STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157555	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A PLUS HOME HEALTH CARE INCORPOR	**2246-A INDUSTRIAL DR , HIGHLAND, Indiana, 46322**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 3/14/2022 to 3/17/2022. Facility ID: 003986 At this Emergency Preparedness survey, A Plus Home Health Care Incorporated was found to be in compliance with 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies.	E0000		
G0000	INITIAL COMMENTS This visit was a recertification, re-licensure, and emergency preparedness survey. The survey visit took place from 3/14/2022 to 3/17/2022. Facility ID: 003986 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. Quality Review Completed 04/05/2022	G0000		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment included the patient's current health status in 1 of 1 patient records reviewed with a feeding tube (#1). The findings include:	G0528		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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G0528	Continued from page 1 Record review on 3/17/2022, evidenced an agency policy titled, "CHART - GENERAL INFORMATION", dated 2004, which stated, " ... General Instructions ... Be pertinent and concise ... Reflect the patient's status (assessment) ... Address the patient's needs, problems, capabilities...." Record review evidenced an agency document titled, "JOB DESCRIPTION - TITLE: PHYSICAL THERAPIST", dated 2004, which stated, " ... Writes clear, concise and accurate clinical notes, evaluations and other required documentations on a timely basis...." Clinical record review on 3/14/2022, for patient #1, start of care 11/1/2021, certification period 3/1/2022 to 4/29/2022, primary diagnosis of Epilepsy (seizure disorder), evidenced an agency document titled, "PT [physical therapy] Evaluation", dated 3/2/2022 and signed by PT (physical therapist) G. The evaluation had a subsection titled, "Physical Assessment", which stated, " ... Skin: Impairment present. Pressure ulcer (sacral [area at the base of the spine] region)...." Clinical record review evidenced an agency document titled, "OASIS [the patient-specific, standardized assessment used in Medicare home health care] D1 Recertification", dated 2/24/2022, signed by RN (registered nurse) H. This assessment had a section titled, "Integumentary [related to the skin] Status". In the subsection titled, "Skin", "Ulcer [a sore or wound that develops on the skin]" was indicated with a check-mark. The subsection titled, "Current Number of Unhealed Pressure Ulcers / Injuries at Each Stage", indicated the patient had no pressure ulcers / injuries. Clinical record review evidenced an agency document titled, "LPN [licensed practical nurse] / LVN [licensed vocational nurse] Skilled Nursing Visit", dated 3/1/2022, and signed by LPN I. Review of this assessment failed to evidence a patient wound. During an interview on 3/17/2022 at 10:18 a.m., the administrator indicated each discipline performed their own comprehensive assessment. The administrator indicated the patient did not have a wound from 2/24/2022 to present. The administrator	G0528		

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G0528	Continued from page 2 indicated the physical therapist's evaluation failed to include a current assessment. The administrator indicated the patient did not have a wound at the time of the OASIS Recertification, and the nurse may have marked "Ulcer" in error. 17-14-1(a)(1)(A)	G0528		
G0572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure services were provided as ordered in the plan of care in 2 of 4 records reviewed not receiving therapy services (#3, #7). The findings include: 1. Record review on 3/17/2021, evidenced an agency policy titled, "PLAN OF CARE", dated 2004, which stated, " ... A plan of care is developed for each patient admitted to the home health program in consultation with the referring physician. ... The plan is based on the patient's diagnosis and and assessment of the patient's immediate and long-range needs and resources...." 2. Record review evidenced an agency policy titled, "CONFORMANCE WITH PHYSICIAN'S ORDERS", dated 2004, which stated, " ... A Plus Home Health Care Inc. staff administers drugs and treatments ONLY AS ORDERED by the physician...." 3. Record review evidenced an agency document titled, "JOB DESCRIPTION - TITLE: HOME HEALTH NURSE (REGISTERED NURSE)", dated 2004, which stated, " ... PRINCIPAL FUNCTION: Provides nursing	G0572		

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G0572	Continued from page 3 care to assigned patients utilizing the Nursing Process to assess, plan, implement and evaluate patient service based upon a physician's plan of care ... 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...." 4. Clinical record review for patient #3, start of care 6/28/2021, certification period 2/23/2022 to 4/23/2022, primary diagnosis of Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar as a fuel), evidenced an agency document titled, "Home Health Certification and Plan of Care". The plan of care had a subsection titled, "Orders and Treatments", which stated, " ... SN [skilled nurse] to assess skin for breakdown Q [each] visit...." Observation of a home visit for patient #3 was conducted on 3/15/2022, at 12:53 p.m. At 1:02 p.m., LPN [license practical nurse] I was observed checking the patient's vital signs. The patient was observed sitting in a recliner, wearing a long sleeved shirt, sweatpants, and socks. At 1:03 p.m., LPN I placed a blood pressure cuff on the patient's right arm and checked the patient's blood pressure manually. At 1:05 p.m., LPN I was observed placing their stethoscope to the patient's back and the patient's chest, outside of the patient's shirt. At 1:06 p.m., LPN I was observed feeling the patient's feet, outside of the patient's socks. LPN failed to move or remove any of the patient's clothing while performing the physical assessment. Observation of the home visit failed to evidence LPN I assessed the patient's skin for breakdown. During an interview on 3/17/2022, at 11:02 a.m., the administrator indicated a nurse should assess skin for breakdown by visualizing the skin, and looking for any new signs of a wound. When informed of the findings, the administrator indicated the nurse could not have assessed the patient's skin if all clothing remained intact. Clinical record review for patient #3 evidenced an agency document titled, "Home Health Certification and Plan of Care". The plan of care had a subsection titled, "Orders and Treatments", which stated, " ... Notify physician of: ... Fasting blood sugar greater than (>) 150 or less than (<	G0572		

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G0572	Continued from page 4 60. Random blood sugar greater than (>) 250 or less than (<) 200...." Clinical record review evidenced an agency document titled, "LPN [licensed practical nurse] / LVN [licensed vocational nurse] Skilled Nursing Visit", dated 3/8/2022, signed by LPN I, which indicated the patient had a fasting blood sugar of 165. Review of the visit note and all communication notes failed to evidence physician notification of the fasting blood sugar greater than 150. Clinical record review evidenced an agency document titled, "LPN / LVN Skilled Nursing Visit, dated 3/15/2022, signed by LPN I, which indicated the patient had a random blood sugar of 355. Review of the visit note and all communication notes failed to evidence physician notification of the random blood sugar greater than 250. During an interview on 3/17/2022, at 11:11 a.m., the administrator indicated any assessment findings outside of established parameters should be communicated to the physician, and the nurse should document that communication in the visit notes. When informed of the findings, the administrator and employee B reviewed the patient's record and indicated it failed to evidence physician notification of the blood sugar readings outside of parameters established in the plan of care. 5. Clinical record review on 3/16/2022 for patient #7, start of care 6/2/2021, certification period 11/29/2021 to 1/27/2022, primary diagnosis of Chronic venous hypertension with ulcer (increased pressure in the veins, resulting in damage to the skin) and inflammation of left lower extremity (left leg), evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 12/20/2021. The plan of care had a subsection titled, "Orders and Treatments", which stated, " ... HHA [home health aide]: 3X8 [three times a week for eight weeks], 2X1 wks [twice a week for one week]...." Review of the patient's electronic medical record (Kinnser), evidenced two HHA visits scheduled per week for the certification period reviewed. During an interview on 3/17/2022, at 11:43 a.m., the administrator indicated the patient visits should be scheduled with the frequency ordered in	G0572		

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G0572	Continued from page 5 the plan of care. When informed of the findings, the administrator indicated she thought the patient's family requested two HHA visit per week, but this was not reflected in the plan of care. 17-13-1(a)	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) 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	G0574		

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G0574	Continued from page 6 (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure the individualized plan of care included all services, medications and treatments in 2 of 7 records reviewed (#1, #7). The findings include: 1. Record review on 3/17/2022, evidenced an agency policy titled, "PLAN OF CARE", dated 2004, which stated, " ... The Plan of care ... includes the following information: ... Functional limitations and activities permitted as well as safety measures ... Orders for treatments and medications ordered ... Medical supplies and DME [durable medical equipment] ordered, and those already available to patient ... Significant clinical findings...." 2. During observation of a home visit for patient #1 on 3/16/2022, at 7:30 a.m., HHA [home health aide] F was observed giving the patient a bed bath. At 8:07 a.m., HHA F exposed the patient's abdomen. A feeding tube with a gauze dressing around it was observed on the patient's abdomen. Clinical record review on 3/14/2022, for patient #1, start of care 11/1/2021, certification period 3/1/2022 to 4/29/2022, primary diagnosis of Epilepsy (seizure disorder), evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the administrator on 3/14/2022. Review of the plan of care failed to evidence feeding tube assessment and site care. During an interview on 3/17/2022 at 10:23 a.m., the administrator indicated the assessment and care of a feeding tube should be included in the plan of care for all patients with a feeding tube. 3. Clinical record review on 3/16/2022, for patient #7, start of care 6/2/2021, certification period 11/29/2021 to 1/27/2022, primary diagnosis of Chronic venous hypertension with ulcer (increased pressure in the veins, resulting in damage to the skin) and inflammation of left lower extremity (left leg), evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 12/20/2021. The	G0574		

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G0574	Continued from page 7 plan of care had a subsection titled, "Medications", which stated, " ... Oxygen Permeable Lens Products 1 ml [milliliter] 3 L/min [liters per minute] continues [sic] at home, 2L/min portable...." During an interview on 3/17/2022 at 11:40 a.m., the administrator indicated she did not know what "Oxygen Permeable Lens Products" was, and that it should not be on the plan of care. The administrator indicated the plan of care failed to evidence the patient was on oxygen per nasal cannula (a short tube that sits inside the nostril). 17-13-1(a)(1)(B)	G0574		
G0578	Conformance with physician orders CFR(s): 484.60(b) Standard: Conformance with physician or allowed practitioner orders. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to conform with all physician orders in 2 of 3 records reviewed receiving physical therapy (#2, #5). The findings include: 1. Record review on 3/17/2022, evidenced an agency policy titled, "CONFORMANCE WITH PHYSICIAN'S ORDERS", dated 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 ... 5. All discontinued orders are to be cancelled in writing and signed by the physician, if the original order does not include an expiration date...." 2. Clinical record review for patient #2 on 3/15/2022, start of care 2/1/2022, certification period 2/1/2022 to 4/1/2022, primary diagnosis of Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar as a fuel), evidenced an agency document titled, "FACE TO FACE ENCOUNTER FORM", signed by the physician. This form stated, " ... I feel that the following home health services are medically necessary (check all	G0578		

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G0578	Continued from page 8 that apply): ...." The following services were indicated: Skilled Nursing, Physical Therapy, Occupational Therapy, and Home Health Aide. Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care", signed by the physician on 2/4/2022. The plan of care had a subsection titled, "Orders and Treatments", which stated, " ... SN [skilled nurse]: 1 X 5 wks every other week ... PT [physical therapy]: 1 X 1 wk to eval [evaluate] and treat ... HHA [home health aide]: refused...." Review of the plan of care failed to evidence occupational therapy. Clinical record review of all visit notes, physician orders, and communication notes failed to evidence the patient received any occupational therapy or the discontinuation of the order for occupational therapy. During an interview on 3/17/2022, at 10:50 a.m., the administrator indicated the orders to initiate care were received from the physician on the Face to Face form, which was signed by the physician. The administrator indicated the patient was receiving only skilled nursing and physical therapy services, and had refused home health aide and occupational therapy services. When queried, the administrator indicated the clinical record failed to evidence patient's refusal of occupational therapy or discontinuation of the order for occupational therapy. 3. Clinical record review on 3/16/2022, for patient #5, start of care 2/9/2022, certification period 2/9/2022 to 4/9/2022, primary diagnosis of Encounter for change or removal of surgical wound dressing evidenced an agency document titled, "FACE TO FACE ENCOUNTER FORM", signed by the physician. This form stated, " ... No driving for 6 weeks, no heavy lifting more than 10 lbs [pounds] for 6 - 8 weeks, avoid continuous arm movements above head...." Clinical record review evidenced an agency document titled, "Home Health Certification and Plan of Care". Review of the plan of care failed to evidence any driving, lifting, or arm movement restrictions. Clinical record review evidenced a group of agency documents titled, "LPN [licensed practical nurse] / LVN [licensed vocational nurse] - Skilled Nursing Visit", dated 2/11/2022, 2/15/2022, 2/18/2022, 2/22/2022, 3/1/2022, and	G0578		

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G0578	Continued from page 9 3/8/2022. Review of each of the nurse's notes failed to evidence any driving, lifting, or arm movement restrictions. Clinical record review evidenced a group of agency documents titled, "PT [physical therapy] Visit", dated 2/13/2022, 2/23/2022 and 2/25/2022. Review of each of the physical therapy notes failed to evidence any driving, lifting, or arm movement restrictions. Clinical record review evidenced an agency document titled, "PT Evaluation", dated 2/11/2022, signed by the physician and PT [physical therapist] E. Review of the evaluation failed evidence any driving, lifting, or arm movement restrictions. During an interview on 3/17/2022, at 10:50 a.m., the administrator indicated the orders to initiate care were received from the physician on the Face to Face form, which was signed by the physician. When informed of the findings, the administrator indicated she talked to the physical therapist about the restrictions and the therapist failed to include them in the plan of care. The administrator stated about the restrictions, "They should be in there".	G0578		