

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K009	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2021
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NAME OF PROVIDER OR SUPPLIER HOME CARE WITH A HEART INC	STREET ADDRESS, CITY, STATE, ZIP COD 1220 W MAIN ST STE D GREENFIELD, IN 46140
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G 0000 Bldg. 00	<p>This visit was for a recertification survey of a home health agency. This survey was partially extended, and the administrator was notified on 5-12-2021, at 2:15 PM.</p> <p>Facility #: IN 002640</p> <p>Provider #: 15K009</p> <p>Medicaid #: 200305630</p> <p>Survey Dates: 5-10, 5-11, and 5-12-2021</p> <p>The findings cited in this survey are also reflected in deficiencies 410 IAC 17.</p> <p>Quality Review Completed on 5/18/21 by Area 3</p>	G 0000		
G 0572 Bldg. 00	<p>484.60(a)(1) Plan of care</p> <p>Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan.</p>			

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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>Based on record review and interview, the agency failed to ensure the home health aide followed the plan of care for 1 (Patient #3) of 6 active patients records reviewed.</p> <p>The findings included:</p> <p>Review of the clinical record for patient #3, start of care date of 10-29-2018, contained a plan of care for the certification period of 4-17 to 6-15-2021, with order for home health aide (HHA) " ... to provide ADL's (activities of daily living) including, but not limited to: Bath/Shower ... provide personal care, hair care, skin care, check for pressure areas, open areas, red areas or changes ... Provide ambulation assistance, remind client to utilize his/her walker to help prevent falls, no throw rugs, and follow fall precautions, nail hygiene ... meal assistance ... "</p> <p>Review of the HHA care plan, last reviewed/revised 4-16-2021, evidenced HHA assignments of Bath/Shower, assist with dressing, hair care, skin care, check for pressure/open areas, elimination assistance, ambulation assist (wheel chair/walker), mobility assist, meal preparation, equipment care--clean and inspect for client safety, household safety and hygiene for client area and care and eating areas and utensils, clean up bathroom area and spills after client care.</p> <p>Review of HHA care visit notes, dated 4-19, 4-21, and 4-23-2021, failed to evidence the following assigned tasks had been provided: check for pressure areas, ambulation assist, mobility assist, meal assist, nail care/cleaning, equipment care, clean up bathroom area and spills.</p> <p>On 5-13-2021, at 1:45 PM, clinical record #3 was</p>	G 0572	<p>1.) Findings of surveys shared with Home Health Aides. Education implemented regarding importance of following care plan, and documentation of following the care plan as well as any client request for an activity not to be completed for the day. Education provided to Home Health Aides to report observations of skin changes, and that when giving a bath the visualization of the skin is a check for pressure areas, walking with the client to safely get to the bathroom is ambulation assist, safe transfers in or out of chairs, beds, tubs includes mobility assist, bringing the client meals on wheels & opening container is meal assist, nail care should be included with bath, and documented, and clean up after bathing is equipment care and clean up for safety and should be documented as completed each time. Each client chart reviewed with chart audit form to check for documentation to match the care plan in place.</p> <p>2.) Ongoing Educational Reviews will be provided with annual in-services (typically provided to Home Health Aides on a monthly basis) regarding Care Plans, providing care according to the current care plan, and documentation according to the client's current care plan, as well as documentation for any client</p>	05/21/2021	

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G 0574 Bldg. 00	<p>reviewed with the Administrator. When queried if the HHA visit notes were completed according to agency expectations, the administrator stated, "No," I should have caught that.</p> <p>410 IAC 17-13-1 (a)</p> <p>484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and</p>		<p>request of an activity not to be completed for the day. Additionally the Alternate Administrator will assist with chart checks every month to have a fresh set of eyes on the documentation to ensure adherence. Chart Audit Forms will be utilized to review charting quarterly.</p> <p>3.) The Administrator shall be responsible for the correction of this deficiency with ongoing documentation review and use of chart audit forms.</p>		

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	<p>training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.</p> <p>Based on record review, observation, and interview, the agency failed to ensure the all goals were objective, measurable, and attainable for 3 (Patients 1, 2, and 3) of 6 active clinical records reviewed, and failed to include all required durable medical equipment in the home for 1 (Patient #6) of 6 active patient records reviewed.</p> <p>The findings included:</p> <p>1. Review of an agency policy, "Care Plans," last reviewed/revised 2005, evidenced the policy stated, " ... The Plan of Plan shall include ... " ...reasonable, measurable and realistic goals as determined by the assessment ... indicators for measuring goal achievement and identified time frames ... medical supplies and equipment required ... ""</p> <p>2. Review of the plan of care for patient #1, evidenced primary diagnosis of history of cardiovascular accident (CVA), and also congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and dyspnea. Home health aide visits were provided 5 times a week for 8 hours each visit. Review of the goals evidenced "Client will remain safe in [his/her] home with HCA [home care assistance] and family assist, and remain free from falls, injuries and or skin breakdown." The goal</p>	G 0574	<p>1.) Signed Doctors orders obtained to Update Care Plans for each client to include individualized realistic, measurable and objective goals and to include all Durable Medical Equipment. (For example Mechanical lifts, and Pure Wick the external urine collection device) Education provided to all clients to help prevent falls and injuries, skin breakdown& infections. (patient #1) With each nurse assessment during the recertification period client to verbalize 2-3 ways to help prevent exacerbation of existing conditions (CHF, CVA, COPD, Diabetes, dyspnea,) Client will verbalize 2-3 ways to help prevent falls or injuries in the home, client will verbalize 2-3 ways to help maintain skin integrity. (patient #2) with each nurse assessment during the recertification period will be able to verbalize 2-3 ways to help prevent exacerbation of existing conditions including COPD, HTN, sleep apnea, Asthma client will be able to verbalize 2-3 ways to help prevent falls or injuries & client will be able</p>	05/24/2021

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	<p>failed to be reasonable, measurable, and objective. It was not reasonable to expect limited care visits could prevent all falls, injuries, or skin breakdown, and the goal failed to identify indicators and time frames.</p> <p>3. Review of the clinical record for patient #2, evidenced primary diagnosis COPD, and also knee replacement, hypertension, history of lung collapse, sleep apnea, and asthma. HHA visits were provided 7 days a week for 7 hours each visit. Review of the goals evidenced "Client to remain at home with assist, without falls, injuries, or skin breakdown." The goal failed to be reasonable, measurable, and objective. It was not reasonable to expect limited care visits could prevent all falls, injuries, or skin breakdown, and the goal failed to identify indicators and time frames.</p> <p>4. Review of the clinical record for patient #3, evidenced primary diagnosis diabetes, and also acute respiratory distress, asthma, and arthritis. HHA visits were provided 7 days a week, 2 hours each visit. One of the goals reviewed was "Client to remain at home with assist, without falls, injuries, or skin breakdown." The goal failed to be reasonable, measurable, and objective. It was not reasonable to expect limited care visits could prevent all falls, injuries, or skin breakdown, and the goal failed to identify indicators and time frames.</p> <p>5. Review of the plan of care for patient #6, start of care date of 2-6-2019, contained a plan of care for the certification period of 3-27 to 5-25-2021, with orders for HHA services. Review of the plan of care failed to evidence as durable medical equipment, a mechanical (Hoyer) lift and suction device, which were observed during a home</p>		<p>to verbalize 2-3 ways to maintain skin integrity. (patient#3) with each assessment during the recertification period client will be able to verbalize 2-3 ways to help prevent exacerbation of existing conditions including diabetes, respiratory distress, asthma, arthritis. Client will verbalize 2-3 ways to help maintain skin integrity, and prevent falls or injuries in the home. (patient#6) Signed orders obtained & added to care plan for All Durable Medical Equipment ; mechanical lift, and external urine collection device (Pure Wick)</p> <p>2.) Findings of Surveys shared with Alternate Administrator to help with documentation reviews and provide updates as needed. Chart review forms will include lines to check for all durable medical equipment as well as reasonable, objective and measurable goals</p> <p>3.) The Administrator shall be responsible for the correction of this deficiency with ongoing quarterly chart reviews</p>		

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G 0798 Bldg. 00	<p>health aide home visit for patient #6 on 5-11-2021, at 11 AM. Patient #6 indicated the items were for use in his/her home health services.</p> <p>6. On 5-13-2021, at 1:45 PM, clinical records above were reviewed with the Administrator. When queried if the goals were all realistic, measurable, and realistic, the administrator replied, "No." The administrator verified necessary durable medical equipment for patient #6 was not on the plan of care, and should have been.</p> <p>410 IAC 17-13-1 (a)(1)(D)(ii)</p> <p>484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).</p> <p>Based on observation, record review, and interview, the agency failed to ensure the home health aide's plan of care included the task of use of a mechanical lift for transfers, the patient's weight bearing status, and the use of a non-invasive urinary device for 1 (Patient #6) of 7 patients whose clinical record was reviewed.</p> <p>The findings include:</p> <p>On 5-11-2021, at 11 AM, during a home visit observation of a home health aide (HHA,)</p>	G 0798	1.) Home Health Aide Care plan Updated to reflect a current, accurate weight bearing status of client as well as including the task of use of mechanical lift for safe transfers and empty external urine collection device container. All Home Health Aide Care Plans Reviewed for accuracy with devices needed for care and including client interviews to current care needs.	05/12/2021			

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	<p>employee A, for patient #6, in the presence of the administrator, a mechanical lift and a suction device were observed in the home near patient #6's bed. Patient #6 identified these durable medical equipment items as for his/her use. At this time, patient #6 reported not being able to bear weight due to a February 2021 right leg tibia/fibula fracture.</p> <p>Review of a document in patient #6's clinical record, titled, "Home Care with A Heart, Inc Home Health/Home Care Aide Assignment Sheet," dated 4-12-2021, indicated in the "Activity" section the following: "Ambulation Assist" WC (wheelchair)/Walker/Cane. Review of the document failed to evidence patient #6 utilized a Hoyer type lift for transfers, was not able to bear weight, or used any type of suctioning device.</p> <p>On 5-11-21, at 2:19 P.M., the administrator, when queried if the lift and suction machines were included in the home health aide (HHA) plan for patient # 6, replied "No." The administrator further explained the suction device was an attachment for a non-invasive urinary incontinence device and the aide's only pertinent assigned duty was to empty the collection container, for which the HHA was competent. The administrator confirmed the above durable medical equipment/supplies were not included in the HHA care plan for patient #6, as they should have been.</p> <p>On 5-12-21, at 12 noon, the administrator was asked, "What changed in regard to care (referring to patient #6's return home after hospitalization for tibia/fibula fracture)?" The administrator replied, "[name of patient #6] is mostly bedbound, [patient #6] has a Hoyer (mechanical lift), gets bed baths</p>		<p>2.) Review of updated care plan information provided to all caregivers (Home Health Aides & Nurses) Verbal acknowledgement from each stating we were aware of that, will update our forms and charting to include devices needed for client care accurately. Chart Audit form to include a new line to review current equipment needed on Home Health Aide Care Plans.</p> <p>3.) The Administrator will be responsible for the correction of this deficiency with ongoing review of all Home Health Aide charting and Care Plans and use of Chart Audit Forms with quarterly reviews.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	but has the option to get up." The administrator was also asked "where in the home health aide plan of care is this information?" The administrator replied, "I need to update that." 410 IAC 17-13-2 (a)				