

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 05/06/2021
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NAME OF PROVIDER OR SUPPLIER A PLUS HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP COD 2246-A INDUSTRIAL DR HIGHLAND, IN 46322
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G 0000 Bldg. 00	<p>This visit was a federal focused infection control and complaint survey with 1 complaint. The survey visit took place 5/3/2021 to 5/6/2021.</p> <p>Facility ID: 003986</p> <p>Complaint: IN00331046 - substantiated with related and unrelated findings.</p> <p>This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.</p>	G 0000	Please see the following sections for corrections. Thank you for your consideration with these corrections, and assisting us to improve the care we provide to our patients.	
G 0534 Bldg. 00	<p>484.55(c)(4) Patient's needs</p> <p>The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on clinical record review and interview, the home health agency failed to meet the patient's needs , in 1 of 1 active records reviewed receiving wound care. (#3).</p> <p>The findings include:</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "JOB DESCRIPTION - TITLE: HOME HEALTH NURSE (REGISTERED NURSE)", with copyright date 2004, which stated, "PRINCIPAL FUNCTION: Provides nursing care to assigned patients utilizing the Nursing Process to assess, plan, implement and evaluate patient service based upon a physician's plan of care. Coordinates care delivered by other health disciplines for assigned patients ... C. Implementation 1. Provides direct patient care</p>	G 0534	<p>The Skilled Nursing staff was inserviced (See Attachments A, B, and C) on the correct method of providing wound care services, and documenting the provision of wound care. Points emphasized in the inservice included:</p> <p>1.Wounds should be documented correctly and accurately, and ONLY if the nurse is able to see the wound. (The patient in question was receiving wound care from a wound clinic, and therefore the nurse was not able to remove the dressing and observe the wound.);</p> <p>2.If the patient is receiving care from a wound clinic, the Skilled</p>	06/04/2021

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 disclosable 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>with clinical competence according to the plan of treatment, nursing care plan and established standards. 2. Initiates preventative and rehabilitation nursing procedures as planned for patient's care and safety. 3. Observes and monitors patient's status and progress toward planned outcomes ... 5. Coordinates and supervises care delivery and patient status related to other health disciplines...."</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "PATIENT CARE PLAN", with copyright date 2004, which stated, "1. The Patient care plan shall be written by appropriate member of the home health services team based upon plan of care and an assessment of the patient's needs, resources, family, environment, and goals ... The patient care plan shall be updated as often as the patient's condition necessitates, or at least every 60 days...."</p> <p>Record review on 5/6/2021, evidenced and agency policy titled, "PERIODIC REVIEW OF PLAN OF CARE", with copyright date 2004, which stated, "... The professional personnel ... are expected to alert the physician to any changes in the patient's condition, which would indicate the need for altering the plan of care...."</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "COORDINATION OF PATIENT SERVICES", with copyright date 2004, which stated, "All personnel providing services are to maintain liaison to ensure that their efforts effectively complement one another and support the objectives of the company and those outlined in the Plan of care. a. Individual responsibilities to further coordination of patient care are delineated in the job description and standard of performance. b. Documentation of effective</p>		<p>Nurse must contact the office and notify her Quality Assurance officer of the wound clinic care. The Quality Assurance officer or other personnel shall obtain wound care visit/progress notes on a regular basis, no less often than monthly, and the information gathered shall be inserted into the patient's electronic medical record;</p> <p>3. The Skilled Nurse must notify the patient's doctor on record if a wound is get worse, or does not show signs of progress within 30 days. This communication MUST be documented in WellSky through a Physician Order, including the date and time of the communication, and any changes in care ordered by the physician.</p> <p>4. The SN will create an order to the patient's doctor stating that the patient is receiving wound care at a clinic.</p> <p>Patient #3 is discharged from the agency, and therefore cannot be corrected going forward. The agency does not currently have any patients receiving wound care. In the future, 100% of charts for all patients receiving wound care will be audited for compliance. (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure</p>	

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	<p>interchange, reporting, and coordinated patient evaluation is to be maintained in the clinical records...."</p> <p>Clinical record review on 5/5/2021 for patient #3, start of care 6/20/2017, certification period 4/5/2020 to 6/3/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/13/2020. This plan of care had a subcategory titled, "Medications", which stated, "Santyl [a topical medication that removes dead tissue from wounds] External 250 UNIT / GM [units per gram] 1 apply to the left buttock daily until healed. Cleanse left buttock with normal saline, apply Santyl ointment and cover with gauze daily till healed..." This plan of care had a subcategory titled, "Goals and Outcomes", which stated, "SN [skilled nurse] goals ... Patient skin integrity will remain intact during this episode...."</p> <p>Clinical record review evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] -D1 Recertification", dated 3/31/2020, signed by employee D, RN [registered nurse]. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.3 cm, Width: 0.2 cm, Depth: 0.1cm...."</p> <p>Skilled nurse visit notes dated 4/9/2020, 4/14/2020, 4/21/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.3 cm, Width: 0.2cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p>		that this deficiency is corrected and will not recur.	

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	<p>A skilled nursing visit note dated 4/29/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.2cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>Skilled nursing visit notes dated 5/5/2020, 5/12/2020, 5/18/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>A skilled nursing visit note dated 5/26/2020 failed to evidence any wound documentation.</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Recertification", dated 6/2/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Review of all skilled nurse's notes and communication notes during the certification period failed to evidence physician notification of the wound not healing with current treatment.</p> <p>Clinical record review for patient #3 of certification period 6/4/2020 to 8/2/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 6/9/2020. This plan of care had a subcategory titled, "Medications", which stated, "Santyl [a topical medication that removes dead tissue from</p>			

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	<p>wounds] External 250 UNIT / GM [units per gram] 1 apply to the left buttock daily until healed. Cleanse left buttock with normal saline, apply Santyl ointment and cover with gauze daily till healed..." This plan of care had a subcategory titled, "Goals and Outcomes", which stated, "SN [skilled nurse] goals ... Patient / caregiver skin integrity will remain intact during this episode...."</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Recertification", dated 6/2/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Clinical record review evidenced a group of agency documents titled, "Skilled Nursing Visit". A skilled nursing visit note dated 6/8/2020 failed to evidence any wound documentation.</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Transfer", dated 6/15/2020, signed by employee D, RN. This document stated, " ... Comments: Admitted at ... [hospital A] ... due to dyspnea [shortness of breath]".</p> <p>Review of patient's #3's medical record from hospital A evidenced a document titled, "Ancillary Progress Notes", dated 6/17/2020, signed by person B, RN, employee of hospital A. This note evidenced a wound photo and assessment which stated, "Wound #1 ... Pressure Injury Left Ischium [the lower, back part of the hip] ... Pressure Injury Stage 4 [a wound that is very deep, reaching into muscle and bone and causing extensive damage] Wound length 4.5</p>			

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	<p>cm, Wound Width 2.5 cm, Wound Depth 1 cm...."</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Resumption of Care", dated 6/19/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Clinical record review evidenced skilled nursing visits dated 6/22/2020, 6/29/2020, and 7/6/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>Review of all skilled nurse's notes and communication notes during the certification period failed to evidence physician notification of the wound not healing with current treatment.</p> <p>Review of the patient's electronic medical record [Kinnser] evidenced the wound care orders had not changed since initiated on 9/17/2019.</p> <p>During an interview on 5/6/2021 at 11:11 a.m., the administrator indicated the agency should ensure a patient with wounds' needs were being met by assessing the wound at each visit, informing the physician if the wound was not healing, and changing wound care as needed. The administrator stated, "The nurse should update the doctor if treatment isn't working. We tell them it doesn't work. Wounds should heal in less than 60 days".</p> <p>When informed of the findings on 5/6/2021 at</p>			

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G 0544 Bldg. 00	<p>11:45 a.m., the administrator stated about the discrepancy between the hospital wound assessment on 6/17/2020 and the agency's SN assessment on 6/19/2021, "It's impossible. I'm going to investigate." When queried if the agency met the patient's needs, the administrator stated, "No. I'm going to see what's going on. It's really concerning".</p> <p>17-14-1(a)(1)(B)</p> <p>484.55(d) Update of the comprehensive assessment Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the home health agency failed to update and revise the comprehensive assessment of the OASIS (Outcome and Assessment Information Set) as frequently as the patient's condition warrants due to a major decline in the patient's health status in 1 of 2 discharged records reviewed receiving wound care (#4).</p> <p>The findings include:</p> <p>Review of the agency policy copyrighted in 2004, titled "Plan of Care," 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 ... includes the following information ... Orders for treatments and medications ordered ... Periodic review of the Plan of care will occur at least once every sixty</p>	G 0544	<p>The Skilled Nursing staff was inserviced (See Attachments A, B, and C) on the importance of completing a Significant Change in Condition (Follow Up) OASIS when a patient has a significant decline in her condition, such as worsening wounds, development of new wounds, worsening weakness or ADL ability, or any other significant decline. The Therapy staff were informed to notify the Skilled Nurse for the patient if they have noticed any significant decline, so that the OASIS can be completed.</p> <p>The Skilled Nursing and Therapy staff were all instructed in the</p>	06/04/2021

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	<p>(60) days, or after hospitalization (resumption of care) or significant changes in status, as delineated in Medicare regulations ... The patient care plan shall be updated as often as the patient's condition necessitates, or at least every 60 days"</p> <p>Clinical record review on 5/5/2021 for patient #4, primary diagnosis: Cellulitis (bacterial skin infection where the infected skin appears swollen and red and is typically painful and warm to the touch) of buttock, start of care 9/25/2020, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 9/25/20 - 11/23/20, and signed by the administrator. This document stated "... Patient's fasting blood sugar (measuring blood sugar after an overnight fast of not eating) will remain between 100 mg/dL [milligrams per deciliter] and 120 mg/dL ... Notify physician of: ... Fasting blood sugar greater than (>) 120 or less than (<) 60 ... SN (Skilled Nurse) to report to physician if patient experiences pain level not acceptable to patient, pain level greater than 6/10 [pain scale with 0 being no pain and 10 being the most severe]"</p> <p>A record review evidenced an untitled agency comprehensive assessment, dated 9/25/2020, signed by the administrator. This document had a subsection titled "Integumentary [skin] Status," which indicated the patient had two wounds. This subsection indicated wound 1 measurements were 0cm (centimeters) in length x 0cm in width x 0cm in depth. This document had a subsection titled "Pain Scale," which indicated the intensity of pain was a 5 (on a scale of 0-10, with 0 being no pain and 10 being the most severe). This document had a subsection titled "Endocrine</p>		<p>same inservice (See Attachments A, B, and C) that they must complete a Plan of Care Addendum order in WellSky (see Attachment E for a blank example) whenever a change in the patient's care or treatments occurs during a certification period, such as a new medication, a change in visit frequency, or a new precaution arises. This is so that all staff members caring for that patient will remain fully updated on any relevant changes in the patient's care. The Plan of Care Addendum is treated as an order in WellSky, so that the doctor will receive the addendum to sign. It is also sent to all members of the staff assigned to the patient, so that each staff member will be aware of the changes. Once this form is submitted to the appropriate Quality Assurance staff member, the QA staff will create or update a new form created by the agency titled "Plan of Care Addendum List" (See Attachment F). This form will compile all of the changes in the plan of care for each patient during a certification period. After the new change is added to the Plan of Care Addendum List form, the form will be taken to the patient's home, and added to the very back of the patient's home book. Each staff member is to look for this form before providing care to any</p>	

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G 0572 Bldg. 00	<p>(System of glands that secrete hormones directly into the blood)," which indicated the blood sugar was 91 mg/dL.</p> <p>A record review evidenced an agency document titled "RN [Registered Nurse] - Skilled Nursing Visit," dated 10/6/2020, and signed by the administrator. This document indicated there were 5 wounds, 3 of which were not present on admission. This document indicated wound 1 measurements were 3.0 cm in length, 1.5cm in width, and 0 cm in depth. This document indicated the patient's pain intensity was a 10. This document also indicated the fasting blood sugar was 138 mg/dL.</p> <p>A record review evidenced an untitled agency discharge comprehensive assessment, dated 10/12/2020, and signed by the administrator. Record review failed to evidence the agency performed a new comprehensive assessment after the patient experienced a major decline in their health status on 10/6/2020. Clinical record review failed to evidence an updated comprehensive assessment to include the patient's 3 new wounds, the uncontrolled fasting blood sugar, and the patient's increase in pain.</p> <p>During an interview on 5/5/21 at 10:39 a.m., the administrator indicated wound 1 got worse since admission. She indicated the patient was noncompliant with her pain medication, resulting in her pain being a 10 out of 10. The administrator indicated the comprehensive assessment should have been updated due to the major decline in the patient's health status.</p> <p>484.60(a)(1) Plan of care Each patient must receive the home health</p>		<p>patient, to ensure the care she provides is meeting any changes to the plan of care.</p> <p>100% of all currently active charts were monitored for this deficiency. Patient #4 specifically has been discharged from the agency, and therefore cannot be corrected. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	<p>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> <p>Based on record review and interview, the home health agency failed to ensure the plan of care was followed and individualized in 3 of 3 records reviewed receiving home health aide services (#1, #2, #3).</p> <p>1. Record review on 5/6/2021, evidenced an agency policy titled, "PLAN OF CARE", with copyright date 2004, which stated, "1. 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 is based on the patient's diagnosis and an assessment of the patient's immediate and long-range needs and resources. The patient and / or caregiver(s) are to be active participants in creating the plan of care ... 2. The Plan of care is recorded on HCFA form 485 and includes the following information: ... g. Functional limitations and activities permitted as well as safety measures. h. Orders for treatments and medications ordered ... 3. Orders for therapy services include the specific procedures and modalities to be used, amount, frequency, and duration."</p>	G 0572	The entire field staff of A Plus Home Health Care was instructed during an inservice (see Attachments A, B, and C) that each of them must educate the patient and address every relevant safety precaution (such as fall precautions, bleeding precautions, etc.) on each visit. In addition, this conversation must be noted in the Comments section of the visit note for every visit performed. In addition, the cover page of the patient's home book has been revised to include checklists for which safety precautions are relevant for the patient (see Attachment G) such as fall, bleeding, or seizure precautions. These checklists will be updated as necessary, and makes it easy for each staff member to identify which safety precautions the patient should be educated about. We also presented to the field staff two resources to be used to assist in teaching the patients	06/04/2021

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	<p>2. Record review on 5/6/2021, evidenced an agency policy titled, "CONFORMANCE WITH PHYSICIAN'S ORDERS", with copyright date 2004, which stated, "1. Original orders of a physician and all subsequent intermittent orders must be signed by the patient's physician and incorporated as part of the patient's record maintained by the agency ... staff administers drugs and treatments ONLY AS ORDERED by the physician...."</p> <p>3. Record review on 5/6/2021, evidenced an agency policy titled, "JOB DESCRIPTION - TITLE: HOME HEALTH NURSE (REGISTERED NURSE)", with copyright date 2004, which stated, "PRINCIPAL FUNCTION: Provides nursing care to assigned patients utilizing the Nursing Process to assess, plan, implement and evaluate patient service based upon a physician's plan of care. Coordinates care delivered by other health disciplines for assigned patients ... C. Implementation 1. Provides direct patient care with clinical competence according to the plan of treatment, nursing care plan and established standards. 2. Initiates preventative and rehabilitation nursing procedures as planned for patient's care and safety. 3. Observes and monitors patient's status and progress toward planned outcomes ... 5. Coordinates and supervises care delivery and patient status related to other health disciplines...."</p> <p>4. Clinical record review on 5/3/2021 for patient #1, start of care 3/25/2021, certification period 3/25/2021 to 5/23/2021, and primary diagnosis of Pressure ulcer of right buttock, stage 2, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/20/2021. The plan of care had a</p>		<p>about fall risk, titled "Check for Safety" (see Attachment H) and "Talking about Fall Prevention with Your Patients" (see Attachment I). Further, we presented two new resources created by our agency to assist with education on blood thinner safety, titled "Warfarin (Coumadin)" (see Attachment J) and "Blood Thinner Pills: Your Guide to Using Them Safely" (see Attachment K).</p> <p>Additionally, at the same inservices discussed above, the Skilled Nursing staff was instructed on the correct method of providing wound care services, and documenting the provision of wound care. Points emphasized in the inservice included:</p> <p>1.Wounds should be documented correctly and accurately, and ONLY if the nurse is able to see the wound. (The patient in question was receiving wound care from a wound clinic, and therefore the nurse was not able to remove the dressing and observe the wound.);</p> <p>2.If the patient is receiving care from a wound clinic, the Skilled Nurse must contact the office and notify their Quality Assurance officer of the wound clinic care. The Quality Assurance officer or other personnel shall obtain wound care visit/progress notes on a regular basis, no less often than monthly, and the information</p>	

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	<p>subcategory titled, "Safety Measures", which stated, "Keep pathway clear ... Anticoagulant Precautions. Safety in ADLs [activities of daily living] ... Fall Precautions...." The plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... SN [skilled nurse] 1 x 5 wks - Educate on disease process, meds, changing dressing, safety ... HHA [home health aide] 1x1 wk, 2 x 8 wks - To assist with ADL, personal hygiene and bathing ... SN will educate patient / caregiver on fall and injury risk reduction techniques ... SN will educate patient / caregiver on home safety...."</p> <p>Review of patient #1's electronic medical record (Kinnser) on 5/3/2021, evidenced skilled nursing visit notes on 4/9/2021 and 4/22/2021. The note dated 4/9/2021, failed to evidence fall precautions, anticoagulant precautions, or any other safety measures were taught, enforced, or assessed. The note dated 4/22/2021, failed to evidence anticoagulant precautions were taught, enforced, or assessed.</p> <p>Review of the patient's electronic medical record (Kinnser) on 5/3/2021, evidenced home health aide visit notes dated 3/25/2021, 3/26/2021, 3/29/2021, 4/1/2021, 4/5/2021, 4/8/2021, 4/12/2021, 4/15/2021, 4/22/2021, 4/26/2021 and 4/29/2021. Each of these notes failed to evidence fall precautions and anticoagulant precautions.</p> <p>During an interview on 5/6/2021 at 11:23 a.m., the administrator indicated the patient, family, and all disciplines of staff should be aware of and enforce fall and anticoagulant precautions. The administrator indicated safety precautions should be addressed by all disciplines of staff at each visit, and should be documented in the visit notes. When informed of the findings, the</p>		<p>gathered shall be inserted into the patient's electronic medical record;</p> <p>3. The Skilled Nurse must notify the patient's doctor on record if a wound get worse, or is not showing signs of progress within 30 days. This communication MUST be documented in WellSky through a Physician Order, including the date and time of the communication.</p> <p>All field staff members were instructed at the same inservice (see Attachments A, B, and C) that they must be clear on the frequencies they document in an order and the Plan of Care. For instance, if the Skilled Nurse is visiting the patient once every other week, the frequency should not simply be "1 X 5", but should instead be described as "1 X 5, every other week". In addition, all field staff members were told that if a patient has a hospital bed, and the patient is considered to be at elevated risk for falls, that the bed rails MUST be raised whenever she is left unattended. If there is a legitimate reason for not raising the bed rails, such as the patient refusing to use the bed rails, then the doctor should be informed, and that discussion with the doctor should be documented in the patient's record by a Physician Order.</p>	

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	<p>administrator indicated the skilled nurse and home health aide documentation failed to evidence following the safety precautions (anticoagulant precautions and fall precautions) established in the plan of care.</p> <p>Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/20/2021. The plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... SN [skilled nurse] 1x5 wks - Educate on disease process, meds, changing dressing, safety ... Assessment of patient with Pressure ulcer...."</p> <p>Clinical record review evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] -D1 Start of Care", dated 3/25/2021, signed by the administrator. This assessment had a section titled, "(M1311) Current Number of Unhealed Pressure Ulcers / Injuries at Each Stage", which indicated the patient had one stage 2 pressure ulcer [a partial thickness loss of skin presenting as a shallow open ulcer]. This wound assessment stated, "Wound 1 - Location: inner buttock - right, Status: Open, Present on Admission, Type: Pressure Ulcer, Stage: II, Size: Length: 2.0 cm, Width: 0.5 cm...."</p> <p>Review of the patient's electronic medical record (Kinnser), evidenced the next SN visit was 4/9/2021. The skilled nursing note from 4/9/2021, failed to evidence assessment of the pressure ulcer.</p> <p>During an interview on 5/6/2021 at 11:04 a.m., the administrator indicated the skilled nurse should assess the wound and perform wound care at</p>		<p>Lastly, the Home Health Aides were told at the inservice (see Attachments A and C) that it is essential for them to follow the Plan of Care and Home Health Aide Care Plan completed for each patient. This includes raising the bed rails for a patient with a hospital bed when the Plan of Care directs the Aide to do so.</p> <p>All active patient charts were audited to identify patients with hospital beds. All staff members were instructed to raise the bed rails whenever the patient is unattended, unless that patient refuses to use them. If the patient refuses to use the bed rails, this must be documented in a physician's order. Patient #1 and #3 are discharged from the agency, so this deficiency could not be addressed for them. For patient #2, the patient has refused to use the bed rails, because they "make him feel trapped". This was documented in a physician's order. All staff caring for patient #2 was already aware of the patient's request to leave the bed rails down. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure</p>	

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	<p>each visit for this patient. When informed of the findings, the administrator indicated the documentation failed to evidence a wound assessment or wound care was performed on 4/9/2021.</p> <p>5. Clinical record review on 5/5/2021 for patient #3, start of care 6/20/2017, certification period 6/4/2020 to 8/2/2020, and primary diagnosis of Cutaneous abscess of buttock, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 6/9/2020. The plan of care had a subcategory titled, "Safety Measures", which stated, "Keep pathway clear ... Fall Precautions ... Anticoagulant Precautions...."</p> <p>Review of patient #3's electronic medical record (Kinnser) on 5/5/2021, evidenced skilled nursing visits on the following dates which failed to evidence anticoagulant precautions: 6/8/2020, 6/22/2020, 6/29/2020, and 7/6/2020.</p> <p>Clinical record review for patient #3, certification period 4/5/2020 to 6/3/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/13/2020. The plan of care had a subcategory titled, "Safety Measures", which stated, "Keep pathway clear ... Fall Precautions ... Anticoagulant Precautions...."</p> <p>Review of patient #3's electronic medical record (Kinnser) on 5/5/2021, evidenced skilled nursing visits on the following dates which failed to evidence anticoagulant precautions: 4/9/2020, 4/14/2020, 4/29/2020, 5/5/2020, 5/12/2020, 5/18/2020 and 5/26/2020.</p> <p>During an interview on 5/6/2021 at 11:42 a.m., the</p>		that this deficiency is corrected and will not recur.	

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	<p>administrator indicated the skilled nurse visit notes failed to evidence the anticoagulant precautions established in the plan of care.</p> <p>Clinical record review of certification period 4/5/2020 to 6/3/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/13/2020. This plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... SN [skilled nurse] 1 x 9 [once a week for 9 weeks] ... Assessment of patient with Cutaneous abscess of buttock, Encounter for change or removal of surgical wound dressing....". This plan of care had a subcategory titled, "Treatments" which stated, "Medications Santyl [a topical medication that removes dead tissue from wounds] External 250 UNIT / GM [units per gram] 1 apply to the left buttock daily until healed. Cleanse left buttock with normal saline, apply Santyl ointment and cover with gauze daily till healed..."</p> <p>Clinical record review evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] -D1 Recertification", dated 3/31/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Size: Length: 0.3 cm, Width: 0.2 cm, Depth: 0.1cm...."</p> <p>Skilled nurse visit notes dated 4/9/2020, 4/14/2020, 4/21/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.3 cm, Width: 0.2cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p>			

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	<p>A skilled nursing visit note dated 4/29/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound... Size: Length: 0.2 cm, Width: 0.2cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>Skilled nursing visit notes dated 5/5/2020, 5/12/2020, 5/18/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>A skilled nursing visit note dated 5/26/2020 failed to evidence any wound documentation.</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Recertification", dated 6/2/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Clinical record review for patient #3 of certification period 6/4/2020 to 8/2/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 6/9/2020. This plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... SN [skilled nurse] 1 x 8 [once a week for 8 weeks] ... Assessment of patient with Cutaneous abscess of buttock, Encounter for change or removal of surgical wound dressing....". This plan of care had a subcategory titled, "Treatments", which stated, "Medications Santyl [a topical medication</p>			

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	<p>that removes dead tissue from wounds] External 250 UNIT / GM [units per gram] 1 apply to the left buttock daily until healed. Cleanse left buttock with normal saline, apply Santyl ointment and cover with gauze daily till healed..." This plan of care had a subcategory titled, "Goals and Outcomes", which stated, "SN [skilled nurse] goals ... Patient / caregiver skin integrity will remain intact during this episode...."</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Recertification", dated 6/2/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Clinical record review evidenced a group of agency documents titled, "Skilled Nursing Visit". A skilled nursing visit note dated 6/8/2020 failed to evidence any wound documentation.</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Resumption of Care", dated 6/19/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Clinical record review evidenced skilled nursing visits dated 6/22/2020, 6/29/2020, and 7/6/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p>			

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	<p>During an interview on 5/6/2021 at 11:04 a.m., the administrator indicated the skilled nurse should assess the wound and perform wound care at each visit for this patient. When informed of the findings, the administrator indicated the skilled nurse's documentation failed to evidence a wound assessment or wound care was performed on 5/26/2020 and 6/8/2020.</p> <p>6. Clinical record review on 5/4/2021 for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non dominate side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 4/16/2021 - 6/14/2021, and signed by RN (registered nurse) D. This document had a subsection titled "Safety Measures," which stated "... Keep side Rails up"</p> <p>During a home visit on 5/4/21 at 11:25 a.m. for patient #2, the home health aide was observed performing a bed bath. The home health aide was observed taking the two basins being used for the bed bath into the bathroom located in a different room to be cleaned out and refilled with fresh water. When the clinician left the patient's side to clean the basins, she was observed to have left the side rail down while leaving the patient unattended. The home health aide failed to follow the plan of care.</p> <p>During an interview on 5/6/21 at 10:04 a.m., the administrator indicated the side rails should be down while performing a bed bath, but the</p>			

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G 0574 Bldg. 00	<p>clinician should have put the side rails up when she left the patient's side.</p> <p>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 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 and interview, the agency failed to ensure the individualized plan of care</p>	G 0574	The Skilled Nursing staff was instructed at inservices (see	06/04/2021

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	<p>included all services, safety measures, medications and treatments in 3 of 3 records receiving home health aide services (#1, #2, #3).</p> <p>The findings include:</p> <p>1. Record review on 5/6/2021, evidenced an agency policy titled, "PLAN OF CARE", with copyright date 2004, which stated, "1. 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 is based on the patient's diagnosis and an assessment of the patient's immediate and long-range needs and resources. The patient and / or caregiver(s) are to be active participants in creating the plan of care ... 2. The Plan of care is recorded on HCFA form 485 and includes the following information: ... g. Functional limitations and activities permitted as well as safety measures. h. Orders for treatments and medications ordered ... 3. Orders for therapy services include the specific procedures and modalities to be used, amount, frequency, and duration."</p> <p>2. Clinical record review on 5/3/2021 for patient #1, start of care 3/25/2021, certification period 3/25/2021 to 5/23/2021, and primary diagnosis of Pressure ulcer of right buttock, stage 2, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/20/2021. The plan of care had a subcategory titled, "Orders and Treatments", which stated, " ... SN [skilled nurse]: 1 x 5 wks - Educate on disease process, meds, changing dressing, safety...."</p>		<p>Attachment A, B, and C) of the following requirements for medications:</p> <p>1.All medications must have a frequency listed. PRN medications must still have a frequency, even for ointments. "PRN" is not sufficient, and must also include a maximum frequency of use. This includes ointments.</p> <p>2.All ointments must list one or more specific locations for use. "Apply to affected area" is not sufficient. A new nurse filling in or taking over a patient should be know exactly where it is to be used from the description, and "affected area" does not give the necessary detail.</p> <p>3.All medications listed must be checked for accuracy. One patient had "Cranberry Concentrate, 500 mg, 30 caps daily" on her medication profile. This apparently was meant to indicate that the bottle contained 30 capsules, but actually indicates that the patient was to take 30 capsules a day.</p> <p>All field staff members were instructed at the same inservice (see Attachments A, B, and C) that they must be clear on the frequencies they document in order and the Plan of Care. For instance, if the Skilled Nurse is visiting the patient once every other week, the frequency should</p>	

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	<p>Review of the patient's electronic medical record (Kinnser) on 5/3/2021, evidenced skilled nursing visits were made on 3/25/2021, 4/9/2021, and 4/22/2021.</p> <p>During an interview on 5/6/2021 at 11:16 a.m., the administrator indicated "1 x 5 wks" meant 5 visits within the certification period, and the skilled nurse visits should be every other week. When queried, the administrator indicated the plan of care failed to clearly evidence the frequency of skilled nursing visits. The administrator stated, "We should write every other week. I should specify."</p> <p>Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/20/2021. The plan of care had a subcategory titled, "Medications", which stated, " ... Tolnaftate External [an anti-fungal medication] 1% 1 Apply to under breast bilateral [both sides] - topical...."</p> <p>During an interview on 5/6/2021 at 11:27 a.m., the administrator indicated all medication orders should contain the frequency the medication was taken. When informed of the findings, the administrator indicated the plan of care failed to evidence a complete order for the medication.</p> <p>3. Clinical record review on 5/5/2021 for patient #3, start of care 6/20/2017, certification period 6/4/2020 to 8/2/2020, and primary diagnosis of Cutaneous abscess of buttock, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 6/9/2020. The plan of care had a subcategory titled, "Medications", which stated, " ... Cranberry Concentrate Oral 500 MG [milligram]</p>		<p>not simply be "1 X 5", but should instead be described as "1 X 5, every other week". In addition, all field staff members were told that if a patient has a hospital bed, and the patient is considered to be at elevated risk for falls that the bed rails MUST be raised whenever she is left unattended. If there is a legitimate reason for not raising the bed rails, such as the patient refusing to use the bed rails, then the doctor should be informed, and that discussion with the doctor should be documented in the patient's record by a Physician Order.</p> <p>100% of current charts were audited for this deficient practice, and corrected if necessary. For patient #1 and #3 are discharged from the agency, and so deficient processes could not be corrected. For patient #2, the chart was audited, and correct as necessary. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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NAME OF PROVIDER OR SUPPLIER A PLUS HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP COD 2246-A INDUSTRIAL DR HIGHLAND, IN 46322
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G 0576 Bldg. 00	<p>30 Cap(s) daily...."</p> <p>When informed of the findings on 5/6/2021 at 11:36 a.m., the administrator stated, "No, it should be one cap daily. That's not right".</p> <p>4. Clinical record review on 5/4/2021 for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non dominate side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 4/16/2021 - 6/14/2021, and signed by RN (registered nurse) D. This document had a subsection titled "Medications," which stated "... Calmoseptine [moisture barrier to prevent irritation] External 0.44-20.6% 1 application to the affected are [sic] topically twice a day as needed" Clinical record review failed to evidence the agency included where the affected area was located to apply the Calmoseptine and indications for when the Calmoseptine should be applied.</p> <p>During an interview on 5/6/21 at 10:10 a.m., the administrator indicated the plan of care did not specify where the Calmoseptine was to be applied and that it should say where the affected area was located.</p> <p>17-13-1(a)(1)(B)(D)(iii, ii, x)</p> <p>484.60(a)(3) All orders recorded in plan of care All patient care orders, including verbal orders, must be recorded in the plan of care.</p>			

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	<p>Based on record review and interview, the home health agency failed to record the verbal orders in the plan of care in 1 of 2 discharged records reviewed receiving wound care (#4).</p> <p>The findings include:</p> <p>Review of the agency policy copyrighted in 2004, titled "Plan of Care," 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 ... includes the following information ... Orders for treatments and medications ordered ... Periodic review of the Plan of care will occur at least once every sixty (60) days, or after hospitalization (resumption of care) or significant changes in status, as delineated in Medicare regulations ... The patient care plan shall be updated as often as the patient's condition necessitates, or at least every 60 days...."</p> <p>Clinical record review on 5/5/2021 for patient #4, primary diagnosis: Cellulitis (bacterial skin infection where the infected skin appears swollen and red and is typically painful and warm to the touch) of buttock, start of care 9/25/2020, evidenced an agency document titled "Physician Order," dated 10/1/20, and signed by the administrator. This document stated "... Current Medication ... New ... Bepreve Ophthalmic Solution [used to treat itching of the eye due to allergies] ... New ... Olopatadine HCL [hydrochloride] Ophthalmic Solution [used to treat itching of the eye caused by pink eye] ... New ... Phytoplex Silicone Cream [creates a water-resistant film over the skin to help reduce moisture loss] ... New ... Bydureon BCise [improve glycemic control in adults with type 2 diabetes mellitus]...."</p>	G 0576	The Skilled Nursing and Therapy staff were all instructed in an inservice (See Attachments A, B, and C) that they must complete a Plan of Care Addendum order in WellSky (see Attachment E for a blank example) whenever a change in the patient's care or treatments occurs during a certification period, such as a new medication, a change in visit frequency, or a new precaution arises. This is so that all staff members caring for that patient will remain fully updated on any relevant care in the patient's care. The Plan of Care Addendum is treated as an order in WellSky, so that the doctor will receive the addendum to sign. It is also sent to all members of the staff assigned to the patient, so that each staff member will be aware of the changes. Once this form is submitted to the appropriate Quality Assurance staff member, the QA staff will create or update a new form created by the agency titled "Plan of Care Addendum List" (See Attachment F). This form will compile all of the changes in the plan of care for each patient during a certification period. After the new change is added to the Plan of Care Addendum List form, the form will be taken to the patient's home, and added to the very back of the patient's home book. Each staff member is to look for this form	06/04/2021

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G 0590 Bldg. 00	<p>A record review evidenced an agency document titled "Home Health Certification and Plan of Care," dated 9/25/2020, and signed by the administrator. This document had a subsection titled "Medications." This subsection failed to include the medications Bepreve Ophthalmic Solution, Olopatadine HCL Ophthalmic Solution, Phytoplex Silicone Cream, and Bydureon BCise. Clinical record review failed to evidence the agency updated the plan of care to include the new medications ordered per the verbal order from 10/1/20.</p> <p>During an interview on 5/5/21 at 10:19 a.m., the administrator indicated they would not add these medications to the plan of care because the verbal order was received after the plan of care was established. She indicated the only time medications are updated in the plan of care is when care is initiated or recertified.</p> <p>484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.</p>		<p>before providing care to any patient, to ensure the care she provides is meeting any changes to the plan of care.</p> <p>100% of all active charts have been audited for changes to the plan of care, and any plan of care changes identified were listed on the Plan of Care Addendum form in the EMR. In addition, each of these patients had a Plan of Care Addendum List added to their home books. Each of these patients' home books was audited for the inclusion of these forms. Patient #4 has been discharged for the agency's services, so the chart and home folder could not be corrected. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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	<p>Based on record review and interview, the home health agency failed to ensure the physician was alerted to patient's conditions indicating outcomes were not being achieved and the plan of care should be altered in 1 of 2 discharged records receiving wound care (#3).</p> <p>The findings include:</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "JOB DESCRIPTION - TITLE: HOME HEALTH NURSE (REGISTERED NURSE)", with copyright date 2004, which stated, "PRINCIPAL FUNCTION: Provides nursing care to assigned patients utilizing the Nursing Process to assess, plan, implement and evaluate patient service based upon a physician's plan of care. Coordinates care delivered by other health disciplines for assigned patients ... C. Implementation 1. Provides direct patient care with clinical competence according to the plan of treatment, nursing care plan and established standards. 2. Initiates preventative and rehabilitation nursing procedures as planned for patient's care and safety. 3. Observes and monitors patient's status and progress toward planned outcomes ... 5. Coordinates and supervises care delivery and patient status related to other health disciplines...."</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "PATIENT CARE PLAN", with copyright date 2004, which stated, "1. The Patient care plan shall be written by appropriate member of the home health services team based upon plan of care and an assessment of the patient's needs, resources, family, environment, and goals ... The patient care plan shall be updated as often as the patient's condition necessitates, or at least every 60 days...."</p>	G 0590	<p>The Skilled Nursing and Therapy staff were educated in inservices (see Attachments A, B, and C) that the patient's physician MUST be informed of any decline in a patient's status, such as developing new wounds, worsening wounds, or increasing pain, or if a patient fails to meet her goals, such as a wound that does not improve with treatment. In addition, the communication with the physician must be documented in the patient's chart.</p> <p>100% of all active patient charts were audited for this deficient practice. For all patients identified as declining, the relevant nurse or therapist was instructed to contact the physician about the decline, and document that notification in the WellSky EMR system.</p> <p>Patient #3 has been discharged from the agency's services, so the chart could not be corrected. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	06/04/2021

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	<p>Record review on 5/6/2021, evidenced and agency policy titled, "PERIODIC REVIEW OF PLAN OF CARE", with copyright date 2004, which stated, " ... The professional personnel ... are expected to alert the physician to any changes in the patient's condition, which would indicate the need for altering the plan of care...."</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "COORDINATION OF PATIENT SERVICES", with copyright date 2004, which stated, "All personnel providing services are to maintain liaison to ensure that their efforts effectively complement one another and support the objectives of the company and those outlined in the Plan of care. a. Individual responsibilities to further coordination of patient care are delineated in the job description and standard of performance. b. Documentation of effective interchange, reporting, and coordinated patient evaluation is to be maintained in the clinical records...."</p> <p>Clinical record review on 5/5/2021 for patient #3, start of care 6/20/2017, certification period 4/5/2020 to 6/3/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/13/2020. This plan of care had a subcategory titled, "Medications", which stated, "Santyl [a topical medication that removes dead tissue from wounds] External 250 UNIT / GM [units per gram] 1 apply to the left buttock daily until healed. Cleanse left buttock with normal saline, apply Santyl ointment and cover with gauze daily till healed..." This plan of care had a subcategory titled, "Goals and Outcomes", which stated, "SN [skilled nurse] goals ... Patient skin integrity will remain intact during this episode...."</p>			

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	<p>Clinical record review evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] -D1 Recertification", dated 3/31/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Size: Length: 0.3 cm, Width: 0.2 cm, Depth: 0.1cm...."</p> <p>Skilled nurse visit notes dated 4/9/2020, 4/14/2020, 4/21/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.3 cm, Width: 0.2cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>A skilled nursing visit note dated 4/29/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound... Size: Length: 0.2 cm, Width: 0.2cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>Skilled nursing visit notes dated 5/5/2020, 5/12/2020, 5/18/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>A skilled nursing visit note dated 5/26/2020 failed to evidence any wound documentation.</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Recertification",</p>			

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	<p>dated 6/2/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Review of all skilled nurse's notes and communication notes during the certification period failed to evidence physician notification of the wound not healing with current treatment.</p> <p>Clinical record review for patient #3 of certification period 6/4/2020 to 8/2/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 6/9/2020. This plan of care had a subcategory titled, "Medications", which stated, "Santyl [a topical medication that removes dead tissue from wounds] External 250 UNIT / GM [units per gram] 1 apply to the left buttock daily until healed. Cleanse left buttock with normal saline, apply Santyl ointment and cover with gauze daily till healed..." This plan of care had a subcategory titled, "Goals and Outcomes", which stated, "SN [skilled nurse] goals ... Patient / caregiver skin integrity will remain intact during this episode...."</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Recertification", dated 6/2/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Clinical record review evidenced a group of agency documents titled, "Skilled Nursing Visit". A skilled nursing visit note dated 6/8/2020 failed</p>			

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G 0614	<p>to evidence any wound documentation.</p> <p>Clinical record review evidenced an agency document titled, "OASIS-D1 Resumption of Care", dated 6/19/2020, signed by employee D, RN. This assessment had a subcategory titled, "Wound Care Worksheet", which stated, "Wound 1 - Location: left buttock ... Size: Length: 0.2 cm, Width: 0.1 cm, Depth: 0.1cm...."</p> <p>Clinical record review evidenced skilled nursing visits dated 6/22/2020, 6/29/2020, and 7/6/2020, signed by employee D, RN, stated, "Wound 1 - Location: left buttock ... Type: Surgical wound ... Size: Length: 0.2 cm, Width: 0.1cm, Depth, 0.1 cm ... Treatment: cleansed with 0.9% NS [normal saline] Santyl and gauze applied...."</p> <p>Review of all skilled nurse's notes and communication notes during the certification period failed to evidence physician notification of the wound not healing with current treatment.</p> <p>During an interview on 5/6/2021 at 11:12 a.m., the administrator indicated the skilled nurse should assess wounds at every visit, and if the wound was not improving, the nurse should inform the physician. The administrator stated, "The nurse should update the doctor if treatment wasn't working. We tell them it doesn't work. Wounds should heal in less than 60 days". When informed of the findings, the administrator indicated the home health agency failed to ensure the physician was notified of the wound not healing with current treatment.</p> <p>17-13-1(a)(2) 484.60(e)(1) Visit schedule</p>			

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Bldg. 00	<p>Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.</p> <p>Based on observation, record review and interview, the home health agency failed to provide the patient and caregiver with a copy of written instructions outlining the visit schedule, including frequency of visits by the agency personnel and personnel acting on behalf of the agency in 1 of 1 home visits (#2)</p> <p>The findings include:</p> <p>Review of the agency policy, copyrighted in 2004 titled "Patient Bill of Rights - Home Health Agency," stated "... A Plus Home Health Care Inc. exists primarily for the purpose of providing high quality care that meets or exceeds accepted standard for care ... In accordance with this philosophy, A Plus Home Health Care Inc. wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights ... Patient's Rights: As part of A Plus Home Health Care, Inc. you and your representative(s) have the right to ... Be fully informed in advance about the care and treatment to be furnished, including the skilled staff that will furnish the care and the proposed number of visits they will make to your home...."</p> <p>Clinical record review on 5/4/2021 for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non dominate side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 4/16/2021 - 6/14/2021, and signed by RN (registered nurse) D. This document stated "...</p>	G 0614	<p>The agency will begin adding projected schedules to the patient's home book. The home book will contain blank calendar pages for each month that the patient receives care (see Attachment M for an example). Each staff member visiting the patient will mark on the calendar the days that she or he will be visiting, along with the approximate time of the visit start. Agency field staff were informed of this requirement at inservices (see Attachments A, B, and C).</p> <p>100% of the patient's home books were audited to ensure inclusion and completion of these visit calendars in the patient's home book, including patient #2. Any home folders not including these calendars were corrected. This correction was done by 6/7/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	06/07/2021

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G 0616 Bldg. 00	<p>SN [Skilled Nursing]: 1x4 [once a week for 4 weeks] ... PT [Physical Therapy]: 2x3 [twice a week for three weeks] ... HHA [Home Health Aide]: 1x1 [once a week for one week]"</p> <p>During a home visit on 5/4/2021 at 10:55 a.m. for patient #2, the patient's admission packet folder was observed and failed to evidence the patient and caregivers were provided with a visit schedule of when the SN, PT, and home health aide were to visit as ordered in the plan of care.</p> <p>During an interview on 5/6/2021 at 10:00 a.m., the administrator indicated they call and tell the patient when they will be there. She indicated they also call the day before they arrive and when they are on their way and indicated even though she always calls three times, the patient should still have a visit schedule.</p> <p>484.60(e)(2) Patient medication schedule/instructions including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview, the home health agency failed to provide the patient and caregiver with the medication schedule/instructions, including: medication name, dosage, frequency and which medications will be administered by the home health agency in 1 of 1 home visits. (#2)</p> <p>The findings include:</p> <p>Review of the agency policy, copyrighted in 2004, titled "Patient Bill of Rights - Home Health Agency," stated "... A Plus Home Health Care</p>	G 0616	The Skilled Nursing staff were educated in an inservice (see Attachments A, B, and C) that the medication list in the patient's home book must match the medications listed in the patient's chart. The patient's nurse is to check the medications in the chart during each visit, and compare them to the medications listed in the home book. Any missing medications must be added to the home medication list.	06/07/2021			

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	<p>Inc. exists primarily for the purpose of providing high quality care that meets or exceeds accepted standard for care ... In accordance with this philosophy, A Plus Home Health Care Inc. wishes to advise you of the following rights and responsibilities and to assist you in understanding and exercising these rights ...</p> <p>Patient's Rights: As part of A Plus Home Health Care, Inc. you and your representative(s) have the right to ... Be fully informed in advance about the care and treatment to be furnished...."</p> <p>Clinical record review on 5/4/2021 for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non dominate side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 4/16/2021 - 6/14/2021, and signed by RN (registered nurse) D. This document indicated the patient was taking the medications Calmoseptine (used to treat and prevent minor skin irritations), Meloxicam (reduces pain, swelling, and stiffness of the joints), and Cetirizine hydrochloride (used to treat allergies).</p> <p>During a home visit on 5/4/2021 at 10:55 a.m. for patient #2, the patient's admission packet folder was observed and evidenced an unsigned agency document titled "Home Medication Schedule," dated 10/26/2019. Clinical record review of the medication profile failed to evidence the patient was taking the medications Calmoseptine, Meloxicam, and Cetirizine hydrochloride as indicated in the plan of care.</p> <p>During an interview on 5/6/2021 at 10:00 a.m., the administrator indicated the medication profile should match the medications in the plan of care,</p>		<p>100% of the home folders were audited for accuracy of the medication lists in the folder compared to the Plan of Care/Medication Profiles in the patient's charts, including patient #2. Any home books not containing updated medication lists were corrected. In the future, the Director of Nursing will periodically perform spot checks of patient home books to ensure compliance.</p> <p>This correction will be done by 6/7/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G 0682 Bldg. 00	<p>but it depends on whether or not the patient or family member informs us of all the medications the patient is taking. She indicated the medications from the plan of care should be included in the medication profile in the home.</p> <p>484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to ensure the home health aide followed accepted standards of practice to prevent the transmission of infections and communicable diseases in 1 of 1 home visits (#2)</p> <p>The findings include:</p> <p>Review of the agency policy, copyrighted in 2004, titled "Job Description-Title: Home Health Aide," stated "... Provides personal care, physical assistance, therapeutic exercises, and nursing supervised procedures to patients with medical and nursing needs. Maintains a clean and safe environment for the patient. Care is provided under the supervision of a Registered Professional Nurse and in accordance with the physician's plan of care ... Responsibilities ... Provides personal care; bathing, positioning, oral hygiene, hair care, shaving and linen changes ... Provides supportive service as needed to maintain a sanitary, safe environment for the patient, i.e. cleans bathroom, changes linens, etc ... Performs other duties appropriate to education or experience, as assigned ... Adheres to the agency's policies and procedures, and follows all</p>	G 0682	<p>The Home Health Aides were educated on the proper bed bath procedure, specifically the frequency of water changes. The Aides were instructed to change the water after every change of body section. In addition, the wash cloth should be rinsed with each water change.</p> <p>The Director of Nursing will observe each Home Health Aide perform a bed bath to ensure proper standard precautions, particularly water changes, are performed.</p> <p>This correction will be done by 6/11/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	06/11/2021

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	<p>applicable Indiana and Medicare regulations...."</p> <p>Clinical record review on 5/4/2021 for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non dominate side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an agency document titled "Aide Care Plan," dated 4/12/21, and signed by RN (Registered Nurse) D. This document had a subsection titled "Personal Care," which stated "... Complete Bath ... Q visit [every visit]...."</p> <p>A record review evidenced an agency document titled "Certified Home Health Aide and Personal Care Assistant Skills Check List," dated 11/16/20, signed by RN (Registered Nurse) C and home health aide E. This document indicated home health aide E met the demonstration of skills required to perform a bath at the bedside on 11/16/20.</p> <p>During a home visit on 5/4/21 at 11:18 a.m., home health aide E was observed while giving the patient a bed bath. The aide was observed filling two basins with clean water and cleaning the patient's face, arms, hands, chest, and abdominal area. The home health aide failed to be evidenced to have cleaned the two basins and add fresh water after cleaning each body section. The home health aide failed to follow standard / universal precautions.</p> <p>During an interview on 5/6/21 at 9:51 a.m., the administrator indicated in order to do a proper bed bath the clinician needs to prepare two basins, one with clean water and one with soap. She indicated the clinician should clean head to toe, starting with the head then obtains clean water and changes gloves. She indicated the clinician</p>			

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G 0798 Bldg. 00	<p>should then clean the armpits and get a new basin. She indicated the clinician should then clean the torso and private area and again obtain another clean basin. She indicated the clinician should then clean the extremities, turn the patient, and clean the back. The administrator indicated the basins should be cleaned after the clinician cleans the face, body, armpits, and private areas. She indicated the basins should be cleaned anytime the clinician moves to a new part of the body. The administrator also indicated the clinician that was observed giving the bed bath to patient #2 should have cleaned the basins after cleaning every section.</p> <p>17-12-1(m)</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). Based on record review and interview, the agency failed to ensure the registered nurse provided a complete care plan for the home health aide [HHA] in 1 of 1 active clinical records reviewed for patient's receiving wound care (#1).</p> <p>The findings include:</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "JOB DESCRIPTION - TITLE: HOME HEALTH NURSE (REGISTERED</p>	G 0798	The entire field staff of A Plus Home Health Care was instructed during an inservice (see Attachments A, B, and C) that each of them must educate the patient and address every relevant safety precaution (such as fall precautions, bleeding precautions, etc.) on each visit. In addition, this conversation must be noted in the Comments section of the visit	06/04/2021

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	<p>NURSE)", with copyright date 2004, which stated, "PRINCIPAL FUNCTION: Provides nursing care to assigned patients utilizing the Nursing Process to assess, plan, implement and evaluate patient service based upon a physician's plan of care. Coordinates care delivered by other health disciplines for assigned patients ... B. Planning ... 2. Develops nursing care lan for each assigned patient ... 3. Collaborates with other health disciplines in the development of a care plan, as indicated ... C. Implementation ... 5. Coordinates and supervises care delivery and patient status related to other health disciplines...."</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "JOB DESCRIPTION - TITLE: HOME HEALTH AIDE", with copyright date 2004, which stated, "PRINCIPAL FUNCTION: Provides personal care, physical assistance, therapeutic exercises, and nursing supervised procedures to patients with medical and nursing needs. Maintains a clean and safe environment for the patient. Care is provided under the supervision of a Registered Professional Nurse and in accordance with the physician's plan of care. RESPONSIBILITIES: 1. Provides patient care in accordance with the written care plan ... 10. Maintains patient safety ... 13. Documents patient care appropriately and completes necessary documentation according to agency policy...."</p> <p>Record review on 5/6/2021, evidenced an agency policy titled, "PATIENT CARE PLAN", with copyright date 2004, which stated, "1. The Patient care plan shall be written by appropriate member of the home health services team based upon plan of care and an assessment of the patient's needs, resources, family, environment, and goals. The</p>		<p>note for every visit performed. In addition, the cover page of the patient's home book has been revised to include checklists for which safety precautions are relevant for the patient (see Attachment G, such as fall, bleeding, or seizure precautions. These checklists will be updated as necessary, and makes it easy for each staff member to identify which safety precautions the patient should be educated about. We also presented to the field staff two resources to be used to assist in teaching the patients about fall risk, titled "Check for Safety" (see Attachment H) and "Talking about Fall Prevention with Your Patients" (see Attachment I). Further, we presented two new resources created by our agency to assist with education on blood thinner safety, titled "Warfarin (Coumadin)" (see Attachment J) and "Blood Thinner Pills: Your Guide to Using Them Safely" (see Attachment K).</p> <p>In the same inservice (see Attachments A, B, and C), the agency's skilled nurses were instructed to list all relevant safety precautions in Additional Comments section of the Home Health Aide Care Plan (see Attachment L). The Home Health Aides will then educate the patient on the proper precautions, and document that education in the</p>		

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	<p>initial assessment is to be made by a Registered Nurse...."</p> <p>Clinical record review on 5/3/2021 for patient #1, start of care 3/25/2021, certification period 3/25/2021 to 5/23/2021, and primary diagnosis of Pressure ulcer of right buttock, stage 2, evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 4/20/2021. The plan of care had a subcategory titled, "Safety Measures", which stated, "Keep pathway clear ... Anticoagulant Precautions. Safety in ADLs [activities of daily living] ... Fall Precautions...."</p> <p>Clinical record review evidenced an agency document titled "Aide Care Plan", dated 3/25/2021, and signed by the administrator. The aide care plan had a subcategory titled "Personal Care", which stated, " ... Back Rub / Massage PRN [as needed] ... Complete Bath PRN ... Oral Hygiene Denture Care PRN ... Partial Bath / Sponge PRN ... Shampoo Hair PRN ... Shower PRN....". The aide care plan had a subcategory titled "Activity", which stated, " ... Assist in Transfer Q [each] Visit PRN ... Range of Motion PRN ... Turn or Position PRN". The aide care plan failed to evidence anticoagulant precautions, fall precautions, or any safety measures. The skilled nurse failed to list the indications for when the home health aide was to perform the PRN tasks.</p> <p>During an interview on 5/6/2021 at 11:23 a.m., the administrator indicated the patient, family, and all disciplines of staff should be aware of and enforce fall and anticoagulant precautions. The administrator indicated safety precautions should be addressed by all disciplines of staff at each visit. When informed of the findings, the</p>		<p>Additional Comments box of the HHA Visit Note (see Attachment N). In addition, the Skilled Nurse completing the Home Health Aide Care Plan must delineate the parameters or frequency of PRN tasks, such as "Perform bed bath PRN per patient request" or "Change linens PRN when soiled".</p> <p>100% of the active patient charts for patients were audited for this correction. Patient #1 has been discharged from the agency, and so the chart could not be corrected. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G 0804 Bldg. 00	<p>administrator indicated the skilled nurse failed to include safety precautions (anticoagulant precautions and fall precautions) in the aide care plan, and stated, "It needs to be revised".</p> <p>17-13-2(a)</p> <p>484.80(g)(4)</p> <p>Aides are members of interdisciplinary team Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures.</p> <p>Based on observation, record review, and interview the home health agency failed to ensure the home health aide reported changes in the patient's condition to a registered nurse or other appropriate skilled professional in 1 of 1 clinical records reviewed of patient's with a home visit. (#2)</p> <p>The findings include:</p> <p>Review of the agency job description copyrighted in 2004, titled "Job Description: Home Health Aide," stated "... Principal Function ... Provides personal care, physical assistance, therapeutic exercises, and nursing supervised procedures to patients with medical and nursing needs ... Care is provided under the supervision of a Registered Professional Nurse and in accordance with the physician's plan of care ... Responsibilities ... Recognizes and reports changes in client's condition to Nursing Supervisor and or Registered Nurse...."</p> <p>Clinical record review on 5/4/2021 for patient #2,</p>	G 0804	<p>All field staff of the agency was educated during inservices (see Attachments A, B, and C) that ALL communications with other field staff, physicians, and patients must be documented in the patient's chart. If the conversation is associated with a visit, it can be documented in the visit note. Otherwise, it should be documented in the Communication task in WellSky.</p> <p>The Home Health Aides were also instructed in an inservice (see Attachments A and B) that they must notify the Skilled Nurse of any changes in patient condition, or when a patient's condition is outside of agency parameters, such as when too much time has elapsed between bowel movements, blood pressure or blood sugar is too high or too low,</p>	06/04/2021

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	<p>primary diagnosis: Hemiplegia following cerebral infarction affecting left non dominant side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an untitled agency aide care plan, dated 2/14/21, and signed by RN (Registered Nurse) D. This document stated "... Vital Sign Notification ... No Bowel Movement in 3 Days"</p> <p>A record review on 5/4/21 evidenced an agency document titled "HHA [Home Health Aide] Visit," dated 3/9/21, and signed by home health aide E. This document stated "... Last Bowel Movement ... 3/5/21" Clinical record review failed to evidence the home health aide notified the nurse that the last bowel movement was 4 days prior.</p> <p>A record review on 5/4/21 evidenced an agency document titled "HHA [Home Health Aide] Visit," dated 4/9/21, and signed by home health aide E. This document stated "... Last Bowel Movement ... 4/1/21" Clinical record review failed to evidence the home health aide notified the nurse that the last bowel movement was 8 days prior.</p> <p>During observation of a home visit on 5/4/21 at 11:07 a.m. for patient #2, the home health aide asked the family member when the patient last had a bowel movement. The family member indicated the patient last had a bowel movement on Friday 4/30/21.</p> <p>During observation of a home visit on 5/4/21 at 12:00 p.m. for patient #2, the home health aide was evidenced leaving the patient's home and indicated she was not going to notify the nurse about anything. The home health aide failed to notify the nurse about the patient not having a bowel movement for 4 days.</p>		<p>or if the Aide notices new or worsening wounds on the patient.</p> <p>100% of the active patient charts for patients were audited for this correction. This correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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G 0808 Bldg. 00	<p>During an interview on 5/6/21 at 9:55 a.m., the administrator indicated the aide should notify the nurse if the patient did not have a bowel movement after two days. She indicated if the aide was unable to get a hold of the nurse she has to call the administrator. She also indicated that during the home visit, the aide should have notified the nurse that the last bowel movement was on Friday.</p> <p>484.80(h)(1)(i) Onsite supervisory visit every 14 days If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.</p> <p>Based on record review and interview, the home health agency failed to ensure a registered nurse or other appropriately skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions made an onsite visit to the patient's home no less frequently than every 14 days in 1 of 1 clinical records reviewed of a patient with a home visit. (#2)</p> <p>The findings include:</p> <p>Review of the agency job description, copyrighted in 2004, titled "Job Description - Title: Nursing Supervisor," stated "... A Registered Professional Nurse who is responsible for</p>	G 0808	<p>All Skilled Nurses were instructed in inservices (see Attachments A, B, and C) that in-person Home Health Aide supervisory visits must be done no less often than every 14 days. The QA staff member for each nurse will schedule the HHA supervisory visits, and they must be completed no later than the date scheduled.</p> <p>100% of charts for patients receiving home health aide services were audited for completion of the HHA supervisory</p>	06/04/2021

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	<p>supervision and coordination of field services in accordance with agency objectives, standards and policies. Assists with the development and implementation of home health services programs ... Responsibilities: ... Conducts supervision every 2 weeks for Home Health aide and in person supervisory visit every 60-day certification period to assess quality and appropriateness of service provision assess ongoing needs of client and caregivers. Assures documentation of assessment, intervention and plans...."</p> <p>Clinical record review on 5/4/2021 for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non-dominate side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 2/15/21 - 4/15/21, and signed by RN (registered nurse) D. This document stated "... SN [Skilled Nursing]: 1x8 [once a week for 8 weeks] ... HHA [Home Health Aide]: 2x8 [twice a week for 8 weeks], 1x1 [then once a week for 1 week]"</p> <p>A record review evidenced an agency document titled "SNV[Skilled Nursing Visit] w/ [with] Aide Supervision," dated 4/6/21, and signed by RN D. This document indicated the home health aide was supervised while the aide was present. Clinical record review failed to evidence the agency made another supervisory visit of the aide within 14 days after this visit.</p> <p>During an interview on 5/6/21 at 10:12 a.m., the administrator indicated the aide should be supervised every 14 days, but the aide does not have to be there for the supervisory visit. She indicated after 4/6/21, the next supervisory visit</p>		<p>visits in a timely fashion. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>	

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 05/06/2021
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NAME OF PROVIDER OR SUPPLIER A PLUS HOME HEALTH CARE INCORPORATED	STREET ADDRESS, CITY, STATE, ZIP COD 2246-A INDUSTRIAL DR HIGHLAND, IN 46322
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G 1024 Bldg. 00	<p>was on 4/28/21 and they should have did an indirect supervisory visit on the recertification date of 4/11/21 and another one done before 4/25/21.</p> <p>484.110(b) Authentication Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the home health agency failed to ensure all entries were appropriately authenticated in 2 of 7 clinical records reviewed. (#2, #4)</p> <p>The findings include:</p> <p>1. Clinical record review on 5/4/2021, for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non-dominant side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced agency documents titled "SNV [Skilled Nursing Visit] w/ [with] Aide Supervision, " dated 2/22/21, 3/1/21, 3/8/21, 3/16/21, 3/23/21, 3/30/21, 4/6/21, and signed by RN (Registered Nurse) D. These documents had a subsection titled "Cardiovascular." These subsections indicated the peripheral pulses (pulses in the extremities) were weak. These same sections stated "... Cardiovascular ... WNL [within normal limits] ...". Clinical record review failed to evidence the clinician appropriately documented cardiovascular as outside normal limits as indicated by the weak pulses.</p>	G 1024	<p>The field staff was educated in inservices about some charting discrepancies that cannot continue. They were instructed to review their charting and documentation carefully. Two examples were used as examples. The first was a case in which a patient had a Stage II pressure ulcer during the start of care visit, yet the Skilled Nurse completed the OASIS stating that the patient did not have any Stage II pressure ulcers. The other example was a Skilled Nurse charted that the patient's pulse was weak, but indicating on the visit note that the patient's cardiovascular system was "WNL" (within normal limits). It was explained to the staff that both of those statements cannot be true at the same time.</p> <p>100% of all active patient charts</p>	06/04/2021

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N 0604 Bldg. 00	<p>During an interview on 5/6/21 at 10:18 a.m., the administrator indicated these documents should not be documented as WNL.</p> <p>2. Clinical record review on 5/5/2021 for patient #4, primary diagnosis: Cellulitis (bacterial skin infection where the infected skin appears swollen and red and is typically painful and warm to the touch) of buttock, start of care 9/25/2020, evidenced an untitled agency comprehensive assessment, dated 10/12/2020, and signed by the administrator. This document had a subsection titled "Integumentary [skin] Status," which indicated there were 4 stage 2 pressure ulcers (shallow open ulcer with a red or pink wound bed) and none of them were present at the start of care. Clinical record review failed to evidence the clinician appropriately documented that 1 of the 4 stage 2 pressure ulcers were present on admission.</p> <p>During an interview on 5/5/21 at 10:52 a.m., the administrator indicated the document should state some of the stage 2 pressure ulcers were present on admission instead of saying none of the stage 2 pressure ulcers were present on admission, as it currently says.</p> <p>17-15-1(a)(7)</p> <p>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 observation, record review and interview, the home health agency failed to ensure the home health aide reported changes in the</p>	N 0604	<p>were audited for this deficient process. In the future, this correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by 6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p> <p>The home health aides were educated in an inservice (See Attachment A and Attachment C)</p>	06/04/2021

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	<p>patient's condition to a registered nurse or other appropriate skilled professional in 1 of 1 clinical records reviewed of patient's with a home visit. (#2)</p> <p>The findings include:</p> <p>Review of the agency policy copyrighted in 2004 titled "Job Description: Home Health Aide," stated "... Principal Function ... Provides personal care, physical assistance, therapeutic exercises, and nursing supervised procedures to patients with medical and nursing needs ... Care is provided under the supervision of a Registered Professional Nurse and in accordance with the physician's plan of care ... Responsibilities ... Recognizes and reports changes in client's condition to Nursing Supervisor and or Registered Nurse...."</p> <p>Clinical record review on 5/4/2021 for patient #2, primary diagnosis: Hemiplegia following cerebral infarction affecting left non-dominate side (paralysis of one side of the body following a stroke), start of care 10/24/2019, evidenced an untitled agency aide care plan, dated 2/14/21, and signed by RN (Registered Nurse) D. This document stated "... Vital Sign Notification ... No Bowel Movement in 3 Days"</p> <p>A record review on 5/4/21 evidenced an agency document titled "HHA [Home Health Aide] Visit," dated 3/9/21, and signed by home health aide E. This document stated "... Last Bowel Movement ... 3/5/21" Clinical record review failed to evidence the home health aide notified the nurse that the last bowel movement was 4 days prior.</p> <p>A record review on 5/4/21 evidenced an agency document titled "HHA [Home Health Aide] Visit,"</p>		<p>on the following requirements:</p> <ol style="list-style-type: none"> 1.All Home Health Aides MUST notify the Skilled Nurse for that patient of any changes in the patient's condition, including new wounds, worsening wounds, or other concerns; 2.The Home Health Aide shall immediately inform the Skilled Nurse if a patient has not had a bowel movement for more than 2 days in a row. The Aide must always inform the Skilled Nurse each time this happens, unless the Skilled Nurse has informed the Aide that this is normal for the patient in question, and should then be given a new criteria to follow; 3.If the Aide cannot reach the assigned Skilled Nurse within 24 hours, she is to contact the Director of Nursing; 4.Any communications between the Home Health Aide and the Skilled Nurse MUST be documented in the agency's EMR system, WellSky. The HHA shall document the communication in the comments section of the note for the visit in question. <p>100% of all active patient charts were audited for this deficient practice. This correction will be verified via chart audit of 50% of the patient charts each month (See Attachment D).</p> <p>This correction will be done by</p>		

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	<p>dated 4/9/21, and signed by home health aide E. This document stated "... Last Bowel Movement ... 4/1/21" Clinical record review failed to evidence the home health aide notified the nurse that the last bowel movement was 8 days prior.</p> <p>During a home visit observation on 5/4/21 at 11:07 a.m. for patient #2, the home health aide asked the family member when the patient last had a bowel movement. The family member indicated the patient last had a bowel movement on Friday 4/30/21.</p> <p>During a home visit observation on 5/4/21 at 12:00 p.m. for patient #2, the home health aide was evidenced leaving the patient's home and indicated she was not going to notify the nurse about anything. The home health aide failed to notify the nurse about the patient not having a bowel movement for 4 days.</p> <p>During an interview on 5/6/21 at 9:55 a.m., the administrator indicated the aide should notify the nurse if the patient did not have a bowel movement after two days. She indicated if the aide is unable to get a hold of the nurse she has to call the administrator. She also indicated that during the home visit, the aide should have notified the nurse that the last bowel movement was on Friday.</p>		6/4/2021. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	