

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 04/25/2012	
NAME OF PROVIDER OR SUPPLIER  FIVE STAR HOME HEALTH OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 2601 COVINGTON COMMONS DRIVE FORT WAYNE, IN 46804			
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N0000	<p>This was a Home Health initial State licensure survey</p> <p>Survey dates: April 23, 24, and 25, 2012</p> <p>Facility #: 012775</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled Nursing: 13 Home Health Aide only: 25 Total: 39</p> <p>Sample:</p> <p>RR w/HV: 5 RR wo/HV: 6 Total: 11</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN April 26, 2012</p>	N0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 employees changed gloves when contaminated and cleaned equipment prior to using on a patient for 3 of 5 home visits with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. During home visit with patient #8 on 4/23/12 at 2:00 PM, employee I, a home health aide, was observed assisting patient with a shower. While undressing the patient, employee I removed a soiled under garment from the patient and proceeded to pick up clean towels without changing gloves. The employee continued with the shower.</p> <p>A. During interview on 4/23/12 at 2:30 PM, employee L indicated the Aide was nervous, but the aide should have changed the gloves after removing the soiled undergarments.</p> <p>B. During interview on 4/25/12 at</p>	N0470	<p>N470 Home Health Agency Administration/ManagementIt is the practice of this agency that policies and procedures are written and implemented for the control of communicable disease in compliance with applicable federal and state laws.1. The Home Health Agency/Management shall have a written policy and procedure to include glove use specifying proper use when moving from a contaminated site to a clean-body site during resident care, and/or after contact with soiled or contaminated articles such as blood or bodily fluids. 5/24/12The Home Health Agency/Management shall also have a written policy and procedure to include the proper cleaning of diagnostic equipment including but not limited to, blood pressure cuffs and stethoscope use before and after each contact with agency clients. 5/24/122. The Administrator/Director of Nursing has taken communicative action with employee "I" in re-educating the Standard and Universal Precautions of glove use. 4/23/12The Administrator has taken communicative action</p>	05/24/2012			

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	<p>11:00 AM, employee L indicated there is not a written policy concerning the use of gloves but all employees are educated on universal precautions during orientation and are instructed when to use and change gloves during resident care.</p> <p>2. During home visit with patient #11 on 4/24/12 at 9:45 AM, employee K was observed using a stethoscope, automatic blood pressure cuff, and a manual blood pressure cuff. None of this equipment was observed to have been cleaned before or after use.</p> <p>3. During home visit with patient #9 on 4/24/12 at 10:00 AM, employee K was observed using a stethoscope and a manual blood pressure cuff. None of this equipment was observed to have been cleaned before or after use.</p> <p>4. During interview on 4/24/12 at 10:10 AM, employee L indicated there is not a policy for cleaning any equipment before and after use except for the thermometers.</p> <p>5. The agency's policy titled "Hand Washing," #CL-IC-3024, revision date 10/1/09, states under section "5.0 Procedure, 1. Hand washing is performed: ... d. Wash hands if moving from a contaminated-body site to a clean-body site during resident care, e. After contact</p>		<p>with employee "K" in re-education of personal equipment cleaning before and after use of each client. 4/24/123. The Administrator has scheduled a mandatory in-service for all home health staff to educate and review policies on glove use and cleaning of diagnostic equipment. 5/24/124. The Administrator/Director of Nursing will ensure that the new policies will be part of new hire orientation and annual review. On-going.</p>				

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	with soiled or contaminated articles, such as articles that are contaminated with blood or body fluids."			

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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 observation, clinical record review, policy review, and interview, the agency failed to ensure the plan of care included all DME (durable medical equipment) used by patients 3 of 11 records reviewed with the potential to affect all the agency's patients. (#3, 8, and 11).</p> <p>Findings include:</p> <p>1. Clinical record #3 included a plan of</p>	N0524	N 525 Home Health Agency Administration/ManagementIt is the practice of this agency to enter all DME's and/or equipment which are used or may be used on the Plan of Care.1. The Administrator/Director of Nursing shall enter all DME and/or equipment which is used or may be used on each Medical/Non-Medical Plan of Care to be sent to physician, dentist, chiropractor, optometrist, or podiatrist for periodic review (every 60 days) beginning	05/24/2012			

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	<p>care for the care dates 3/2/12 -5/1/12. The care period should end on 4/30/12.</p> <p>On 4/24/12 at 11 AM, employee L indicates she counts days for a 60 day certification period.</p> <p>1. On 4/23/12 at 2:00 PM during home visit observation, DME observed in the home of patient #8 included a wheel chair, shower chair, walker, and assistive bed rail. The plan of care dated 3/14 - 5/12/12 failed to include the wheel chair, shower chair, and assistive bed rail.</p> <p>2. On 4/24/12 at 9:45 AM during home visit observation, DME observed in the home of patient #11 included an assistive bed rail. The plan of care dated 3/26 - 5/24/12 failed to include the assistive bed rail.</p> <p>3. On 4/24/12 at 2:30 PM, employees K and L both indicated that sometimes patients' families will bring in equipment and/or medications and not tell staff right away.</p> <p>4. The agency's policy titled "Admission Plan of Care," #CL-HH-3003, dated 6/1/2011, states under section "4.0 Procedure, ... 2. ... b. DME: Enter all DME's and/or equipment which are used or may be used. (For example:</p>		<p>5/24/12.2. The Administrator/Director of Nursing shall ensure accuracy of DME listed on Medical/Non-Medical Plan of Care by visual inspection of client's apartment and during re-assessment prior to sending the Medical/Non-Medical Plan of Care to physician, dentist, chiropractor, optometrist, or podiatrist for periodic review (every 60 days) beginning 5/24/12.</p>	

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	wheelchairs, walkers, canes, glucometers, O2, etc.)."			

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N0610	<p>410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the Plan of Care was dated when the physician signed the orders for 9 of 11 clinical records and correct dates entered on nursing visit note for 1 of 11 records reviewed with the potential to affect all the agency's patients. (# 1, 2, 4, 5, 6, 7, 8, 9, and 10).</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a Medical/Non-Medical Plan of Care for the care period 3/9-5/7/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>A. Clinical record #1, start of care date 3/9/12, contained a Nursing Visit Note dated 3/8/12.</p> <p>B. On 4/24/12 at 3:00 PM, employee L indicated the Nursing Visit Note was incorrectly dated and the actual visit was 3/9/12, same date as start of care.</p>	N0610	<p>N 610 Home Health Agency Administration/ManagementIt is the practice of this agency that entries in the clinical record shall be clear, concise and objective. Records shall be complete and focus on those elements necessary to assure effective nursing care.1. The Admistrator/Director of Nursing shall ensure the nursing staff will not enter nursing notes prior the start of care. To begin immediately and on-going2. The Admistrator/Director of Nursing shall prompt physician, dentist, chiropractor, optometrist, or podiatrist to include a date with their signature space at the end of the Medical/Non-Medical Plan of Care. To begin 5/24/12 and thereafter.</p>	05/24/2012			

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	<p>2. Clinical record #2 contained a Medical/Non-Medical Plan of Care for the care period 3/9-5/7/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>3. Clinical record #4 contained a Medical/Non-Medical Plan of Care for the care period 2/28-4/27/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>4. Clinical record #5 contained a Medical/Non-Medical Plan of Care for the care period 2/22-4/17/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>5. Clinical record #6 contained a Medical/Non-Medical Plan of Care for the care period 3/9-5/7/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>6. Clinical record #7 contained a Medical/Non-Medical Plan of Care for the care period 3/23-5/21/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p>			

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	<p>7. Clinical record #8 contained a Medical/Non-Medical Plan of Care for the care period 3/14-5/12/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>8. Clinical record #9 contained a Medical/Non-Medical Plan of Care for the care period 3/9-5/7/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>9. Clinical record #10 contained a Medical/Non-Medical Plan of Care for the care period 3/26-5/24/12. The clinical record failed to evidence the date of the physician signature and when it was received.</p> <p>10. During interview on 4/24/12 at 2:00 PM, employee L indicated the agency mails the Plan of Care for physician signature and receives them back by mail. Sometimes they will fax them and receive them by fax. Employee L also indicated there is not a prompt on the Plan of Care for the physicians to put a date with their signatures.</p> <p>11. The agency's policy titled "The Clinical Record," #CL-HH-4001, dated</p>			

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	<p>6/1/2011, states under section "3.0 Fundamental Information, Entries made in the record shall be clear, concise, and objective. Records shall be complete and focus on those elements necessary to assure effective nursing care. The agency shall accept faxed signature from physicians."</p> <p>12. The agency's policy titled "Orders for Medication/Treatments and ADL Care," #CL-HH-3009, dated 6.1.2011, states under the section "4.0 Procedure ... 5. Orders are initiated within 24 hours of noted change. Verbal Order Form is to be submitted to the physician for signature and date."</p>			