

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15K173</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 06/11/2021</b>	
NAME OF PROVIDER OR SUPPLIER <b>ADAPTIVE NURSING AND HEALTHCARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>938 MEZZANINE DRIVE. SUITE A LAFAYETTE, IN 47905</b>			
(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
{G 000}	INITIAL COMMENTS		{G 000}		
	<p>This was the second post condition revisit (PCR) for the Federal and State home health recertification survey originally completed on December 28, 2020.</p> <p>Survey Date: June 10, 11, 2021</p> <p>Facility Number: 014339</p> <p>Provider Number: 15K173</p> <p>Unduplicated Admissions for Last 12 Months: 161</p> <p>Active Census: 150</p> <p>Skilled Patients Only: 2</p> <p>Home Health Aide Only Patients: 74</p> <p>Personal Service Only Patients: 76</p> <p>During this survey, 1 condition level deficiency was found corrected, 14 standard level deficiencies were found corrected, 2 standard level deficiencies were re-cited, and 1 new standard level deficiencies was cited.</p> <p>These deficiencies reflects State Findings cited in accordance with 410 IAC 17.</p>				
G 536	<p>A review of all current medications</p> <p>CFR(s): 484.55(c)(5)</p> <p>A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>This Element is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed to ensure the comprehensive assessment included an accurate and complete medication list for 1 of</p>		G 536		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15K173</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 06/11/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>ADAPTIVE NURSING AND HEALTHCARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>938 MEZZANINE DRIVE. SUITE A LAFAYETTE, IN 47905</b>		
(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)
G 536	<p>Continued From page 1</p> <p>1 home visit observations (#2) and 1 of 3 records reviewed (#5), in a total sample of 5 records.</p> <p>Findings include:</p> <p>1. An agency job description titled "Adaptive Nursing and Healthcare Services. Job Description. Position: ... Case Manager ...," revised 4/8/21, stated " ... Responsibilities / Essential Functions: ... 2. Performs and initial and ongoing client assessments based on Agency policy and standards of practice to ensure effective and appropriate home care services ...."</p> <p>2. A home visit observation was conducted on 6/10/21 at 3:58 PM with Patient #2 (start of care 5/14/21) and RN #1. During the home visit, a bottle of Triad Hydrophilic Wound cream was observed in the patient's bathroom. RN #1 was observed performing a medication reconciliation with the patient's current medications. The nurse failed to add the Triad Hydrophilic Wound cream to the patient's medication list.</p> <p>A second home visit observation was conducted on 6/10/21 at 6:47 PM with Patient #2 and HHA #1. During the visit, HHA #1 was observed assisting Patient #2 with a shower. After the patient completed their shower and dried with a towel, Patient #2 handed the home health aide a bottle of Triad Hydrophilic Wound Dressing cream, and HHA #1 applied a small amount to the patient's inner buttocks using gloved hands. HHA #1 reported the patient had been using the medication for the past week.</p> <p>The clinical record of Patient #2 was reviewed on 6/10/21 and indicated patient diagnoses including but not limited to chronic kidney disease, urinary retention, anxiety disorder, major depressive</p>		G 536	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15K173</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 06/11/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>ADAPTIVE NURSING AND HEALTHCARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>938 MEZZANINE DRIVE. SUITE A LAFAYETTE, IN 47905</b>		
(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)
G 536	<p>Continued From page 2</p> <p>disorder, Bipolar disorder, and Essential hypertension (elevated blood pressure with no known cause), and mixed incontinence (inability to control bowel and bladder function). The record included a medication list, reviewed and signed by RN #1 on 5/16/21, which failed to evidence Triad Hydrophilic Wound dressing as an active medication.</p> <p>3. The clinical record of Patient #5 was reviewed on 6/11/21, and indicated a start of care of 8/30/2020, with patient diagnoses including but not limited to vascular dementia, essential hypertension, chronic atrial fibrillation (irregular heart rhythm), bed confinement status, and mixed incontinence. The clinical record included a comprehensive assessment conducted on 5/26/21 by RN #2. The comprehensive assessment contained a medication list, signed and reviewed by RN #2 on 5/27/21, which included the medications "... Nystatin [given to treat fungal infections of the skin] 100,000 units/g [gram] topical cream, take 1 application once a day ... as needed (prn) for Rash/anti-fungal ... hydrocortisone [topical steroid given to decrease itch and inflammation caused from a variety of skin conditions] 2.5% topical cream, take 1 application once a day ... as needed (prn) for Itch ...." The medication list failed to evidence clear and concise directions on where to apply the topical (applied to the skin) medications.</p> <p>4. An interview was conducted on 6/14/21 at 10:11 AM with the administrator and alternate administrator. During the interview, the Administrator indicated the medication list should include all medications the patient was currently using, including topical medications.</p> <p>17-14-1(a)(1)(B)</p>		G 536	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15K173</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 06/11/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>ADAPTIVE NURSING AND HEALTHCARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>938 MEZZANINE DRIVE. SUITE A LAFAYETTE, IN 47905</b>		
(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)
{G 706} {G 706}	<p>Continued From page 3</p> <p>Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1)</p> <p>Ongoing interdisciplinary assessment of the patient; This Element is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed to obtain a blood pressure per professional standards for 1 of 1 skilled nurse observations (#2).</p> <p>Findings include:</p> <p>An agency job description titled "Adaptive Nursing and Healthcare Services. Job Description. Position: ... Case Manager ...," revised 4/8/21, stated " ... Responsibilities / Essential Functions: ... 2. Performs and initial and ongoing client assessments based on Agency policy and standards of practice to ensure effective and appropriate home care services ...."</p> <p>Pickering et al (2004). "Blood Pressure Measurement in Humans: A Statement for Professionals From the Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research." Obtained June 14, 2021 from <a href="http://www.ahajournals.org">www.ahajournals.org</a>. " ... A number of factors related to the subject can cause significant deviations in measured blood pressure. These include ... positioning of the arm ... The individual should be comfortably seated, with the legs uncrossed, and the back and arm supported, such that the middle of the cuff on the upper arm is at the level of ... the mid-point of the sternum [chest] ...."</p> <p>A home visit observation was conducted on</p>		{G 706} {G 706}	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15K173</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 06/11/2021</b>
NAME OF PROVIDER OR SUPPLIER <b>ADAPTIVE NURSING AND HEALTHCARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>938 MEZZANINE DRIVE. SUITE A LAFAYETTE, IN 47905</b>		
(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)
{G 706}	<p>Continued From page 4</p> <p>6/10/21 at 3:58 PM with Patient #2 (start of care 5/14/21) and RN #1. During the home visit, RN #1 was observed obtaining Patient #2's vital signs (group of measurements that help to assess the general health of the patient, includes blood pressure, heart rate, temperature, respiratory rate, and oxygen saturation (SpO2)). The patient's SpO2 (94%) and heart rate (119) were obtained using a finger SpO2 probe. The nurse then obtained the patient's blood pressure using a manual sphygmomanometer (blood pressure monitor) on the patient's left arm. Patient #2 was standing with their left arm slightly elevated above their arm while the blood pressure was measured. RN #1 reported the patient's blood pressure was "115/80."</p> <p>An interview was conducted on 6/11/21 at 10:11 AM with the administrator and alternate administrator. During the interview, the Administrator indicated the patient should be sitting, and their arm should be level when obtaining a blood pressure.</p> <p>17-12-2(g)</p>		{G 706}	