STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K035	A. BUILDING B. WING	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOME HEALTH CARE INC	3502 STELLHORN ROAD, FORT WAYNE, IN, 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; 1. Review of an undated copyright Briggs Healthcare, Operational Guidelines: Home Care agency policy C-145 titled Comprehensive Client Assessment indicated & comprehensive assessment must accurately reflect the client s status & must include & client s current health & functional & status & OASIS (outcome and assessment information set) data items & must include & clinical record items & elimination status & neuro status & medications &. 2. Review of an undated copyright Briggs Healthcare, Operational Guidelines: Home Health agency policy C-155 titled Client Reassessment/Update of Comprehensive Assessment indicated & reassessments are conducted every visit based on physician orders, client conditions, and/or professional staff judgment &.	G0528	TheAdministrator will inservice Case Managers and RNs on agency's policies (C-145) (C-155) forcomprehensive client assessments and reassessments. This encompassesreeducation on assessments and plans of care, ensuring the correct informationis documented and the assessments and plans of care are reflections of eachother. This includes the patient's health, psychosocial, functional, cognition status and safety measures properly documented. Processes have been defined for review of each assessment with the planof care before it is sent to the physician. The Director of Nursing isresponsible for ensuring compliance that the patient's current health status isproperly documented on the assessment. Charts will be audited quarterly forquality assurance.	2021-12-19

	3. Clinical record for patient #2 was reviewed on 11/18/2021, start of care date 5/17/2013, and certification period 10/2/2021-11/30/2021. An agency document evidenced a document dated 9/28/2021, titled 2020 OASIS-D1 Recert Comprehensive 1.40. The document indicated the patient had a primary diagnosis of other sequelae of other cerebrovascular disease (long term complications of restriction of blood flow to brain) and cerebral infarction (disrupted blood flow to the brain). The plan of care indicated patient took Clopidogrel (blood thinner to lessen the chance of a stroke), but comprehensive assessment failed to evidence Anticoagulant Precautions (measures to prevent cuts or injuries that could cause bleeding) were identified under Safety Measures. The document indicated patient had a diagnosis of type 2 diabetes and used a glucometer (measures blood sugar levels) but failed to evidence diabetic supplies were identified under Supplies. The document indicated patient had a diagnosis of seizures but failed to evidence Seizure Precautions (measures to prevent injury during a seizure) were identified under Safety Measures.			

	During an interview on 11/19/2021 at 1:35 PM, when asked if the comprehensive assessment should include anticoagulant precautions, director of nursing indicated if there was an issue with blood thinners it would be in the comprehensive assessment. When asked why diabetic supplies were not included under supplies, administrator indicated it must have been an oversight. When asked if the comprehensive assessment should include seizure precautions, the director of nursing indicated it was included in patient's plan of care. 3. Clinical record for patient #3 was reviewed on 11/18/2021, start of care date 1/3/2020, with a certification period of 10/24/2021-12/22/2021. An agency document dated 10/19/2021, titled 2020 OASIS-D1 Recert Comprehensive 1.40 indicated the patient had a diagnosis of neurogenic bowel (the loss of normal bowel function caused by a nerve problem) but failed to evidence bowel problems under elimination status. The document indicated patient had a primary diagnosis quadriplegia (paralysis of all 4 limbs) but hand grips under neurological status indicated patient had strong hand grips			

	and indicated under safety measures patient could ambulate within limits of endurance. During an interview on 11/19/2021 at 1:40 PM, when asked if no bowel problems was an accurate assessment of a patient who depended on suppositories to initiate bowel movements, director of nursing indicated patient has a bowel movement each day after receiving a suppository. When asked if strong hand grips would be expected with a patient with paralysis of all limbs, director of nursing indicated patient s hands are contracted inward (hands pull in towards the body and stiffen) but patient is strong. When asked would you expect ambulation (ability to walk) to be included in the comprehensive assessment, director of nursing indicated there is no way to exclude this in the OASIS assessment.			

G1012	Required items in clinical record 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; Findings include: Review of an undated copyright Briggs Healthcare, Operational Guidelines: Home Health agency policy C-680 titled Clinical Documentation indicated & documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within seven (7) days after the care has been provided. Clinical record for patient #3 was reviewed on 11/18/2021, start of care date 1/3/2020, certification period 10/24/2021-12/22/2021, primary diagnosis quadriplegia (paralysis of all four limbs). The clinical record failed to evidence HHA documentation for 11/6/21, 11/7/21. 11/9/21, and 11/11/21 and SN documentation for 11/5/21, 11/6/21, 11/8/21, and 11/9/21. During an interview on 11/18/2021 at 11:15 AM, when asked what the timeframe is for documentation of services in the clinical record, administrator indicated within 14 days of the visit. Indicated this employee provided the care of both a HHA and SN which blocked the	G1012	The Administrator will inservice Case Managersand RNs on agency's policies and processes (C-680) regarding clinical documentation, including required items in the clinical record. Processchanges have been instituted for visit documentation to be incorporated in theclient's chart automatically once the visit is rendered. This ensures the documentation of services ordered is incorporated into the clinical record within seven (7) days after the care has been provided. The Director ofNursing is responsible for ensuring compliance that the patient's currentcomprehensive assessment, including all of the assessments from the most recenthome health admission, clinical notes, plans of care, and physician orders arein the clinical record. Charts will be audited quarterly for qualityassurance.	2021-12-19

	charting in the EMR (electronic medical record) of another employee with the same classification.			
G1030	Retrieval of records 484.110(e) Standard: Retrieval of clinical records. A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). Review of an agency document dated 7/28/2021 titled Notice of Privacy Practices indicated & right to inspect and copy & you have the right to inspect and obtain a copy of medical information about you & your request should state specifically what medical information you want to inspect or copy & we will act on your request within 14 calendar days after we receive your request &. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy titled Client Privacy Rights indicated & clients receiving services from this agency have the following privacy rights & to access their protected health information for inspection and copying &. During an interview on 11/19/2021 at 1:55 PM, when asked if the agency provided the patient with the current	G1030	Theagency's master admission packet/home folder was updated to include corrected informationon a patient's right to access their protected health information for inspection or copying. The agency will complete this request within 4 days, not 14. In addition, the agency's Briggs Healthcare Operational Manual policy on Client Privacy Rights (C-382) was updated to include the 4-day timeframe. Nurses were inserviced on this rule. All (100%) current patients will receive anupdated packet in their home and will sign off on receiving packet. Thepackets/home folder will continue to be reviewed monthly on each supervisoryvisit with the patient and/or patient representative. This practice will beongoing. The Director of Nursing is responsible for ensuring compliance with makinga patient's clinical record available to a patient, free of charge, uponrequest at the next home visit, or within 4 business days (whichever comesfirst). Charts will be auditedquarterly for quality assurance.	2021-12-19

	information regarding requests for copies of their medical record, the administrator indicated that information was in the Notice of Privacy Practices. IAC 410 17-12-3(b)(3)			

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 reverse for further 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.

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