given to each current patient and will be maintained in their home admission packet. The Administrator will be responsible for monitoring the above corrective action to ensure this type of deficiency is corrected and will not recur in the future. The Administrator will be responsible for making sure the agency has the most updated edition of Indiana's Advanced Directives at all times.</p>				

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N000524	<p>indicated the May 2004 Advanced Directives is the only one the agency has and they did not know there was a new one.</p> <p>3. During home visit observation with patient #1 on 4/9/14 at 10:00 AM, the admission packet in the home failed to evidence a 2013 copy of the Indiana State Department of Health Advance Directives.</p> <p>4. During home visit observation with patient #2 on 4/9/14 at 10:30 AM, the admission packet in the home failed to evidence a 2013 copy of the Indiana State Department of Health Advance Directives.</p> <p>5. During home visit observation with patient #3 on 4/9/14 at 11:00 AM, the admission packet in the home failed to evidence a 2013 copy of the Indiana State Department of Health Advance Directives.</p> <p>6. On 4/9/14 at 10:28 AM, employee C indicated the Advance Directives were in each admission folder and read by the interpreter with each patient. Each patient signed the acknowledgement of receipt of the packet, but they were the old packets.</p> <p>7. The agency's undated policy titled "Advance Directives," # 2.86 states, "Procedure: 1. during the admission visit, the admitting qualifying staff member will: ... c. Provide the patient/client with written and verbal information regarding: ... i. State Advance Directive Guidelines." 410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff.</p>			

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	<p>(B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the plan of care included duration of time for visits and the dates for the time frame of the care period were correct for 4 of 4 clinical records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, and 4)</p> <p>Findings include</p> <ol style="list-style-type: none"> Clinical record #1, start of care date (SOC) 3/19/14, contained a Home Health Certification and Plan of Care (POC) dated 3/19-4/17/14 with orders for skilled nursing (SN) 1 time a week. The POC failed to include a duration of SN services. Clinical record #2, SOC 3/19/14, 	N000524	<p>The Administrator has inserviced the Director of Nursing on correct frequency and duration of visits to be included on the Plan of Care. All patient's Plans of Care have been revised to reflect a corrected 60 day time frame and have been re-faxed to their respective physicians for signature.</p> <p>The Administrator will be responsible for monitoring the above corrective action to ensure this type of deficiency is corrected and will not recur in the future.</p>	04/10/2014

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	<p>contained a POC dated 3/19-4/17/14 with orders for SN 1 time a week. The POC failed to include a duration of SN services.</p> <p>3. Clinical record #3, SOC 3/18/14, contained a POC dated 3/18-4/16/14 with orders for SN times 1 visit every 30 days for supervision of home health aide (HHA) and HHA 1-2 hours a week, two times a week ... times 60 day certification period. The POC failed to include a duration of SN services, and the certification period dates failed to evidence a 60 day time frame as ordered. The dates should have been 3/18-5/16/14 for a 60 day time frame.</p> <p>4. Clinical record #4, SOC 3/18/14, contained a POC dated 3/18-4/16/14 with orders for SN 1 time weekly. The POC failed to evidence a duration for SN services.</p> <p>5. On 4/9/14 at 3:10 PM, employee C indicated they looked at the wrong dates when creating the POC and forgot about the duration of services because they are used to using software to create the POC.</p> <p>6. The agency's undated policy titled "Care Plan," # 2.8 states, "Steps to be taken in developing the care plan include: 1. Collection of baseline data including all pertinent diagnoses, ... frequency and duration of visits."</p>			