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	15K009	A. BUILDING 00 B. WING	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME CARE WITH A HEART INC	104 GRANBY DR STE D CUMBERLAND, IN 46229

(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 Bldg. 00	This was a federal home health agency recertification survey. This was a partial extended survey. Survey dates were January 21-28, 2015 Facility number IN002640 Medicaid Vendor number 200305630 Surveyor: Michelle Weiss RN MSN Public Health Nurse Surveyor Census Unduplicated last 12 months: 43 Skilled patients: 17 Quality Review: Joyce Elder, MSN, BSN, RN February 19, 2015	G 000		
G 110 Bldg. 00	484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written			

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

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	information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on observation, document review, and interview, the agency failed to ensure patients were provided the current Indiana Advanced Directives in 5 (#1, 2, 4, 5 and 6) out of 5 home visit patients. Findings include; 1. An admission packet provided on January 21, 2015. The most recent advance directives in the folder were the revised copy dated March 1999, Revised May 2004. 2. During a home visit on January 21, 2015, at 4:26 PM with patient #1, the patient folder was observed to include the 2004 advance directives information. The daughter of the patient confirmed that updated information from the agency is kept in the folder. 3 During a home visit on January 21, 2015, at 3:10 PM with patient #2, the 2004 advance directives were viewed in the patient's folder from the Home Care with a Heart Agency.	G 110	G 00110 Home Care with a Heart Inc will provide existing clients with the most current available copy of Advanced Directives including revisions July 1, 2013 Nurse Supervisors (RN's) will be responsible to deliver updated copies of advanced directives The most current copy of Advanced Directives including revisions July 1, 2013 will be available for all future admissions of clients, the Director of Nursing will be responsible to ensure this plan is complete in the future The most current form of DNR (Do not resuscitate) wishes will be made available for staff to follow as produced by client or family, Nurse Supervisors will request updated DNR wishes with scheduled assessment and re-assessment visits The Director of Nursing will be responsible to ensure this plan is complete in the future	02/27/2015

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3. During a home visit on January 22, 2015, at 1:00 PM with patient #4, the patient folder was observed to include the 2004 advance directives information. Employee E, the home health aide, the employee stated, "No, everything is kept in this folder."

The most recent oasis form, page 2 out of 8, dated 1/19/15 and signed by RN, employee C, states, "Clients family states [she/he] is now a DNR [Do Not Resuscitate] but had not produced a copy for the office."

4. During a home visit on January 22, 2015, at 2:40 PM with patient #5, the patient folder in the home included the 2004 advance directives information.

5. At a home visit on January 22, 2015, at 4:30 PM, with patient #6, the patient folder in the home included the 2004 advance directives information. The employee F said that this was the most updated information the patient and their family has.

6. In an interview with administrator, employee B, on January 23, 2015, at 3:30 PM, the employee provided a document stating, "here- here is our advance directives." This was the 2004 copy. At

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	4:00 PM, the administrator, employee B, provided a copy of the most recent 2013 Indiana State Department of Health, advance directives, stating "See, we do have the updated one, you didn't have the most recent folder; does this help?"			
G 121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on clinical record review, agency policy review, professional standards review, and interview, the agency failed to follow professional standard and document skill integrity or wound measurement in 2 (#1 and #4) out of 3 patient charts reviewed with a wound. Findings: 1. Patient record #1 included skilled nurse visit notes dated 1/12/15 when it was documented there was a wound "R	G 121	G 0121 Home Care with a Heart Inc. will follow professional standards of documentation regarding skill integrity and wound assessment. Nurses will receive education regarding existing policies of wound/skin assessment, and receive education to document appropriately and consistently on nurse visit forms, according to Doctors orders and current policy and procedures. All nurses will receive a copy of current policy utilized which is "Mosby's Policies for assessments" (page 183	02/27/2015

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	upper thigh L .5 cm , W 1.5 cm" and described as a "pink blister" per licensed practical nurse (LPN), employee M. It does not specify front of thigh or back of thigh. A. The nursing assessment by LPN, Employee N, on 1/13/15 documented that skin was "warm/dry" but marked through the skin wound location and did not assess or document any issue with skin integrity. B. The nursing assessment by LPN, Employee N, on 1/14/15 documented the skin was warm and dry. The area to document wound #1 is marked through with a line, but there is a narrative that includes the statement, "upon assessment client told me about an open area on R upper thigh. Area is red and small in diameter, area is being treated, client wanted to bring that to my attention. There are no measurements or further description. C. The nursing assessment by LPN, Employee M, on 1/15/15 describes the wound as "blister R upper thigh has ruptured but skin is intact" and includes in the narrative, "Underlying tissue dark red et. yellowish." There are no measurements.		regarding skin assessment) Nurses will receive education to follow up with any open areas, including documentation of measurements, treatments as ordered or if family or client is able to care for the area and healed status. The Nurse Supervisors (RN's) will obtain and follow MD orders for wound care, or if family/client demonstrates ability to provide wound care This documentation will include wound healing progress or changes, and report to MD on a weekly basis. LPN's will be instructed to follow MD orders, if no ordered wound treatment, LPN's will be instructed to follow policy and procedures to document measurements, appearance, and healed status of wounds. The Director of Nursing will be responsible to ensure this plan of correction is complete for current clients and in the future	

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	D. In the nursing assessment by LPN, Employee M, on 1/16/15 there is no documentation of a blister or wound at the right thigh. 2. Clinical Record #4 revealed a left eyebrow laceration marked on the OASIS resumption of care after an incident in which the patient had fallen and was injured, The laceration is documented on the drawing which depicts location and noted in comments by the registered nurse, employee C, and signed on date 12/11/14. There is not any measurement or further description of the laceration at the left eyebrow. 3. In an interview with administrator, employee A, on January 26, 2015, at 2:00 PM, the assessment of the laceration is discussed. Employee A states, "Yes, it is our expectation to measure the size of a wound." 4. Administrator, Employee B, indicated "Home Care with a Heart Utilizes Mosby's Policy for Assessments" on a copy of "Physical and Psychosocial Assessment Procedures", dated 2000, and included its purpose which was "To identify patient problems or needs on the patient care plan, to establish a baseline physiologic status." Skin assessment included, "Rashes, masses, lesions,			

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	itching, dryness, color changes, changes in nails, pustules, papules, turgor, dermal wounds, bedsores or ulcerations, and surgeries." 5. P 183 Illustrated Manual of Nursing Practice 1994 states, " While inspecting the patient ' s skin, note the location, size, number, and appearance of any lesions. Dry, open lesions on the lower extremities accompanied by pallor, cool skin, and lack of hair growth signify arterial insufficiency, perhaps caused by arterial peripheral vascular disease. Wet, open lesion with red or purplish edges that appear on the legs may result from venous stasis associated with venous peripheral disease." 6. p 387 Luckman and Sorensen ' s Medical-Surgical Nursing 1993 states, " when assessing a wound, be certain to obtain the following points of information: 1. What is the size of the wound? Use objective measures to indicate length and width (such as cm or mm) ... Consider photographs to provide a baseline and serial evaluations. 2. Where is the wound located anatomically? 3. What is the color of the wound? A red wound is a new wound or one that is not infected. It is healing properly and is filled with red granulation tissue and fragile capillaries. A yellow wound is covered with yellow or ivory eschar. It may contain us, debris, and exudate."			

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G 159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on clinical record review and interview, the agency failed to develop the plan of care to include the correct activities permitted, equipment required, and safety measures to protect against injury in 2 (# 1 and 6) out of 10 records reviewed. Findings include: 1. The Form CMS-485 Home Health Certification and Plan of Treatment" for patient #1, dated 10/13/14 to 12/11/14, failed to include activities permitted. The secondary diagnosis of the patient is lumbar diskectomy, dated 2010. In an interview with the Employee "H", on January 21, 2015, at 4:30 PM, the employee stated patient #1 is "up as tolerated with assistance."	G 159	G 0159 Home Care with a Heart Inc will develop a plan of care for each client to include correct activities permitted, equipment required, and safety measures to protect against injury Educational review shall be provided to Registered Nurses regarding appropriate assessment of activities permitted, and DME (durable medical equipment) and supplies. The DME equipment and supplies utilized shall be included in the 485, even if the equipment is not typically utilized by the home care staff. (for example family utilizes the equipment for the night time) Educational review shall also include the assessment procedure and to include the secondary diagnosis and consider how this also affects the health and overall mobility and ability or limitations of the client. Educational review will be provided to Nurse Supervisors to include "up as tolerated" to the client's overall condition and to	02/27/2015

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	2. The Form CMS-485 "Home Health Certification and Plan of Treatment" for patient # 6, dated 10/27/14 to 12/25/2014, neglects to list bilateral hand braces to the DME [Durable Medical Equipment] and supplies. A. On January 22, 2015, at 5:00 PM, the family member of patient #6 stated, "Yes, [he/she] wears hand braces every night." The patient is a quadriplegic. B. The plan of care has "activities permitted" marked "up as tolerated" although the patient is completely nonweightbearing. "Transfer Bed/Chair" is not marked.		state if "up as tolerated" is up in a wheel chair or if the client is ambulatory or partial weight bearing, or to the client's ability., and to spell this out very clearly as if the caregiver of each client is a new staff member. The Director of Nursing shall be responsible to ensure this plan of correction is complete for current clients and in the future	
G 173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review and interview, the agency failed to ensure the registered nurse updated the plan of care to include the correct activities permitted, equipment required, and safety measures to protect against injury in 2 (# 1 and 6) out of 10 records reviewed.	G 173	G 0173 Home Care with a Heart Inc will ensure Home Health Aides have accurately complete and update Home Health Aide Care plans both in the client home and available to them via office charts including all Physician ordered activities Educational Review will be provided to Registered Nurses to	02/27/2015

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	Findings include: 1. The Form CMS-485 Home Health Certification and Plan of Treatment" for patient #1, dated 10/13/14 to 12/11/14, failed to include activities permitted. The secondary diagnosis of the patient is lumbar diskectomy, dated 2010. In an interview with the Employee "H", on January 21, 2015, at 4:30 PM, the employee stated patient #1 is "up as tolerated with assistance." 2. The Form CMS-485 "Home Health Certification and Plan of Treatment" for patient # 6, dated 10/27/14 to 12/25/2014, neglects to list bilateral hand braces to the DME [Durable Medical Equipment] and supplies. A. On January 22, 2015, at 5 PM, the family member of patient #6 stated, "Yes, [he/she] wears hand braces every night." The patient is a quadriplegic. B. The plan of care has "activities permitted" marked "up as tolerated" although the patient is completely nonweightbearing. "Transfer Bed/Chair" is not marked.		create and update home health aide care plans including but not limited to "activities permitted" and to include if "up as tolerated" is up in the wheel chair or up as ambulatory or partial weight bearing, and to accurately reflect clients ability. The care plan shall include all DME (durable medical equipment) utilized for example walkers, canes, wheel chair, braces, and include the equipment if typically utilized by staff or not and explain if family typically applies the equipment at night (hand braces) or if the client is able to apply the braces or independently use the equipment whatever the case may be. The Director of Nursing will be responsible to ensure the plan of correction is complete for current charts and in the future	

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G 224 Bldg. 00	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on record and agency procedure review, the agency failed to ensure the registered nurse accurately completed the aide care plan and updated it every 60 days in 4 (#1, #4, #5, and #6) out of 10 clinical records reviewed. Findings include: 1. The "Home Care with a Heart, Inc. Home Health Assignment Sheet" for patient #1, updated 11/25/2014 by employee C, failed to specify the task "Check for Pressure/ Open areas", although it is ordered on plan of care for the certification period 10/13/14 to 12/11/14. A. The "Home care with a Heart Inc. Home Care Assignment Sheet" for patient #1 on 10/13/14 and updated on 11/25/2014 omits range of motion [ROM] or any other activities or exercise, active or passive for arms or legs, although "encourage activities to increase flexibility, muscle strength ..." is ordered on the plan of care for the certification	G 224	G 0224 Home Care with a Heart Inc will ensure that Home Health Aide Care plans are accurately completed and updated to include current MD orders as pertaining to Home Health Aide activities, and that current care plans are available to Home Health Aides in both the client's homes, and via the office charts Registered Nurses will receive educational review regarding the home health aide care planning process and to include client specific care needs and write in any additional information not located in the typical check off portion of the care plan for home health aides to follow. Registered Nurses will be educated to update the care plan located in the client home as well as in the office chart with each OASIS review, and client change, as well as with new Doctor's orders. The Director of Nursing will be responsible to ensure that this plan of correction is complete for current clients and in the future	02/27/2015

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	period 10/13/14 to 12/11/14. B. Home Care Assignment sheet for patient #1, dated 10/13/2014 and revised 11/25/2014, were reviewed. The 10/13/2014 Home care assignment sheet stated to encourage fluids, the 11/25/2014 home care assignment sheet stated to limit fluids. The patient had been admitted 10/23/14 for diagnosis of renal failure. C. The Plan of Care dated 10/13/14 to 12/11/14 includes an order for the Home health aide "to encourage activities to increase flexibility." Range of motion (ROM) or any other activities or exercises are not included in the aide care plan. 2. The "Home care with a Heart Inc. Home Care Assignment Sheet" for patient #4 updated on 1/19/15 by employee C, omits "HHA to remind client to take pre-set medications daily," although ordered on the plan of care for patient #4 for the certification period 1/20/15 to 3/20/15. The "Home care with a Heart Inc. Home Care Assignment Sheet" for patient #4 updated on 1/19/15 omits activities or exercise, or range of motion [ROM] active or passive for arms or legs,			

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	although "encourage activities to increase flexibility, muscle strength ..." is ordered on the plan of care for the certification period 1/20/15 to 3/20/15. 3. On a home visit on January 22, 2015 at 2:40 PM to patient #5, the home health aide was asked for the home health aide assignment sheet. The document provided was most recently updated 5/14/13, almost 2 years ago and was illegible in some areas. The home health aide stated, "This is the only copy here, but there may be an updated one in the office." A. The plan of care for certification periods 1/4/2015 to 3/4/2015 and 11/4/14 to 1/4/15 state, "HHA [Home Health Aide] to provide all ADL's [activities of daily living] including but not limited to; Bathing, Personal Care, Assist with Dressing, skin care, hair care, clean under nails only, oral care, remind patients to take medications, remind patient to complete glucose monitoring, diabetic diet and meal prep and report any changes to SN." B. There is not a place dedicated on the aide care plan to "remind patient to complete glucose monitoring." Therefore, it was not on the aide care plan. It was also unclear if "Meal Assist" is			

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	synonymous with "Meal Prep" ordered by the physician in plan of care. On the undated aide are plan the nurse has written "meal preparation as client requests." 4. The aide care plan in the patient's home folder was written 1/14/11 and most recently revised 12/11/2013 and the home health aide, employee F, did not have a copy of anything more recent. A. In an interview with the home health aide of patient #6, employee F, on January 22, 2015, at 4:45 PM when asked what skilled activities they are required to perform without an updated plan of care, the home health aide replied, "I know this patient well, I do whatever the patient tells me to do." B. The aide care plan updated 12/24/2014 in the patient's chart in the office with dates of revision approximately each sixty days previous to 12/30/2013 listed range of motion (ROM)- Active/Passive Arm-R/L Leg-R/L. There is not a circle for those items separated by slashes, specifying Active or Passive. Some nurses checked both Active and Passive ROM some indicated "finger" indicating the only active range of motion ability, and some only checked passive. The patient is quadriplegic and			

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(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
	unable to perform any active range of motion in arms and legs.			
G 225 Bldg. 00	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on record review, agency document review, and interview, the home health aide failed to provide services ordered by the physician in the plan of care in 1 (#1) of 5 records reviewed of patients with home visits. Findings: 1. For patient #1, the aide plan of care for the certification period 10/13/14 to 12/11/14 includes "HHA [home health aide] 5-7 days a week up to 16 hrs [hours] a day. HHA to provide ADLs including but not limited to: Complete bathing needs, assist client in and out of tub/shower for safety. wash hair weekly or more frequently. Haircare daily. Assist with dressing client especially zippers and buttons. Assist with oral care, reminding client to brush and rinse teeth and mouth. Apply clients makeup and deodorant as desired. Provide skin care. Shave clients legs and underarms as desired. Check for pressure ulcers as	G 225	G 0225 Home Care with a Heart Inc will ensure Home Health Aides provide services as ordered by a Physician Nurse Supervisors will update home health aide careplans to specify hair care, and if this is washing client's hair, combing clients hair, and or styling client's hair The Director of Nursing will ensure that the plan of correction is complete for current clients and in the future	02/27/2015

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	client sits for most of day. Assist client with toileting and cleaning bedside commode. Assist with pericare. Cook meals as needed. Light housekeeping include making the bed after client awakes, changing linens to maintain a clean environment. Clean bathtub/shower. sink and floor after showering/bathing. Wash dishes after meal prep. HHA to remind client to take pre-set medications. To encourage activities to increase flexibility, muscle strength and decrease depression. Weigh daily, take B/P [blood pressure] daily. Report any changes to the caregiver or nurse." 2. For patient #1, the plan of care for the certification period 10/13/14 to 12/11/14 includes "HHA 5-7 days a week up to 16 hrs a day. HHA to provide ADLs including but not limited to: Complete bathing needs, assist client in and out of tub/shower for safety. Wash hair weekly or more frequently. Haircare daily." The aide plan of care does not distinguish between "Haircare" which is ordered daily, and "Wash hair weekly or more frequently". Subsequently, "Haircare" was not documented daily as ordered, missing days 10/21/14, 12/1/14, 12/10/14, 12/12/14 or on days that it was documented, it is unclear whether the patient had their hair washed.			

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G 324 Bldg. 00	484.20(c)(2) TRANSMITTAL OF OASIS DATA The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section. Based on the document review, the agency failed to ensure the OASIS data was transmitted within 30 days from the M 0090 date for 3 out of 6 months reviewed (August, October, and December, 2014). Findings: Document review of agency documents dated August, October, and December, 2014, evidenced 26.92% of submitted assessments were transmitted greater than 30 days from the M 0090 date..	G 324	G 0324 Home Care with a Heart Inc will ensure OASIS data is transmitted every 30 days or less Nurse Supervisors will enter data every 60 days or less for OASIS evaluations, data collected will be transmitted twice a month instead of once a month in the future The Director of Nursing will be responsible to ensure this plan of correction is complete	02/27/2015
N 000 Bldg. 00	This was a state home health agency	N 000		

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	relicensure survey. Survey dates were January 21-27 , 2015 Facility number IN002640 Medicaid number 200305630 Surveyor: Michelle Weiss RN MSN Public Health Nurse Surveyor Census Unduplicated last 12 months: 43 Skilled patients: 171 Quality Review: Joyce Elder, MSN, BSN, RN February 19, 2015			
N 518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on observation, document review, and interview, the agency failed to ensure patients were provided the current	N 518	N 0518 Home Care with a Heart Inc will ensure clients receive the most current copies of Indiana State Department of Health Advanced Directives including	02/27/2015

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	Indiana Advanced Directives in 5 (#1, 2, 4, 5 and 6) out of 5 home visit patients. Findings include; 1. An admission packet provided on January 21, 2015. The most recent advance directives in the folder were the revised copy dated March 1999, Revised May 2004. 2. During a home visit on January 21, 2015, at 4:26 PM with patient #1, the patient folder was observed to include the 2004 advance directives information. The daughter of the patient confirmed that updated information from the agency is kept in the folder. 3 During a home visit on January 21, 2015, at 3:10 PM with patient #2, the 2004 advance directives were viewed in the patient's folder from the Home Care with a Heart Agency. 3. During a home visit on January 22, 2015, at 1:00 PM with patient #4, the patient folder was observed to include the 2004 advance directives information. Employee E, the home health aide, the employee stated, "No, everything is kept in this folder." The most recent oasis form, page 2		revisions dated July 1, 2013 The Nurse Supervisors will be responsible to deliver updated Advanced Directives including revisions dated July 1, 2013 to all current client home care charts The Director of Nursing will be responsible to ensure this plan of correction is complete for current clients and in the future	

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	out of 8, dated 1/19/15 and signed by RN, employee C, states, "Clients family states [she/he] is now a DNR [Do Not Resuscitate] but had not produced a copy for the office." 4. During a home visit on January 22, 2015, at 2:40 PM with patient #5, the patient folder in the home included the 2004 advance directives information. 5. At a home visit on January 22, 2015, at 4:30 PM, with patient #6, the patient folder in the home included the 2004 advance directives information. The employee F said that this was the most updated information the patient and their family has. 6. In an interview with administrator, employee B, on January 23, 2015, at 3:30 PM, the employee provided a document stating, "here- here is our advance directives." This was the 2004 copy. At 4:00 PM, the administrator, employee B, provided a copy of the most recent 2013 Indiana State Department of Health, advance directives, stating "See, we do have the updated one, you didn't have the most recent folder; does this help?"			
N 524	410 IAC 17-13-1(a)(1) Patient Care			

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Bldg. 00	Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on clinical record review and interview, the agency failed to develop the plan of care to include the correct activities permitted, equipment required, and safety measures to protect against injury in 2 (# 1 and 6) out of 10 records reviewed. Findings include: 1. The Form CMS-485 Home Health Certification and Plan of Treatment" for patient #1, dated 10/13/14 to 12/11/14, failed to include activities permitted. The	N 524	N 0524 Home Care with a Heart Inc will ensure the plan of care is accurate and includes current activities permitted, equipment required and safety measures to protect against injury Nurse Supervisors (RN's) will receive educational review of the care planning process and how to accurately spell out actual activities permitted due to client's physical limitations, to include all equipment utilized for client care under DME (durable medical equipment) portion of the CMS-485, utilizing information collected from client, and from	02/27/2015

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	secondary diagnosis of the patient is lumbar diskectomy, dated 2010. In an interview with the Employee "H", on January 21, 2015, at 4:30 PM, the employee stated patient #1 is "up as tolerated with assistance." 2. The Form CMS-485 "Home Health Certification and Plan of Treatment" for patient # 6, dated 10/27/14 to 12/25/2014, neglects to list bilateral hand braces to the DME [Durable Medical Equipment] and supplies. A. On January 22, 2015, at 5:00 PM, the family member of patient #6 stated, "Yes, [he/she] wears hand braces every night." The patient is a quadriplegic. B. The plan of care has "activities permitted" marked "up as tolerated" although the patient is completely nonweightbearing. "Transfer Bed/Chair" is not marked.		client's family, or existing caregivers as appropriate. RN's shall include in the care plan if "up as tolerated" means the client is up in a wheel chair or up and ambulatory, or up and partial weight bearing, what is applicable to the client's situation and spelled out clearly for staff to follow the care plan appropriately and safely for client care. The Director of Nursing will be responsible to ensure the plan of correction is complete for current clients and in the future	
N 533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.			

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	(b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.			
	Based on clinical record review and interview, the agency failed to ensure the registered nurse updated the plan of care to include the correct activities permitted, equipment required, and safety measures to protect against injury in 2 (# 1 and 6) out of 10 records reviewed. Findings include: 1. The Form CMS-485 Home Health Certification and Plan of Treatment" for patient #1, dated 10/13/14 to 12/11/14, failed to include activities permitted. The secondary diagnosis of the patient is lumbar diskectomy, dated 2010. In an interview with the Employee "H", on January 21, 2015, at 4:30 PM, the employee stated patient #1 is "up as tolerated with assistance."	N 533	N 0533 Home Care with a Heart Inc will ensure updated plan of care to include correct activities permitted, equipment required, and safety measures to protect against injury Registered Nurses will receive educational review to include how to accurately include activities permitted according to client's physical abilities and circumstances, as well as any equipment utilized in client's care under the DME (durable medical equipment) portion of CMS-485, as well as safety measures to protect client against injury the DME equipment is to be included in the care plan if home care staff utilizes the equipment or if the equipment is utilized by family or if the client is able to use the equipment without assistance, whatever the case may be. The Director of Nursing will be responsible to ensure this plan of correction is complete for current	02/27/2015

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			clients and in the future	
	2. The Form CMS-485 "Home Health Certification and Plan of Treatment" for patient # 6, dated 10/27/14 to 12/25/2014, neglects to list bilateral hand braces to the DME [Durable Medical Equipment] and supplies. A. On January 22, 2015, at 5 PM, the family member of patient #6 stated, "Yes, [he/she] wears hand braces every night." The patient is a quadriplegic. B. The plan of care has "activities permitted" marked "up as tolerated" although the patient is completely nonweightbearing. "Transfer Bed/Chair" is not marked.			
N 550 Bldg. 00	410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on record and agency procedure review, the agency failed to ensure the registered nurse accurately completed the	N 550	N 0550 Home Care with a Heart Inc will ensure Home Health Aide Care plans are accurate and updated, and follow Physician's	02/27/2015

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	aide care plan and updated it every 60 days in 4 (#1, #4, #5, and #6) out of 10 clinical records reviewed. Findings include: 1. The "Home Care with a Heart, Inc. Home Health Assignment Sheet" for patient #1, updated 11/25/2014 by employee C, failed to specify the task "Check for Pressure/ Open areas", although it is ordered on plan of care for the certification period 10/13/14 to 12/11/14. A. The "Home care with a Heart Inc. Home Care Assignment Sheet" for patient #1 on 10/13/14 and updated on 11/25/2014 omits range of motion [ROM] or any other activities or exercise, active or passive for arms or legs, although "encourage activities to increase flexibility, muscle strength ..." is ordered on the plan of care for the certification period 10/13/14 to 12/11/14. B. Home Care Assignment sheet for patient #1, dated 10/13/2014 and revised 11/25/2014, were reviewed. The 10/13/2014 Home care assignment sheet stated to encourage fluids, the 11/25/2014 home care assignment sheet stated to limit fluids. The patient had been admitted 10/23/14 for diagnosis of renal		orders for client care Nurse Supervisors (RN's) will receive educational review regarding utilization of current MD orders to create accurate care plans for Home Health Aides to follow and make sure the care plans are updated including but not limited to: as required by scheduled assessments, MD ordered changes, client's physical status changes. the care plans shall be updated in the office charts and in the home charts so the most recent changes are made available to all staff. The Director of Nursing will be responsible to ensure this plan of correction is complete for current clients and for the future	

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	failure. C. The Plan of Care dated 10/13/14 to 12/11/14 includes an order for the Home health aide "to encourage activities to increase flexibility." Range of motion (ROM) or any other activities or exercises are not included in the aide care plan. 2. The "Home care with a Heart Inc. Home Care Assignment Sheet" for patient #4 updated on 1/19/15 by employee C, omits "HHA to remind client to take pre-set medications daily," although ordered on the plan of care for patient #4 for the certification period 1/20/15 to 3/20/15. The "Home care with a Heart Inc. Home Care Assignment Sheet" for patient #4 updated on 1/19/15 omits activities or exercise, or range of motion [ROM] active or passive for arms or legs, although "encourage activities to increase flexibility, muscle strength ..." is ordered on the plan of care for the certification period 1/20/15 to 3/20/15. 3. On a home visit on January 22, 2015 at 2:40 PM to patient #5, the home health aide was asked for the home health aide assignment sheet. The document provided was most recently updated			

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	5/14/13, almost 2 years ago and was illegible in some areas. The home health aide stated, "This is the only copy here, but there may be an updated one in the office." A. The plan of care for certification periods 1/4/2015 to 3/4/2015 and 11/4/14 to 1/4/15 state, "HHA [Home Health Aide] to provide all ADL's [activities of daily living] including but not limited to; Bathing, Personal Care, Assist with Dressing, skin care, hair care, clean under nails only, oral care, remind patients to take medications, remind patient to complete glucose monitoring, diabetic diet and meal prep and report any changes to SN." B. There is not a place dedicated on the aide care plan to "remind patient to complete glucose monitoring." Therefore, it was not on the aide care plan. It was also unclear if "Meal Assist" is synonymous with "Meal Prep" ordered by the physician in plan of care. On the undated aide are plan the nurse has written "meal preparation as client requests." 4. The aide care plan in the patient's home folder was written 1/14/11 and most recently revised 12/11/2013 and the home health aide, employee F, did not			

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	have a copy of anything more recent. A. In an interview with the home health aide of patient #6, employee F, on January 22, 2015, at 4:45 PM when asked what skilled activities they are required to perform without an updated plan of care, the home health aide replied, "I know this patient well, I do whatever the patient tells me to do." B. The aide care plan updated 12/24/2014 in the patient's chart in the office with dates of revision approximately each sixty days previous to 12/30/2013 listed range of motion (ROM)- Active/Passive Arm-R/L Leg-R/L. There is not a circle for those items separated by slashes, specifying Active or Passive. Some nurses checked both Active and Passive ROM some indicated "finger" indicating the only active range of motion ability, and some only checked passive. The patient is quadriplegic and unable to perform any active range of motion in arms and legs.			