

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
--------------------	--	---------------	---	----------------------

G 0000  Bldg. 00	<p>This was a revisit for the Federal home health recertification survey completed on July 7, 2016</p> <p>Survey Date: August 17 and 18, 2016</p> <p>Facility #: 004219</p> <p>Medicaid Vendor #: 200889890B</p> <p>Sample: RR w/HV: 2 RR w/o HV: 3 Total: 5</p> <p>During this survey, 1 Condition of Participation and 14 standard level deficiencies were found corrected. One (1) Condition was re-cited, and one (1) standard level deficiency was re-cited.</p> <p>Homepoinet Healthcare is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning August 18, 2016, for being found out of compliance with the Conditions of Participation 42 CFR 484.48: Clinical Records.</p>	G 0000		
------------------------	---	--------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
G 0176  Bldg. 00	<p>484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on document review, observation, and interview, the agency failed to ensure the nursing staff prepared clinical notes and documented per policy for 2 of 5 clinical records reviewed. (# 2 and 4)</p> <p>Findings include</p> <p>1. Clinical record # 2 was reviewed on 8/17/16. Start of care date 7/14/08. The plan of care dated 6/26-8/24/16 contained orders for skilled nursing (SN) 8-12 hours a day, 3-5 days a week; diagnosis Unspecified Spina Bifida with hydrocephalus, Presence of CSF [cerebrospinal fluid] drainage device; total fluid goal of 2000 mL [milliliters] a day which includes enteral nutrition (formula) to be given at parents' discretion; and If heart rate &gt; 100 bpm [beats per minute] in morning, may give extra 120 mL (4 ounces) water to</p>	G 0176	<p>Nursing documentation in-service was sent on 7/22/16. On 8/15/16, the Director sent out an emailmessage to staff that had not turned in their in-service to date. This message is part of the employee timereporting system, so the message must be read before their time worked can beentered. The office has received 100%of the in-service completed by staff. Currentclient charts have been audited and the agency will continue with the auditprocess. Audits are being performed byour team which includes the following: Administrator, Regional Director,Director, Clinical Care Managers (CCM) and an internal compliance RegisteredNurse. Nursing flowsheets, medication administrationrecords and physician orders were reviewed and compared to the current485. If new orders are indicated theywill be obtained. All</p>	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>increase volume; regular diet with no "fluid restrictions." Patient also has urostomy drainage bag. Goals section stated "To achieve/maintain adequate nutrition &amp; hydration PO [by mouth]/enterally. ... To keep [patient] free of illness or complications (especially UTI [Urinary Tract Infection] or URI [Upper Respiratory Infection]) and out of the hospital. To monitor fiord signs of shunt malfunction &amp; intervene promptly." The record failed to evidence the nurses totaled the Intake for monitoring intake and fluid goals.</p> <p>A. The Nursing Flow Sheet dated 7/25/16 by employee D, RN (Registered Nurse), failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>B. The Nursing Flow Sheet dated 7/28/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>C. The Nursing Flow Sheet dated 7/29/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>D. The Nursing Flow Sheet dated 8/4/16 by employee D, RN, failed to evidence the patient's total fluid intake</p>		<p>nursing flowsheetsare being audited for accuracy/compliance with the 485. All nursing flowsheets are being audited fortotals of input and output (I&amp;O) to ensure that physician orders and orgoals are being met. If there is nursing documentation that fallsout of compliance, the nurse will receive a phone call and will be instructedon areas in need of improvement. A "Nursing Flow Sheet Audit Form-SurveyFollow Up" will also be completed. Toensure ongoing accuracy, all sections of the 485 will be reviewed with thecurrent nurse and/or caregiver during the home supervisory visits. To ensurecontinued compliance, 10% or 10 charts will be audited quarterly by theDirector/CCM.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
--------------------	--	---------------	---	----------------------

	<p>had been calculated for the shift.</p> <p>E. The Nursing Flow Sheet dated 8/5/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>F. The Nursing Flow Sheet dated 8/12/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>G. During home visit with patient # 2 on 8/18/16 at 9:15 AM, employee D was observed administering extra fluid as ordered for heart rate over 100 bpm. During interview, employee D stated the extra fluid (water) is to help keep the patient's kidneys flushed and clean.</p> <p>2. Clinical record # 4 was reviewed on 8/18/16. Start of care date 1/4/11. The plan of care dated 8/1-9/29/16 contained orders for SN 6-14 hours a day 4-6 days a week; Peptamen Junior 120 mL per G tube bolus every 3 hours during day; diagnosis Cerebral Palsy and other diagnosis Hydrocephalus; Goals included to achieve/maintain adequate nutrition &amp; hydration either enterally or PO. The record failed to evidence the nurses totaled the Intake for monitoring intake goals.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>A. The Nursing Flow Sheet dated 8/8/16 by employee G, LPN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>B. The document titled "Hand and Glove Hygiene and Documentation Review IN-Service Receipt" was signed by employee G on 8/15/16, and the agency received it on 8/18/16.</p> <p>C. During interview on 8/18/16 at 1:30 PM, employee A stated yea it's not totaled (in response to the 8/8 missing documentation for patient # 4).</p> <p>3. During interview on 8/17/16 at 2:30 PM, employee A (Nursing Supervisor) stated the nurses should be totaling the intake each day, and he has been auditing records but it is a random sample, and when he see holes he writes it up.</p> <p>4. During interview on 8/17/16 at 2:40 PM, employee B (Administrator) stated she does not expect the total intake to be documented for a patient who is not on fluid restrictions.</p> <p>5. During home visit observation with patient # 1 on 8/17/16 at 8:30 AM, employee B Licensed Practical Nurse (LPN) stated he always totals up intake and output and if the previous nurse did</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>not place totals then he could add it up because the agency leaves carbon copies of documentation in the patients' homes.</p> <p>6. The nursing in-service for Hand washing and documentation was provided on 8/17/16 by employee A who stated the agency mailed the in-services to the nursing staff on 7/22/16. A list of employees' last names with notation of whether or not they were received back by the agency was also provided. This document was dated 8/17/16 and failed to evidence employee D had returned the signed in-service to the agency as of 8/18/16.</p> <p>7. A copy of an email message was provided on 8/18/16 by employee A who stated he sent this email on 8/15/16 to the remaining staff who had not yet returned the in-service forms; the email stated "Subject: Reminder ... Hello All, Just a reminder. For those who have not turned in their signed In-Service that you received in the mail. We need those ASAP [as soon as possible]. If we don't get them in the next 2 weeks, we will have to bring you into the office to perform the In-Service. This will be mandatory."</p> <p>8. During interview on 8/18/16 at 2:25 PM, employee A provided an updated list</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>of employees who had returned the in-service documents (still dated as 8/17/16) and stated he does not have [employee D's] in-service back yet but he called him and was told it is in the mail.</p> <p>9. The agency's policy titled "Clinical Documentation," # C-680, revised 2/9/15 stated "PURPOSE To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care ... PROCEDURE A. All skilled services provided by Nursing ... will be documented in the clinical record. ... C. Additional information that is pertinent to the client's care or condition may be documented on an addendum. ... E. Documentation of services ordered on the Plan of Care will be completed the day and time service is rendered."</p> <p>10. The 4 page document titled "Nursing Documentation Review," was provided on 8/18/16 at 2:00 PM by employee A who stated this is the nitre in-service document mailed to staff. This document stated "The purpose of this review is to guide you through HPHC documentation requirements. ... Nursing documentation is also a direct reflection of what is contained in the Plan of Care (POC)/485 as directed by the primary physician. All</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
G 0235  Bldg. 00	<p>care and documented care should reflect what is contained in the client orders. ... Page 3: Intake, Output and Narrative Record ... Make sure yo document all intake and output for your client during the shift; place the numbers in the correct boxes. Also the totals should be tallied across for each hours and then on the bottom for each category. Lastly the shift total at the bottom of the section should be completed for all intake and output. Amounts should be clearly marked. ... Record the amount in oz [ounces] or mLs. ... Narrative Notes: ... Sometimes it is easy to get lax in charting due to the fact that the client's care can sometimes be the same every day, or when you fee really comfortable with the family and the nursing team and assume they can "fill in the blanks." ... Be specific and record important details."</p> <p>484.48 CLINICAL RECORDS</p> <p>Based on document review, observation, and interview, the agency failed to ensure the nursing staff prepared clinical notes and documented per policy for 2 of 5 clinical records reviewed (See G 236).</p>	G 0235	Credible Allegation of Compliance Action: Nursing documentation in-service was sent on7/22/16. On 8/15/16, the Director sentout an email message to staff that had not turned in their in-service todate.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48 Clinical Records.		This message is part of the employee time reporting system, so the message must be read before their time worked can be entered. The office has received 100% of the in-service completed by staff. Current client charts have been audited and the agency will continue with the audit process. Audits are being performed by our team which includes the following: Administrator, Regional Director, Director, Clinical Care Managers (CCM) and an internal compliance Registered Nurse. Nursing flowsheets, medication administration records and physician orders were reviewed and compared to the current 485. If new orders are indicated they will be obtained. All nursing flowsheets are being audited for accuracy/compliance with the 485. All nursing flowsheets are being audited for totals of input and output (I&O) to ensure that physician orders and goals are being met. If there is nursing documentation that falls out of compliance, the nurse will receive a phone call and will be instructed on areas in need of improvement. A "Nursing Flow Sheet Audit Form-Survey Follow Up" will also be completed. To ensure ongoing accuracy, all sections of the 485 will be reviewed with the current nurse and/or caregiver during the home supervisory visits. To ensure continued compliance, 10% or 10 charts will be audited	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
G 0236  Bldg. 00	<p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>Based on document review, observation, and interview, the agency failed to ensure the nursing staff prepared clinical notes and documented per policy for 2 of 5 clinical records reviewed. (# 2 and 4)</p> <p>Findings include</p> <p>1. Clinical record # 2 was reviewed on 8/17/16. Start of care date 7/14/08. The plan of care dated 6/26-8/24/16 contained orders for skilled nursing (SN) 8-12 hours a day, 3-5 days a week; diagnosis Unspecified Spina Bifida with hydrocephalus, Presence of CSF [cerebrospinal fluid] drainage device; total fluid goal of 2000 mL [milliliters] a day which includes enteral nutrition (formula) to be given at parents' discretion; and If heart rate &gt; 100 bpm [beats per minute] in morning, may give</p>	G 0236	<p>quarterly by the Director/CCM.</p> <p>Nursing documentation in-service was sent on 7/22/16. On 8/15/16, the Director sent out an email message to staff that had not turned in their in-service to date. This message is part of the employee time reporting system, so the message must be read before their time worked can be entered. The office has received 100% of the in-service completed by staff. Current client charts have been audited and the agency will continue with the audit process. Audits are being performed by our team which includes the following: Administrator, Regional Director, Director, Clinical Care Managers (CCM) and an internal compliance Registered Nurse. Nursing flowsheets, medication administration records and physician orders were reviewed and compared to the current 485. If new orders are indicated</p>	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>extra 120 mL (4 ounces) water to increase volume; regular diet with no "fluid restrictions." Patient also has urostomy drainage bag. Goals section stated "To achieve/maintain adequate nutrition &amp; hydration PO [by mouth]/enterally. ... To keep [patient] free of illness or complications (especially UTI [Urinary Tract Infection] or URI [Upper Respiratory Infection]) and out of the hospital. To monitor for signs of shunt malfunction &amp; intervene promptly." The record failed to evidence the nurses totaled the Intake for monitoring intake and fluid goals.</p> <p>A. The Nursing Flow Sheet dated 7/25/16 by employee D, RN (Registered Nurse), failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>B. The Nursing Flow Sheet dated 7/28/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>C. The Nursing Flow Sheet dated 7/29/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>D. The Nursing Flow Sheet dated 8/4/16 by employee D, RN, failed to</p>		<p>theywill be obtained. All nursing flowsheetsare being audited for accuracy/compliance with the 485. All nursing flowsheets are being audited for totals of input and output (I&amp;O) to ensure that physician orders and orgoals are being met. If there isnursing documentation that falls out of compliance, the nurse will receive aphone call and will be instructed on areas in need of improvement. A "Nursing Flow Sheet Audit Form- SurveyFollow Up" will also be completed. Toensure ongoing accuracy, all sections of the 485 will be reviewed with thecurrent nurse and/or caregiver during the home supervisory visits. To ensurecontinued compliance, 10% or 10 charts will be audited quarterly by theDirector/CCM.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>evidence the patient's total fluid intake had been calculated for the shift.</p> <p>E. The Nursing Flow Sheet dated 8/5/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>F. The Nursing Flow Sheet dated 8/12/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>G. During home visit with patient # 2 on 8/18/16 at 9:15 AM, employee D was observed administering extra fluid as ordered for heart rate over 100 bpm. During interview, employee D stated the extra fluid (water) is to help keep the patient's kidneys flushed and clean.</p> <p>2. Clinical record # 4 was reviewed on 8/18/16. Start of care date 1/4/11. The plan of care dated 8/1-9/29/16 contained orders for SN 6-14 hours a day 4-6 days a week; Peptamen Junior 120 mL per G tube bolus every 3 hours during day; diagnosis Cerebral Palsy and other diagnosis Hydrocephalus; Goals included to achieve/maintain adequate nutrition &amp; hydration either enterally or PO. The record failed to evidence the nurses totaled the Intake for monitoring intake goals.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>A. The Nursing Flow Sheet dated 8/8/16 by employee G, LPN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>B. The document titled "Hand and Glove Hygiene and Documentation Review IN-Service Receipt" was signed by employee G on 8/15/16, and the agency received it on 8/18/16.</p> <p>C. During interview on 8/18/16 at 1:30 PM, employee A stated yea it's not totaled (in response to the 8/8 missing documentation for patient # 4).</p> <p>3. During interview on 8/17/16 at 2:30 PM, employee A (Nursing Supervisor) stated the nurses should be totaling the intake each day, and he has been auditing records but it is a random sample, and when he see holes he writes it up.</p> <p>4. During interview on 8/17/16 at 2:40 PM, employee B (Administrator) stated she does not expect the total intake to be documented for a patient who is not on fluid restrictions.</p> <p>5. During home visit observation with patient # 1 on 8/17/16 at 8:30 AM, employee B Licensed Practical Nurse (LPN) stated he always totals up intake</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>and output and if the previous nurse did not place totals then he could add it up because the agency leaves carbon copies of documentation in the patients' homes.</p> <p>6. The nursing in-service for Hand washing and documentation was provided on 8/17/16 by employee A who stated the agency mailed the in-services to the nursing staff on 7/22/16. A list of employees' last names with notation of whether or not they were received back by the agency was also provided. This document was dated 8/17/16 and failed to evidence employee D had returned the signed in-service to the agency as of 8/18/16.</p> <p>7. A copy of an email message was provided on 8/18/16 by employee A who stated he sent this email on 8/15/16 to the remaining staff who had not yet returned the in-service forms; the email stated "Subject: Reminder ... Hello All, Just a reminder. For those who have not turned in their signed In-Service that you received in the mail. We need those ASAP [as soon as possible]. If we don't get them in the next 2 weeks, we will have to bring you into the office to perform the In-Service. This will be mandatory."</p> <p>8. During interview on 8/18/16 at 2:25</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>PM, employee A provided an updated list of employees who had returned the in-service documents (still dated as 8/17/16) and stated he does not have [employee D's] in-service back yet but he called him and was told it is in the mail.</p> <p>9. The agency's policy titled "Clinical Documentation," # C-680, revised 2/9/15 stated "PURPOSE To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care ... PROCEDURE A. All skilled services provided by Nursing ... will be documented in the clinical record. ... C. Additional information that is pertinent to the client's care or condition may be documented on an addendum. ... E. Documentation of services ordered on the Plan of Care will be completed the day and time service is rendered."</p> <p>10. The 4 page document titled "Nursing Documentation Review," was provided on 8/18/16 at 2:00 PM by employee A who stated this is the nitre in-service document mailed to staff. This document stated "The purpose of this review is to guide you through HPHC documentation requirements. ... Nursing documentation is also a direct reflection of what is contained in the Plan of Care (POC)/485</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
N 0000  Bldg. 00	<p>as directed by the primary physician. All care and documented care should reflect what is contained in the client orders. ... Page 3: Intake, Output and Narrative Record ... Make sure yo document all intake and output for your client during the shift; place the numbers in the correct boxes. Also the totals should be tallied across for each hours and then on the bottom for each category. Lastly the shift total at the bottom of the section should be completed for all intake and output. Amounts should be clearly marked. ... Record the amount in oz [ounces] or mLs. ... Narrative Notes: ... Sometimes it is easy to get lax in charting due to the fact that the client's care can sometimes be the same every day, or when you fee really comfortable with the family and the nursing team and assume they can "fill in the blanks." ... Be specific and record important details."</p> <p>This was a revisit for the home health state licensure survey completed on July 7, 2016</p>	N 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
--------------------	--	---------------	---	----------------------

N 0544 Bldg. 00	<p>Survey Date: August 17 and 18, 2016</p> <p>Facility #: 004219</p> <p>Medicaid Vendor #: 200889890B</p> <p>Sample: RR w/HV: 2 RR w/o HV: 3 Total: 5</p> <p>410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on document review, observation, and interview, the agency failed to ensure the nursing staff prepared clinical notes and documented per policy for 2 of 5 clinical records reviewed. (# 2 and 4)</p>	N 0544	Nursing documentation in-service was sent on 7/22/16. On 8/15/16, the Director sent out an email message to staff that had not turned in their in-service to date. This message is part of the employee time reporting system, so the message	09/02/2016
--------------------	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>Findings include</p> <p>1. Clinical record # 2 was reviewed on 8/17/16. Start of care date 7/14/08. The plan of care dated 6/26-8/24/16 contained orders for skilled nursing (SN) 8-12 hours a day, 3-5 days a week; diagnosis Unspecified Spina Bifida with hydrocephalus, Presence of CSF [cerebrospinal fluid] drainage device; total fluid goal of 2000 mL [milliliters] a day which includes enteral nutrition (formula) to be given at parents' discretion; and If heart rate &gt; 100 bpm [beats per minute] in morning, may give extra 120 mL (4 ounces) water to increase volume; regular diet with no "fluid restrictions." Patient also has urostomy drainage bag. Goals section stated "To achieve/maintain adequate nutrition &amp; hydration PO [by mouth]/enterally. ... To keep [patient] free of illness or complications (especially UTI [Urinary Tract Infection] or URI [Upper Respiratory Infection]) and out of the hospital. To monitor fiord signs of shunt malfunction &amp; intervene promptly." The record failed to evidence the nurses totaled the Intake for monitoring intake and fluid goals.</p> <p>A. The Nursing Flow Sheet dated 7/25/16 by employee D, RN (Registered Nurse), failed to evidence the patient's</p>		<p>must be read before their timeworked can be entered. The office hasreceived 100% of the in-service completed by staff. Current client charts have been audited andthe agency will continue with the audit process. Audits are being performed by our team whichincludes the following: Administrator, Regional Director, Director, ClinicalCare Managers (CCM) and an internal compliance Registered Nurse. Nursing flowsheets, medication administrationrecords and physician orders were reviewed and compared to the current485. If new orders are indicated theywill be obtained. All nursing flowsheetsare being audited for accuracy/compliance with the 485. All nursing flowsheets are being audited fortotals of input and output (I&amp;O) to ensure that physician orders and orgoals are being met. If there isnursing documentation that falls out of compliance, the nurse will receive aphone call and will be instructed on areas in need of improvement. A "Nursing Flow Sheet Audit Form-SurveyFollow Up" will also be completed. Toensure ongoing accuracy, all sections of the 485 will be reviewed with thecurrent nurse and/or caregiver during the home supervisory visits. To ensurecontinued compliance, 10% or 10 charts will be audited quarterly by theDirector/CCM.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/18/2016
NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809		
(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	
	<p>total fluid intake had been calculated for the shift.</p> <p>B. The Nursing Flow Sheet dated 7/28/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>C. The Nursing Flow Sheet dated 7/29/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>D. The Nursing Flow Sheet dated 8/4/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>E. The Nursing Flow Sheet dated 8/5/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>F. The Nursing Flow Sheet dated 8/12/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>G. During home visit with patient # 2 on 8/18/16 at 9:15 AM, employee D was observed administering extra fluid as ordered for heart rate over 100 bpm. During interview, employee D stated the extra fluid (water) is to help keep the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>patient's kidneys flushed and clean.</p> <p>2. Clinical record # 4 was reviewed on 8/18/16. Start of care date 1/4/11. The plan of care dated 8/1-9/29/16 contained orders for SN 6-14 hours a day 4-6 days a week; Peptamen Junior 120 mL per G tube bolus every 3 hours during day; diagnosis Cerebral Palsy and other diagnosis Hydrocephalus; Goals included to achieve/maintain adequate nutrition &amp; hydration either enterally or PO. The record failed to evidence the nurses totaled the Intake for monitoring intake goals.</p> <p>A. The Nursing Flow Sheet dated 8/8/16 by employee G, LPN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>B. The document titled "Hand and Glove Hygiene and Documentation Review IN-Service Receipt" was signed by employee G on 8/15/16, and the agency received it on 8/18/16.</p> <p>C. During interview on 8/18/16 at 1:30 PM, employee A stated yea it's not totaled (in response to the 8/8 missing documentation for patient # 4).</p> <p>3. During interview on 8/17/16 at 2:30 PM, employee A (Nursing Supervisor)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>stated the nurses should be totaling the intake each day, and he has been auditing records but it is a random sample, and when he see holes he writes it up.</p> <p>4. During interview on 8/17/16 at 2:40 PM, employee B (Administrator) stated she does not expect the total intake to be documented for a patient who is not on fluid restrictions.</p> <p>5. During home visit observation with patient # 1 on 8/17/16 at 8:30 AM, employee B Licensed Practical Nurse (LPN) stated he always totals up intake and output and if the previous nurse did not place totals then he could add it up because the agency leaves carbon copies of documentation in the patients' homes.</p> <p>6. The nursing in-service for Hand washing and documentation was provided on 8/17/16 by employee A who stated the agency mailed the in-services to the nursing staff on 7/22/16. A list of employees' last names with notation of whether or not they were received back by the agency was also provided. This document was dated 8/17/16 and failed to evidence employee D had returned the signed in-service to the agency as of 8/18/16.</p> <p>7. A copy of an email message was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>provided on 8/18/16 by employee A who stated he sent this email on 8/15/16 to the remaining staff who had not yet returned the in-service forms; the email stated "Subject: Reminder ... Hello All, Just a reminder. For those who have not turned in their signed In-Service that you received in the mail. We need those ASAP [as soon as possible]. If we don't get them in the next 2 weeks, we will have to bring you into the office to perform the In-Service. This will be mandatory."</p> <p>8. During interview on 8/18/16 at 2:25 PM, employee A provided an updated list of employees who had returned the in-service documents (still dated as 8/17/16) and stated he does not have [employee D's] in-service back yet but he called him and was told it is in the mail.</p> <p>9. The agency's policy titled "Clinical Documentation," # C-680, revised 2/9/15 stated "PURPOSE To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care ... PROCEDURE A. All skilled services provided by Nursing ... will be documented in the clinical record. ... C. Additional information that is pertinent to the client's care or condition may be documented on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>an addendum. ... E. Documentation of services ordered on the Plan of Care will be completed the day and time service is rendered."</p> <p>10. The 4 page document titled "Nursing Documentation Review," was provided on 8/18/16 at 2:00 PM by employee A who stated this is the nitre in-service document mailed to staff. This document stated "The purpose of this review is to guide you through HPHC documentation requirements. ... Nursing documentation is also a direct reflection of what is contained in the Plan of Care (POC)/485 as directed by the primary physician. All care and documented care should reflect what is contained in the client orders. ... Page 3: Intake, Output and Narrative Record ... Make sure yo document all intake and output for your client during the shift; place the numbers in the correct boxes. Also the totals should be tallied across for each hours and then on the bottom for each category. Lastly the shift total at the bottom of the section should be completed for all intake and output. Amounts should be clearly marked. ... Record the amount in oz [ounces] or mLs. ... Narrative Notes: ... Sometimes it is easy to get lax in charting due to the fact that the client's care can sometimes be the same every day, or when you fee really comfortable with the family and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
N 0608 Bldg. 00	<p>the nursing team and assume they can "fill in the blanks." ... Be specific and record important details."</p> <p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on document review, observation, and interview, the agency failed to ensure the nursing staff prepared clinical notes and documented per policy for 2 of 5 clinical records reviewed. (# 2 and 4)</p> <p>Findings include</p>	N 0608	Nursing documentation in-service was sent on 7/22/16. On 8/15/16, the Director sent out an email message to staff that had not turned in their in-service to date. This message is part of the employee time reporting system, so the message must be read before their time worked can be entered. The	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>1. Clinical record # 2 was reviewed on 8/17/16. Start of care date 7/14/08. The plan of care dated 6/26-8/24/16 contained orders for skilled nursing (SN) 8-12 hours a day, 3-5 days a week; diagnosis Unspecified Spina Bifida with hydrocephalus, Presence of CSF [cerebrospinal fluid] drainage device; total fluid goal of 2000 mL [milliliters] a day which includes enteral nutrition (formula) to be given at parents' discretion; and If heart rate &gt; 100 bpm [beats per minute] in morning, may give extra 120 mL (4 ounces) water to increase volume; regular diet with no "fluid restrictions." Patient also has urostomy drainage bag. Goals section stated "To achieve/maintain adequate nutrition &amp; hydration PO [by mouth]/enterally. ... To keep [patient] free of illness or complications (especially UTI [Urinary Tract Infection] or URI [Upper Respiratory Infection]) and out of the hospital. To monitor fiord signs of shunt malfunction &amp; intervene promptly." The record failed to evidence the nurses totaled the Intake for monitoring intake and fluid goals.</p> <p>A. The Nursing Flow Sheet dated 7/25/16 by employee D, RN (Registered Nurse), failed to evidence the patient's total fluid intake had been calculated for the shift.</p>		<p>office hasreceived 100% of the in-service completed by staff. Current client charts have been audited andthe agency will continue with the audit process. Audits are being performed by our team whichincludes the following: Administrator, Regional Director, Director, ClinicalCare Managers (CCM) and an internal compliance Registered Nurse. Nursing flowsheets, medication administrationrecords and physician orders were reviewed and compared to the current485. If new orders are indicated theywill be obtained. All nursing flowsheetsare being audited for accuracy/compliance with the 485. All nursing flowsheets are being audited fortotals of input and output (I&amp;O) to ensure that physician orders and orgoals are being met. If there isnursing documentation that falls out of compliance, the nurse will receive aphone call and will be instructed on areas in need of improvement. A "Nursing Flow Sheet Audit Form-SurveyFollow Up" will also be completed. Toensure ongoing accuracy, all sections of the 485 will be reviewed with thecurrent nurse and/or caregiver during the home supervisory visits. To ensurecontinued compliance, 10% or 10 charts will be audited quarterly by theDirector/CCM.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>B. The Nursing Flow Sheet dated 7/28/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>C. The Nursing Flow Sheet dated 7/29/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>D. The Nursing Flow Sheet dated 8/4/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>E. The Nursing Flow Sheet dated 8/5/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>F. The Nursing Flow Sheet dated 8/12/16 by employee D, RN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>G. During home visit with patient # 2 on 8/18/16 at 9:15 AM, employee D was observed administering extra fluid as ordered for heart rate over 100 bpm. During interview, employee D stated the extra fluid (water) is to help keep the patient's kidneys flushed and clean.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>2. Clinical record # 4 was reviewed on 8/18/16. Start of care date 1/4/11. The plan of care dated 8/1-9/29/16 contained orders for SN 6-14 hours a day 4-6 days a week; Peptamen Junior 120 mL per G tube bolus every 3 hours during day; diagnosis Cerebral Palsy and other diagnosis Hydrocephalus; Goals included to achieve/maintain adequate nutrition &amp; hydration either enterally or PO. The record failed to evidence the nurses totaled the Intake for monitoring intake goals.</p> <p>A. The Nursing Flow Sheet dated 8/8/16 by employee G, LPN, failed to evidence the patient's total fluid intake had been calculated for the shift.</p> <p>B. The document titled "Hand and Glove Hygiene and Documentation Review IN-Service Receipt" was signed by employee G on 8/15/16, and the agency received it on 8/18/16.</p> <p>C. During interview on 8/18/16 at 1:30 PM, employee A stated yea it's not totaled (in response to the 8/8 missing documentation for patient # 4).</p> <p>3. During interview on 8/17/16 at 2:30 PM, employee A (Nursing Supervisor) stated the nurses should be totaling the intake each day, and he has been auditing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>records but it is a random sample, and when he see holes he writes it up.</p> <p>4. During interview on 8/17/16 at 2:40 PM, employee B (Administrator) stated she does not expect the total intake to be documented for a patient who is not on fluid restrictions.</p> <p>5. During home visit observation with patient # 1 on 8/17/16 at 8:30 AM, employee B Licensed Practical Nurse (LPN) stated he always totals up intake and output and if the previous nurse did not place totals then he could add it up because the agency leaves carbon copies of documentation in the patients' homes.</p> <p>6. The nursing in-service for Hand washing and documentation was provided on 8/17/16 by employee A who stated the agency mailed the in-services to the nursing staff on 7/22/16. A list of employees' last names with notation of whether or not they were received back by the agency was also provided. This document was dated 8/17/16 and failed to evidence employee D had returned the signed in-service to the agency as of 8/18/16.</p> <p>7. A copy of an email message was provided on 8/18/16 by employee A who stated he sent this email on 8/15/16 to the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>remaining staff who had not yet returned the in-service forms; the email stated "Subject: Reminder ... Hello All, Just a reminder. For those who have not turned in their signed In-Service that you received in the mail. We need those ASAP [as soon as possible]. If we don't get them in the next 2 weeks, we will have to bring you into the office to perform the In-Service. This will be mandatory."</p> <p>8. During interview on 8/18/16 at 2:25 PM, employee A provided an updated list of employees who had returned the in-service documents (still dated as 8/17/16) and stated he does not have [employee D's] in-service back yet but he called him and was told it is in the mail.</p> <p>9. The agency's policy titled "Clinical Documentation," # C-680, revised 2/9/15 stated "PURPOSE To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care ... PROCEDURE A. All skilled services provided by Nursing ... will be documented in the clinical record. ... C. Additional information that is pertinent to the client's care or condition may be documented on an addendum. ... E. Documentation of services ordered on the Plan of Care will</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809
---	---

(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
	<p>be completed the day and time service is rendered."</p> <p>10. The 4 page document titled "Nursing Documentation Review," was provided on 8/18/16 at 2:00 PM by employee A who stated this is the nitre in-service document mailed to staff. This document stated "The purpose of this review is to guide you through HPHC documentation requirements. ... Nursing documentation is also a direct reflection of what is contained in the Plan of Care (POC)/485 as directed by the primary physician. All care and documented care should reflect what is contained in the client orders. ... Page 3: Intake, Output and Narrative Record ... Make sure yo document all intake and output for your client during the shift; place the numbers in the correct boxes. Also the totals should be tallied across for each hours and then on the bottom for each category. Lastly the shift total at the bottom of the section should be completed for all intake and output. Amounts should be clearly marked. ... Record the amount in oz [ounces] or mLs. ... Narrative Notes: ... Sometimes it is easy to get lax in charting due to the fact that the client's care can sometimes be the same every day, or when you fee really comfortable with the family and the nursing team and assume they can "fill in the blanks." ... Be specific and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/18/2016
NAME OF PROVIDER OR SUPPLIER  HOMEPOINTE HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8515 BLUFFTON RD FORT WAYNE, IN 46809		
(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	
	record important details."				