STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOME HEALTH CARE	2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
G0000	This was a Home Health Federal recertification survey. This was a partial extended survey. Survey Dates: June 4-7, 2012 Partial Extended date: June 6, 2012 Facility #: IN008749 Medicaid #: 2000065690A Surveyor: Miriam Bennett, RN, BSN, PHNS Census Service Type: Skilled: 45 Home Health Aide Only: 111 Personal Care Only: 38 Total: 194 Sample: RR w/HV: 6 RR w/o HV: 6 Total: 12 Quality Review: Joyce Elder, MSN, BSN, RN June 12, 2012	G0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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	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. Based on observation during home visits, policy review, and interview, the agency failed to ensure employees were following infection control policies and procedures for 5 of 6 home visits with the potential to affect all the agency's patients. (# 2, 3, 4, 6, and 7) Findings include: 1. During home visit observation on 6/4/12 at 3:15 PM, employee R, a physical therapist, used an automatic blood pressure cuff and a thermometer on patient #2. These pieces of equipment were returned to their holders without being cleaned first. 2. During home visit observation on 6/5/12 at 8:30 AM, employee R was observed preparing to give patient #3 a bed bath. The employee's equipment / paperwork bag was sitting on top of a clothing drawer container with no barrier under the bag. The employee moved the bag to the floor and preceded to place clean towels on the clothing drawer container without cleaning the surface.	G0121	G121 The Clinical Manager will inservice all direct care staff for the control of communicable disease with applicable state and federal laws.RN Case Managers will be responsible for monitoring compliance with agency policy regarding infection control on monthly supervisory visits.The Clinical Manager will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	07/26/2012

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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806	

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	During observation of the bed bath, employee R did not change the bath water and used the same gloves for the entire bath, including applying Vaseline to the patient's buttocks area, and then preceded to lotion the patient's back and applying Nystatin powder to the abdominal folds. The same water, gloves, and wash cloth were used next to provide catheter care after washing the buttocks area. The same water and gloves were used to clean around the g-tube site after having washed the entire body. 3. During home visit observation on 6/5/12 at 10:30 AM, employee A, an aide, was observed washing hands in preparation to provide a bed bath for patient #4. Employee only washed hands for approximately 10 seconds. After changing the bath water, employee washed hands again but only scrubbed with soap for approximately 5 seconds. During perineal area care and catheter care, employee cleaned the catheter tubing in the direction toward the patient. 4. During home visit observation on 6/6/12 at 8:00 AM, employee C, a Home Health Aide, was observed to provide a bed bath for patient #6. Employee C was observed washing the patient's perineal area in a back to front, front to back, up and down motion. After completing bath,			

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	employee C cleaned bedside table with a Clorox wipe, removed gloves, and put on clean gloves then preceded directly to applying deodorant and lotion to patient without washing hands in between glove change. Employee C's equipment / paperwork bag was sitting directly on floor without a barrier between the bag and the floor. 5. During home visit observation on 6/6/12 at 10:30 AM, employee F, a LPN (Licensed Practical Nurse), was observed brushing the teeth of patient #7. Once finished, employee removed gloves and donned new gloves without washing hands. When bath was completed and patient's deodorant and shirt were applied, employee removed gloves and went to kitchen to prepare food for patient. Employee did not wash hands prior to preparing food. Once food was in microwave to warm it up, employee washed hands for approximately 5 seconds. 6. The agency's policy titled "Infection Control," dated 3/1/95 and revised 3/12/04, states, "1. All Community Home Health Care staff will follow infection control procedures. ... 4. Universal precautions will be consistently used for all clients." Under the section titled "Procedure" the policy states, " ... 3.			

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	Effective handwashing techniques should be carried out before and after any client contact or procedure, before meal preparation, after handling soiled contaminated materials, and after going to the toilet. This procedure consists of the following steps: ... b. Wash hands and wrists using friction 10-15 seconds, longer if hands are visibly soiled." Also, the policy states, " ... 11. Environmental infection control procedures include, but are not limited to, the following: ... h. Maintain the maintenance and cleaning schedule for all client equipment and supplies." 7. The agency's handout sheets used during employee orientation and Blitz (yearly competency) education were provided on 6/6/12 by employee J and indicated these are currently used for orientation and Blitz. Under the section "Wash hands as required," the education paperwork states, "Even if you wear gloves, be sure to wash your hands before and after: ... handling items that may be (or could get) contaminated. Always wash your hands before putting on and after removing gloves." 8. The agency's policy titled "Infection Control: Cleaning of Company-Owned Medical Equipment," dated 4/1/96 and revised 9/1/98, states, "Company-owned			

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	medical equipment will be cleaned and disinfected with an antimicrobial agent monthly, when equipment returned to the office after client use, and after office staff use." During interview on 6/6/12 at approximately 1:40 PM, employee B indicated there should be a comma between "office and after" in the policy so that it reads as follows: ...when equipment returned to the office, after client use, ...". 9. The agency's policy titled "Infection Control: Bag Technique", dated 9/1/98, states, "All CHHC staff will follow infection control procedures for bag technique." Under the section titled "Procedure" it states, "2. All bags will be placed on a disposable barrier (i.e. newspaper) while in the client home. ... 4. Do not place bags on the floor." 10. During interview on 6/6/12 at 12:50 PM, employee B indicated the agency will have to refresh their employees on policies for hand washing and bag technique as some may have forgotten about them since orientation. But also each employee signed the orientation sheets indicating they understood the policies as presented at that time. This would be another check during			

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	supervisory visits when the employees are present.			

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G0159	484.18(a) PLAN OF CARE 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. Based on observation during home visits, clinical record review, policy review, and interview, the agency failed to ensure all DME (Durable Medical Equipment) was entered on the POC (Plan of Care) and the physician signed a Do Not Resuscitate order timely for 5 of 6 home visit patients with the potential to affect all the agency's patients. (# 2, 4, 5, 6, and 7) Findings include: 1. Clinical record #2, SOC (Start of Care) 1/02/10, contained a POC for the certification period 4/21/-6/19/12. During home visit on 6/4/12 at 3:20 PM, patient was observed to have a shower chair and CPAP (Constant Positive Airway Pressure) machine in the home. These DME were not listed on the POC. 2. Clinical record #4, SOC 3/24/03, contained a POC for the certification	G0159	G 159 The Clinical Manager has inserviced all RN Case Managers to ensure that all DME (Durable Medical Equipment) is entered on the Plan of Care (POC).10% of all POC's will be monitored quarterly for evidence that all DME is entered on the POC.The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	06/19/2012

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	period 6/4-8/2/12. During home visit on 6/5/12 at 10:30 AM, patient was observed to have a hospital bed and an electric wheelchair. These DME were not listed on the POC. 3. Clinical record #5, SOC 12/22/11, contained a POC for the certification period 5/30-7/28/12. During home visit on 6/5/12 at 1:30 PM, patient was observed to have an electric wheelchair in the room. This DME was not listed on the POC. During interview on 6/5/12 during home visit, patient indicated they use the electric wheelchair off and on. The record evidenced a "Do Not Resuscitate Request/Order" indicating the patient did want this order, signed by the patient and the Care Manager for the agency on 12/30/11. The physician did not sign order until 5/31/12. A. During interview on 6/6/12 at at 2:50 PM, employee E indicated the plan of care did not reflect the DNR (Do Not Resuscitate) status since the order was not back yet. B. During interview on 6/7/12 at 3:10 PM, employees B and J agreed the length of time was not efficient for receiving the document back and during that time the patient was considered a Resuscitate			

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	patient. C. The agency's policy titled "Client Plan of Care," dated 7/5/95, Revised 9/1/98, states, "3. Changes in the plan of treatment are documented through written and signed physician orders." 4. Clinical record #6, SOC 10/17/11, contained a POC for the certification period 4/14-6/12/12. During home visit on 6/6/12 at 8:00 AM, patient was observed to have a Shower Buddy chair. This DME was not listed on the POC. During home visit at approximately 8:50 AM, employee C, a HHA (Home Health Aide), indicated the Shower Buddy chair is used twice a week to give the patient a full shower. 5. Clinical record #7, SOC 3/19/07, contained a POC for the certification period 4/21-6/19/12. During home visit on 6/6/12 at 10:00 AM, patient was observed to have a stander board, nebulizer, trach humidifier, air mattress, and hand splints. These DME were not listed on the POC. 6. The agency's policy titled "Client Plan of Care," dated 7/5/95, Revised 9/1/98, states "2. The client plan of care: ... b. includes the following ... (14) medical supplies/appliances necessary"			

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	7. During interview on 6/5/12 at 11:40 AM, employee B indicated sometimes the patients acquire new equipment the office is not aware of.			

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G0170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on home visit observation, clinical record review, and interview, the agency failed to ensure skilled nursing services were provided as ordered on the plan of care for 1 of 6 home visit patients. (#7) Findings include: 1. Clinical record #7, SOC (start of care) 3/19/07, contained a Plan of Care for the certification period 4/21 - 6/19/12 that identified the patient was NPO (nothing by mouth). The patient has a trach. During home visit on 6/6/12 at 11:00 AM, employee F, a LPN (Licensed Practical Nurse), was observed brushing the patient's teeth. The patient swallowed an initial bolus of tooth paste at the beginning of the procedure. The LPN wet the tooth brush with water to give a rinsing to the teeth. Once the watered tooth brush was in the patient's mouth, the patient swallowed two gulps of water. The LPN indicated this is normal for the patient during tooth brushing. 2. During interview on 6/6/12 at 12:40 PM, employee J indicated the nursing task list is tailored to each patient according to what the physician has ordered for their	G0170	G 170 The Clinical Manager contacted the patient's physician for clarification and received an updated order for brushing the patient's teeth.The RN Case Manager will monitor for compliance on supervisory visits.10% of all clinical records will be audited quarterly for evidence that skilled nursing services are provided in accordance with the plan of care.The Clinical Manager will be responsible for monitoring these corrective services to ensure that this deficiency is corrected and will not recur.	07/03/2012

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	care and also for nursing duty tasks.			

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G0225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on employee file review, clinical record review, and interview, the agency failed to ensure a Home Health Aide was on and in good standing on the Indiana Home Health Aide registry for a period of 5 years and allowed the aide to provide Home Health Aide services as a CNA (Certified Nursing Assistant) for that time frame for 1 of 11 Home Health Aide files reviewed and failed to ensure the Home Health Aides performed duties as assigned for 3 of 12 records reviewed with the potential to affect all the agency's patients. (employee A), (patient # 1, 5, and 12) Findings include: 1. Employee file A indicated the employee completed the IAHHC (Indiana Association of Home Health Care) Test on 2/27/07. The file failed to evidence the agency had checked to see if the aide was on and in good standing on the Home Health Aide Registry. The file also failed to contain an application to place the aide on the registry and the Home Health Aide verification paperwork.	G0225	G 225 The agency HR department has filed an application to place the Home Health Aide on the registry.10% of all employee files will be monitored quarterly for evidence that the individuals that furnish services on the agency's behalf be entered on and in good standing on the state aide registry.The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	07/26/2012

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	2. During interview on 6/5/12 at 12:50 PM, employee E indicated that employee S checked Access Indiana for the Home Health Aide Registry verification and confirmed the aide was not placed on the Indiana Aide registry in 2007. 3. Under Indiana's Article 17. Home Health Agencies, 410 IAC 17-9-17 "Home health aide services" defined, Authority: IC 16-27-1-7, Affected: IC 16-27-1, Section 17 states, "Home health aide services" means only those home health serviced that may be performed by a home health aide. (Indiana State Department of Health; 410 IAC 17-9-17)." Rule 9 states, "The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: ... (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and (B) be entered on and in good standing on the state aide registry." 4. Clinical record #1 contained a Home Care Assignment Sheet for the certification period 3/28-5/26/12. Duties assigned for "each visit" included Bed			

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	Bath Complete, Skin Intact, Assist w/Dressing, Hair Care, Foot Care, Lotion, and Encourage Fluids. Shampoo was assigned weekly on Fridays. a. The Home Health Aide Charting sheet dated 5/21/12, 5/23/12, 5/25/125/15/12, 5/16/12, and 5/18/12 failed to evidence a complete bed bath was performed and the patient received a Bed Bath Assist. b. The Home Health Aide Charting sheets dated 5/4/12, and 5/11/12 failed to evidence a shampoo was performed on those Fridays. 5. Clinical record #5 contained a Home Care Assignment Sheet for the certification period 3/31-5/29/12. Duties assigned for "each visit" include: Client choice each visit for Shower / tub assist bath or Bed Bath Assist, Skin Intact, Hair Care, Lotion / Massage, Last B.M. (Bowel Movement) Date, Meal / snack preparation, Encourage Fluids, and Medication remind / assist. a. The Home Health Aide Charting sheet dated 4/4/12 failed to evidence the duties of a bath, encourage fluids, meal / snack preparation, and medication remind / assist were performed on that day.			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806	

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	b. The Home Health Aide Charting sheet dated 4/21/12, 5/22/12, 5/24/12, and 5/26/12 failed to evidence the duties of encourage fluids, meal / snack preparation, and medication remind / assist were performed on those days. 6. Clinical record #12 contained a Home Care Assignment Sheet for the certification period 4/5-6/3/12. Duties assigned for "each visit" included client choice of tub assist bath or chair bath partial, skin intact, assist w/dressing, deodorant remind, hair care, foot care, lotion, last B.M. Date, meal / snack preparation, encourage fluids. Shampoo every Friday. The Home Health Aide Charting Sheet dated 4/20/12, 5/4/12, 5/11/12, 5/25/12, and 6/1/12 failed to evidence the client received a shampoo on those Fridays.			

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N0470	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. Based on observation during home visits, policy review, and interview, the agency failed to ensure employees were following infection control policies and procedures for 5 of 6 home visits with the potential to affect all the agency's patients. (# 2, 3, 4, 6, and 7) Findings include: 1. During home visit observation on 6/4/12 at 3:15 PM, employee R, a physical therapist, used an automatic blood pressure cuff and a thermometer on patient #2. These pieces of equipment were returned to their holders without being cleaned first. 2. During home visit observation on 6/5/12 at 8:30 AM, employee R was observed preparing to give patient #3 a bed bath. The employee's equipment / paperwork bag was sitting on top of a clothing drawer container with no barrier under the bag. The employee moved the bag to the floor and preceded to place clean towels on the clothing drawer	N0470	N470 The Clinical Manager will inservice all direct care staff for the control of communicable disease with applicable state and federal laws.RN Case Managers will be responsible for monitoring compliance with agency policy regarding infection control on monthly supervisory visits.The Clinical Manager will be responsible for monitoring these corrective actions to ensure that the deficiency is corrected and will not recur.	07/26/2012

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	container without cleaning the surface. During observation of the bed bath, employee R did not change the bath water and used the same gloves for the entire bath, including applying Vaseline to the patient's buttocks area, and then preceded to lotion the patient's back and applying Nystatin powder to the abdominal folds. The same water, gloves, and wash cloth were used next to provide catheter care after washing the buttocks area. The same water and gloves were used to clean around the g-tube site after having washed the entire body. 3. During home visit observation on 6/5/12 at 10:30 AM, employee A, an aide, was observed washing hands in preparation to provide a bed bath for patient #4. Employee only washed hands for approximately 10 seconds. After changing the bath water, employee washed hands again but only scrubbed with soap for approximately 5 seconds. During perineal area care and catheter care, employee cleaned the catheter tubing in the direction toward the patient. 4. During home visit observation on 6/6/12 at 8:00 AM, employee C, a Home Health Aide, was observed to provide a bed bath for patient #6. Employee C was observed washing the patient's perineal area in a back to front, front to back, up			

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	and down motion. After completing bath, employee C cleaned bedside table with a Clorox wipe, removed gloves, and put on clean gloves then preceded directly to applying deodorant and lotion to patient without washing hands in between glove change. Employee C's equipment / paperwork bag was sitting directly on floor without a barrier between the bag and the floor. 5. During home visit observation on 6/6/12 at 10:30 AM, employee F, a LPN (Licensed Practical Nurse), was observed brushing the teeth of patient #7. Once finished, employee removed gloves and donned new gloves without washing hands. When bath was completed and patient's deodorant and shirt were applied, employee removed gloves and went to kitchen to prepare food for patient. Employee did not wash hands prior to preparing food. Once food was in microwave to warm it up, employee washed hands for approximately 5 seconds. 6. The agency's policy titled "Infection Control," dated 3/1/95 and revised 3/12/04, states, "1. All Community Home Health Care staff will follow infection control procedures. ... 4. Universal precautions will be consistently used for all clients." Under the section titled			

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	"Procedure" the policy states, " ... 3. Effective handwashing techniques should be carried out before and after any client contact or procedure, before meal preparation, after handling soiled contaminated materials, and after going to the toilet. This procedure consists of the following steps: ... b. Wash hands and wrists using friction 10-15 seconds, longer if hands are visibly soiled." Also, the policy states, " ... 11. Environmental infection control procedures include, but are not limited to, the following: ... h. Maintain the maintenance and cleaning schedule for all client equipment and supplies." 7. The agency's handout sheets used during employee orientation and Blitz (yearly competency) education were provided on 6/6/12 by employee J and indicated these are currently used for orientation and Blitz. Under the section "Wash hands as required," the education paperwork states, "Even if you wear gloves, be sure to wash your hands before and after: ... handling items that may be (or could get) contaminated. Always wash your hands before putting on and after removing gloves." 8. The agency's policy titled "Infection Control: Cleaning of Company-Owned Medical Equipment," dated 4/1/96 and			

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	revised 9/1/98, states, "Company-owned medical equipment will be cleaned and disinfected with an antimicrobial agent monthly, when equipment returned to the office after client use, and after office staff use." During interview on 6/6/12 at approximately 1:40 PM, employee B indicated there should be a comma between "office and after" in the policy so that it reads as follows: ...when equipment returned to the office, after client use, ...". 9. The agency's policy titled "Infection Control: Bag Technique", dated 9/1/98, states, "All CHHC staff will follow infection control procedures for bag technique." Under the section titled "Procedure" it states, "2. All bags will be placed on a disposable barrier (i.e. newspaper) while in the client home. ... 4. Do not place bags on the floor." 10. During interview on 6/6/12 at 12:50 PM, employee B indicated the agency will have to refresh their employees on policies for hand washing and bag technique as some may have forgotten about them since orientation. But also each employee signed the orientation sheets indicating they understood the policies as presented at that time. This			

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	would be another check during supervisory visits when the employees are present.			

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N0524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (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: (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. Based on observation during home visits, clinical record review, policy review, and interview, the agency failed to ensure all DME (Durable Medical Equipment) was entered on the POC (Plan of Care) and the physician signed a Do Not Resuscitate order timely for 5 of 6 home visit patients with the potential to affect all the agency's patients. (# 2, 4, 5, 6, and 7) Findings include:	N0524	N 524 The Clinical Manager has inserviced all RN Case Managers to ensure that all DME (Durable Medical Equipment) is entered on the Plan of Care (POC).10% of all POC's will be monitored quarterly for evidence that all DME is entered on the POC.The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	06/19/2012

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	1. Clinical record #2, SOC (Start of Care) 1/02/10, contained a POC for the certification period 4/21/-6/19/12. During home visit on 6/4/12 at 3:20 PM, patient was observed to have a shower chair and CPAP (Constant Positive Airway Pressure) machine in the home. These DME were not listed on the POC. 2. Clinical record #4, SOC 3/24/03, contained a POC for the certification period 6/4-8/2/12. During home visit on 6/5/12 at 10:30 AM, patient was observed to have a hospital bed and an electric wheelchair. These DME were not listed on the POC. 3. Clinical record #5, SOC 12/22/11, contained a POC for the certification period 5/30-7/28/12. During home visit on 6/5/12 at 1:30 PM, patient was observed to have an electric wheelchair in the room. This DME was not listed on the POC. During interview on 6/5/12 during home visit, patient indicated they use the electric wheelchair off and on. The record evidenced a "Do Not Resuscitate Request/Order" indicating the patient did want this order, signed by the patient and the Care Manager for the agency on 12/30/11. The physician did not sign order until 5/31/12.			

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	A. During interview on 6/6/12 at at 2:50 PM, employee E indicated the plan of care did not reflect the DNR (Do Not Resuscitate) status since the order was not back yet. B. During interview on 6/7/12 at 3:10 PM, employees B and J agreed the length of time was not efficient for receiving the document back and during that time the patient was considered a Resuscitate patient. C. The agency's policy titled "Client Plan of Care," dated 7/5/95, Revised 9/1/98, states, "3. Changes in the plan of treatment are documented through written and signed physician orders." 4. Clinical record #6, SOC 10/17/11, contained a POC for the certification period 4/14-6/12/12. During home visit on 6/6/12 at 8:00 AM, patient was observed to have a Shower Buddy chair. This DME was not listed on the POC. During home visit at approximately 8:50 AM, employee C, a HHA (Home Health Aide), indicated the Shower Buddy chair is used twice a week to give the patient a full shower. 5. Clinical record #7, SOC 3/19/07, contained a POC for the certification period 4/21-6/19/12. During home visit			

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	on 6/6/12 at 10:00 AM, patient was observed to have a stander board, nebulizer, trach humidifier, air mattress, and hand splints. These DME were not listed on the POC. 6. The agency's policy titled "Client Plan of Care," dated 7/5/95, Revised 9/1/98, states "2. The client plan of care: ... b. includes the following ... (14) medical supplies/appliances necessary" 7. During interview on 6/5/12 at 11:40 AM, employee B indicated sometimes the patients acquire new equipment the office is not aware of.			

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N0537	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on home visit observation, clinical record review, and interview, the agency failed to ensure skilled nursing services were provided as ordered on the plan of care for 1 of 6 home visit patients. (#7) Findings include: 1. Clinical record #7, SOC (start of care) 3/19/07, contained a Plan of Care for the certification period 4/21 - 6/19/12 that identified the patient was NPO (nothing by mouth). The patient has a trach. During home visit on 6/6/12 at 11:00 AM, employee F, a LPN (Licensed Practical Nurse), was observed brushing the patient's teeth. The patient swallowed an initial bolus of tooth paste at the beginning of the procedure. The LPN wet the tooth brush with water to give a rinsing to the teeth. Once the watered tooth brush was in the patient's mouth, the patient swallowed two gulps of water. The LPN indicated this is normal for the patient during tooth brushing. 2. During interview on 6/6/12 at 12:40 PM, employee J indicated the nursing task	N0537	N 537 The Clinical Manager contacted the patient's physician for clarification and received an updated order for brushing the patient's teeth.The RN Case Manager will monitor for compliance on supervisory visits.10% of all clinical records will be audited quarterly for evidence that skilled nursing services are provided in accordance with the plan of care.The Clinical Manager will be responsible for monitoring these corrective services to ensure that this deficiency is corrected and will not recur.	07/03/2012

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	list is tailored to each patient according to what the physician has ordered for their care and also for nursing duty tasks.			

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N0597	410 IAC 17-14-1(l)(1)(B) Scope of Services Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on employee file review and interview, the agency failed to ensure a Home Health Aide was on and in good standing on the Indiana Home Health Aide registry for 1 of 11 Home Health Aide files reviewed with the potential to affect all the agency's patients. Findings include: 1. Employee file A indicated the employee completed the IAHHC (Indiana Association of Home Health Care) Test on 2/27/07. The file failed to evidence the agency had checked to see if the aide was on and in good standing on the Home Health Aide Registry. The file also failed to contain an application to place the aide on the registry and the Home Health Aide verification paperwork. 2. During interview on 6/5/12 at 12:50 PM, employee E indicated that employee S checked Access Indiana for the Home Health Aide Registry verification and confirmed the aide was not placed on the Indiana Aide registry in 2007.	N0597	N 597 The agency HR department has filed an application to place the Home Health Aide on the registry.10% of all employee files will be monitored quarterly for evidence that the individuals that furnish services on the agency's behalf be entered on and in good standing on the state aide registry.The Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur.	07/26/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
N0606	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. Based on clinical record review, policy review, and interview, the agency failed to ensure the registered nurse completed a Home Health Aide supervisory visit every thirty days for 1 of 5 records reviewed of patients receiving Home Health Aide only services, with the potential to affect all the agency's patients who receive Home Health Aide only services. (#12) Findings include: 1. Clinical record #12, start of care 2/15/10, contained a plan of care for the certification period 4/5-6/3/12 with orders for HHA (Home Health Aide) only services 2-4 days a week. A HHA supervisory visit was performed on 4/2/12. The next HHA supervisory visit was performed on 5/4/12. 2. During interview on 6/6/12 at 2:20 PM, employee J indicated the supervisory visit was not performed on 5/2/12 as expected due to the aide was not scheduled to be there that day and the	N0606	N 606 The agency will revise its policy to remove the procedure that the Home Health Aide must be present at every other supervisory visit.10% of all clinical records will be audited quarterly for evidence that supervisory visits occur every 30 days, either when the home health aide is absent or present.The Clinical Manager will be responsible for monitoring this corrective action to ensure that this deficiency will not recur.	07/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/07/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOME HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 S LAFAYETTE ST STE 210 FORT WAYNE, IN 46806	

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	current agency policy states the aide has to be present at every other supervisory visit. Employee B indicated this policy was written per the Indiana regulations for Home Health Aide supervisory visits back when the regulations stated the aide had to be present at every other supervisory visit. 3. The agency's policy titled "Home Health Aide Supervisory Visits," dated 3/1/95 and revised July 1997, states under the section "Procedure," "a. Clients receiving Home Health Aide services only: i. Registered Nurse makes supervisory visit in the client's residence every 30 days. ii. The Home Health Aide must be observed / present in the client's home every 60 days."			