STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODVIEW HOME CARE LLC	3417 E STATE BLVD FORT WAYNE, IN 46805

(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
N0000	This was an Initial Home Health State Licensure survey. Survey Dates: 3/6/12 to 3/8/12. Facility Number: 012730 Surveyor: Miriam Bennett, RN, BSN, PHNS Census Service Type: Skilled: 1 Home Health Aide Only: 2 Personal Care Only: 0 Total: 3 Sample: RR w/HV: 2 RR w/o HV: 3 Total: 5 Quality Review: Joyce Elder, MSN, BSN, RN March 14, 2012	N0000	This plan of correction is to serve as Woodview Home Care, LLC's allegation of compliance.	

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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N0462	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.			
	Based on policy review, job description review, and employee file review, the home health agency failed to follow its own policy for employee physical documentation for 11 of 11 employee files reviewed (employees A - K) with the potential to affect all patients of the agency. Findings include: 1. The agency's policy titled "Employee Health Certificate," policy #: 11-B, not dated, states, "The physical examination and certification that indicates the employee is free from communicable disease, must be signed by a physician, and is required prior to any work with clients." 2. The qualifications listed for job descriptions titled "Director of Patient Care Services," Policy #2, states, "(5)	N0462	It is the practice of Woodview Home Care, LLC to ensure all employees are free of infection/communicable disease prior to providing care. No clients were affected by the deficient practice. Employee's A-K previously had physicals which did not indicate the presence of any infection and/or communicable disease. Woodview Home Care physical form has been updated to include the words "Employee is free of Infectious and/or Communicable Disease" (Attachment A). All 11 employees have received signed certifications to ensure they are "free of Infectious and/or communicable Disease" (Sample form-Attachment B). To prevent reoccurrence, the Physical form has been updated to reflect correct terminology and the Director of Nursing Services will oversee that the correct form is utilized for all new employees. Date of Completion: 4/6/2012	04/06/2012

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	Physician's Statement: ... Free from communicable disease in all forms." The section labeled "Essential Functions" states, "The personnel records of the director shall: ... (B) Include a copy of the following ... (D) Documentation that Director is free from tuberculosis and communicable ...." 3. The qualifications listed for job description titled "Director (Manager) of Home Care Services," Policy #15, states, "(5) Physician's Statement: ... Free from communicable disease." The section labeled "Responsibilities" states, "The Administrator shall ensure Personnel practices for employees are supported by written policies ... Personnel records of employees who deliver home health services shall be kept current and shall include ... (F) ... The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to clients." 4. The qualifications listed for job description titled "Administrator," Policy #1, states, "(5) Physician's Statement: ... free from communicable disease in all forms." The section labeled "Responsibilities" states, "The Administrator shall ensure Personnel practices for employees are			

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	supported by written policies ... Personnel records of employees who deliver home health services shall be kept current and shall include ... (F) ... The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients." 5. The qualifications listed for job description titled "Home Health Aide," Policy #6, states, "(5) Physician's Statement: ... free from communicable disease in all forms." 6. The physical for employees A, B, C, D, E, F, G, H, I, J, and K states, "Employee has been found free of infectious disease (Tuberculosis)."			

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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 and policy review, the agency failed to ensure employees are following infection control policies for 2 of 2 home visits (employees J and G). Findings include: 1. On 3/7/12 at 8:00 am during home visit, employee J did not wash hands prior to donning gloves to begin patient care. 2. On 3/7/12 at 10:15 am during home visit, employee G did not wash hands after removing gloves and prior to taking patient to the beauty shop. 3. Agency policy titled "Hand Hygiene (Hand Washing)", policy #1, not dated, states, "Considerations: (a.) Decontaminate hands before having direct contact with patients; ...(d.) Decontaminate hands after removing gloves and or glove changes. ... (i.) after giving direct care to a patient. ... (k.) When hands are soiled."	N0470	It is the practice of Woodview Home Care, LLC to practice good hand hygiene and according to agency policy. No clients were affected by the deficient practice. Employee J, G and other current employees were inserviced on 3-16-12 on proper handwashing and glove use (Attachment C). To prevent reoccurrence, all staff will be educated regarding hand hygiene procedures during initial orientation and annually. The Director of Nursing Services or designee will be responsible for ensuring proper handwashing and glove use. The Director of Nursing Services will observe staff for proper handwashing and glove use during supervisory visits. The Director of Nursing Services or designee will re-educate any staff who are observed to be non-compliant with agency handwashing procedures. Date of Completion: 4/6/2012	04/06/2012

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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:			
	Based on clinical record and policy review, agency failed to ensure the plan of care for visits was followed as ordered by physician for 2 of 3 clinical records reviewed of patients receiving home health aide services (#2 and 3). Findings include: 1. Clinical Record #2, start of care 1/27/12, contains Care Plan/Coordination of Care with orders for home health aide (HHA) 1 hour visits twice daily 7 days a week to assist with AM and PM care, showers, toileting, peri and incontinent care. The record failed to evidence the aide made a PM visit on 2/18/12. A. Documentation by the aide for 1/27 thru 3/4/12 failed to evidence any showers had been provided. B. On 3/8/12 at 12:50 PM, employee C indicated the patient was always already up and dressed or dressed for bed so the HHAs did not provide the showers. 2. Clinical Record #3, start of care 1/25/12, contained Service	N0522	It is the practice of Woodview Home Care, LLC to follow the medical plan of care established by the physician. No residents were affected by the deficient practice. The HHA did see resident #2 (see attachment D) but did not fill out Aide Visit form. On 3-8-12 resident did receive bath on the PM visit instead of AM(attachment E). Resident #3 had orders for weekly skilled visits not every third day visits, no skilled visits were missed for resident #3. Surveyor could possibly mean resident #5, who's visits werer miscalculated on the calendar. To prevent a reoccurrence in the future, a New Triple check form (attachment F-2) is to be utilized weekly to ensure all visits are timely. Woodview Home Care, LLC will prevent future missed visits with use of Triple Check form. If future missed visits, the Director of Nursing Services or designee will follow facility policy regarding Missed Client Visits (attachment F-1) including notifying client (responsible party if applicable), physician, and administrator of missed visits. The Triple Check Program will be	04/06/2012

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	Quotation/Care Plan instructions for the HHA to visit 2-3 times a week. Visits were increased on 2/6/12 to 5 days a week. The record failed to evidence an Aide Visit Note for the visit on 2/6/. The Home Health Certification and Plan of Care contained orders dated 2/6/12 for the skilled nurse to the patient's change dressing every 3 days. The record failed to evidence the skilled nurse provided care on 2/12/12 or 2/21/12. The record evidenced an extra skilled nurse visit was made on 2/7/12. The record failed to evidence the physician was notified of the missed skilled nurse visits. 3. Agency policy titled "Client Decline of Services", Policy #5, not dated, states, "For missed skilled nurse visits, the Nurse Supervisor shall notify the client's physician, if the missed visit is a skilled service visit. If a scheduled skilled visit is not planned for and actually missed, the Director of Nursing Services shall immediately notify the client's physician of the missed visit."		used to assess compliance regarding visits and identify any missed visits. The form will contain data for the entire month and be overseen by Quality Improvement Committee monthly. Date of Completion: 4/6/2012	

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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. Based on clinical record review and interview, the Registered Nurse (RN) failed to ensure proper documentation of clinical notes for 2 of 5 clinical records reviewed with the potential to affect all the patients the RN provides care to. Findings include: 1. Aide Visit Record dated 3/3/12 states that pt #3 was noted to have "Open sores on belly." The record failed to evidence the aide notified the RN of the sores. On 3/8/12 at 12:50 PM, employee C indicated the aide did notify the RN of the open sores, but employee C did not document it. 2. Clinical Record #4 contained a Skilled Nurse Visit Note dated 2/17/12 that was not signed. During interview on 3/8/12 at 11:50 am, employee C indicated the orders for increasing visits to 3 times a week for 2 weeks were told to the agency by the	N0544	It is the practice of Woodview Home Care, LLC during practice in the home health setting for the RN to Prepare Clinical Notes. No clients were affected by the deficient practice. The RN was aware of the "open sores on belly", for patient #3, and the RN arranged for the client to see client's personal physician on 3/9/2012. The RN did fail to document the actions she took in regards to the "open sores on belly" on 3/3/2012. For Client #4, skilled nurse visit note, dated 2/17/2012 was completed by RN, but the RN failed to sign name to note, at the time the note was written, but the RN has since signed her name to certify that she completed the note. To prevent a future reoccurrence and failure to complete clinical notes, All RNs have been inserviced regarding documentation of care and services (see Attachment G-1) The Director of Nursing Services or designee will check RN Nurse visit notes for all clients weekly, x 4 weeks, and document any non-compliance on the "Home Care Weekly Monitoring Chart Form" (see attachment G-2), then if compliant,	04/06/2012

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	Rehabilitation nurse at the Assisted Living facility, but employee C did not write the orders, just updated the Care Plan.		move to auditing of 10% of records on a monthly basis. The Quality Improvement 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	

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N0596	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) 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			
	Based on interview, employee file review, and policy review, the agency failed to ensure the skills competency of Home Health Aides (HHA) was complete for 5 of 5 Home Health Aide skills competency evaluations reviewed (employees E, F, G, H, and J) with the potential to affect all of the patients receiving care from the Home Health Aides. Findings include: 1. The agency's policy titled "Registry of Home Health Aides," policy # 32, not dated, states, "The Director of Patient Care Services or Registered Nurse (RN) will test each HHA to evaluate their competency and skills to assess their ability to perform duties required by Woodview Home Care." 2. The job description titled "Director of Patient Care Services", policy #2, not dated, states, "The Director will ensure	N0596	It is the practice of Woodview Home Care, LLC to ensure all HHA are competent prior to the provision of home care services . All HHA staff, identified by Surveyor, to not be competency checked, were previously competency checked in our sister facility. All were already employed at sister facility, as "Certified Nursing Assistants", who are observed to perform the care tasks indicated on the competency check, on a daily basis. All are competent in the care tasks required for HHA competency. No clients were affected by the deficient practice. All HHA have been re-verified for aide competency and observed to give bed bath, tub bath, sponge bath, shower bath, shampoo, Nail and Skin Care, Oral Hygiene, Toileting/Elimination, Range of Motion, Providing nutrition/Fluid intake (See attachment H-1 for a sample of Competency Evaluation) Woodview Home Care, LLC observes	03/26/2012

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	sufficient orientation, training and required in-service training is provided to ensure Quality Patient Care Services." 3. The agency's policy titled "Plan of Care, Aide Plan of Care and Daily and Weekly Aide Visit Record(s)" policy #4, not dated, states, "The RN Supervisor will initiate the Aide Plan of Care ... and ensure Home Health Aides competency, prior to the Home Health Aide providing care." 4. During interview on 3/8/12 at 11:50 am, employee C indicated the registered nurse signed the competency evaluation forms for employees E, G, H, and J without verifying the aide's competency. The forms were dated 1/23/12 for employees E, F, and G; 1/27/12 for employee H; and 3/1/12 for employee J in the areas of Tub Bath, Sponge Bath, Shower Bath, Shampoo, Nail and Skin Care, Oral Hygiene, Toileting / Elimination, Range of Motion, and Providing Nutrition/Fluid Intake. Employee C indicated they only observed employees E, G, and H providing a bed bath and only a bed bath and shower were observed for employee F. 5. Aide Visit Records for patient #3, dated 2/8/12, 2/13/12, 2/15/12, 2/21/12, 2/27/12, and 2/29/12, indicated employee		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 Home 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 Services will be responsible for ensuring all HHA are observed to provide each task on the competency checklist, and satisfactorily passed on competency evaluation, prior to allowing them to provide any care in the home settingDate of Completion 3/26/2012	

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	G gave the patient shower, hair care, oral care, skin care, medication reminder, meal preparation, limit / encourage fluids, assist with ambulation walker, and assist with mobility chair bed commode. 6. Aide Visit Records for patient #2, dated 2/14/12, indicate employee G provided oral care, assisted with ambulation, and assisted with commode.			

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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. Based on clinical record review, the agency failed to ensure the Home Health Aide notified the nurse with observed reportable findings for 2 of 3 records (#2 and 3) reviewed of patients receiving home health aide services with the potential to affect all the patients the aides provide care to. Findings include: 1. Aide Visit Record dated 2/14/12 states patient #2 was noted to have a "bruise on right bottom." The record failed to evidence the aide notified the nurse. 2. Related to patient #3: A. The Aide Visit Record dated 3/3/12 states pt #3 was noted to have "Open sores on belly." The record failed to evidence the aide notified the nurse. B. The Aide Visit Record dated 2/14/12 states pt #3 was noted as having "Dark red areas remains plus new red areas to buttocks." The record failed to evidence the aide notified the nurse.	N0604	It is the practice of Woodview Home Care, LLC that any change in the client's condition will be reported by the HHA to the Director of Nursing Services or designee. No client was affected by the deficient practices. The HHA(s) failed to report possible changes in the client(s) condition on 3/3/12, 2/6/12, and 2/14/12. The client issues identified by the surveyor, that were not reported by HHA, are at this time resolved. To prevent a reoccurrence, all HHA have been inserviced regarding reporting of changes in client's conditions. The inservice was held on 3/16/2012 (Attachment C). The Director of Nursing Services or designee will be responsible for reading all HHA Visit Notes, prior to filing on clinical record, to ensure there were no changes in the client's condition, which were not reported. The Director of Nursing Services or designee will be responsible for documenting any non-compliance on "Home Care Weekly Monitoring chart Form" (see attachment G-2), weekly x 4 weeks and if compliant, will then move auditing to 10% of records on a monthly basis. The Quality Improvement Committee will oversee that 10% of	04/06/2012

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	C. The Aide Visit Record dated 2/6/12 states pt #3 was "Complaining of pain on her coxis. [sic] There is a red area afraid it might be pressure sore starting ... Start of some burns on (patient's) thighs." The record failed to evidence the aide notified the nurse. D. The Aide Visit Record dated 2/6/12 states pt #3 was noted to have "Burning and itching in peri area ... little red spots (round) to upper thighs ... states it is from the heating pad." The record failed to evidence the aide notified the nurse. E. The Aide Visit Record dated 2/8/12 states pt #3 was noted to have "Complaining about burning in peri area ... red area to upper thighs remains." The record failed to evidence the aide notified the nurse. 6.		records are audited for compliance of HHA reporting of changes in a client's condition, and determine how long monitoring of HHA notes will remain in effect. Completion date: 4/6/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/08/2012

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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.			
	Based on clinical record review and interview, the agency failed to ensure all documents were complete, signed, and dated for 4 of 5 records reviewed (#2-5). Findings include: 1. Related to record #2: A. The Aide Visit Record for patient #2 dated 2/12/12 failed to evidence what care was provided to patient. B. The Aide Care Plan for patient #2, start of care 1/27/12, was not dated. C. The Care Plan / Coordination of Care form does not specify a care period. 2. Related to record #3: A. The Aide Visit Record dated 2/20/12 is not signed by the aide. B. The aide Care Plan dated 1/25/12 does not indicate patient is "No Code" as indicated on Record of Admission dated 1/25/12.	N0610	It is the practice of Woodview Home Care, LLC to have all documented entries be legible, clear, complete and properly authenticated and include certification dates and Dr. Signatures on orders. No clients were affected by the deficient practice. The RN who was responsible for not signing skilled nurse visits regarding client #4, has signed the note. The drug regimine review was signed and dated for client #4. For client #2, the surveyor addressed lack of physician's signature on orders, dated 2/9/12. The surveyor mistakenly identified the physician's signature as signed by a nurse practitioner (NP). Dr. Muhler (MD) signed the orders (Attachment I). As of 3/23/2012, certification periods will be completed on Home Health Certificate/Plan of Care/ 485, according to agency policy. To ensure compliance, the Director of Nursing Services or designee will be responsible for overseeing chart documentation for blanks, signatures, dates, certification dates, and ensuring orders for client services are signed by a physician. Any identified documentation	04/06/2012

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	Summary of Care notes dated 1/27/12 at 9:00 am state, "Patient is a full code." C. The record does not specify the care period. The record included a Service Quotation / Care Plans for the Plan of Care. D. The Service Quotation / Care Plans dated 1/25/12 identified the CNA (not the aide) was to assist with shower 2-3 times weekly as needed. E. Skilled Nursing orders dated 2/9/12 were signed by a Nurse Practitioner. 3. Related to record #4: A. Clinical Record #4, start of care 2/15/12,included a verbal order to start care dated 2/9/12. B. The Drug Regimen Review was not signed and dated with completion date. C. A Skilled Nurse Visit Note dated 2/17/12 was not signed. D. Home Health Certification and Plan of Care form does not have care period dates.		non-compliance(s) will be documented on “Home Care Weekly Monitoring chart Form” (see attachment G-2), weekly x 4 weeks and if compliant, will then move auditing to 10% of records on a monthly basis. The Quality Improvement Committee will oversee that 10% of records are audited for documentation compliance including blanks, signatures, dates, certification dates, and physician signatures on orders, and determine how long use of Home Care Weekly Monitoring Chart Form audits (Attachment G-2) will be performed during documentation audits. Date of Completion: 4/6/2012	

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	4. Clinical Record #5, start of care 1/25/12, included a Home Health Certification and Plan of Care that failed to evidence care period dates. The Drug Regimen Review 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 Health Certification and Plan of Care forms unless they receive orders for skilled nursing and they were told they do not need to use them or enter certification period dates if the patient does not have Medicaid or Medicare. 6. On 3/8/12 at 12:50 PM, employee C indicated orders for home care in charts for patients from Assisted Living facility are faxed to the agency and the orders are transcribed to the Care Plan / Coordination of Care sheets, not written on order forms. The agency does not have their own physician order sheet at this time. 7. On 3/8/12 at 1:30 PM, employee K indicated the agency does not have a specific policy for taking and transcribing physician orders. 8. Agency policy titled "Home Health Clinical Records #21," Policy #1, not dated, states, "The records shall be			

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	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."			

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