

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/03/2014
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW HOME HEALTH & HOSPICE	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 CAREW ST STE 6 FORT WAYNE, IN 46805
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G000000	<p>This was a home health recertification survey. This was a partial extended survey.</p> <p>Survey Dates: February 25, 26, 27, and 28 and March 3, 2014. Partial Extended Survey Dates: February 28 and March 3, 2014.</p> <p>Facility Number: IN008347</p> <p>Medicaid Number: 200034360A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 3360 Home Health Aide Only: 5 Personal Care Only: 0 Total: 3365</p> <p>Sample: RR w/HV: 10 RR w/o HV: 10 Total: 20</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 4, 2014</p>	G000000		
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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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G000229	<p>484.36(d)(2) SUPERVISION</p> <p>The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse (RN) completed a supervisory visit of the Home Health Aide (HHA) every 14 days in 1 of 1 record reviewed of patients who received skilled and HHA services for longer than 14 days, creating the potential to affect all the agency's patients who receive skilled and HHA services for longer than 14 days. (#9)</p> <p>Findings include</p> <p>1. Clinical record #9, start of care 6/6/13, contained a Plan of Care dated 12/13/13-2/10/14 with orders for Skilled Nurse (SN) 1 time a month for 2 months to start week of 12/19/13 and recheck PT/INR 12/19/13 and HHA 2 times a week for 9 weeks. The record failed to evidence a HHA supervisory visit had been completed between 12/19/13 and 2/10/14. The record evidenced a supervisory visit was not completed until 2/13/14, in the next certification period of 2/11-4/11/14.</p>	G000229	<p>An RN will complete and document a home health aide supervisory visit every 14 days on all home care patients that have skilled nursing and home health aide services ordered. An audit will be conducted on 30 open records that have both nursing and aide visits ordered to check the frequency of the aide supervision and ensure they were done every 14 days. The first 30 records will be audited by 4/1/14. Further auditing will be conducted every month of 10 open records with a total of 30 records every quarter for the next 9 months. If compliance is not sustained by 12/31/14, monthly auditing of 10 open records a month will continue until compliance is sustained for 3 consecutive months. Any error found on the record regarding aide supervision will be reported to the manager and the lead RN who will follow up with the clinician who was responsible for the error. Detailed education on the error and the correct process will be provided. The policy for aide supervision will be updated to provide better detail on the process. The clinical staff will be educated on the process of ensuring home health</p>	04/01/2014			

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G000236	<p>2. On 2/28/14 at 1:40 PM, employee H indicated the aide supervisory visits only need to be done every 30 days because the nurse only does a lab draw. The VA pays for the lab draw and aide services, and the lab draw is not a qualifying skill for Medicare.</p> <p>3. The agency's policy titled "Home Health Aide Supervision every 14 days," dated 8/1/10 states "If the patient receives skilled nursing care - The Registered Nurse must perform the supervisory visit. The RN must make an on-site visit to the patient's home no less frequently than every 14 days."</p> <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. Based on clinical record review, policy review, and interview, the agency failed to ensure a discharge summary was</p>	G000236	<p>aide supervisory visits are made every 14days when a nurse or therapist is also providing ordered care in the home. The clinical staff will also be provided with the written updated policy for aide supervision. The Clinical Manager will be responsible for auditing this process and preventing re-occurrence of non-compliance with all the corrective actions noted above.</p> <p>A Discharge summary will be documented on all discharge home care patients. An audit will be conducted on 50 discharged</p>	04/01/2014

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	<p>prepared and entered into the record for 1 of 10 discharge records reviewed, creating the potential to affect all discharge records. (#19)</p> <p>Findings include</p> <ol style="list-style-type: none"> <li>1. Clinical record #19, start of care date 8/29/13, evidenced the patient was discharged on 9/10/13. The record failed to evidence a discharge summary had been prepared and placed in the record.</li> <li>2. On 2/25/14 at 9:40 AM, employee H indicated the timeframe for documents to be filed within the patient records is 14 days.</li> <li>3. On 3/3/14 at 10:35 AM, employees H and I both indicated the discharge summary was not in this record.</li> <li>4. On 3/3/14 at 10:45 AM, employee H indicated discharge paperwork should all be in the record within 30 days of the discharge date, and summaries are automatically sent to the physicians upon discharge.</li> <li>5. The agency's policy titled "Discharge Process," # 2.022, revised 3/26/12 states "9. a discharge summary is completed for all discharged patients 10. The</li> </ol>		<p>records to ensure a discharge summary is completed and documented. The 50 discharged records will be audited by 4/1/14. Further auditing will be conducted every month of 10 discharged records with a total of 30 records every quarter for the next 9 months. If compliance is not sustained by 12/31/14, monthly auditing of 10 discharge records a month will continue until compliance is sustained for 3 consecutive months. Any discharged record found without a discharge summary will be reported to the manager and the lead RN who will follow up with the clinician who was responsible for the error. All clinical staff will be educated on the process of completing a discharge summary. The Clinical Manager will be responsible for auditing this process and preventing re-occurrence of non-compliance with all the corrective actions noted above.</p>				

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N000000	<p>discharge summary and medication profile is mailed to the physician. ... Documentation ... 3. Information will be documented on the Discharge summary form. ... 5. All discharge paperwork will be completed within 30 days. 6. The discharge record is organized according to Parkview Home Health &amp; Hospice policy regarding clinical record contents."</p> <p>This was a home health state licensure survey.</p> <p>Survey Dates: February 25, 26, 27, and 28 and March 3, 2014. Partial Extended Survey Dates: February 28 and March 3, 2014.</p> <p>Facility Number: IN008347</p> <p>Medicaid Number: 200034360A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 3360 Home Health Aide Only: 5 Personal Care Only: 0 Total: 3365</p>	N000000		

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N000606	<p>Sample: RR w/HV: 10 RR w/o HV: 10 Total: 20</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 4, 2014</p> <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, policy review, and interview, the agency failed to ensure the registered nurse (RN) completed a supervisory visit of the Home Health Aide (HHA) every 14 days as required by agency policy in 1 of 1 record reviewed of patients who received skilled and HHA services for longer than 14 days, creating the potential to affect all the agency's patients who receive skilled and HHA services for longer than 14 days. (#9)</p> <p>Findings include</p>	N000606	An RN will complete and document a home health aide supervisory visit every 14 days on all home care patients that have skilled nursing and home health aide services ordered. An audit will be conducted on 30 open records that have both nursing and aide visits ordered to check the frequency of the aide supervision and ensure they were done every 14 days. The first 30 records will be audited by 4/1/14. Further auditing will be conducted every month of 10 open records with a total of 30 records every quarter for the next 9 months. If compliance is not sustained by 12/31/14, monthly auditing of 10 open records a month will	04/01/2014	

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N000608	<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 review, policy review, and interview, the agency failed to ensure a discharge summary was prepared and entered into the record for 1 of 10 discharge records reviewed, creating the potential to affect all discharge records. (#19)</p> <p>Findings include</p> <p>1. Clinical record #19, start of care date 8/29/13, evidenced the patient was discharged on 9/10/13. The record failed to evidence a discharge summary had been prepared and placed in the record.</p>	N000608	A Discharge summary will be documented on all discharge home care patients. An audit will be conducted on 50 discharged records to ensure a discharge summary is completed and documented. The 50 discharged records will be audited by 4/1/14. Further auditing will be conducted every month of 10 discharged records with a total of 30 records every quarter for the next 9 months. If compliance is not sustained by 12/31/14, monthly auditing of 10 discharge records a month will continue until compliance is sustained for 3 consecutive months. Any discharged record found without a discharge summary will be	04/01/2014			

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