| DEPARTMEN | T OF HEALTH AND HU | UMAN SERVICES | | | | FO | RM APPROVED |
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| CENTERS FO | R MEDICARE & MEDI | CAID SERVICES | | | | OM | IB NO. 0938-0391 |
| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE C | ONSTRUCTION | (X3) DATE | SURVEY |
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| WOODV | IEW HOME CARE | LLC | | FORT | WAYNE, IN 46805 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIES | | ID | DROUIDERIS DI AN OF CORRECTION | | (X5) |
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| | | | | | | | |
| | This was an Ini | tial Home Health State | N0 | 000 | This plan of correction is to s | | |
| | Licensure surve | ey. | | | as Woodview Home Care, L allegation of compliance. | LC's | |
| | Survey Dates: 3 | 3/6/12 to 3/8/12. | | | | | |
| | Facility Numbe | ar: 012730 | | | | | |
| | Pacinity Number | 1. 012750 | | | | | |
| | Surveyor: Miri | am Bennett, RN, BSN, | | | | | |
| | PHNS | | | | | | |
| | Census Service | Type: | | | | | |
| | Skilled: 1 | | | | | | |
| | Home Health A | Aide Only: 2 | | | | | |
| | Personal Care C | Only: 0 | | | | | |
| | Total: 3 | 5 | | | | | |
| | Sample: | | | | | | |
| | RR w/HV: 2 | | | | | | |
| | RR w/o HV: 3 | | | | | | |
| | Total: 5 | | | | | | |
| | 10tal. 5 | | | | | | |
| | Quality Review | z: Joyce Elder, MSN, BSN, | | | | | |
| | RN | | | | | | |
| | Ma | arch 14, 2012 | | | | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

PRINTED:

03/30/2012

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.

TITLE

| STATEMEN | Γ OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | (X3) DATE SURVEY | | |
|-------------------|--|--|-------------------|--------------|--|---|--------------------|
| AND PLAN O | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII B. WIN | | 00 | COMPI 03/08 | leted /2012 |
| NAME OF PR | ROVIDER OR SUPPLIE | R | | STREET | ADDRESS, CITY, STATE, ZIP CODE | | |
| | EW HOME CARE | | | | STATE BLVD WAYNE, IN 46805 | | |
| (X4) ID PREFIX | (EACH DEFICIE | STATEMENT OF DEFICIENCIES | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | IATE | (X5) COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE) | | DATE |
| | have direct pati physical examin practitioner no no (180) days befor has direct patie examination sh ensure that the infectious or co- patients. Based on policy review, and emp home health age own policy for of documentation files reviewed (potential to affer agency. Findings includ 1. The agency's Health Certification employee is free disease, must be and is required clients." 2. The qualification descriptions title | h) Each employee who will ent contact shall have a nation by a physician or nurse more than one hundred eighty re the date that the employee int contact. The physical all be of sufficient scope to employee will not spread mmunicable diseases to review, job description bloyee file review, the ency failed to follow its employee physical for 11 of 11 employee employees A - K) with the ct all patients of the | N04 | 62 | It is the practice of Woodview Home Care, LLC to ensure a employees are free of infection/communicable dise prior to providing care. No c were affected by the deficient practice. Employee's A-K previously had physicals whi did not indicate the presence any infection and/or communicable disease. Woodview Home Care physi form has been updated to int the words "Employee is free Infectious and/or Communica Disease" (Attachment A). A employees have received sig certifications to ensure they a "free of Infectious and/or communicable Disease" (Sat form-Attachment B). To pre reoccurrence, the Physical f has been updated to reflect correct terminology and the Director of Nursing Services oversee that the correct form utilized for all new employee Date of Completion: 4/6/201 | III ase lients t ch of cal clude of able II 11 gned are mple event orm will is s. | 04/06/201 |

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| | R MEDICARE & MEDI NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (Y2) M | IIII TIPI E CO | INSTRUCTION | (Y3) DAT | OMB NO. 0938-039 (X3) DATE SURVEY | | |
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| | | ement: Free from | | | | | | | |
| | | disease in all forms." The | | | | | | | |
| | | "Essential Functions" | | | | | | | |
| | - | sonnel records of the | | | | | | | |
| | | . (B) Include a copy of the | | | | | | | |
| | - · |) Documentation that | | | | | | | |
| | | from tuberculosis and | | | | | | | |
| | communicable | " | | | | | | | |
| | | | | | | | | | |
| | - | ations listed for job | | | | | | | |
| | - | d "Director (Manager) of | | | | | | | |
| | | vices," Policy #15, states, | | | | | | | |
| | · , • | Statement: Free from | | | | | | | |
| | communicable | disease." The section | | | | | | | |
| | - | nsibilities" states, "The | | | | | | | |
| | Administrator s | hall ensure Personnel | | | | | | | |
| | - | ployees are supported by | | | | | | | |
| | written policies | Personnel records of | | | | | | | |
| | | deliver home health | | | | | | | |
| | services shall b | e kept current and shall | | | | | | | |
| | include (F). | The physical | | | | | | | |
| | examination sha | all be of sufficient scope to | | | | | | | |
| | ensure that the | employee will not spread | | | | | | | |
| | infectious or co | mmunicable diseases to | | | | | | | |
| | clients." | | | | | | | | |
| | 4 751 110 | | | | | | | | |
| | - | ations listed for job | | | | | | | |
| | - | d "Administrator," Policy | | | | | | | |
| | | Physician's Statement: | | | | | | | |
| | | nunicable disease in all | | | | | | | |
| | forms." | | | | | | | | |
| | | eled "Responsibilities" | | | | | | | |
| | | ministrator shall ensure | | | | | | | |
| | Personnel pract | ices for employees are | | | | | | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIP A. BUILDINC B. WING | 3 <u>0</u> | (X3) DATE SURVEY COMPLETED 03/08/2012 | | |
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| | PROVIDER OR SUPPLIEF | | 34 | 17 E STA | ess, city, state, zip code .TE BLVD NE, IN 46805 | | |
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| | records of employhealth services signal include examination shatensure that the employee has the examination shatensure that the employee has the employee | for employees A, B, C, | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 03/08/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3417 E STATE BLVD WOODVIEW HOME CARE LLC FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 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. N0470 04/06/2012 Based on observation during home visits It is the practice of Woodview Home Care, LLC to practice good hand and policy review, the agency failed to hygiene and according to agency ensure employees are following infection policy. control policies for 2 of 2 home visits No clients were affected by the (employees J and G). deficient practice. Employee J, G and other current Findings include: employees were inserviced on 3-16-12 on proper handwashing and glove use (Attachment C). 1. On 3/7/12 at 8:00 am during home To prevent reoccurrence, all staff visit, employee J did not wash hands prior will be educated regarding hand to donning gloves to begin patient care. hygiene procedures during initial orientation and annually. 2. On 3/7/12 at 10:15 am during home The Director of Nursing Services or visit, employee G did not wash hands designee will be responsible for ensuring proper handwashing and after removing gloves and prior to taking glove use. The Director of Nursing patient to the beauty shop. Services will observe staff for proper handwashing and glove use during 3. Agency policy titled "Hand Hygiene supervisory visits. The Director of (Hand Washing)", policy #1, not dated, Nursing Services or designee will states, "Considerations: (a.) re-educate any staff who are observed to be non-compliant with Decontaminate hands before having direct agency handwashing procedures. contact with patients; ...(d.) Date of Completion: 4/6/2012 Decontaminate hands after removing gloves and or glove changes. ... (i.) after giving direct care to a patient. ... (k.) When hands are soiled."

Event ID: Z06W11

Facility ID: 012730

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| | | AID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN B. WING | ple conste _G 0 | | (X3) DATE SURVEY COMPLETED 03/08/2012 | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 03/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3417 E STATE BLVD WOODVIEW HOME CARE LLC FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE N0522 410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: N0522 04/06/2012 Based on clinical record and policy It is the practice of Woodview Home Care, LLC to follow the medical plan review, agency failed to ensure the plan of of care established by the physician. care for visits was followed as ordered by No residents were affected by the physician for 2 of 3 clinical records deficient practice. The HHA did see reviewed of patients receiving home resident #2 (see attachment D) but health aide services (#2 and 3). did not fill out Aide Visit form. On 3-8-12 resident did receive bath on Findings include: the PM visit instead of AM(attachment E). Resident #3 had orders for weekly skilled visits not 1. Clinical Record #2, start of care every third day visits, no skilled visits 1/27/12, contains Care Plan/Coordination were missed for resident #3. of Care with orders for home health aide Surveyor could possibly mean (HHA) 1 hour visits twice daily 7 days a resident #5, who's visits werer week to assist with AM and PM care, miscalculated on the calendar. showers, toileting, peri and incontinent To prevent a reoccurrence in the future, a New Triple check form care. The record failed to evidence the (attachment F-2) is to be utilized aide made a PM visit on 2/18/12. weekly to ensure all visits are timely. A. Documentation by the aide for Woodview Home Care, LLC will 1/27 thru 3/4/12 failed to evidence any prevent future missed visits with use showers had been provided. of Triple Check form. If future missed visits, the Director of Nursing Services or designee will follow B. On 3/8/12 at 12:50 PM, employee facility policy regarding Missed C indicated the patient was always Client Visits (attachment F-1) already up and dressed or dressed for bed including notifying client so the HHAs did not provide the showers. (responsible party if applicable), physician, and administrator of 2. Clinical Record #3, start of care missed visits. The Triple Check Program will be 1/25/12, contained Service

State Form

Event ID: Z06W11

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| | R MEDICARE & MEDIONT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | ONSTRUCTION | (X3) DATE | 1B NO. 0938-03 |
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| | Quotation/Care | Plan instructions for the | | used to assess compliance regard | ding | |
| | | 3 times a week. Visits | | visits and identify any missed visi | ts. | |
| | | on 2/6/12 to 5 days a | | The form will contain data for the | | |
| | | ord failed to evidence an | | entire month and be overseen by | | |
| | | for the visit on $2/6/$. | | Quality Improvement Committee monthly. | 2 | |
| | | | | Date of Completion: 4/6/2012 | | |
| | The Home | Health Certification and | | | | |
| | | ntained orders dated | | | | |
| | | killed nurse to the patient's | | | | |
| | | g every 3 days. The record | | | | |
| | | ce the skilled nurse | | | | |
| | | n $2/12/12$ or $2/21/12$. The | | | | |
| | - | d an extra skilled nurse | | | | |
| | | on $2/7/12$. The record | | | | |
| | | ce the physician was | | | | |
| | | nissed skilled nurse visits. | | | | |
| | | missed skined nurse visits. | | | | |
| | 3. Agency poli | cy titled "Client Decline of | | | | |
| | | y #5, not dated, states, | | | | |
| | | lled nurse visits, the Nurse | | | | |
| | | l notify the client's | | | | |
| | - | e missed visit is a skilled | | | | |
| | | a scheduled skilled visit is | | | | |
| | | and actually missed, the | | | | |
| | - | sing Services shall | | | | |
| | | tify the client's physician | | | | |
| | of the missed vi | | | | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 03/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3417 E STATE BLVD WOODVIEW HOME CARE LLC FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE N0544 410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. N0544 04/06/2012 Based on clinical record review and It is the practice of Woodview Home Care, LLC during practice in the interview, the Registered Nurse (RN) home health setting for the RN to failed to ensure proper documentation of Prepare Clinical Notes. clinical notes for 2 of 5 clinical records No clients were affected by the reviewed with the potential to affect all deficient practice. The RN was the patients the RN provides care to. aware of the "open sores on belly", for patient #3, and the RN arranged for the client to see client's personal Findings include: physician on 3/9/2012. The RN did fail to document the actions she 1. Aide Visit Record dated 3/3/12 states took in regards to the "open sores that pt #3 was noted to have "Open sores on belly" on 3/3/2012. on belly." The record failed to evidence For Client #4, skilled nurse visit note, the aide notified the RN of the sores. dated 2/17/2012 was completed by RN, but the RN failed to sign name to note, at the time the note was On 3/8/12 at 12:50 PM, employee C written, but the RN has since signed indicated the aide did notify the RN of the her name to certify that she open sores, but employee C did not completed the note. document it. To prevent a future reoccurrence and failure to complete clinical 2. Clinical Record #4 contained a Skilled notes, All RNs have been inserviced regarding documentation of care Nurse Visit Note dated 2/17/12 that was and services (see Attachment G-1) not signed. The Director of Nursing Services or designee will check RN Nurse visit During interview on 3/8/12 at 11:50 notes for all clients weekly, x 4 am, employee C indicated the orders for weeks, and document any increasing visits to 3 times a week for 2 non-compliance on the "Home Care Weekly Monitoring Chart Form" (see weeks were told to the agency by the attachment G-2), then if compliant,

State Form

Event ID: Z06W11 Facility

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| AME OF PROVIDER OR SUPPLICE STREET ADDRESS CITY STATE, ZP CODE STREET ADDRESS CITY STATE, ZP CODE STATE BLVD FORT WAYNE, IN 46805 (X) FORT WAYNE, | | | | | | | 03/08/ | 2012 |
| WOODVIEW HOME CARE LLC 3417 E STATE BLVD FORT WAYNE, IN 46805 COMPLETA SUMMARY STATEMENT OF DEFICIENCIES D Reprint Management (EACH DEFICIENCY MIST BE PERCEDED BY PUL). REPRINT AG D Reconstruction of completion of the control operation of the control operation of the control operation of the control operation of the control operation of the control operation of the control operation of the control operation operation of the control operation of the control operation operation of the control operation of the control operation operation operation of the control operation op | NAMEOF | PROVIDER OR SUBDITE | 2 | _ | | ADDRESS, CITY, STATE, ZIP CODE | - | |
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| REPEX 01ACH DEFICIENCY MUST BE PERCEDED BY PLUL TAG REGULATORY OR ISC DENTIFYING INFORMATION) TAG REGULATORY OR ISC DENTIFYING INFORMATION) Rehabilitation nurse at the Assisted Living facility, but employee C did not write the orders, just updated the Care Plan. Plan. Note: Second | (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| Rehabilitation nurse at the Assisted move to auditing of 10% of records Living facility, but employee C did not on a monthly basis. Write the orders, just updated the Care The Quality improvement Plan. Committee will oversee that 10% of records are audited for compliance of RN nurse visit notes and determine how long monitoring of RN visit notes will remain in effect. Date of Completion: 4/6/2012 Date of Completion: 4/6/2012 | PREFIX | | | | | (EACH CORRECTIVE ACTION SHOULD BE | TE | COMPLETIC |
| Living facility, but employee C did not write the orders, just updated the Care Plan. | TAG | | | | TAG | | | DATE |
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| of RN nurse visit notes and determine how long monitoring of RN visit notes will remain in effect. Date of Completion: 4/6/2012 | | Plan. | | | | | I | |
| determine how long monitoring of RV visit notes will remain in effect. Date of Completion: 4/6/2012 | | | | | | | | |
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| n Even ID: Z06W11 Facility ID: 012730 If continuation sheet Page 10 of 20 | | | | | | | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 03/08/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3417 E STATE BLVD WOODVIEW HOME CARE LLC FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE N0596 410 IAC 17-14-1(I)(A) Scope of Services Rule 14 Sec. 1(I) 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: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and N0596 03/26/2012 It is the practice of Woodview Home Based on interview, employee file review, Care, LLC to ensure all HHA are and policy review, the agency failed to competent prior to the provision of ensure the skills competency of Home home care services . Health Aides (HHA) was complete for 5 All HHA staff, identified by Surveyor, of 5 Home Health Aide skills competency to not be competency checked, evaluations reviewed (employees E, F, G, were previously competency H, and J) with the potential to affect all of checked in our sister facility. All were already employed at sister the patients receiving care from the Home facility, as "Certified Nursing Health Aides. Assistants", who are observed to perform the care tasks indicated on Findings include: the competency check, on a daily basis. All are competent in the care 1. The agency's policy titled "Registry of tasks required for HHA competency. Home Health Aides," policy # 32, not No clients were affected by the dated, states, "The Director of Patient deficient practice. All HHA have Care Services or Registered Nurse (RN) been re-verified for aide will test each HHA to evaluate their competency and observed to give competency and skills to assess their bed bath, tub bath, sponge bath, ability to perform duties required by shower bath, shampoo, Nail and Skin Care, Oral Hygiene, Woodview Home Care." Toileting/Elimination, Range of Motion, Providing nutrition/Fluid 2. The job description titled "Director of intake (See attachment H-1 for a Patient Care Services", policy #2, not sample of Competency Evaluation) dated, states, "The Director will ensure Woodview Home Care, LLC observes Facility ID: 012730

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| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C A. BUILDING B. WING | 00 | (X3) DATE SURVEY COMPLETED - 03/08/2012 | |
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| WOODV (X4) ID PREFIX TAG | (EACH DEFICIE REGULATORY O sufficient orient required in-serve ensure Quality 3. The agency's Care, Aide Plan Weekly Aide V not dated, statestinitiate the Aidde ensure Home H prior to the Horcare." 4. During inter am, employee C nurse signed the forms for employ without verifyin The forms were employees E, F employee H; an the areas of Tul Shower Bath, S Care, Oral Hyg Elimination, Ra Providing Nutri Employees E, C bath and only a observed for em 5. Aide Visit R dated 2/8/12, 2/ | STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) tation, training and vice training is provided to Patient Care Services." s policy titled "Plan of a of Care and Daily and lisit Record(s)" policy #4, s, "The RN Supervisor will e Plan of Care and lealth Aides competency, me Health Aide providing view on 3/8/12 at 11:50 C indicated the registered e competency evaluation byees E, G, H, and J ng the aide's competency. e dated 1/23/12 for l', and G; 1/27/12 for ad 3/1/12 for employee J in b Bath, Sponge Bath, shampoo, Nail and Skin iene, Toileting / ange of Motion, and ition/Fluid Intake. dicated they only observed G, and H providing a bed bed bath and shower were | | WAYNE, IN 46805 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) all HHA(s) provide care to patients and evaluates their competency by having the HHA provide designated tasks in a healthcare setting, at our sister facility Woodview Healthcare Inc, under the supervision of a Horr Care RN (See Attachment H-2). The RN checks HHA competency prior to the HHA providing client care in the home setting. The RN will document competency by documenting "pass or fail" on competency check (attachment H-1). All HHA will be rechecked for competency on an annual basis. The Director of Nursing Service will be responsible for ensurin HHA are observed to provide each task on the competency checklist, and satisfactorily passed on competency evaluation, prior to allowing th to provide any care in the hom settingDate of Completion 3/26/2012 | , , , , , , , , , , , , , , , , , , , | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/30/2012

FORM APPROVED

| OT A TEN O | R MEDICARE & MEDIC | | (22) 10 | | NETRICTION | | MB NO. 0938-0 |
|--------------------------|---|--|-------------------|------------------|----------------------------|-----------------------------------|-------------------------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUII B. WIN | LDING | NSTRUCTION 00 | COM | e survey pleted 18/2012 |
| | | | B. WIN | | DDRESS, CITY, STATE, ZIP C | ODE | |
| | PROVIDER OR SUPPLIE | | | | STATE BLVD | | |
| | /IEW HOME CARE | | | | VAYNE, IN 46805 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION) | | PREFIX (EACH COF | | RECTION IOULD BE PPROPRIATE | (X5) COMPLETIO DATE |
| | G gave the patie care, skin care, r meal preparation assist with ambu with mobility ch 6. Aide Visit Ro dated 2/14/12, in provided oral ca | nt shower, hair care, oral medication reminder, n, limit / encourage fluids, ilation walker, and assist air bed commode. ecords for patient #2, ndicate employee G | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 03/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3417 E STATE BLVD WOODVIEW HOME CARE LLC FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE N0604 410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist. N0604 04/06/2012 Based on clinical record review, the It is the practice of Woodview Home Care, LLC that any change in the agency failed to ensure the Home Health client's condition will be reported by Aide notified the nurse with observed the HHA to the Director of Nursing reportable findings for 2 of 3 records (#2 Services or designee. and 3) reviewed of patients receiving No client was affected by the home health aide services with the deficient practices. The HHA(s) potential to affect all the patients the aides failed to report possible changes in the client(s) condition on 3/3/12, provide care to. 2/6/12, and 2/14/12. The client issues identified by the surveyor, Findings include: that were not reported by HHA, are at this time resolved. 1. Aide Visit Record dated 2/14/12 states To prevent a reoccurrence, all HHA patient #2 was noted to have a "bruise on have been inserviced regarding reporting of changes in client's right bottom." The record failed to conditions. The inservice was held evidence the aide notified the nurse. on 3/16/2012 (Attachment C). The Director of Nursing Services or 2. Related to patient #3: designee will be responsible for reading all HHA Visit Notes, prior to A. The Aide Visit Record dated filing on clinical record, to ensure there were no changes in the client's 3/3/12 states pt #3 was noted to have condition, which were not reported. "Open sores on belly." The record failed The Director of Nursing Services or to evidence the aide notified the nurse. designee will be responsible for documenting any non-compliance B. The Aide Visit Record dated on "Home Care Weekly Monitoring chart Form" (see attachment G-2), 2/14/12 states pt #3 was noted as having weekly x 4 weeks and if compliant, "Dark red areas remains plus new red will then move auditing to 10% of areas to buttocks." The record failed to records on a monthly basis. evidence the aide notified the nurse. The Quality Improvement Committee will oversee that 10% of

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| NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING B. WING | | Co 03. | (X3) DATE SURVEY COMPLETED 03/08/2012 | |
|--|---|------------------------|--|---|---|--|
| PROVIDER OR SUPPLIEF | | 34 ⁻ | EET ADDRESS, CITY, ST 17 E STATE BLVD RT WAYNE IN 468(| | | |
| SUMMARY S (EACH DEFICIEN REGULATORY OR C. The Aidd 2/6/12 states pt # pain on her coxis afraid it might bu Start of some bu The record failed notified the nurs D. The Aidd 2/6/12 states pt # "Burning and itc red spots (round) it is from the hea failed to evidence nurse. E. The Aidd 2/8/12 states pt # "Complaining at red area to up | TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) e Visit Record dated 43 was "Complaining of s. [sic] There is a red area e pressure sore starting rns on (patient's) thighs." d to evidence the aide | | RT WAYNE, IN 4680 | PLAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE "ICIENCY) ed for compliance of changes in a , and determine ring of HHA notes ect. | (X5) COMPLETIO DATE | |
| 6. | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 03/08/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3417 E STATE BLVD WOODVIEW HOME CARE LLC FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG N0610 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. N0610 04/06/2012 It is the practice of Woodview Based on clinical record review and Home Care, LLC to have all interview, the agency failed to ensure all documented entries be legible. documents were complete, signed, and clear, complete and properly dated for 4 of 5 records reviewed (#2-5). authenticated and include certification dates and Dr. Signatures on orders. No clients Findings include: were affected by the deficient practice. The RN who was 1. Related to record #2: responsible for not signing skilled nurse visits regarding client #4, has signed the note. The drug A. The Aide Visit Record for patient regimine review was signed and #2 dated 2/12/12 failed to evidence what dated for client #4. For client #2, care was provided to patient. the surveyor addressed lack of physician's signature on orders. dated 2/9/12. The surveyor B. The Aide Care Plan for patient #2, mistakenly identified the start of care 1/27/12, was not dated. physician's signature as signed by a nurse practitioner (NP). Dr. Muhler (MD) signed the orders C. The Care Plan / Coordination of (Attachment I). As of 3/23/2012, Care form does not specify a care period. certification periods will be completed on Home Health 2 Related to record #3. Certificate/Plan of Care/ 485, according to agency policy. To ensure compliance, the Director A. The Aide Visit Record dated of Nursing Services or designee 2/20/12 is not signed by the aide. will be responsible for overseeing chart documentation for blanks, B. The aide Care Plan dated 1/25/12 signatures, dates, certification dates, and ensuring orders for does not indicate patient is "No Code" as client services are signed by a indicated on Record of Admission dated physician. Any identified 1/25/12. documentation

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| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | ONSTRUCTION 00 | · · · | FE SURVEY IPLETED |
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| WOOD | IEW HOME CARE | LLC | | WAYNE, IN 46805 | | |
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| PREFIX TAG | | NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | | COMPLETIC DATE |
| | 1/27/12 at 9:00 code." C. The records are period. The Service Quotation Plan of Care. D. The Service Quotation Plans dated 1/25 (not the aide) with a dide) with a dide with a dide) with a times weekly E. Skilled II 2/9/12 were signed and context and a context and a dide. C. A Skilled 2/17/12 was note and context and a dide. D. Home Hereit and a dide dide dide dide dide. | Nursing orders dated ned by a Nurse cord #4: Record #4, start of care d a verbal order to start 2. g Regimen Review was lated with completion | | non-compliance(s) wil documented on "Home Weekly Monitoring cha (see attachment G-2), weeks and if complian move auditing to 10% on a monthly basis. T Improvement Committ oversee that 10% of re audited for documenta compliance including I signatures, dates, cert dates, and physician s on orders, and determ long use of Home Car Monitoring Chart Form (Attachment G-2) will performed during docu audits. Date of Comp 4/6/2012 | e Care art Form" weekly x 4 it, will then o of records the Quality tee will ecords are ation blanks, tification signatures ine how e Weekly n audits be umentation | |

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| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | 1.115 | | | | | |
| | | ord #5, start of care | | | | | |
| | | ed a Home Health | | | | | |
| | | d Plan of Care that failed | | | | | |
| | | e period dates. The Drug | | | | | |
| | Regimen Revie | w was not dated or signed. | | | | | |
| | 5. On 3/6/12 at | 2:25 PM, employees C | | | | | |
| | and K indicated | the agency does not use | | | | | |
| | the Home Healt | h Certification and Plan of | | | | | |
| | Care forms unle | ess they receive orders for | | | | | |
| | | and they were told they do | | | | | |
| | not need to use | them or enter certification | | | | | |
| | period dates if t | he patient does not have | | | | | |
| | Medicaid or Me | - | | | | | |
| | 6. On 3/8/12 at | 12:50 PM, employee C | | | | | |
| | | s for home care in charts | | | | | |
| | | n Assisted Living facility | | | | | |
| | - | agency and the orders are | | | | | |
| | transcribed to the | 0 | | | | | |
| | | Care sheets, not written | | | | | |
| | | The agency does not | | | | | |
| | | physician order sheet at | | | | | |
| | this time. | physician order sheet at | | | | | |
| | uns une. | | | | | | |
| | 7. On 3/8/12 at | 1:30 PM, employee K | | | | | |
| | | ency does not have a | | | | | |
| | | for taking and transcribing | | | | | |
| | physician order | | | | | | |
| | | | | | | | |
| | 8. Agency poli | cy titled "Home Health | | | | | |
| | | s #21," Policy #1, not | | | | | |
| | | The records shall be | | | | | |
| | , 5.u.co, 1 | | | | 1 | | 1 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED . BUILDING 03/08/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3417 E STATE BLVD WOODVIEW HOME CARE LLC FORT WAYNE. IN 46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information, (2) Name of the physician ... (3) Drug, dietary, treatment, and activity orders, (4) Signed and dated clinical notes, ... (7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry." 9. Agency policy titled "Aide Plan of Care and Daily and Weekly Aide Visit Records," Policy #4, not dated, states, "Documentation must indicate when services furnished and what services were furnished. The Home Health Aide will document on the Multidisciplinary note any information which is pertinent to the client's care during the visit." 10. Agency policy titled "Medical Plan of Care," policy #1, not dated, states, "Medical care (including any/all nursing care) shall follow a written medical plan of care ... considerations: medical plan of care defined means written instructions signed by the physician, dentist, chiropractor, podiatrist, or optometrist for the provision of care or treatment to be given" and "Woodview Home Care will use CMS 485 as a Medical Plan of Care." State Form Event ID: Z06W11 Facility ID: 012730 If continuation sheet Page 19 of 20

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| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DA COM | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED - 03/08/2012 | |
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