

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 03/16/2012	
NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH CARE AGENCY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3001 FAIRFIELD AVENUE FORT WAYNE, IN 46807			
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G0000	<p>This was a home health initial Medicaid certification survey. This was a partial extended survey.</p> <p>Survey dates: March 14-16, 2012.</p> <p>Facility #: 012746</p> <p>Surveyor: Miriam Bennett, RN, PHNS</p> <p>Census: 10</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 29, 2012</p>			G0000			

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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G0121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure the Home Health Aide followed infection control guidelines while providing care for 1 of 3 home visits with the potential to affect all the patients the Aide provides care for. (E)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/15/12 at 12:00 PM, employee E (Home Health Aide) was observed providing the patient a bed bath. Aide was observed to don gloves without washing hands prior to donning gloves. After washing patient's upper torso, the aide continued on to providing peri care to patient without changing gloves. Once patient was washed, the aide removed gloves and did not wash hands prior to clothing patient. After cleaning up bathing items and soiled laundry, aide went to sink and rinsed hands with water for approximately 5 seconds, did not wash with soap, then proceeded to dry hands with paper towel. Agency policy titled "Hand Washing 	G0121	<p>G121 The Director of Nursing (DON) will conduct a mandatory In-service for all Home Health Aides on the proper procedures for donning and doffing gloves. HHA's must demonstrate proper hand washing procedures and will be given agency policy 46 entitled "Hand Washing with and Without Water", and policy 43, "Standard Precautions". Aides will also receive and review the State approved step-by-step procedures used by agency when giving a complete bed bath. On-going activities will include: During supervisory visits the RN will require demonstration from Aides on hand washing and cross contamination. All new Home Health Aides must go through mandatory orientation focusing on Universal Precautions and the above stated policies, and must demonstrate proficiency each time during the RN's supervisory visit. All Home Health Aides must demonstrate proficiency in proper hand washing and Standard Precautions at least once a month until all are 100% for 3 consecutive months. RN will keep a record of each demonstration and will review with Aides. The record of each</p>	04/11/2012			

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	<p>with and Without Water", #46, dated 12/2011, states, "Indications for hand washing and antisepsis: ... (2) Before giving direct care to patient, (3) After giving direct care to patient. ... (11) If moving from a contaminated body site to a clean body side [sic] during patient care." Under the section titled "B. Hand Hygiene Techniques: (2) ... turn water faucet on with paper towel, wet hand first with water, apply soap, rub hands together fro [sic] at least 15 seconds covering all surfaces of the hands between fingers."</p> <p>3. Agency policy titled "Standard Precautions", policy 43, dated 12/2011, states, "(C) Hands must be washed ... immediately after removing gloves ... It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross contamination of different body sites."</p> <p>4. Procedure book used by agency to train and competency test Home Health Aides contains step-by-step instructions for giving a bed bath titled "Procedure 14-5 Giving a Complete Bed Bath" which states, "1. Explain what you are doing. 2. Wash your hands."</p> <p>5. On 3/15/12 at 1:00 PM, employee B indicated the aide should have used soap while washing hands and should have</p>		demonstration will be kept in the Aides personnel file. The DON shall be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 04/11/2012				

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	changed gloves prior to providing peri care to patient.			

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G0159	<p>484.18(a) PLAN OF CARE</p> <p>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, observation, and interview, the agency failed to ensure the plan of care included frequency of visits for ordered services, all DME (durable medical equipment) used by patients, and correct 60 day certification period dates for 8 of 10 records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, 4, 5, 6, 7, and 8).</p> <p>Findings include:</p> <p>1. Clinical record #1 included a plan of care for the care dates 2/27/12-4/27/12. The care dates beginning 2/27/12 should have ended on 4/26/12. The plan of care included orders for HHA (Home Health Aide) services but the orders did not include frequency of visits.</p> <p>On 3/15/12 at 12:30 PM during home visit observation, DME observed in the</p>	G0159	G 159 RN will be responsible for ensuring that the plan of care (POC) includes frequency of visits and all other pertinent data as required in 484.18 for ordered services. The plans will be re-checked by the Patient Care Coordinator. RN shall ensure all DME (durable medical equipment) used by patients is properly documented by asking during each visit if patient has received any new or used DME and by conducting a walk through during each re-assessment period. The 60 day certification periods have been corrected in clinical records 1 thru 8. The agency will use the CMS calendars generated from the CMS website as a guide to ensure the certification periods are correct. Clarification orders have been sent to the appropriate physicians reflecting the correct certification dates for clinical records 1 thru 8. Patient Coordinator will be responsible for checking the dates	04/09/2012			

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	<p>home of patient #1 included a shower chair, toilet riser, commode, and hospital bed. The plan of care in clinical record #1 did not list these DME. During interview, the patient indicated they do use the shower chair, toilet riser, commode, and hospital bed.</p> <p>2. Clinical record #2 included a plan of care for the care dates 2/27/12-4/27/12. The care date beginning 2/27/12 should have ended on 4/26/12.</p> <p>On 3/15/12 at 12:00 PM during home visit observation, DME observed in the home of patient #2 included a shower chair, toilet riser, and commode. The plan of care in clinical record #2 did not list these DME.</p> <p>3. On 3/15/12 at 12:15 PM, during home visit observation of care and interview, employees B and E indicated patients #1 and #2 both use the shower chair, toilet riser, and commode. Employee B indicated patient #1 uses the hospital bed.</p> <p>4. Clinical record #3 included a plan of care for the care dates 2/29/12-4/29/12. The care date beginning 2/29/12 should have ended on 4/28/12.</p> <p>5. Clinical record #4 included a plan of care for the care dates 3/1/12-4/26/12.</p>		documented by the RN in the 485 Plan of Care to ensure this deficiency is corrected and will not recur.	

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	<p>The care date beginning 3/1/12 should have ended on 4/29/12.</p> <p>6. On 3/15/12 at 1:00 PM during home visit observation, DME observed in the home of patient #5 included a walker, hospital bed, and wheel chair. The plan of care in clinical record #5 did not list hospital bed and wheel chair. The patient indicated they do use the hospital bed and use the wheel chair when they have an appointment.</p> <p>7. Clinical record #6 included a plan of care for the care dates 3/1/12-4/2/12. The care date beginning 3/1/12 should have ended on 4/29/12. During interview on 3/14/12 at 3:05 PM, employee B indicated they mistakenly mis-dated the form.</p> <p>8. Clinical record #7 included a plan of care for the care dates 2/29/12-4/30/12. The care date beginning 2/29/12 should have ended on 4/28/12.</p> <p>9. Clinical record #8 included a plan of care for the care dates 3/9/12-5/9/12. The care date beginning 3/9/12 should have ended on 5/7/12. The plan of care indicates SN visits to be 1x wk x 8 wks. The duration should be for 9 weeks.</p> <p>10. Agency policy titled "Physician</p>						

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	<p>Orders," #25, dated 12/2011, states, "The contents of the Plan of Care for orders will include: ... 2. A description of equipment, if any, necessary in the provision of care; 3. A description of the treatment and/or procedure to be done, including the type, frequency and duration and the discipline to perform the treatment or procedure."</p> <p>11. On 3/15/12 at 3:05 PM, employee B indicated the care dates on the plan of care did not include the first visit date due to previous experience with insurance benefits and they omitted the first visit date by accident.</p>			

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G0166	<p>484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS</p> <p>Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.</p> <p>Based on clinical record and policy review and interview, agency failed to ensure verbal orders included the name of the physician for 3 of 3 records reviewed of patients with verbal orders with the potential to affect all the agency's patients. (#5, 6, 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #5 contained a V.O. (verbal order) dated 2/27/12 signed by employee B, RN (Registered Nurse). The order did not include the name of the prescribing physician. 2. Clinical record #6 contains a V.O. dated 3/13/12 signed by employee B. The order did not include the name of the prescribing physician. 3. Clinical record #10 contains a V.O. dated 2/29/12 signed by employee B. The order did not include the name of the prescribing physician. 	G0166	<p>G166 A Mandatory In-Service was conducted by all nursing staff on the correct way to write verbal orders as stated in Agency policy #25, dated 12/2011 which states, "(L). Telephone or verbal orders will be taken by licensed staff, as specified above. 1. Documented on the physician's order form, read back for verification, dated, signed, and a copy placed in the patient's clinical record." Patient Coordinator will review all verbal orders to ensure they are completed properly. DON will audit 100% of verbal orders until audit is 100% for 3 consecutive months. Patient Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	04/05/2012			

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	<p>4. On 3/14/12/ at 3:05 PM, employee B indicated verbal orders should contain the name of the physician representative giving the order to the RN, the name of the prescribing physician, and the name of the RN accepting the order. For orders the agency needs to write and send to the physician for approval and signature, only the RN name will be on the order.</p> <p>5. Agency policy titled "Physician Orders," #25, dated 12/2011 states, "(L). Telephone or verbal orders will be taken by licensed staff, as specified above, and are: 1. Documented on the physician's order form, read back for verification, dated, signed, and a copy placed in the patient's clinical record."</p>			

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G0224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>Based on clinical record review and interview, agency failed to ensure the Aide care plans were clear for Aides to provide care for 1 of 3 records reviewed of patients receiving Home Health Aide services with the potential to affect all the agency's patients who will receive Home Health Aide services. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a "Home Health Aide / CNA /Patient Support / Attendant" Plan of Care dated 2/27/12. Items are checked for Aides to complete but are not identified as how often other than "As Desired."</p> <p>2. On 3/14/12 at 3:05 PM, employee B indicated there needs to be an update to the Aide Care Plans to include how often each task should be done so nothing gets missed. Employee B also indicated the Aides are instructed to call office if a patient refuses any service too many times as that may indicate a need for change in</p>	G0224	<p>G224 DON has developed a new Home Health Aide Plan of Care. The old form had items that were to be checked "as desired". "As desired" has been eliminated from the new form. Frequency of HHA's visits added. RN will ensure that Aides have Plan of Care in the home and adhere to the plan. RN will check monthly during supervisory visits to ensure plan is in the home and the Aide is compliant. See new HHA POC below: HOME HEALTH AIDE PLAN OF CARE PATIENT NAME _____ _____ RECORD# _____ _____ Home Health Aide Frequency: _____ _____</p> <p>(See patient face sheet for additional information, phone number, address, directions, diagnosis, etc) Information: Check all that apply. Circle appropriate item if separated by slash mark. ___Lives alone ___Enter: Front/Back/Side</p>	04/05/2012			

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	services or for a nurse to assess patient.		<p>___ Animal(s) _____ _ ___ Key Available _____ Lives with other ___ Alone during the day ___ Speech/Communication deficit ___ Vision Deficit ___ Glassess/Contacts ___ Hearing Deficit: ___ Hearing aide ___ Dentures: Upper/Lower/Partial ___ Amputee (specify) _____</p> <p>Mental Status: ___ Alert ___ Oriented to Person/Place/Time ___ Forgetful/Confused Other: _____</p> <p>Allergies: (specify-soap, lotion, food, etc) _____</p> <p>_____ Special precautions: ___ Diabetic ___ Bleeding Precautions ___ Prone to fracture Fall</p> <p>Risk Measures: _____</p> <p>_____ Goals for Care: ___ Effective personal care ___ Patient Environment clean, safe, comfortable ___ Respite for Caregivers HHA</p> <p>Assignment-Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc. as needed beside the appropriate item.</p>	

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			<p><u>Report all patient refusal of care to office as soon as possible with reason of refusal.</u></p> <p>Personal Care, Hygiene, Grooming: ___ Bath: Bed/Tub/Sponge ___ Shower: Sit/Stand/ ___ Shampoo: Wet/Dry ___ Clean Eyeglasses prn ___ Hair: Blow Dry/Comb/Brush/Set ___ Oral Care: Brush/Swab/Dentures ___ Shave: Electric/Safety/Lotion/Cologne ___ Skin: Lotion/Powder/Deodorant/Other: ___ ___ Assist patient to dress <u>Elimination:</u> ___ Elimination Assist as Requested ___ Toileting: Bedpan/Urinal/Commode/Toilet ___ Catheter Care: Foley/External ___ Change Bag: Frequency _____ Ostomy Care: Empty bag as needed</p> <p><u>Activity:</u> ___ Activity Level: Bedbound/Bedrest with BRPs/Up as tolerated ___ Mobility Assist: Chair/Dangle/Bedside Commode ___ Encourage: Assist to turn q ___ hours ___ Position with pillows ___ ROM: RUE/RLE/LUE/LLE: Frequency _____ ___ Ambulation with: Cane/Walker/Crutches ___ Ambulation assist: Min/Mod/Max/Independent ___ Partial weight bearing: ___ Right/Left ___ Non Weight bearing: Right/Left ___ Assist with Exercise per PT/OT care plan ___ Transfers:</p>	

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			Stand/pivot/sliding board/gait belt/ with assist of ___people Special Equipment: ___Brace (type)____ ___ Prosthesis ___ Hoyer lift ___ Shower-tub Chair ___ Bedside Commode ___ Air mattress ___ Other _____ _____ Equipment Care: _____ _____ _____ <u>Nutrition:</u> Diet: ___ Regular ___ As Tolerated ___ Diabetic: _____ Calories ___ Low Sodium ___ Other _____ ___ Limit/Encourage Fluids ___ Assist with feeding <u>Other:</u> ___ Assist with Medications (<u>DO NOT ADMINISTER</u> <u>MEDICATIONS</u>) ___ Vital Signs: Temp/Pulse/Resp/BP/Frequency: ___ <u>NOTIFY NURSING SUPERVISOR FOR ANY CHANGE IN CONDITION</u> <u>Signatures/Revisions (Must be reviewed at least every 60 days):</u> Initial Assignment: (Signature/Title): _____ _____ Date: _____ ___ Reviewed/Revised: (Signature/Title): _____ _____ Date: _____ ___ Reviewed/Revised:		

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			(Signature/Title): _____ _____ Date: _____	
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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 03/16/2012	
NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH CARE AGENCY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3001 FAIRFIELD AVENUE FORT WAYNE, IN 46807			
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G0236	<p>484.48 CLINICAL RECORDS 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 clinical record and policy review and interview, the agency failed to ensure the accuracy and completeness of records for 4 of 10 records reviewed with the potential to affect all the agency's patients. (#1, 3, 8, and 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 contained a comprehensive assessment dated 2/27/12 that did not contain ICD-9 codes. 2. Clinical record #3 contained a comprehensive assessment dated 2/19/12 that did not contain ICD-9 codes. 3. Clinical record #8 contained a plan of care with start date of 3/9/12. Physician order for assessment and admission to home health care is dated 3/7/12. Agency referral form indicated the referral date of 3/8/12. Consent for Treatment form, 	G0236	<p>G236 All clinical records will be reviewed first by the admitting Registered Nurse as stated in At Home's policy, titled "Outcome and Assessment Information Set (OASIS-C), next by the Director of Nursing and then by the Administrator to ensure completeness of the records. All clinical records will contain pertinent past and current findings in accordance with accepted professional standards for every patient receiving home health services. In addition to the plan of care, the records will contain 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. A protocol has been implemented that before files are deemed complete, the administrator must review files. The DON will be</p>	04/09/2012			

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	<p>comprehensive assessment form, and medication profile form are all dated 3/8/12.</p> <p>4. Clinical record #10 contained a plan of care with start date of 3/2/12. Physician order for assess and admit to home health care was dated 2/29/12. Agency referral form indicated the referral date of 3/1/12.</p> <p>5. On 3/15/12 at 9:35 am, employee B indicated the paperwork was dated wrong for the referral forms for records #8 and #10. Employee B also indicated patient #8's start of care date should have been on 3/8/12 because that was the date the comprehensive assessment was done and the patient was admitted.</p> <p>6. Agency policy titled "Outcome and Assessment Information Set (OASIS-C)," #17, dated 12/2011, states, "F. the admitting Registered Nurse or Registered Therapist is responsible for the completion of all information. If not completed, the forms will be returned to the admitting discipline for completion."</p> <p>7. On 3/14/12 at 3:05 PM, employee B indicated the codes were not on the paperwork yet because they had to look them up.</p>		responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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G0325	<p>484.20(c)(3) TRANSMITTAL OF OASIS DATA The HHA must successfully transmit test data to the State agency or CMS OASIS contractor.</p> <p>Based on interview and review of state agency information, the agency failed to submit test data for OASIS for 1 of 1 agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/14/12 at 3:05 PM, employee B indicated the agency does not do OASIS reporting yet. On 3/16/12 at 12:00 PM, employee B indicated the agency attempted to begin the OASIS data test report to the State agency on 3/14/12 and had to change the password. Also the agency was now having difficulties accessing OASIS and was calling the help line for assistance at the time of surveyor exit. As of 3/16/12 at 12:15 PM, the state agency had not received an OASIS data test submission. 	G0325	<p>G325 OASIS DATA Transmission was successfully transmitted on March 21, 2012 16:56:22. Agency has completed the test and obtained both State and Federal passwords. Protocol established that OASIS must be submitted within 30 days after the agency is licensed. The DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. A copy of the Test will be included.</p>	03/21/2012			

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G0334	<p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT</p> <p>The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.</p> <p>Based on clinical record review and interview, agency failed to ensure the comprehensive assessment of patients was complete for 2 of 10 records reviewed with the potential to affect all the agency's patients. (#1 and 3).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #1 contained a comprehensive assessment dated 2/27/12 that did not contain ICD-9 codes. 2. Clinical record #3 contained a comprehensive assessment dated 2/29/12 that did not contain ICD-9 codes. 3. Agency policy titled "Outcome and Assessment Information Set (OASIS-C)," #17, dated 12/2011, states, "F. the admitting Registered Nurse or Registered Therapist is responsible for the completion of all information. If not completed, the forms will be returned to the admitting discipline for completion." 4. On 3/14/12 at 3:05 PM, employee B indicated the codes were not on the 	G0334	<p>G334 The discharging nurse will adhere to 484.55(d)(3), "The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Agency policy titled "Outcome and Assessment Information Set (OASIS-C), #17, dated 12/20/11, states, under Section B, "The assessment will measure patient outcomes from data collected at start of care, at 60 day intervals, (Not 63 day intervals) thereafter and upon discharge. The error in Policy #17 has been corrected to reflect 60 days. 100% of comprehensive assessments will be audited until they are all 100% for 3 consecutive months. The Director of Nursing of At Home Health Care Agency will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	04/04/2012			

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	paperwork yet because they had to look them up.			

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G0341	<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.</p> <p>Based on clinical record review, policy review, and interview, agency failed to ensure a discharge comprehensive assessment was completed for 3 of 3 discharge records reviewed with the potential to affect all the agency's patients and the agency's policy was congruent with federal regulations. (# 6, 7, 10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #6 contained a physician order for discharge per patient request dated 3/13/12. The record failed to evidence a discharge comprehensive assessment. 2. Clinical record #7 contained a physician order for discharge per patient choice dated 3/5/12. The record failed to evidence a discharge comprehensive assessment. 3. Clinical record #10 contained a physician order for discharge per patient choice dated 3/5/12. The record failed to evidence a discharge comprehensive assessment. 	G0341	<p>G341 The discharging nurse will complete an updated comprehensive assessment at discharge (including the administration of the OASIS at discharge). All patients will have a discharge comprehensive assessment. The agency has also corrected our policy titled, "Outcome and Assessment Information Set (OASIS-C), #17, dated 12/2011, which states, under section B, The assessment will measure patient outcomes from data collected at start of care, at 60 instead of 63 day intervals thereafter and upon discharge. Agency will complete discharge comprehensive assessment on all discharged patients. The agency's policy has been corrected to reflect 60 days, per federal regulations. The DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	04/05/2012			

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	<p>4. On 3/14/12 at 3:05 PM, employee B indicated patient #7 refused to let the agency come to the home for discharge assessment. Also the agency does not do OASIS comprehensive assessments if the patient refuses to allow agency to return to their home.</p> <p>5. Agency policy titled "Outcome and Assessment Information Set (OASIS-C)," #17, dated 12/2011, states, under section B, "The assessment will measure patient outcomes from data collected at start of care, at sixty-three (63) day intervals thereafter and upon discharge." Under section "N" the policy states, "Timelines for Completion: The comprehensive assessment including the OASIS-Cs will be updated and revised no less frequently than: ... 4. Within 48 hours of (or knowledge of) discharge to the community or death at home (Discharge OASIS)."</p> <p>Federal regulations require assessments to be completed every 60 days.</p>			

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N0470	<p>410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure the Home Health Aide followed infection control guidelines while providing care for 1 of 3 home visits with the potential to affect all the patients the Aide provides care for. (E)</p> <p>Findings include:</p> <p>1. On 3/15/12 at 12:00 PM, employee E (Home Health Aide) was observed providing the patient a bed bath. Aide was observed to don gloves without washing hands prior to donning gloves. After washing patient's upper torso, the aide continued on to providing peri care to patient without changing gloves. Once patient was washed, the aide removed gloves and did not wash hands prior to clothing patient. After cleaning up bathing items and soiled laundry, aide went to sink and rinsed hands with water for approximately 5 seconds, did not wash with soap, then proceeded to dry hands with paper towel.</p>	N0470	N0470 The DON will conduct a mandatory In-service for all Home Health Aides on the proper procedures on donning and doffing gloves. HHA's must demonstrate proper hand washing procedures and will be given agency policy 46 titled "Hand Washing with and Without Water", and policy 43 "Standard Precautions". Aides will also receive and review the procedure step-by-step used by agency on giving a complete bed bath. During supervisory visits the RN will require demonstration from Aides on handwashing and cross containment. All new Home Health Aides must go through mandatory orientation focusing on Universal Precautions and the above policies, and must demonstrate proficiency each time during the RN's supervisory visit until 100% X 3 months. All Home Health Aides must demonstrate at least once a month until 100% X 3 months proper Hand washing and Standard Precautions. RN will keep a record of each demonstration and will review with Aides. Documentation will be maintained in the personnel files.	04/11/2012			

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	<p>2. Agency policy titled "Hand Washing with and Without Water", #46, dated 12/2011, states, "Indications for hand washing and antisepsis: ... (2) Before giving direct care to patient, (3) After giving direct care to patient. ... (11) If moving from a contaminated body site to a clean body side [sic] during patient care." Under the section titled "B. Hand Hygiene Techniques: (2) ... turn water faucet on with paper towel, wet hand first with water, apply soap, rub hands together fro [sic] at least 15 seconds covering all surfaces of the hands between fingers."</p> <p>3. Agency policy titled "Standard Precautions", policy 43, dated 12/2011, states, "(C) Hands must be washed ... immediately after removing gloves ... It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross contamination of different body sites."</p> <p>4. Procedure book used by agency to train and competency test Home Health Aides contains step-by-step instructions for giving a bed bath titled "Procedure 14-5 Giving a Complete Bed Bath" which states, "1. Explain what you are doing. 2. Wash your hands."</p> <p>5. On 3/15/12 at 1:00 PM, employee B indicated the aide should have used soap</p>		DON shall be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 04/11/2012				

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	while washing hands and should have changed gloves prior to providing peri care to patient.			

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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 clinical record review, observation, and interview, the agency failed to ensure the plan of care included duration and frequency of visits for ordered services, all DME (durable medical equipment) used by patients, and correct 60 day care period dates for 8 of 10 records reviewed with the potential to affect all the agency's patients. (#1, 2, 3, 4, 5, 6, 7, and 8).</p> <p>Findings include:</p>	N0524	N0524 RN will be responsible for ensuring that the plan of care (POC) includes frequency of visits and all other pertinent data as required in 484.18 for ordered services. The plans will be re-checked by the Patient Care Coordinator. RN shall ensure all DME(durable medical equipment) used by patients is properly documented by asking during each visit if patient has received any new or used DME and by conducting a walk through during each re-assessment period. The	04/09/2012			

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	<p>1. Clinical record #1 included a plan of care for the care dates 2/27/12-4/27/12. The care dates beginning 2/27/12 should have ended on 4/26/12. The plan of care included orders for HHA (Home Health Aide) services but the orders did not include frequency and duration.</p> <p>On 3/15/12 at 12:30 PM during home visit observation, DME observed in the home of patient #1 included a shower chair, toilet riser, commode, and hospital bed. The plan of care in clinical record #1 did not list these DME. During interview, the patient indicated they do use the shower chair, toilet riser, commode, and hospital bed.</p> <p>2. Clinical record #2 included a plan of care for the care dates 2/27/12-4/27/12. The care date beginning 2/27/12 should have ended on 4/26/12.</p> <p>On 3/15/12 at 12:00 PM during home visit observation, DME observed in the home of patient #2 included a shower chair, toilet riser, and commode. The plan of care in clinical record #2 did not list these DME.</p> <p>3. On 3/15/12 at 12:15 PM, during home visit observation of care and interview, employees B and E indicated patients #1</p>		60 day certification periods have been corrected in clinical records 1 thru 8. The agency will use the CMS calendars generated from the CMS website as a guide to ensure the certification periods are correct. Clarification orders have been sent to the appropriate physician reflecting the corrected certification dates for clinical records 1 thru 8. Patient Coordinator will be responsible fo checking the dates documented by the RN in the 485 Plan of Care to ensure this deficiency is corrected and will not recur.				

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	<p>and #2 both use the shower chair, toilet riser, and commode. Employee B indicated patient #1 uses the hospital bed.</p> <p>4. Clinical record #3 included a plan of care for the care dates 2/29/12-4/29/12. The care date beginning 2/29/12 should have ended on 4/28/12.</p> <p>5. Clinical record #4 included a plan of care for the care dates 3/1/12-4/26/12. The care date beginning 3/1/12 should have ended on 4/29/12.</p> <p>6. On 3/15/12 at 1:00 PM during home visit observation, DME observed in the home of patient #5 included a walker, hospital bed, and wheel chair. The plan of care in clinical record #5 did not list hospital bed and wheel chair. The patient indicated they do use the hospital bed and use the wheel chair when they have an appointment.</p> <p>7. Clinical record #6 included a plan of care for the care dates 3/1/12-4/2/12. The care date beginning 3/1/12 should have ended on 4/29/12. During interview on 3/14/12 at 3:05 PM, employee B indicated they mistakenly mis-dated the form.</p> <p>8. Clinical record #7 included a plan of care for the care dates 2/29/12-4/30/12.</p>			

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	<p>The care date beginning 2/29/12 should have ended on 4/28/12.</p> <p>9. Clinical record #8 included a plan of care for the care dates 3/9/12-5/9/12. The care date beginning 3/9/12 should have ended on 5/7/12. The plan of care indicates SN visits to be 1x wk x 8 wks. The duration should be for 9 weeks.</p> <p>10. Agency policy titled "Physician Orders," #25, dated 12/2011, states, "The contents of the Plan of Care for orders will include: ... 2. A description of equipment, if any, necessary in the provision of care; 3. A description of the treatment and/or procedure to be done, including the type, frequency and duration and the discipline to perform the treatment or procedure."</p> <p>11. On 3/15/12 at 3:05 PM, employee B indicated the care dates on the plan of care did not include the first visit date due to previous experience with insurance benefits and they omitted the first visit date by accident.</p>						

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NAME OF PROVIDER OR SUPPLIER AT HOME HEALTH CARE AGENCY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3001 FAIRFIELD AVENUE FORT WAYNE, IN 46807			
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N0547	<p>410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written).</p> <p>Based on clinical record and policy review and interview, agency failed to ensure verbal orders included the name of the physician for 3 of 3 records reviewed of patients with verbal orders with the potential to affect all the agency's patients. (#5, 6, 10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #5 contained a V.O. (verbal order) dated 2/27/12 signed by employee B, RN (Registered Nurse). The order did not include the name of the prescribing physician. 2. Clinical record #6 contains a V.O. dated 3/13/12 signed by employee B. The order did not include the name of the prescribing physician. 3. Clinical record #10 contains a V.O. dated 2/29/12 signed by employee B. The order did not include the name of the prescribing physician. 	N0547	<p>N547 A mandatory In-Service was conducted for all nursing staff on the correct way to write verbal orders as stated in Agency policy #25, dated 12/2011, which states, "(L). Telephone or verbal orders will be taken by licensed staff, as specified above. 1. Documented on the physician's order form, read back for verification, dated, signed, and a copy placed in the patient's clinical record." Patient Coordinator will review all verbal orders to ensure they are completed properly. DON will audit 100% of verbal orders until audit is 100% for 3 consecutive months. Patient Coordinator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	04/05/2012			

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	<p>4. On 3/14/12/ at 3:05 PM, employee B indicated verbal orders should contain the name of the physician representative giving the order to the RN, the name of the prescribing physician, and the name of the RN accepting the order. For orders the agency needs to write and send to the physician for approval and signature, only the RN name will be on the order.</p> <p>5. Agency policy titled "Physician Orders," #25, dated 12/2011 states, "(L). Telephone or verbal orders will be taken by licensed staff, as specified above, and are: 1. Documented on the physician's order form, read back for verification, dated, signed, and a copy placed in the patient's clinical record."</p>			

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N0550	<p>410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate.</p> <p>Based on clinical record review and interview, agency failed to ensure the registered nurse created the Aide care plans so that tasks to be completed were clear for 1 of 3 records reviewed of patients receiving Home Health Aide services with the potential to affect all the agency's patients who will receive Home Health Aide services. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2 contained a "Home Health Aide / CNA /Patient Support / Attendant" Plan of Care dated 2/27/12. Items are checked for Aides to complete but are not identified as how often other than "As Desired."</p> <p>2. On 3/14/12 at 3:05 PM, employee B indicated there needs to be an update to the Aide Care Plans to include how often each task should be done so nothing gets missed. Employee B also indicated the Aides are instructed to call office if a patient refuses any service too many times</p>	N0550	<p>N0550 DON has developed a new Home Health Aide Plan of Care. The old form had items that were to be checked "as desired". "As desired" has been eliminated from the new form. Frequency of HHA's visits added. RN will ensure that Aides have Plan of Care in the home and adhere to the plan. RN will check monthly during supervisory visits to ensure POC is in the home and the Aide is compliant. See new HHA POC below: HOME HEALTH AIDE PLAN OF CARE PATIENT NAME _____ _____ RECORD# _____ _____ Home Health Aide Frequency: _____ _____ (See patient face sheet for additional information, phone number, address, directions, diagnosis, etc) Information: Check all that apply. Circle appropriate item if separated by slash mark. ___Lives alone</p>	04/05/2012			

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	as that may indicate a need for change in services or for a nurse to assess patient.		<p>___ Enter: Front/Back/Side ___ Animal(s) _____ ___ Key Available _____ Lives with other ___ Alone during the day ___ Speech/Communication deficit ___ Vision Deficit ___ Glassess/Contacts ___ Hearing Deficit: ___ Hearing aide ___ Dentures: Upper/Lower/Partial ___ Amputee (specify) _____</p> <p>Mental Status: ___ Alert ___ Oriented to Person/Place/Time ___ Forgetful/Confused Other: _____</p> <p>Allergies: (specify-soap, lotion, food, etc) _____</p> <p>_____ Special precautions: ___ Diabetic ___ Bleeding Precautions ___ Prone to fracture Fall</p> <p>Risk Measures: _____</p> <p>_____ Goals for Care: ___ Effective personal care ___ Patient Environment clean, safe, comfortable ___ Respite for Caregivers HHA</p> <p>Assignment-Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc. as needed</p>		

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			<p><i>beside the appropriate item.</i></p> <p><u>Report all patient refusal of care to office as soon as possible with reason of refusal.</u></p> <p>Personal Care, Hygiene, Grooming: ___ Bath: Bed/Tub/Sponge ___ Shower: Sit/Stand/ ___ Shampoo: Wet/Dry ___ Clean Eyeglasses prn ___ Hair: Blow Dry/Comb/Brush/Set ___ Oral Care: Brush/Swab/Dentures ___ Shave: Electric/Safety/Lotion/Cologne ___ Skin: Lotion/Powder/Deodorant/Other: _ ___ Assist patient to dress <u>Elimination:</u> ___ Elimination Assist as Requested ___ Toileting: Bedpan/Urinal/Commode/Toilet ___ Catheter Care: Foley/External ___ Change Bag: Frequency _____ Ostomy Care: Empty bag as needed</p> <p><u>Activity:</u> ___ Activity Level: Bedbound/Bedrest with BRPs/Up as tolerated ___ Mobility Assist: Chair/Dangle/Bedside Commode ___ Encourage: Assist to turn q ___ hours ___ Position with pillows ___ ROM: RUE/RLE/LUE/LLE: Frequency _____ ___ Ambulation with: Cane/Walker/Crutches ___ Ambulation assist: Min/Mod/Max/Independent ___ Partial weight bearing: ___ Right/Left ___ Non Weight bearing: Right/Left ___ Assist with Exercise per PT/OT care</p>		

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			<p>plan ___ Transfers: Stand/pivot/sliding board/gait belt/ with assist of ___ people Special Equipment: ___ Brace (type) _____ ___ Prosthesis ___ Hoyer lift ___ Shower-tub Chair ___ Bedside Commode ___ Air mattress ___ Other _____ _____ _____ Equipment Care: _____ _____ _____</p> <p><u>Nutrition:</u> Diet: ___ Regular ___ As Tolerated ___ Diabetic: _____ Calories ___ Low Sodium ___ Other _____ ___ Limit/Encourage Fluids ___ Assist with feeding <u>Other:</u> ___ Assist with Medications (<u>DO</u> <u>NOT ADMINISTER</u> <u>MEDICATIONS)</u> ___ Vital Signs: Temp/Pulse/Resp/BP/Frequency: ___ <u>NOTIFY NURSING</u> <u>SUPERVISOR FOR ANY</u> <u>CHANGE IN CONDITION</u> <u>Signatures/Revisions (Must be</u> <u>reviewed at least every 60</u> <u>days):</u> Initial Assignment: (Signature/Title): _____ _____ Date: _____ ___ Reviewed/Revised: (Signature/Title): _____ _____ Date: _____</p>	

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			Reviewed/Revised: (Signature/Title): _____ _____ Date: _____	
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N0608	<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:</p> <p>(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.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure the accuracy and completeness of records for 4 of 10 records reviewed with the potential to affect all the agency's patients. (#1, 3, 8, and 10).</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a comprehensive assessment dated 2/27/12 that did not contain ICD-9 codes.</p> <p>2. Clinical record #3 contained a</p>	N0608	N0608 All clinical records will be reviewed first by the admitting Registered Nurse as stated in At Home's policy, titled "Outcome and Assessment Information Set (OASIS-C), next by the DON and then by the Administrator to ensure completeness of the records. All clinical records will contain pertinent past and current findings in accordance with accepted professional standards for every patient receiving home health services. In addition to the plan of care, the records will contain appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders signed and dated clinical progress notes; copies of	04/09/2012			

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	<p>comprehensive assessment dated 2/19/12 that did not contain ICD-9 codes.</p> <p>3. Clinical record #8 contained a plan of care with start date of 3/9/12. Physician order for assessment and admission to home health care is dated 3/7/12. Agency referral form indicated the referral date of 3/8/12. Consent for Treatment form, comprehensive assessment form, and medication profile form are all dated 3/8/12.</p> <p>4. Clinical record #10 contained a plan of care with start date of 3/2/12. Physician order for assess and admit to home health care was dated 2/29/12. Agency referral form indicated the referral date of 3/1/12.</p> <p>5. On 3/15/12 at 9:35 am, employee B indicated the paperwork was dated wrong for the referral forms for records #8 and #10. Employee B also indicated patient #8's start of care date should have been on 3/8/12 because that was the date the comprehensive assessment was done and the patient was admitted.</p> <p>6. Agency policy titled "Outcome and Assessment Information Set (OASIS-C)," #17, dated 12/2011, states, "F. the admitting Registered Nurse or Registered Therapist is responsible for the completion of all information. If not</p>		summary reports sent to the attending physician and a discharge summary. A protocol has been implemented that before files are deemed complete, the Administrator must review files. The DON will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.				

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	<p>completed, the forms will be returned to the admitting discipline for completion."</p> <p>7. On 3/14/12 at 3:05 PM, employee B indicated the codes were not on the paperwork yet because they had to look them up.</p>			