

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  09/23/2024
NAME OF PROVIDER OR SUPPLIER  INDIANA SIGNAL HEALTH GROUP SKILLED INC			STREET ADDRESS, CITY, STATE, ZIP CODE  2013 CHESTER BLVD, RICHMOND, IN, 47374	
(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	<p>Initial Comments</p> <p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102.</p> <p>Survey Dates: September 17th, 18th, 19th, 20th, and 23rd of 2024</p> <p>Active Census: 37</p> <p>At this Emergency Preparedness survey, Indiana Signal Health Group Skilled was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.</p> <p>QR Completed on 10/01/2024 by A4</p>	E0000		
G0000	INITIAL COMMENTS	G0000		

	<p>This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider.</p> <p>Survey Dates: September 17th, 18th, 19th, 20th, and 23rd of 2024</p> <p>12-Month Unduplicated Skilled Admissions: 37</p> <p>A partially extended survey was announced on 09/18/2024 at 11:00 AM.</p> <p>This deficiency report reflects State Findings cited in accordance with 410 IAC 17.</p>			
<p>G0572</p>	<p>Plan of care</p> <p>484.60(a)(1)</p> <p>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.</p> <p>Based on record review and interview, the agency failed to</p>	<p>G0572</p>	<p><b>G0572 Plan of Care (missed Visits)</b></p> <p>1 The Administrator will audit all current patient records for missed visits not faxed to the provider and these missed visits will be immediately faxed to the provider.</p> <p>Pt #1 missed visits were faxed to the provider on (09/18/2024.)</p> <p>2 A missed visit note will be utilized to track missed visits sent to providers and a copy of the missed visit report</p>	<p>2024-10-11</p>

	<p>notify the physician of missed skilled nursing visits for 1 of 3 wound care patients reviewed. (Patient #1)</p> <p>Findings Include:</p> <p>1. A policy titled, "Interruption of Services/Missed Visits" indicated but was not limited to, "If the Agency misses visits or services as required by the plan of care, the Agency must notify the responsible physician of the missed visit if there is any potential for clinical impact upon the patient. The physician will determine whether the patient visit may be skipped or additional intervention is required by the Agency due to the impact on the patient. All documentation will be filed in the patient chart".</p>		<p>uploaded in patients EMR (see attachment titled "Missed Visit Note") these will also be kept in a separate binder.</p> <p>3 A communication note will be entered into the patients EMR stating that the missed visit was faxed to the provider.</p> <p>4 The Administrator will in-service all Management and Office Staff on the following policies and procedures and (Missed Visit Note) to be utilized for all missed visits.</p> <p>Policy C-36 Interruptions of Services/Missed Visits</p> <p>A New Missed Visit tool titled (Missed Visit Note) will be utilized by the agency to track missed visits and uploaded into the patients EMR, this will replace the "Communication Note" being used by the agency at the time of this survey.</p> <p>5 The person faxing missed visit will make notation into the patient's chart that the missed visit was faxed.</p> <p>6 All missed visits will be</p>	
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	<p>2. A document titled, "Communication Note" was sent to the physician on 09/18/2024 by the Administrator. The note indicated dates of missed visits. 08/15/2024, 08/19/2024, 08/20/2024, 08/22/2024, 08/23/2024, 08/29/2024, 09/02/2024, 09/05/2024, and 09/12/2024.</p> <p>3. The clinical record for Patient #1 evidenced missed visits by skilled nursing regarding wound care on 08/15/2024, 08/19/2024, 08/20/2024, 08/22/2024, 08/23/2024, 08/29/2024, 09/02/2024, 09/05/2024, and 09/12/2024. The agency failed to notify the physician of the missed visits until the surveyor identified them.</p> <p>4. During an interview on 09/18/2024 at 10:35 AM, the Administrator indicated that all missed visits should be sent to physicians for notification. The Scheduler typically sends them all at once every 2-4 weeks. The missed nursing visits for Patient #1 were not sent to the physician and he plans to send them now. The Administrator,</p>		<p>Manager and the Scheduling Supervisor.</p> <p>7 The Skilled Scheduler will be responsible to fax missed visits to Providers, utilizing the (Missed Visit Note) and upload faxed items into the clients EMR.</p> <p>8 The Administrator will monitor the missed visits, and these will be reviewed by the QAPI committee at meetings.</p> <p>9 All patient audits of missed visits completed on 9/24/24. A copy of the audit will be placed into the QAPI Binder for QAPI Committee to review.</p> <p>10 QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process.</p> <p>11 The QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process to the Governing Body.</p> <p>12 All corrections will be completed by: 10/11/24</p>	
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	<p>with the Scheduler, that he has only sent home health aide missed visits to the physician. Nursing missed visits are to be sent by the Administrator.</p> <p>IAC 17-13-1(a)</p>			
<p>G0574</p>	<p>Plan of care must include the following</p> <p>484.60(a)(2)(i-xvi)</p> <p>The individualized plan of care must include the following:</p> <ul style="list-style-type: none"> <li>(i) All pertinent diagnoses;</li> <li>(ii) The patient's mental, psychosocial, and cognitive status;</li> <li>(iii) The types of services, supplies, and equipment required;</li> <li>(iv) The frequency and duration of visits to be made;</li> <li>(v) Prognosis;</li> <li>(vi) Rehabilitation potential;</li> <li>(vii) Functional limitations;</li> <li>(viii) Activities permitted;</li> <li>(ix) Nutritional requirements;</li> <li>(x) All medications and treatments;</li> <li>(xi) Safety measures to protect against injury;</li> <li>(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.</li> <li>(xiii) Patient and caregiver education and training to facilitate timely discharge;</li> <li>(xiv) Patient-specific interventions and</li> </ul>	<p>G0574</p>	<p><b>G0574 Plan of Care must Include the following:</b></p> <p>1 An immediate audit of all active patients will be conducted in patients' home to review of all medical DME to ensure what is listed on the most recent plan of care is correct. If the DME is not listed on the plan of care a physician order will be sent to provider with the updated list of DME that should be on the plan of care.</p> <p>P#1, Pt #2 and Pt. #9 DME have been corrected. 10/7/24</p> <p>2 A DME tool was created for the purpose of this audit and will be utilized on all admissions and recertifications to ensure that all DME is on the plan of care. (see attachment titled Durable Medical Equipment)</p> <p>3 All start of care admission packets will include the DME</p>	<p>2024-10-18</p>

	<p>identified by the HHA and the patient;</p> <p>(xv) Information related to any advanced directives; and</p> <p>(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.</p> <p>Based on observation, record review, and interview, the home health agency failed to ensure that all medical equipment in the home was listed on the Plan of Care for 3 of 3 home visits completed. (Patient #1, #2, &amp; #9)</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. A policy titled, "Plan of Care (POC)" indicated but was not limited to, "Required to include ... supplies and equipment required ...".</li> <li>2. During a home visit observation for Patient #1 on 09/18/2024 at 1:00 PM, the surveyor observed a glucometer (used to assess blood glucose levels), a Dexcom (device worn to assess continuous blood glucose level monitoring), and a Continuous Positive Airway Pressure (CPAP) machine (a device used to keep airways open while sleeping) in the home.</li> </ol>		<p>tool to ensure that all DME is on the plan of care.</p> <ol style="list-style-type: none"> <li>4 At each recertification the DME Tool will be reviewed/utilized to ensure that the plan of care has all DME listed.</li> <li>5 The DME Tool will be uploaded into the patients EMR.</li> <li>6 DME Tools will be placed into the QAPI Binder and reviewed by the committee at each meeting.</li> <li>7 The Clinical Manager or Designee will be responsible for obtaining the corrected DME reviewed in the patient's home.</li> <li>8 The Clinical Manager will be responsible for ensuring that the DME listed on the plan of care is current, correct and updated with each recertification.</li> <li>9 QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process.</li> <li>10 The QAPI committee will be responsible for oversight and make recommendations if changes need to be made to</li> </ol>	
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	<p>The Clinical Record/POC for Patient #1, Certification Period 09/13/2024--11/11/2024, failed to include a glucometer, a Dexcom, and a CPAP.</p> <p>3. During a home visit observation for Patient #2 on 09/20/2024 at 9:30 AM, the surveyor observed a glucometer in the home.</p> <p>The Clinical Record/POC for Patient #2, Certification Period 08/11/2024--10/09/2024, failed to include a glucometer.</p> <p>4. During a home visit observation for Patient #9 on 09/20/2024 at 10:00 AM, the surveyor observed hearing aides, a bedside commode, and a urinal in the home.</p> <p>The Clinical Record/POC for Patient #9, Certification Period 07/28/2024--9/25/2024, failed to include hearing aides, a bedside commode, and a urinal.</p> <p>5. During an interview on 09/19/2024 at 9:56 AM, the Administrator indicated that all durable medical equipment in the home should be on the plan of care.</p>		<p>the process to the Governing Body.</p> <p>11 Corrections will be completed and entered the patients EMR by 10/18/24.</p>	
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	<p>410 IAC 17-13-1 (a)(1)(C)(ii)</p>			
<p>G0580</p>	<p>Only as ordered by a physician</p> <p>484.60(b)(1)</p> <p>Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner.</p> <p>Based on record review and interview the agency failed to follow physician orders for wound care in 3 of 3 wound care patients reviewed. (Patient #1, #2, #3)</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. A policy titled "Verbal Orders" indicated but was not limited to: "Conformance with Physician Orders: ... Drugs and treatments are administered by the Agency staff only as ordered by the physician."</li> <li>2. A record review for Patient</li> </ol>	<p>G0580</p>	<p><b>G0580 Only as Ordered by a physician</b></p> <ol style="list-style-type: none"> <li>1 All patients requiring wound care have immediately been audited to ensure that the correct wound care orders are present in the patients' EMR, updated orders will be uploaded into the patients' chart and reviewed by the Administrator or Clinical Manager.</li> </ol> <p>Pt#1 wound care orders were corrected.</p> <p>Pt#2 wound care orders were corrected</p> <p>Pt#3 wound care orders were corrected</p> <ol style="list-style-type: none"> <li>2 The Administrator or Clinical Manger will review all new orders to ensure that the correct orders are entered into</li> </ol>	<p>2024-10-18</p>

	<p>#1, Certification Period 08/11/2024–10/09/2024, evidenced the following:</p> <p>An 08/01/2024 physician wound care order for Patient #1's coccyx indicated but was not limited to, Cleanser: Soap and water, two times per day for 30 days. Primary dressing: Wet to dry, two times per day for 30 days. Secondary dressing: Telfa Island 4x4 (a soft non-woven dressing that conforms around the wound and seals on all four sides), two times per day for 30 days.</p> <p>An 08/12/2024 Skilled Nursing Visit Note: Treatment performed: Skilled nurse performed pressure ulcer care to the coccyx, cleansing/irrigating the wound with Normal Saline (NS), applying a wet-to-dry dressing, and covering and securing with foam dressing using an aseptic technique. The skilled nurse was also to teach the patient/caregiver to perform wound care. LPN 1 failed to cleanse the wound with soap and water and apply a Telfa Island 4x4 dressing twice daily as ordered.</p>		<p>all nursing staff are aware of the current orders and a copy of the order will be placed in the patients EMR so that the nurse can review it prior to seeing the patient.</p> <p>3 If a patient receives wound care from a SN the day following a wound care visit, the SN will call the wound care provider to receive a verbal order of updated wound care orders and will write a verbal order to be signed by the provider to ensure correct wound care orders are followed by the nursing staff.</p> <p>4 A communication note will be recorded into the patients chart each time a verbal order is received to ensure all nursing staff are aware of any change in the wound care orders.</p> <p>5 In-services will be conducted with all nursing staff on Policies regarding wound care services:</p> <p>Wound Care (C-65) ,</p> <p>Plan of Care (C-48),</p> <p>Bag Technique ( C-8)</p> <p>Verbal Orders (C-63)</p>	
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	<p>An 08/13/2024 Skilled Nursing Visit Note: Treatment performed: Skilled nurse performed pressure ulcer care to the coccyx, cleansing/irrigating the wound with NS, applying a wet-to-dry dressing, and covering and securing with foam dressing using an aseptic technique. The skilled nurse may teach the patient/caregiver to perform wound care. LPN 1 failed to cleanse the wound with soap and water and apply a Telfa Island 4x4 dressing twice daily as ordered.</p> <p>An 08/14/2024 Skilled Nursing Visit Note: Treatment performed: Cleansed wound with NS, patted dry, applied wet to dry dressing, covered and secured with an island dressing using an aseptic technique. The Administrator failed to cleanse the wound with soap and water twice daily as ordered.</p> <p>An 08/15/2024 physician wound care order for Patient #1's coccyx indicated but was not limited to, Cleanser: Soap and water, two times per day for 30 days. Primary dressing: Dry gauze, two times per day for 30 days. Secondary dressing: Telfa</p>		<p>6 A binder will be created for all patientsreceiving wound care and a copy of all orders will be kept in this binder witha log for each client and current wound care orders and checked and verified bythe Clinical Manager.</p> <p>7 The QAPI Committee will review all patients thatare receiving wound care at each QAPI meeting, to ensure that nursing staff arefollowing physician wound care orders and to review if wound is getting better,worse, or no change.</p> <p>8 All corrections and audits will be placed in theQAPI binder for Review by QAPI Committee.</p> <p>9 The Administrator or the Clinical Manager willbe responsible for all education of staff nurses.</p> <p><u>10 QAPIcommittee will be responsible for oversight and make recommendations if changesneed to be made to the process.</u></p> <p>11 The QAPIcommittee will be responsible for oversight and make recommendations if changesneed to be made to the process to the Governing Body.</p> <p>12 Allin-services and corrections will be completed</p>	
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	<p>Island 4x4, two times per day for 30 days.</p> <p>An 08/16/2024 Skilled Nursing Visit Note: Treatment performed: Cleansed wound with NS, patted dry, applied wet to dry dressing, covered and secured with an island dressing using an aseptic technique. The Administrator failed to cleanse the wound with soap and water and apply dry gauze twice daily as ordered.</p> <p>An 08/21/2024 Skilled Nursing Visit Note: Treatment performed: Cleansed wound with soap and water, patted dry, applied wet to dry dressing, and covered and secured with a 4x4 island dressing using an aseptic technique. The Administrator failed to apply dry gauze twice daily as ordered.</p> <p>A 09/06/2024 physician wound care order for Patient #1's coccyx indicated but was not limited to, Cleanser: Soap and water, once per day for 30 days. Primary dressing: Silver 4x4 Melgisorb AG (absorbent calcium alginate dressing with silver), once per day for 30 days. Secondary dressing: Telfa Island 4x4, once per day for 30 days.</p>		by 10/18/24.	
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	<p>A 09/06/2024 Skilled Nursing Visit Note: Treatment performed: Cleansed wound with NS, applied silver 4x4 Melgisorb AG, covered and secured with Optifoam dressing using aseptic technique. LPN 1 failed to cleanse the wound with soap and water and apply Telfa Island 4x4 dressing daily as ordered.</p> <p>A 09/09/2024 Skilled Nursing Visit Note: Treatment performed: Cleansed wound with NS, applied silver 4x4 Melgisorb AG, covered and secured with Optifoam dressing using aseptic technique. LPN 1 failed to cleanse the wound with soap and water and apply Telfa Island 4x4 dressing daily as ordered.</p> <p>A 09/10/2024 Skilled Nursing Visit Note: Treatment performed: Cleansed wound with NS, applied silver 4x4 Melgisorb AG, covered and secured with Optifoam dressing using aseptic technique. LPN 1 failed to cleanse the wound with soap and water and apply Telfa Island 4x4 dressing daily as ordered.</p>			
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	<p>3. A record review for Patient #2, Certification Period 09/13/2024–11/11/2024, evidenced the following:</p> <p>A 09/10/2024 physician wound care order for Patient #2's right lateral lower leg indicated but was not limited to, Cleanser: Soap and water, one time per day for 30 days. Primary Dressing: Silver 4x4 Melgisorb AG, one time per day for 30 days. Secondary Dressing: Kerlix (bandage roll providing wicking action, aeration, and absorbency), one time per day for 30 days. Compression Wrap: Ace Wrap, one time per day for 30 days.</p> <p>A 09/14/2024 Skilled Nursing Visit Note: The following treatment was performed: Skilled nurse performed wound care for the right lower leg venous ulcer, cleansing the wound with soap and water, rinsing, patting dry, applying Melgisorb AG, and covering and securing the dressing with an ACE bandage, using aseptic technique. The Administrator failed to apply Kerlix as ordered.</p> <p>A 09/16/2024 Skilled Nursing Visit Note: The following</p>			
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	<p>treatment was performed: Skilled nurse performed wound care for the right lateral leg venous ulcer, cleansing the wound with soap and water, rinsing, patting dry, applying Melgisorb AG, and covering and securing the dressing with an ACE bandage, using aseptic technique. LPN 1 failed to apply Kerlix as ordered.</p> <p>4. A record review for Patient #3, Certification Period 08/31/2024–10/29/2024, evidenced the following:</p> <p>An 08/12/2024 physician wound care order for Patient #3's left ischial pressure wound (buttock) indicated but was not limited to, Applying antifungal powder once every other day.</p> <p>A 09/05/2024 Skilled Nursing Visit Note: The following treatment was performed: The skin around the wound was cleansed with soap and water, rinsed with water, and patted dry. The wound was cleaned with a sterile cotton-tipped applicator and sterile gauze, and a scant amount of ground Metronidazole (500 mg antibiotic tablet) was applied to the wound bed. Prisma (used to</p>			
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	<p>optimize wound healing) was loosely placed in the wound, and the area was covered with 3x3 gauze and secured with a cover roll. LPN 1 failed to apply antifungal powder once every other day and failed to obtain updated physician wound orders.</p> <p>A 09/09/2024 Skilled Nursing Visit Note: The following treatment was performed: The skin around the wound was cleansed with soap and water, rinsed, and patted dry. The wound was cleaned with a sterile cotton-tipped applicator and sterile gauze, and a scant amount of ground Metronidazole 500 mg tablet was applied to the wound bed. Prisma was loosely placed in the wound, and the area was covered with 3x3 gauze and secured with a cover roll. LPN 1 failed to apply antifungal powder once every other day and failed to obtain updated physician wound orders.</p> <p>A 09/12/2024 Skilled Nursing Visit Note: The following treatment was performed: The skin around the wound was cleansed with soap and water, rinsed, and patted dry. The</p>			
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	<p>wound was cleaned with a sterile cotton-tipped applicator and sterile gauze, and a scant amount of ground Metronidazole 500 mg tablet was applied to the wound bed. Prisma was loosely placed in the wound, and the area was covered with 3x3 gauze and secured with a cover roll. LPN 1 failed to apply antifungal powder once every other day and failed to obtain updated physician wound orders.</p> <p>A 09/16/2024 Skilled Nursing Visit Note: The following treatment was performed: The skin surrounding the wound was cleansed with soap and water, rinsed, and patted dry. The wound was cleaned with a sterile cotton-tipped applicator and sterile gauze, and a scant amount of ground Metronidazole 500 mg tablet was applied to the wound bed. Prisma was loosely placed in the wound, and the area was covered with 3x3 gauze and secured with a cover roll. LPN 1 failed to apply antifungal powder once every other day and failed to obtain updated physician wound orders.</p> <p>5. During an interview on</p>			
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	<p>09/17/2024 at 3:13 PM, the Administrator indicated that physician orders for wound care were not followed for Patient #1. The Administrator further indicated that Patient #1's orders change frequently and should be followed at all times. The Administrator was unable to change wound orders on the Plan of Care and could not figure out how to do so within the Electronic Medical Record (EMR) system. The Administrator also indicated that caregivers, specifically the grandson and niece, performed wound care in the evening or when a visit was missed by the nurse. The Administrator was unable to find or provide documentation showing that the caregivers were trained on wound care initially or with each wound care order change. The wound care completed by the caregivers was not documented or tracked, and the Administrator only knew it was completed because Patient #1 reported it.</p> <p>6. During an interview on 09/17/2024 at 4:20 PM, Patient #1 indicated that a friend completes wound care in the absence of the nurse. Patient #1</p>			
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	<p>communicates any new wound care orders to their friend, who then performs the care. Patient #1 did not recall the agency nurses training their friend on how to complete wound care but indicated satisfaction with the current services received from the home health agency.</p> <p>7. During an interview on 09/18/2024 at 9:05 AM, the Administrator acknowledged being aware that Patient #1's caregivers had not been trained on wound care and planned to schedule a date and time for the training.</p> <p>8. During an interview on 09/18/2024 at 10:35 AM, the Administrator indicated that physician orders for wound care were not followed for Patient #2, and Kerlix was not included in the wound orders on the Plan of Care.</p> <p>9. During an interview on 09/18/2024 at 1:30 PM, the Director of Marketing was asked to provide wound care orders for Patient #3. Wound care orders from January 2024 were provided. The Director denied having any further notes or orders from the wound center</p>			
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	<p>for review. The Director indicated that Patient #3's wound orders had not changed but requested an update from the wound center. New orders were provided, which were noted to be significantly different from the current treatment being provided. The most recent wound order was dated 08/12/2024.</p> <p>410 IAC 17-13-1(a)</p>			
<p>G0610</p>	<p>Patients receive education and training</p> <p>484.60(d)(5)</p> <p>Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.</p> <p>Based on record review and interview the agency failed to provide initial and on-going wound care training/education to the caregiver for wound care that was to be provided in the absence of agency nursing staff in 1 of 3 wound care patients reviewed. (Patient #1)</p>	<p>G0610</p>	<p><b>G0610 Patients Receive Education and Training</b></p> <p>1 The Administrator immediately reviewed all patient records of patients that are currently receiving wound care services from the agency. A total of three records were reviewed for accuracy of wound care orders, available caregiver to provide initial and ongoing training and education for wound care to be provided to the patient in the absence of a skilled nurse.</p> <p>Pt #1 was found to have care givers available to assist with wound care when nurse not present. A Friend, and a Grandson are both willing and</p>	<p>2024-10-18</p>

	<p>Findings Include:</p> <p>1. A policy titled, "Admission Documentation/Patient Education" indicated but was not limited to, "Patient/Family Education: Starting with the admission visit, Agency staff will provide education to the patient and caregiver related to: Infection prevention &amp; control... Treatments/care/services ... Such education may be oral or written educational materials sourced from the Agency or any other agency/authority in the topic, and documented in the permanent clinical record that information was provided".</p> <p>2. A policy titled, "Wound Care" indicated but was not limited to, "a. Wound care education will be provided to each patient/caregiver as applies ... c. All education on wound care will include, but not be limited to: ... Self wound care ... Dressings to be utilized in wound care ... Symptoms to report to your nurse or physician ... d. All wound care education is to be documented in nursing notes".</p> <p>3. The Clinical Record for Patient #1, Certification Period</p>		<p>able to assist when a skilled nurse from the agency is not present on the weekends, they are unreliable during the week for various reasons.</p> <p>Pt #3 wound care orders were clarified by the Administrator and a verification order written and placed in the patient's EMR.</p> <p>Pt #2 has no available or willing caregiver to assist with wound care.</p> <p>On 9/20/2024 Both caregivers for Pt#1, were given education on the patient's wound care orders and infection control measures during wound care. Each caregiver gave a return demonstration of the proper wound using the current order and used proper infection control measures during the demonstration. Completion of all corrections will be completed by 10/4/24.</p> <p>2 A new education and training tool will be utilized to validate all education and training of any caregivers that are willing and able to perform</p>	
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	<p>08/11/2024--10/09/2024, failed to include documentation demonstrating that the caregiver received initial and ongoing education/training on wound care to be completed in the absence of the agency nurse. Caregiver infection prevention &amp; control was also absent from the clinical record.</p> <p>4. During an interview on 09/17/2024 at 3:13 PM, the Administrator indicated that the caregivers complete wound care in the absence of agency nursing staff. Caregivers include a grandson and a niece. Agency nursing staff complete home visits once a day, Monday-Friday. The caregivers provide wound care each evening as ordered and on the weekends.</p> <p>5. During an interview on 09/17/2024 at 4:20 PM, Patient #1 indicated that a friend completes wound care in the absence of nursing staff. Cannot recall a friend receiving training/education on wound care initially or ongoing. Patient #1 tells a friend what the wound doctor's orders are and he/she completes wound care.</p>		<p>staff. (please see attachment titled "Wound Care Education Sheet for Caregivers")</p> <p>3 All nursing staff will be required to complete this form on all education/training given to a caregiver and the caregiver will sign to attest the education was given by the skilled nurse.</p> <p>4 The "Wound Care Educational Sheet for Caregivers" will be uploaded into the patient's EMR for attestation that education was provided to the caregiver with each change in wound care orders.</p> <p>5 An in-service to all nursing staff will be given on Policy C-4 Admission Documentation/Patient Education, and the new "Wound Care Education Sheet for Caregivers")</p> <p>6 The Administrator or Clinical Manager will be responsible for monitoring all wound care orders weekly and will ensure that education and training is completed with each wound care order change.</p> <p>7 All wound care orders and</p>	
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	<p>6. During an interview on 09/19/2024 at 9:05 AM, the Administrator indicated that documentation of caregivers' training and education regarding Patient #1's wound care was not found in the clinical record, neither initial or ongoing. Wound care has been and will continue to be provided by the caregiver in the absence of nursing staff. The agency plans to set up a date/time for the caregivers to be trained.</p> <p>7. During an interview on 09/20/2024 at 12:09 PM, the Administrator indicated that the caregiver was trained today on wound care/infection control.</p> <p>410 IAC 17-14-1 (a)(1)(G)</p>		<p>be kept in the wound care binder and will be reviewed by the QAPI committee during each QAPI meeting.</p> <p>8 QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process.</p> <p>9 The QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process to the Governing Body.</p> <p>10 Corrections will be completed by 10/4/2024.</p> <p>11 All corrections/an in-services will be completed by 10/18/2024.</p>	
<p>G0804</p>	<p>Aides are members of interdisciplinary team</p> <p>484.80(g)(4)</p> <p>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</p>	<p>G0804</p>	<p><b>G0804 Aides are Members of the Interdisciplinary Team</b></p> <p>1 HHA #2 for Pt. #4 called the Administrator on 9/23/24 after a phone interview with the Surveyor to clarify what she did wrong. The administrator</p>	<p>2024-10-18</p>

	<p>compliance with the HHA's policies and procedures.</p> <p>Based on record review and interview the Home Health Aide (HHA) failed to report a change in condition to the Registered Nurse in 1 of 3 active records reviewed with HHA services. (Patient #4)</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. A document titled, "Job Title: Home Health Aide (HHA)" indicated but was not limited to, "Reports any changes in the patient's status or home situation immediately to the supervisor, staff nurse, or aide supervisor, including recognizing &amp; reporting skin changes".</li> <li>2. A document dated 09/13/2024 titled, "Client Notes Report" indicated that HHA #2 noted that Patient #4 had a couple of "open spots" on his/her backside, and "cream" was applied. HHA 2 failed to notify the nurse of the change in condition.</li> <li>3. During an interview on 09/20/2024 at 12:49 PM, the Administrator was reviewing</li> </ol>		<p>explained that she failed to notify the nurse of this change inPt #4 skin, that she had written it in her note but failed to call the nurse. The Administrator at this time gave HHA#2,verbal education over the phone, that the agency policy is to call the nursewith any change in the patient's condition, and the HHA#2 sees a message whenshe opens patient chart, and it is also listed in her task to notify the nurseof any changes in the patient's condition. A verbal Educational Warning was given and documented by theAdministrator that this was given to HHA#2. This will be placed into the HHApersonnel file.</p> <p>2 Inservice's will be given to all Home HealthAide staff:</p> <p>Job Title: "Home Health Aide" Job Description</p> <p>Policy C-7A Change of Condition-Significant</p> <p>Disciplinary Action</p> <p>3 The Administrator and Clinical Manager will readall HHA notes daily for the prior</p>	
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	<p>Patient #4's clinical record with the surveyor and read aloud the note entered by HHA #2 and indicated that she was not made aware of these open spots and confirmed that the documentation did not include a note indicating any nurse was made aware. She stated the expectation is for the HHA to notify the nurse of any changes in condition.</p> <p>4. During an interview on 09/23/2024 at 3:30 PM, HHA #2 indicated that Patient #4 did have new open spots identified on his/her bottom on 09/13/2024. She indicated that this was an ongoing thing with Patient #4 and was not uncommon. Surveyor clarified with HHA #2 that these were new open spots and HHA #2 confirmed they were. HHA #2 further indicated that if they were "really open and raw" the nurse would be notified. HHA #2 indicated that the open spots had not cleared to date and planned to notify the Administrator later today.</p>		<p>charts a change and has not notified the nurse. If the aide has not contacted the nurse and filled out the form the HHA will be called in for re-education on the agencies policy for change of condition, and disciplinary action placed into employees file.</p> <p>4 All Home Health Aides will be in-serviced on the new form created titled "Change of Condition" (see attachment titled "Policy C-7A Change of Condition")</p> <p>5 This new form will be added to the admission packet so the form will be accessible to the home health aide at the time of the occurrence. They will also be available at the office for them to fill out after notifying the nurse.</p> <p>6 All new hire HHA's are in-serviced on reporting Change of Condition policy C-7A on hire, it is already part of their on-boarding.</p>	
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			<p>7 The Administrator or Clinical Manager will ensure that all HHA are In-serviced on reporting any change of condition, HHA Job Description, and disciplinary Actions.</p> <p>8 All disciplinary Actions will be reviewed during QAPI mtgs.</p> <p>9 QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process.</p> <p>10 The QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process to the Governing Body.</p> <p>11 All Corrective actions and in-services will be completed by 10/18/24</p>	
G1024	<p>Authentication</p> <p>484.110(b)</p> <p>Standard: Authentication.</p> <p>All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature</p>	G1024	<p><b>G1024 Authentication</b></p> <p>1 An internal Audit was completed on 10/3/24 of all outstanding orders by the Skilled Scheduler. All outstanding orders were placed in abinder and a new tracking</p>	2024-10-18

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 obtain a signed physician order for services in 1 of 3 new admissions reviewed. (Patient #6)

Findings Include:

1. A policy titled, "Orders: Signed in 30 Days", indicated but was not limited to, "Orders are signed by the physician within time frames established by state/federal regulations and our Agency policy, but at least within 30 days. All plans of care, verbal orders, and changes in orders will be signed by the certifying physician in 30 days and filed in the patient's clinical file. Every effort will be made to ensure the order is signed within the timeframe, including refaxing and in person visit to the MD office. All efforts to obtain the MD signature will be documented".

2. A policy titled, "Verbal Orders", indicated but was not limited to, "Verbal orders must

sheet is to be used to track all orders, (see attachment titled "Audit for Plan of Care Outstanding and Audit for Physician Orders Outstanding")

2 Each time an order is faxed, refaxed, called onto request it sent back signed will be documented in the patient's chart and on the audit form for each patient. If the order is not back signed in a 14-day window, office personnel will hand deliver and wait for the order to be signed. If the physician refuses to sign while personnel waits, this will be noted in patient's chart.

3 The Skilled Scheduler will monitor outstanding orders daily, and report to the Administrator any orders that are outstanding 14 days.

4 The QAPI committee will monitor outstanding orders at QAPI meetings and if any trends are seen by committee members, recommendations will be made to the Administrator.

5 The Administrator or designee will be responsible to ensure that all orders are returned in a timely manner.

be authenticated and dated by the physician in accordance with applicable state laws and regulations, and Agency policy".

3. A policy titled, "Plan of Care (POC)" indicated but was not limited to, "Must be signed by the attending medical professional acting within the boundaries of all applicable state laws and regulations".

4. A Clinical Record for Patient #6, Start of Care 07/29/2024, Certification Period 07/29/2024--09/26/2024 failed to include a signed physician order for services. Services included a start of care skilled nursing visit one time and Physical Therapy services once weekly for 1 week, then twice weekly for 8 weeks.

5. During an interview on 09/20/2024 at 12:09 PM, the Administrator indicated starting care for Patient #6. The expectation is to obtain a signed physician order for services and typically does this, however, this one got missed. The Plan of Care was signed by the physician on 09/17/2024 with orders for skilled nursing

6 QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process.

7 The QAPI committee will be responsible for oversight and make recommendations if changes need to be made to the process to the Governing Body.

8 All Corrections and in-services will be completed by 10/18/24.

	therapy but agreed this signature was not obtained in the Agency timeframe expectation, of 30 days.			
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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 Janna McCourt	TITLE RN, Administrator	(X6) DATE 10/7/2024 1:36:59 PM
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