

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157117		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/10/2012	
NAME OF PROVIDER OR SUPPLIER  CAMERON HOME HEALTH CARE & HOSPICE				STREET ADDRESS, CITY, STATE, ZIP CODE 416 E MAUMEE ST ANGOLA, IN 46703			
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N0000	<p>This was a Home Health Agency state license survey.</p> <p>Facility number: 005308</p> <p>Medicaid number: 100263930A</p> <p>Dates of survey: Sept 6, 7, and 10, 2012</p> <p>Surveyor: Miriam Bennett RN, BSN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p style="text-align: center;">September 11, 2012</p>			N0000			

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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N0524	<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> <p>(A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following:</p> <p>(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 home visit observation, record review, policy review, and interview, the agency failed to ensure all Durable Medical Equipment (DME) used by the patient was on the Plan of Care (POC) for 1 of 3 home visits with the potential to affect all the agency's patients with durable medical equipment. (#1)</p> <p>Findings include:</p> <p>1. During home visit with patient #1 on</p>	N0524	<p>1. Educate all staff on the need to list all DME on the POC.2. Audit all admissions and recerts for DME and correlation with OASIS information for 3 months then 10% of charts quarterly for 1 year.3. The Nursing Team Leader will be responsible for this process.</p>	10/05/2012			

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	<p>9/7/12 at 11:00 AM, the following DME were observed in the home: walker, toilet riser, grab bars, shower chair. The POC for the certification period 7/30/12 - 9/27/12 failed to evidence the shower chair in the DME section.</p> <p>2. During interview on 9/7/12 at 12:00 PM, employee A indicated they were not aware that all DME was not listed on the POC. The patient goes between her own house and her daughter's house, so it may have been missed.</p> <p>3. The agency's policy titled "Home Health Care POC, orders, out of state orders, 911 and emergency," reviewed 10/1/10, states "(1) The medical plan of care shall be developed in consultation with the home health agency staff and shall cover all pertinent diagnoses and include the following: ... (B) Types of services and equipment required."</p>				

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N0604	<p>410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.</p> <p>Based on clinical record review, job description review, and interview, the agency failed to ensure the Home Health Aides (HHAs) were completing assignments as ordered by the supervising Registered Nurses (RNs) for 1 of 4 records reviewed with HHA services. (#4)</p> <p>Findings include:</p> <p>1. Clinical record #4 contained a Nursing Assistant Assignment Sheet and Care Summary for the certification period of 5/22-6/15/12, dated as completed by the RN on 3/26/12 and reviewed by a second RN on 3/27/12. The assignment included for the HHAs to do Blood Pressures (BP) with each visit and Catheter care each visit. The Home Health Aide Daily Notes failed to evidence a BP was performed on the patient on 5/22, 5/25, 5/29, 6/1, 6/5, 6/8, 6/12, and 6/21. The Home Health Aide Daily Notes also failed to evidence that catheter care was completed on 5/29/12.</p> <p>2. During interview on 9/6/12 at 1:05 PM, employee A indicated the family was</p>	N0604	<p>1. Educate all clinical staff on the requirement to follow NA assignment sheet and documentation of activity.2. Audit 100% of NA documentation to ensure NA assignment sheet is being followed for 3 months and then 10% of charts quarterly for 1 year.3. Nursing Team Leader to be responsible for process.</p>	10/05/2012

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	documenting the BPs in the home.  3. The agency's Job Description titled "Home Health Care / Hospice Nursing Assistant," #051, Revised 8/12, states, "Performance Standards ... 5. Completes all duties as designated on the aide assignment sheet and reports significant changes in the patient's condition to the RN case manager or other supervising nurse."			

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N0606	<p>410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.</p> <p>Based on clinical record review, interview, and policy review, the agency failed to ensure the Home Health Aide (HHA) supervisory visits were completed every 30 days for 1 of 4 clinical records reviewed of patients receiving Home Health Aide services with the potential to affect all the agency's patients who receive HHA services. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a Plan of Care for Home Health Aide services, Physical Therapy services, Occupational Therapy services, and Medical Social Services. The first HHA visit was 7/27/12. The clinical record failed to evidence a HHA supervisory visit had been completed.</p> <p>2. During interview on 9/7/12 at 9:55 AM, employee A indicated the HHA supervisory visit for patient #2 was not evidenced in the computer.</p>	N0606	<p>1. Educate all RN's and therapists on state and federal regulations related to supervision of NA's.2. Audit 100% of NA charts for NA supervisory visits for 3 months, then 10% quarterly thereafter.3. Nursing Team Leader to be responsible for this process.</p>	10/05/2012			

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	3. The agency's policy titled "Scope of Service - unskilled. Nursing Assistant aka Home Health Aide. Competency for Nursing Assistants aka Home Health Aides," reviewed 4/26/10, states "16. A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met."			