STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157005	A. BUILDING B. WING	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH VNA HOME CARE	707 CEDAR STREET SUITE 320, SOUTH BEND, IN, 46617

(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
G0000	INITIAL COMMENTS This visit was for a Federal Complaint survey of a Deemed HHA provider. Survey Dates: July 11 and 12, 2024 Complaint IN1107581 with related and unrelated deficiencies. 12 Month Unduplicated Skilled Admissions: 1605 QR 7/17/24 A2	G0000		
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review, observation, and interview, the agency failed to ensure	G0534	**Plan**: Home Health has implementedthe following correction plan to ensure the wound assessments accuratelyreflect the patient's current medical status. -All professional clinical staff	2024-08-08

	assessments accurately reflected the patient's current medical status in 1 of 4 active records reviewed of patients with wounds (Patient #2). Findings indicate: 1. Review of an agency policy titled "Wound Measurement Program" indicated utilizes the expertise of the Wound Ostomy Continence Nurse Society (WOCN) and wound care measurements should be done weekly to document wound progress. 2. Review of the WOCN recommendations for measuring wounds indicated the depth of a wound would usually be measured by inserting a Q-tip into the deepest part of the wound and determining how well a wound would be healing depends on consistent measurements and if different care team members measure it differently, it would result in inconsistency, errors, and treatment problems with the healing process. 3. Review of the registered nurse (RN) job description indicated the RN is to accurately assess patient's condition and needs.		(Registered Nursesand Licensed Practical Nurses) will be educated regarding accurate depthmeasurement of the wound and review the Wound Measurement Program policy. -Education will be provided through mandatoryin-service, and attendance will be tracked with sign-in sheets. There were two sessionsfor the clinical staff to attend. Individual meetings will be provided forclinicians unable to participate in the in-service training session. -Staff education training on 8/07/2024 and 8/08/2024 -Records cited during the survey, and all current records, have been broughtinto compliance. **Person Responsible:** Administrator **Date of Completion:** August8, 2024 **Compliance:** -Audits are to be completed by the Clinical Manager to ensure an accurate depth measurement of the wound is completed. -Beginning August 5, 2024,10 %	

	4. Review of the clinical record of Patient #2, start of care date 10/16/2023 with diagnosis, but not limited to, cancer of left breast. The wound record report included a baseline assessment of the left chest area cancer lesion completed on 10/16/2023 with wound depth measurement of 0.3 centimeters (cm). During a home visit on 07/12/2024 beginning at 9:00 AM, RN 2 removed the old dressings to a wound to the left chest area and observed a large wound protruding outward from the skin surface. Review of the wound care report for certification period 04/13/2024 – 06/11/2024 included the following depth measurements: on 05/13/2024 RN 2 documented 0.2 cm, on 05/20/2024 licensed practical nurse (LPN) 1 documented 0.1 cm, on 05/27/24 the clinical manager documented 13.0 cm, on 06/03/2024 RN 2 documented 0 cm, and on 06/10/2024 RN 2 documented 5 cm. Documentation failed to evidence an accurate depth measurement of the wound.		of records of patients with wounds will be audited monthly to ensurecompliance with this standard. Audits will be completed until 100% complianceis met for two consecutive months. Incidents of noncompliance will be addressedthrough individual counseling and re-evaluation. ·Oncethe threshold is met, review of this standard will continue with a quarterlyrecord review of 5 % of patient records with wounds for four consecutivequarters. ·Ifcompliance falls below 90%, staff will be re-educated. Monthly audits will continueat 5 % until compliance is maintained at 100% for two consecutive months, then,audits will resume quarterly as part of the quarterly record review. -Supervisory home visitsare to be completed by the Clinical Manager to observe whether anaccurate depth measurement of the wound is completed. -Beginning August 5, 2024, the Clinical manager will make supervisory home visits to ensure an accurate depthmeasurement of the wound is completed. (5) Home visits will be completed monthlyto ensure compliance with	

	Review of the wound care report for certification period 06/12/2024 – 08/10/2024 included the following depth measurements: on 06/17/2024 RN 2 documented 0.1 cm, on 06/24/2024 LPN 1 documented 0.1 cm, on 07/01/2024 RN 3 documented 7 cm, and on 07/08/2024 LPN 1 documented 0.1 cm. Documentation failed to evidence a consistent depth measurement of the wound. During an interview on 07/12/2024 at 12:12 PM, when asked how to measure the depth of the wound of Patient #2, RN 2 indicated the wound had changed and used to have a small section at the top of the wound with depth, and today during the home visit there was no open area. During an interview on 07/12/2024 at 2:50 PM, when asked about the depth measurement of 13 cm on 05/27/2024, the clinical manager indicated the wound sometimes had a small open area with depth and that the wound had never been 13 cm in depth, that was a mistake. During an interview on		this standard. Monthly home visits will continueuntil 100% compliance has been achieved for (2) consecutive months. Incidentsof noncompliance will be addressed through individual counseling andre-evaluation. -Once thethreshold is met, (5) home visits will be completed quarterly to monitorcompliance for four consecutive quarters. -Ifcompliance falls below 90%, staff will be re-educated, and (5) monthly homevisits will be completed until compliance is maintained at 100% for 2consecutive months. Then, home visits will resume quarterly. ·These findingswill be reviewed by the clinical team monthly and reported quarterly to theQuality Committee, Administrator, and Governing Body during regularly scheduledmeetings.	

	07/12/2024 at 2:56 PM, when asked how to measure the depth of the wound of Patient #2, RN 3 indicated measures depth from the skin level outward, and with Patient #2 the depth measured would be how far the wound protrudes from the skin. During an interview on 07/12/2024 at 3:01 PM, when asked how to measure the depth of the wound of Patient #2, LPN 1 indicated when the wound had a small open area would measure the depth. 410 IAC 17-14-1(a)(1)(B)			
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on record review and interview, the agency failed to provide services as ordered by the physician and included in the plan of care (POC) for 1 of 5 active records reviewed (Patient #4). Findings include:	G0710	**Plan**: Home Health has implementedthe following correction plan to ensure services as ordered by the physicianand included in the plan of care are provided. - All professional clinical staff (Registered Nurses,Licensed Practical Nurses, Physical Therapy, Occupational Therapy, and SpeechTherapy) will be provided with education regarding providing services asordered by the physician and	2024-08-08

	1. Review of an agency policy titled "Care Management and Plan of Care" indicated the agency provides the patient with the services according to the individualized POC that is developed. 2. Review of the registered nurse (RN) job description indicated the RN provides services as indicated in the POC. 3. Review of the medical record of Patient #4 included a POC for certification period 06/13/2024 – 08/11/2024 that included skilled nurse interventions at each visit for wound vac (removes the pressure over a wound, which helps to reduce swelling and helps clean the wound) dressing changes. Review of a physician order dated 06/17/2024 indicated the skilled nurse was to make five visits for one week to Patient #4 effective 06/16/2024.		included in the plan of care and a review of the CareManagement and Plan of Care policy. -Agency leadership(Clinical Mangers) will be provided with education regarding providing servicesas ordered by the physician and included in the plan of care and a review of theCare Management and Plan of Care policy. -Education will be provided through mandatoryin-service, and attendance will be tracked with sign-in sheets. There will be twosessions for the clinical staff to attend. Individual meetings will be providedfor clinicians unable to participate in the in-service training session. -Staff education training on 8/07/2024 and 8/08/2024 Audits to begin after staff training **Person Responsible:**Administrator **Date of Completion:** August8, 2024 **Compliance:**	

	Review of the skilled nurse visits made the week of 06/16/2024 – 06/22/2024 indicated the RN made two visits that week, on 06/17/2024 and on 06/19/2024. Documentation failed to evidence the SN made five visits as ordered. During an interview on 07/12/2024 at 3:08 PM, when asked why 5 SN visits were not made the week of 06/16/2024 – 06/22/2024 as ordered, the administrator indicated the previous clinical manager must have approved the order before making the corrections.		-Audits are to be completed by the Clinical Manager to ensure services as ordered by the physician and included in theplan of care are provided. -Beginning August 9, 2024,10 % of patient records will be audited monthly to ensure compliance with thisstandard. Audits will be completed until 100% compliance is met for two months.Incidents of noncompliance will be addressed through individual counseling andre-evaluation. ·Oncethe threshold is met, review of this standard will continue with a quarterlyrecord review of 5 % of patient records for four consecutive quarters. ·Ifcompliance falls below 90%, staff will be re-educated. Monthly audits willcontinue at 5 % until compliance is maintainedat 100% for two consecutive months, then, audits will resume quarterly as partof the quarterly record review for four consecutive quarters. ·Thesefindings will be reviewed by the clinical team monthly and reported quarterlyto the	

			Administrator, and Governing Body during regularlyscheduled meetings.	
G1024	Authentication 484.110(b) 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 observation, record review, and interview, the agency failed to ensure the accuracy of the medication profile for 1 of 2 home visit observations (Patient #3). Findings include: During a home observation on 7/12/2024 with Patient #3, licensed practical nurse (LPN) 2 compared Patient #3's pill bottles with the medication list on their computer tablet. LPN 2 indicated the medication list had the same medications listed twice. The Clinical Manager, also at the visit, looked at the tablet and indicated they would need to discontinue one of the duplicate entries. The duplicate	G1024	**Plan**: Home Health hasimplemented the following correction plan to ensure an accurate medicationprofile in the EMR. -All professional clinical staff (Registered Nurses,Licensed Practical Nurses, Physical Therapists, Occupational therapists, andSpeech therapists) will be educated regarding ensuring an accurate medicationprofile in the EMR. -Education will be provided through mandatoryin-service, and attendance will be tracked with sign-in sheets. There were two sessionsfor the clinical staff to attend. Individual meetings will be provided forclinicians unable to participate in the in-service training session. -Staff education training on 8/07/2024 and 8/08/2024 Audits to begin after staff training	2024-08-08

	benazepril (for high blood pressure), atorvastatin (for high cholesterol), metformin (for diabetes), low – dose aspirin (may reduce risk of heart attack and stroke), and metoprolol tartrate (for hypertension). The agency failed to ensure the accuracy of the medical record. During an interview on 7/12/2024 at 3:10 PM, LPN 2 indicated they did not know why the medications were listed twice or were not fixed at previous visits. LPN 2 indicated this was the first time they had seen the medications listed twice. During an interview on 7/12/2024 at 3:15 PM, the Administrator indicated the EMR duplicated the medications. When asked, the Alternate Clinical Manager indicated the nurse would see the medication already listed in the system and should have discontinued the duplicate. 410 IAC 17-15-1(a)(7)		**Person Responsible:**Administrator **Date of Completion:** August8, 2024 **Compliance:** -Audits are to be completed by the Clinical Manager to ensure an accurate medication profile in the EMR. -Beginning August 9, 2024,10 % of patient records will be audited monthly to ensure compliance with thisstandard. Audits will be completed until 100% compliance is met for two months.Incidents of noncompliance will be addressed through individual counseling andre-evaluation. ·Oncethe threshold is met, review of this standard will continue with a quarterlyrecord review of 5 % of patient records for four consecutive quarters. ·Ifcompliance falls below 90%, staff will be re-educated. Monthly audits willcontinue at 5 % until compliance is maintainedat 100% for two consecutive months, then, audits will resume quarterly as partof the quarterly record	

			review for four consecutive quarters. -Supervisory home visits are to be completed by the Clinical Manager to observe whether an accurate medication profile is in the EMR. -Beginning August 5, 2024, the Clinical manager will make supervisory home visits to ensure an accurate medicationprofile in the EMR. (5) Home visits will be completed monthly to ensurecompliance with this standard. Monthly home visits will continue until 100%compliance has been achieved for (2) consecutive months. Incidents ofnoncompliance will be addressed through individual counseling andre-evaluation. -Once the threshold is met, (5) home visits will becompleted quarterly to monitor compliance. -If compliance falls below 90%, staff will bere-educated, and (5) monthly home visits will be completed until compliance ismaintained at 100% for 2	

			consecutive months. Then, home visits will resumequarterly. ·Thesefindings will be reviewed by the clinical team monthly and reported quarterlyto the Quality Committee, Administrator, and Governing Body during regularlyscheduled meetings.	
N0000	Initial Comments This visit was for a State Licensure Complaint survey of a Deemed HHA provider. Survey Dates: July 11 and 12, 2024 Complaint: IN1107581 with related and unrelated deficiencies cited. 12 Month Unduplicated Skilled Admissions: 1605	N0000		
N0440	Home health agency administration/management 410 IAC 17-12-1(a)	N0440	**Plan**: Home Healthagency has implemented the following plan of correction to ensure that theorganizational chart identified the lines of authority	2024-07-19

	Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the agency failed to ensure the organizational chart identified the lines of authority for the delegation of responsibility down to the patient care level for 1 of 1 agency. Findings include:		for the delegation ofresponsibility down to the patient care level. -Organizationalchart updated during survey and was brought into compliance. -Agencyleader (Administrator and Clinical Managers) was provided with education regardingthe updated organizational chart to meet this standard. - Education was provided through mandatory in-service,and attendance will be tracked with sign-in sheets. There was one session forthe agency leader to attend. Individual meetings will be provided forclinicians unable to participate in the in-service training session. **Person Responsible:**Administrator **Date of Completion:** July19, 2024 **Compliance:** -TheAdministrator will review the organizational chart annually toensure the	

	Review of agency document, Organizational Chart, dated 01/23/2024, indicated the delineation of authority on the organizational chart from top to bottom was documented as follows: Board of Directors branched to Administrator. Administrator branched to five department managers, which included, but was not limited to, Clinical Managers. Clinical Managers branched to nurses, home health aides, therapists and assistants, and social workers. The document failed to evidence delineation of authority to the patient care level. During an interview on 07/11/2024 at 11:43 AM, when asked where the organizational chart had lines of authority that go to the patient care level, the administrator indicated patients were not included.		organizational chart identified the lines of authority for thedelegation of responsibility down to the patient care level to sustainedcompliance with this standard. -These review findings will be reviewed by theClinical team annually and reported annually to the Quality Committee,Administrator, and Governing Body during regularly scheduled meetings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Bove	Administrator	8/2/2024 11:37:13 AM