

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157607		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2013	
NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 819 E 9TH ST ROCHESTER, IN 46975			
(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			
N000000	<p>This was a home health state relicensure survey.</p> <p>Survey dates: 4/1/13 - 4/3/13</p> <p>Facility: #011756</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Census: 390 Skilled: 382 Aide only: 0 Personal service only: 8 Home visits: 3</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 4, 2013</p>	N000000					

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: 157607	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 819 E 9TH ST ROCHESTER, IN 46975
--	--

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

N000524	<p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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>Based on clinical record review, interview, agency policy review, and observation, the agency failed to ensure the medical plan of care included all the required items in 2 of 5 plans of care reviewed with the potential to affect all the agency's patients. (#2 and #4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Clinical record #2, start of care 3/26/13, included a plan of care for the 	N000524	<p>1. Administrator will in-service clinical staff on the following: A. Policy "PCRM01: Care Planning Process" and Policy "PCRM60: Basic home Safety" to clarify definitions specifically; 1) Plan of Care: The clinical plan of care includes: K) Safety Measures N) Orders for specific home health services and disciplines, treatments and procedures, including amount/frequency/duration O) Supplies and equipment required U) Other appropriate</p>	05/01/2013
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157607	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 819 E 9TH ST ROCHESTER, IN 46975
--	--

(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>certification period of 3/26/13 to 5/24/13 that failed to evidence all of patient's equipment and supplies. The plan of care also included "Other Pertinent Diagnoses" of "V15.88 Personal History of Fall" but failed to list fall precautions under "Safety Measures."</p> <p>A. On 4/2/13 at 10:15 AM, home visit observation evidenced patient had durable medical equipment of shower chair and a walker. These items were not included on the plan of care.</p> <p>B. On 4/3/13 at 12:45 PM, employee B (alternate administrator) and employee C (alternate nursing supervisor) indicated Fall Precautions should have been listed under Safety Measures on the plan of care.</p> <p>2. Clinical record #4, start of care 1/2/13, included a plan of care for the certification period of 3/3/13 to 5/1/13 with the order, "AID provide personal care for safety considerations, personal hygiene / cleanliness, dressing / undressing, bathing, and Foley catheter care / monitoring." The order failed to evidence the duration and frequency of Home Health Aide visits.</p> <p>3. Agency policy titled "Care Planning Process" with a revised / reviewed date of</p>		<p>items such as precautions and contraindications B. Identification of all patients's equipments and supplies and to ensure that these are evidenced and documented in the plan of care. C. Documentation of the diagnosis of History of Falls or any Risk for falls under Safety measures and in the Plan of Care and Home Health Aide Care Plan if a diagnosies of History of Falls or if Fall Risk is identified. D. Ensure that any Home Health Aide (or any discipline) treatment or services is identified in the plan of care and on the Start of Care Assessment should have a corresponding order reflecting frequency and duration.2. One hundred percent of the charts will be audited monthly to ensure deficiencies have been addressed. Threshold is 95% compliance. Once threshold is met, will audit 10% of charts quarterly to ensure ongoing compliance with regulations. This will be presented in the Quality Assurance/Quality Improvement Meetings as part of the benchmarking for clinical improvements.3. Administrator is responsible.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157607	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/03/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TRINITY HEALTHCARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 819 E 9TH ST ROCHESTER, IN 46975
--	--

(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
	2011 states, "Definitions 1. Plan of Care: The clinical plan of care includes: ... K. Safety Measures ... N. Orders for specific home health services and disciplines, treatments and procedures, including amount/frequency/duration O. Supplies and equipment required ... U. Other appropriate items such as precautions and contraindications."			