

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157555	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER A PLUS HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP CODE 2246-A INDUSTRIAL DR HIGHLAND, IN 46322
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G 000 Bldg. 00	<p>This visit was for a home health federal recertification survey. This visit resulted in a partial extended survey.</p> <p>Survey date: March 4, 5, 6, and 13, 2015</p> <p>Facility #: 3986</p> <p>Medicaid Vendor #: N/A</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Skilled unduplicated census: 177 patients in past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 23, 2015</p>	G 000		
G 121 Bldg. 00	<p>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.</p> <p>Based on observation, clinical record review, interview, and review of policies and procedures and personnel files, the</p>	G 121	The Administrator/Director of Nursing has inserviced all field staff members (see Attachments A and B) on new Wound Care	03/27/2015

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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	<p>agency failed to ensure staff had provided services in accordance with agency policies and procedures in 1 of 3 home visit observations (Patient #2) with a Registered Nurse (Employee L, Registered Nurse) and 1 of 2 home visit observations with a physical therapist (Employee R, Physical Therapist.)</p> <p>Findings</p> <p>1. At a home visit observation on 3/5/15 at 11:30 AM, Employee L, Registered Nurse, was observed to cleanse the wounds on patient #2's left lower leg by pouring normal saline from an expired 500 milliliter (ml) bottle onto gauze pads with the lip of the bottle touching the gauze and then cleansing the wounds with this moistened gauze. The bottle, a Baxter bottle of normal saline, had an expiration date of 11/2014 and had approximately 250 ml left prior to the wound cleansing procedure. It had been opened prior to this visit. There was no identification of whom had opened the bottle or when it had been opened. The bottle's label stated, "Discard unused portion."</p> <p>A. On 3/13/15 at 11:55 AM, Employee A, the administrator and director of nursing, indicated the bottle of normal saline was already opened and</p>		<p>Procedures (see Attachment C), emphasizing that staff are to verify that all supplies used are not opened or expired. In addition, the importance of holding the bottle of cleansing solution above the gauze and of pouring the prescribed cleaning solution onto the gauze was discussed. The field staff were informed that each RN would be evaluated using the new Wound Care Competency Checklist (see Attachment D) on their next visit performing wound care. If any education must be performed to bring the staff into compliance with the Procedures and Checklist, that education will be performed over the next 30 days. A re-evaluation using the same checklist shall then be performed to verify compliance. Additionally, the staff was educated on the new policy entitled "Expired Supplies" (see Attachment E). This policy explains that all staff members are to verify that all supplies used are not expired or open before using them, and if they are expired or open, to bring them to the agency office for replacement.</p> <p>The Administrator/Director of Nursing has inserviced all staff on the importance of proper care coordination with other facilities providing care to our patients. At each assessment, the Registered Nurse will ask the patient if he/she is receiving care from any dialysis center, outpatient therapy</p>	

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	<p>expired and should not have been used for the patient's wound care.</p> <p>B. A nursing procedure for the agency titled "Home visiting steps" with no date noted stated, "It is essential to ensure that all supplies that will be used for your visits are not expired. If any supplies are expired, bring them back to the office for proper disposal, and collect non - expired supplies to replace them. This is important, because expired supplies may lose effectiveness, or even become dangerous."</p> <p>2. At a home visit observation on 3/5/15 at 4:45 PM, Employee R, physical therapist, was observed to assist patient #7 with ambulation around the patient's house. While the patient was walking with the therapist, the patient was observed to start dragging his / her cane and falling backwards. Employee R with the assist of an informal caregiver positioned the patient into a kitchen chair with wheels. The patient was observed to show signs of seizure activity while sitting in the kitchen chair. Employee R did not attempt to position the patient onto the floor as the agency procedure for seizure precautions requires. The seizure activity lasted approximately 1 - 2 minutes. The patient regained consciousness over the next 5 - 10</p>		<p>clinic, wound care clinic, or any other outside facility, and complete the appropriate section of the revised Plan Of Care (Attachment G, Section 1) In addition, if the patient is receiving hemodialysis, the RN will complete the appropriate part of Attachment G, Section 1, listing where the AV fistula/graft is located, and any special precautions the staff must take as a result of the fistula/graft If the patient is receiving care from another facility, the RN will then also have the patient sign the "Care Coordination With Outside Facilities" form (see Attachment H), giving us authorization to receive information about the care given to our patient Any important information received by our agency will be relayed to the supervising physician and all field staff visiting the patient All new medications received will be included in the POC and the patient will be educated on the medications</p> <p>The Administrator/Director of Nursing has inserviced the staff on the proper seizure precautions and procedures, and the importance of following them completely In addition, a new handout has been created titled "Seizure Safety Procedures" (see Attachment F) This sheet shall be given to every patient who is a seizure risk or the caregiver/family of such a patient. The</p>				

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	<p>minutes and was kept in the kitchen chair for the entirety of the seizure and recovery from the seizure. Employee B was present at this home visit observation. The patient was still in the chair at 5:08 PM. Employee R did not instruct the patient or caregiver on the proper positioning of the patient during a seizure during the time observed.</p> <p>A. Clinical record #7, Start of care 2/9/15 and diagnosis of late effect of hemiplegia dominant side, included a plan of care for the certification period of 2/9/15 - 4/9/15. This plan of care included safety measures of seizure / convulsion precautions.</p> <p>B. On 3/6/15 at 11:30 AM, Employee B, the alternate administrator, stated, "I was surprised by the position the therapist placed the patient in." Employee B indicated this was not what the seizure precautions stated should be done if seizure activity occurred with a patient.</p> <p>C. The agency procedure titled "Seizure Precautions" with no date stated, "Clients are assisted with safety measures during seizures as indicated ... Procedure 1. Verify physician's order for seizure precautions. 2. Explain the order and procedure for seizure precautions to</p>		<p>patient/caregiver/family will then be educated on the proper steps during a seizure, as described on the handout. All staff members caring for a patient who is a seizure risk will be informed of the patient's risk status.</p> <p>The Administrator/Director of Nursing and Alternate Administrator will be responsible to implementing and monitoring of these corrective actions to ensure that this deficiency is corrected and does not recur</p>	

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G 143 Bldg. 00	<p>client. 3. Clear client's environment of hard, sharp, or hot objects. 4. Lower client to the floor if he or she is in standing position."</p> <p>D. The agency document titled "Job Description - Physical Therapist" signed by Employee R, physical therapist, on 5/15/13 stated, "Description: Gives medical prescribed physical therapy to patients in their homes in accordance with physician's plan of care ... adheres to agency policies and procedures."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>Based on interview, policy review, and clinical record review, the agency failed to ensure coordination of care occurred with other entities providing services for 1 of 2 (clinical record #5) records reviewed of patients receiving services from other entities.</p> <p>Findings</p> <p>1. The agency policy titled "Coordination of Patient Services" with a</p>	G 143	The Administrator/Director of Nursing has inserviced all staff on the importance of proper care coordination with other facilities providing care to our patients At each assessment, the Registered Nurse will ask the patient if he/she is receiving care from any dialysis center, outpatient therapy clinic, wound care clinic, or other facility, and complete the appropriate section of the revised Plan Of Care (see Attachment G, Section 1) In addition, if the patient is receiving hemodialysis, the RN will complete the appropriate part of Attachment G,	03/27/2015

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	<p>date of 2015 stated, "All personnel providing services are to maintain liaison to ensure that their efforts effectively complement on another and support the objectives of the company and those outlined in the Plan of Care ... individual responsibilities to further coordination of patient care are delineated in the job description and standard performance."</p> <p>2. The agency policy titled "Regulatory compliance" with a date of 2015 stated, "A Plus Home Health Care, Inc. shall be in compliance with all applicable federal, state, and local laws and regulations."</p> <p>3. Clinical record #5, start of care 7/24/14, evidenced the patient had chronic kidney disease and an access for hemodialysis. The record failed to evidence the skilled nurse communicated with the dialysis facility.</p> <p>On 3/13/15 at 12:50 PM, Employee A, the administrator and director of nursing, and Employee B, the alternate administrator, indicated the patient's record did not indicate the skilled nurse had communicated with the dialysis facility about the patient's care.</p>		<p>Section 1, listing where the AV fistula/graft is located, and any special precautions the staff must take as a result of the fistula/graft If the patient is receiving care from another facility, the RN will then also have the patient sign the "Care Coordination With Outside Facilities" form (see Attachment H), giving us permission to receive information about the care given at the outside facilities The completed form will then be sent to the outside facility requesting information about the care given to our patient Any important information received by our agency will be relayed to the appropriate members of the field staff visiting the patient The Administrator/Director of Nursing and Alternate Administrator will be responsible to implementing and monitoring of these corrective actions to ensure that this deficiency is corrected and does not recur</p>		

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G 158 Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on observation, clinical record review, interview, and review of policies and procedures, the agency failed to ensure staff had followed the plan of care in 1 of 2 home visit observations (Patient #7) with a physical therapist, Employee R.</p> <p>Findings</p> <p>1. At a home visit observation on 3/5/15 at 4:45 PM, Employee R, physical therapist, was observed to assist patient #7 with ambulation around the patient's house. While the patient was walking with the therapist, the patient was observed to start dragging his / her cane and falling backwards. Employee R with the assist of an informal caregiver positioned the patient into a kitchen chair with wheels. The patient was observed to show signs of seizure activity while sitting in the kitchen chair. Employee R did not attempt to position the patient</p>	G 158	<p>The Administrator/Director of Nursing has inserviced the staff on the proper seizure precautions and procedures and the importance of following them completely In addition, a new handout has been created titled "Seizure Safety Procedures" (see Attachment F) This sheet shall be given to every patient who is a seizure risk or the caregiver/family of such a patient The patient/caregiver/family will then be educated on the proper steps during a seizure, as described on the handout All staff members caring for a patient who is a seizure risk will be informed of the patient's risk status Emphasis was also placed upon the importance of each staff member following the Plan Of Care established by the supervising physician The Administrator/Director of Nursing and Alternate Administrator will be responsible to implementing and monitoring of these corrective actions to ensure that this deficiency is</p>	03/27/2015

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	<p>onto the floor as the agency procedure for seizure precautions requires. The seizure activity lasted approximately 1 - 2 minutes. The patient regained consciousness over the next 5 - 10 minutes and was kept in the kitchen chair for the entirety of the seizure and recovery from the seizure. Employee B was present at this home visit observation. The patient was still in the chair at 5:08 PM. Employee R did not instruct the patient or caregiver on the proper positioning of the patient during a seizure during the time observed.</p> <p>A. Clinical record #7, Start of care 2/9/15 and diagnosis of late effect of hemiplegia dominant side, included a plan of care for the certification period of 2/9/15 - 4/9/15. This plan of care included safety measures of seizure / convulsion precautions.</p> <p>B. On 3/6/15 at 11:30 AM, Employee B, the alternate administrator, stated, "I was surprised by the position the therapist placed the patient in." Employee B indicated that this was not what the seizure precautions stated should be done if seizure activity occurred with a patient.</p> <p>2. The agency procedure titled "Seizure Precautions" with no date stated, "Clients</p>		corrected and does not recur	

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	<p>are assisted with safety measures during seizures as indicated ... Procedure 1. Verify physician's order for seizure precautions. 2. Explain the order and procedure for seizure precautions to client. 3. Clear client's environment of hard, sharp, or hot objects. 4. Lower client to the floor if he or she is in standing position."</p> <p>3. The agency document titled "Job Description - Physical Therapist" signed by Employee R, physical therapist, on 5/15/13 stated, "Description: Gives medical prescribed physical therapy to patients in their homes in accordance with physician's plan of care ... adheres to agency policies and procedures."</p> <p>4. The agency policy titled "Plan of care" with a date of 2015 stated, "A plan of care is developed for each patient ... All disciplines caring for the patient are expected to follow the developed plan of care, unless the plan of care has been changed by a physician's order."</p>			

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G 159 Bldg. 00	<p>484.18(a) PLAN OF CARE</p> <p>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.</p> <p>Based on home visit observation, policy and clinical record review, and interview, the agency failed to ensure the plan of care was signed by the primary care physician in a timely manner and included all required elements for 4 of 12 records reviewed (#1 - 4).</p> <p>Findings</p> <p>1. Clinical record # 1, start of care (SOC) 10/16/14 and diagnosis of chronic obstructive asthma, included a plan of care for the certification period of 2/13/15 - 4/13/15. This plan of care failed to include individualized goals for this patient and an accurate list of durable</p>	G 159	<p>The Administrator/Director of Nursing has inserviced the staff on the importance of listing all DME and related devices and equipment used by the patient, including glasses and life line or related monitors. The Plan of Care form has been updated to include check boxes for glasses and life line monitors (see Attachment G, Section 2). The POC was also revised to be more realistic and individualized. The staff was also educated on the critical nature of ensuring the supervising physician signs and approves the Plan Of Care in a timely manner, 30 days or less after creation. All patient charts will be audited each month to ensure timely signatures by the supervising physician. Any deficiencies or difficulties</p>	03/27/2015

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	<p>medical equipment including a life line monitor and glasses used by the patient. The patient's list of goals on this plan of care stated, "The patient's vision will improve through the use of a device." What type of device this would be was not stated on the plan of care.</p> <p>a. On 3/5/15 at 9:30 AM, patient #1 was observed to have glasses and a life line monitor.</p> <p>b. On 3/13/15 at 11:45 AM, Employee A, the administrator and director of nursing, indicated the plan of care did not show the patient used glasses and a life line monitor and the goals were not individualized.</p> <p>c. The recertification assessment completed on 2/12/15 by the registered nurse evidenced the patient wore glasses.</p> <p>2. Clinical record #2, SOC 7/24/14 and diagnosis of venous insufficiency, included a plan of care for the certification period of 1/20/15 - 3/20/15, not signed by the primary care physician in a timely manner.</p> <p>On 3/4/15 at 4:45 PM, Employee B, the alternate administrator, indicated the plan of care had not been signed at this time. He indicated difficulty obtaining</p>		<p>obtaining signatures will be documented on the "MD Order Checklist-MD Order Signed Within 30 Days" form (see Attachment I), and the issue will be resolved immediately. The Administrator/Director of Nursing and Alternate Administrator will be responsible to implementing and monitoring of these corrective actions to ensure that this deficiency is corrected and does not recur.</p>				

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	<p>signatures from this physician responsible for this patient's medical plan of care.</p> <p>3. Clinical record #3, SOC 2/20/15 and diagnosis of hypertensive heart disease, included a plan of care for the certification period of 2/20/15 - 4/20/15. This plan of care stated, "Goals ... Patient will have stable electrolyte balance." There were orders on the plan of care to measure electrolyte laboratory results.</p> <p>On 3/13/15 at 12:10 PM, Employee A, the administrator and director of nursing, indicated the goal was not measurable at this time.</p> <p>4. Clinical record #4, SOC 8/29/14 and diagnosis of chronic pain, included a plan of care for the certification period of 2/25/15 - 4/25/15. This plan of care stated, "Goals ... patient's vision impairment will improve through the use of a device and medicine." What type of device was not evidenced on the plan of care.</p> <p>a. On 3/13/15 at 12:25 PM, Employee B, the alternate administrator, indicated goals had not been individualized for this patient's plan of care.</p>			

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	<p>b. The recertification assessment completed on 2/20/15 by the registered nurse evidenced the patient wore glasses.</p> <p>5. The agency policy titled "Chart - General Information" with a date of 2015 stated, "to keep an accurate records of the patient's condition ... to aid in following the course of the disease."</p> <p>6. The agency policy titled "Plan of care" with a date of 2015 stated, "A plan of care is developed for each patient admitted to the home health program in consultation with the referring physician. The plan of care must be signed and dated by a physician responsible for the care of the patient and filed into the patient's record .. the plan of care ... includes medical supplies and DME [durable medical equipment] ordered, and those already available to the patient. M. Goals ... attending physician's signature."</p>			

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G 176 Bldg. 00	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.</p> <p>Based on interview, policy review, and clinical record review, the agency failed to ensure the registered nurse coordinated care with other entities providing services for 1 of 1 (clinical record #5) records reviewed of patients receiving services from other entities.</p> <p>Findings</p> <p>1. The agency policy titled "Coordination of Patient Services" with a date of 2015 stated, "All personnel providing services are to maintain liaison to ensure that their efforts effectively complement on another and support the objectives of the company and those outlined in the Plan of Care ... individual responsibilities to further coordination of patient care are delineated in the job description and standard performance."</p> <p>2. The agency policy titled "Regulatory compliance" with a date of 2015 stated, "A Plus Home Health Care, Inc. shall be</p>	G 176	<p>The Administrator/Director of Nursing has inserviced all staff on the importance of proper care coordination with other facilities providing care to our patients. At each assessment, the Registered Nurse will ask the patient if he/she is receiving care from any dialysis center, outpatient therapy clinic, wound care clinic, or other facility, and complete the appropriate section of the revised Plan Of Care (see Attachment G, Section 1). In addition, if the patient is receiving hemodialysis, the RN will complete the appropriate part of Attachment G, Section 1, listing where the AV fistula/graft is located, and any special precautions the staff must take as a result of the fistula/graft. If the patient is receiving care from another facility, the RN will then also have the patient sign the "Care Coordination With Outside Facilities" form (see Attachment H), giving us permission to receive information about the care given at the outside facilities. The completed form will then be sent to the outside facility requesting</p>	03/27/2015

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N 000 Bldg. 00	<p>in compliance with all applicable federal, state, and local laws and regulations."</p> <p>3. Clinical record #5, start of care 7/24/14, evidenced the patient had chronic kidney disease and an access for hemodialysis. The record failed to evidence the skilled nurse communicated with the dialysis facility.</p> <p>4. On 3/13/15 at 12:50 PM, Employee A, the administrator and director of nursing, and Employee B, the alternate administrator, indicated the patient's record did not indicate the RN had communicated with the dialysis facility about the patient's care.</p> <p>This visit was for a state relicensure survey.</p> <p>Survey dates: March 4, 5, 6, and 13, 2015</p> <p>Facility #: 3986</p>	N 000	<p>information about the care given to our patient Any important information received by our agency will be relayed to the appropriate members of the field staff visiting the patient The Administrator/Director of Nursing and Alternate Administrator will be responsible to implementing and monitoring of these corrective actions to ensure that this deficiency is corrected and does not recur</p>		

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N 470 Bldg. 00	<p>Medicaid Vendor #: N/A</p> <p>Surveyor: Ingrid Miller, PHNS, RN</p> <p>Skilled unduplicated census: 177 patients in past year</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 23, 2015</p> <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, interview, and review of policies and procedures, the agency failed to ensure staff had provided services in accordance with infection control policies and procedures in 1 of 3 home visit observations (Patient #2) with a Registered Nurse (Employee L, Registered Nurse).</p> <p>Findings</p> <p>1. At a home visit observation on 3/5/15 at 11:30 AM, Employee L, Registered Nurse, was observed to cleanse the wounds on patient #2's left lower leg by pouring normal saline from an expired 500 milliliter (ml) bottle onto gauze pads</p>	N 470	<p>Administrator/Director of Nursing has inserviced all field staff members (see Attachments A and B) on new Wound Care Procedures (see Attachment C), emphasizing that staff are to verify that all supplies used are not opened or expired. In addition, the importance of holding the bottle of cleansing solution above the gauze and of pouring the prescribed cleaning solution onto the gauze was discussed. The field staff was informed that each RN would be evaluated using the new Wound Care Competency Checklist (see Attachment D) on their initial wound care visit and a month after. If any education must be performed to bring the staff into</p>	03/27/2015			

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N 486	<p>with the lip of the bottle touching the gauze and then cleansing the wounds with this moistened gauze. The bottle, a Baxter bottle of normal saline, had an expiration date of 11/2014 and had approximately 250 ml left prior to the wound cleansing procedure. It had been opened prior to this visit. There was no identification of whom had opened the bottle or when it had been opened. The bottle's label stated, "Discard unused portion."</p> <p>2. On 3/13/15 at 11:55 AM, Employee A, the administrator and director of nursing, indicated the bottle of normal saline was already opened and expired and should not have been used for the patient's wound care.</p> <p>3. A nursing procedure for the agency titled "Home visiting steps" with no date noted stated, "It is essential to ensure that all supplies that will be used for your visits are not expired. If any supplies are expired, bring them back to the office for proper disposal, and collect non - expired supplies to replace them. This is important, because expired supplies may lose effectiveness, or even become dangerous."</p>		<p>compliance with the Procedures and Checklist, that education will be performed between the initial visit and the follow-up visit. Additionally, the staff was educated on the new policy entitled "Expired Supplies" (see Attachment E). This policy explains that all staff members are to verify that all supplies used are not opened or expired before using them, and if they are expired, to bring the supplies back to the office for replacement with supplies that are not opened or expired. The Administrator/Director of Nursing and the Alternate Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				
	410 IAC 17-12-2(h)						

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Bldg. 00	<p>Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on interview, policy review, and clinical record review, the agency failed to ensure coordination of care occurred with other entities providing services for 1 of 2 (clinical record #5) records reviewed of patients receiving services from other entities.</p> <p>Findings</p> <p>1. The agency policy titled "Coordination of Patient Services" with a date of 2015 stated, "All personnel providing services are to maintain liaison to ensure that their efforts effectively complement on another and support the objectives of the company and those outlined in the Plan of Care ... individual responsibilities to further coordination of patient care are delineated in the job description and standard performance."</p> <p>2. The agency policy titled "Regulatory compliance" with a date of 2015 stated, "A Plus Home Health Care, Inc. shall be in compliance with all applicable federal, state, and local laws and regulations."</p> <p>3. Clinical record #5, start of care 7/24/14, evidenced the patient had</p>	N 486	<p>The Administrator/Director of Nursing has inserviced all staff on the importance of proper care coordination with other facilities providing care to our patients At each assessment, the Registered Nurse will ask the patient if he/she is receiving care from any dialysis center, outpatient therapy clinic, wound care clinic, or any other outside facility, and complete the appropriate section of the revised Plan Of Care (Attachment G, Section 1) In addition, if the patient is receiving hemodialysis, the RN will complete the appropriate part of Attachment G, Section 1, listing where the AV fistula/graft is located, and any special precautions the staff must take as a result of the fistula/graft If the patient is receiving care from another facility, the RN will then also have the patient sign the "Care Coordination With Outside Facilities" form (see Attachment H), giving us authorization to receive information about the care given to our patient Any important information received by our agency will be relayed to the supervising physician and all field staff visiting the patient All new medications received will be included in the POC and the patient will be educated on the</p>	03/27/2015

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N 522 Bldg. 00	<p>chronic kidney disease and an access for hemodialysis. The record failed to evidence the skilled nurse communicated with the dialysis facility.</p> <p>On 3/13/15 at 12:50 PM, Employee A, the administrator and director of nursing, and Employee B, the alternate administrator, indicated the patient's record did not indicate the skilled nurse had communicated with the dialysis facility about the patient's care.</p> <p>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 observation, clinical record review, interview, and review of policies and procedures, the agency failed to ensure staff had followed the plan of care in 1 of 2 home visit observations (Patient #7) with a physical therapist, Employee R.</p> <p>Findings</p> <p>1. At a home visit observation on 3/5/15</p>	N 522	<p>medications The Administrator/Director of Nursing and Alternate Administrator will be responsible to implementing and monitoring of these corrective actions to ensure that this deficiency is corrected and does not recur</p> <p>The Administrator/Director of Nursing has inserviced the staff on the proper seizure precautions and procedures and the importance of following them completely In addition, a new handout has been created titled "Seizure Safety Procedures" (see Attachment F) This sheet shall be given to every patient who is a seizure risk or to the patient/caregiver/family of such a patient The patient/caregiver/family will then</p>	03/27/2015

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	<p>at 4:45 PM, Employee R, physical therapist, was observed to assist patient #7 with ambulation around the patient's house. While the patient was walking with the therapist, the patient was observed to start dragging his / her cane and falling backwards. Employee R with the assist of an informal caregiver positioned the patient into a kitchen chair with wheels. The patient was observed to show signs of seizure activity while sitting in the kitchen chair. Employee R did not attempt to position the patient onto the floor as the agency procedure for seizure precautions requires. The seizure activity lasted approximately 1 - 2 minutes. The patient regained consciousness over the next 5 - 10 minutes and was kept in the kitchen chair for the entirety of the seizure and recovery from the seizure. Employee B was present at this home visit observation. The patient was still in the chair at 5:08 PM. Employee R did not instruct the patient or caregiver on the proper positioning of the patient during a seizure during the time observed.</p> <p>A. Clinical record #7, Start of care 2/9/15 and diagnosis of late effect of hemiplegia dominant side, included a plan of care for the certification period of 2/9/15 - 4/9/15. This plan of care included safety measures of seizure /</p>		<p>be educated on the proper steps during a seizure, as described on the handout All staff members caring for a patient who is a seizure risk will be informed of the patient's risk status The Administrator/Director of Nursing and the Alternate Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and does not recur</p>	

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	<p>convulsion precautions.</p> <p>B. On 3/6/15 at 11:30 AM, Employee B, the alternate administrator, stated, "I was surprised by the position the therapist placed the patient in." Employee B indicated that this was not what the seizure precautions stated should be done if seizure activity occurred with a patient.</p> <p>2. The agency procedure titled "Seizure Precautions" with no date stated, "Clients are assisted with safety measures during seizures as indicated ... Procedure 1. Verify physician's order for seizure precautions. 2. Explain the order and procedure for seizure precautions to client. 3. Clear client's environment of hard, sharp, or hot objects. 4. Lower client to the floor if he or she is in standing position."</p> <p>3. The agency document titled "Job Description - Physical Therapist" signed by Employee R, physical therapist, on 5/15/13 stated, "Description: Gives medical prescribed physical therapy to patients in their homes in accordance with physician's plan of care ... adheres to agency policies and procedures."</p> <p>4. The agency policy titled "Plan of care" with a date of 2015 stated, "A plan of</p>			

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N 524 Bldg. 00	<p>care is developed for each patient ... All disciplines caring for the patient are expected to follow the developed plan of care, unless the plan of care has been changed by a physician's order."</p> <p>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</p>			

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	<p>treatment. (xiii) Any other appropriate items. Based on home visit observation, policy and clinical record review, and interview, the agency failed to ensure the plan of care was signed by the primary care physician in a timely manner and included all required elements for 4 of 12 records reviewed (#1 - 4).</p> <p>Findings</p> <p>1. Clinical record # 1, start of care (SOC) 10/16/14 and diagnosis of chronic obstructive asthma, included a plan of care for the certification period of 2/13/15 - 4/13/15. This plan of care failed to include individualized goals for this patient and an accurate list of durable medical equipment including a life line monitor and glasses used by the patient. The patient's list of goals on this plan of care stated, "The patient's vision will improve through the use of a device." What type of device this would be was not stated on the plan of care.</p> <p>a. On 3/5/15 at 9:30 AM, patient #1 was observed to have glasses and a life line monitor.</p> <p>b. On 3/13/15 at 11:45 AM, Employee A, the administrator and director of nursing, indicated the plan of</p>	N 524	<p>The Administrator/Director of Nursing has inserviced the staff on the importance of listing all DME and related devices and equipment used by the patient, including glasses and life line or related monitors The Plan Of Care form has been updated to include check boxes for glasses and life line monitors (see Attachment G, Section 2) In addition, the POC was altered to make it more realistic and individualized</p> <p>The staff was also educated on the critical nature of ensuring the supervising physician signs and approves the Plan Of Care in a timely manner, 30 days or less after creation All patient charts will be audited each month to ensure timely signatures by the supervising physician Any deficiencies or difficulties obtaining signatures will be documented on the "MD Order Checklist-MD Order Signed Within 30 Days" form (see Attachment I), and the issue will be resolved immediately</p> <p>The Administrator/Director of Nursing and the Alternate Administrator will be responsible for implementation and monitoring of these corrective actions to ensure that this deficiency is corrected and will not recur</p>	03/27/2015

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	<p>care did not show the patient used glasses and a life line monitor and the goals were not individualized.</p> <p>c. The recertification assessment completed on 2/12/15 by the registered nurse evidenced the patient wore glasses.</p> <p>2. Clinical record #2, SOC 7/24/14 and diagnosis of venous insufficiency, included a plan of care for the certification period of 1/20/15 - 3/20/15, not signed by the primary care physician in a timely manner.</p> <p>On 3/4/15 at 4:45 PM, Employee B, the alternate administrator, indicated the plan of care had not been signed at this time. He indicated difficulty obtaining signatures from this physician responsible for this patient's medical plan of care.</p> <p>3. Clinical record #3, SOC 2/20/15 and diagnosis of hypertensive heart disease, included a plan of care for the certification period of 2/20/15 - 4/20/15. This plan of care stated, "Goals ... Patient will have stable electrolyte balance." There were orders on the plan of care to measure electrolyte laboratory results.</p> <p>On 3/13/15 at 12:10 PM, Employee A, the administrator and director of</p>			

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	<p>nursing, indicated the goal was not measurable at this time.</p> <p>4. Clinical record #4, SOC 8/29/14 and diagnosis of chronic pain, included a plan of care for the certification period of 2/25/15 - 4/25/15. This plan of care stated, "Goals ... patient's vision impairment will improve through the use of a device and medicine." What type of device was not evidenced on the plan of care.</p> <p>a. On 3/13/15 at 12:25 PM, Employee B, the alternate administrator, indicated goals had not been individualized for this patient's plan of care.</p> <p>b. The recertification assessment completed on 2/20/15 by the registered nurse evidenced the patient wore glasses.</p> <p>5. The agency policy titled "Chart - General Information" with a date of 2015 stated, "to keep an accurate records of the patient's condition ... to aid in following the course of the disease."</p> <p>6. The agency policy titled "Plan of care" with a date of 2015 stated, "A plan of care is developed for each patient admitted to the home health program in consultation with the referring physician.</p>			

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N 545 Bldg. 00	<p>The plan of care must be signed and dated by a physician responsible for the care of the patient and filed into the patient's record .. the plan of care ... includes medical supplies and DME [durable medical equipment] ordered, and those already available to the patient. M. Goals ... attending physician's signature."</p> <p>410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on interview, policy review, and clinical record review, the agency failed to ensure the registered nurse coordinated care with other entities providing services for 1 of 12 (clinical record #5) records reviewed with a registered nurse.</p> <p>Findings</p> <p>1. The agency policy titled "Coordination of Patient Services" with a date of 2015 stated, "All personnel providing services are to maintain liaison to ensure that their efforts effectively complement on another and support the objectives of the company and those outlined in the Plan of Care ... individual responsibilities to further coordination of</p>	N 545	The Administrator/Director of Nursing has inserviced all staff on the importance of proper care coordination with other facilities providing care to our patients. At each assessment, the Registered Nurse will ask the patient if he/she is receiving care from any dialysis center, outpatient therapy clinic, wound care clinic, or any other outside facility, and complete the appropriate section of the revised Plan Of Care (Attachment G, Section 1) In addition, if the patient is receiving hemodialysis, the RN will complete the appropriate part of Attachment G, Section 1, listing where the AV fistula/graft is located, and any special precautions the staff must take as a result of the fistula/graft. If the	03/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157555	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2015
NAME OF PROVIDER OR SUPPLIER A PLUS HOME HEALTH CARE INCORPORATED			STREET ADDRESS, CITY, STATE, ZIP CODE 2246-A INDUSTRIAL DR HIGHLAND, IN 46322		
(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	
	<p>patient care are delineated in the job description and standard performance."</p> <p>2. The agency policy titled "Regulatory compliance" with a date of 2015 stated, "A Plus Home Health Care, Inc. shall be in compliance with all applicable federal, state, and local laws and regulations."</p> <p>3. Clinical record #5, start of care 7/24/14, evidenced the patient had chronic kidney disease and an access for hemodialysis. The record failed to evidence the registered nurse communicated with the dialysis facility.</p> <p>4. On 3/13/15 at 12:50 PM, Employee A, the administrator and director of nursing, and Employee B, the alternate administrator, indicated the patient's record did not indicate the RN had communicated with the dialysis facility about the patient's care.</p>		<p>patient is receiving care from another facility, the RN will then also have the patient sign the "Care Coordination With Outside Facilities" form (see Attachment H), giving us authorization to receive information about the care given to our patient Any important information received by our agency will be relayed to the supervising physician and all field staff visiting the patient All new medications received will be included in the POC and the patient will be educated on the medications The Administrator/Director of Nursing and Alternate Administrator will be responsible to implementing and monitoring of these corrective actions to ensure that this deficiency is corrected and does not recur</p>		