

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	<p>This was a Federal and State post condition revisit of a deemed home health agency.</p> <p>Facility ID: IN005248</p> <p>Provider # 157005</p> <p>Dates of Survey: 7/14, 7/15/2021</p> <p>Current Census: 207</p> <p>Unduplicated census: 1932</p> <p>Sample Selection: Record review for 3 active patients with 1 home visit, and focused record reviews for 2 discharged patients who required 15 days' notice of discharge.</p> <p>During this survey, 3 of 3 Conditions were corrected, 14 standards were corrected, 0 standards were re-cited, and 3 new standards were cited (G374), (G546), and (G592).</p> <p>This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.</p> <p>Saint Joseph VNA Home Health Care is precluded from providing its own home health training and competency evaluation for a period of two years which began 3/2/2021 - 3/2/23 due to being found out of compliance with the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment of Patients, 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care, and 484.105 Organization and Administration of Services during a fully extended</p>	G 0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0374 Bldg. 00	<p>federal and state survey with 2 complaints conducted on 3/2/2021.</p> <p>Quality Reviewed 07/22/2021</p> <p>484.45(b) Accuracy of encoded OASIS data Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment.</p> <p>Based on record review and interview, the agency failed to ensure all encoded OASIS (Outcome and Assessment Information Set) data accurately reflected the patient's health status during the time the assessment was completed for 1 of 3 clinical records reviewed (#3).</p> <p>Findings include:</p> <p>Review of a policy dated 4/2020, titled "Initial Assessment and Admission for Services" stated "... The clinician conducting the initial OASIS assessment completes their assessment during a visit, although the assessment opinions of other clinicians can be included ... as permitted by CMS [Centers for Medicare and Medicaid Services] guidelines for OASIS completion...."</p> <p>Review of a web-based reference site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D-Guidance-Manual-final.pdf, titled "OASIS-D Guidance Manual ... Effective 1/1/2019 ... Centers for Medicare & Medicaid Services" stated "... For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient ... [comprehensive re-assessment] and other follow-up ... the assessments must be completed on, or within 48 hours ... Follow-Up</p>	G 0374	<p>G 374 Accuracy of encoded OASIS data CFR(s) 484.45(b) Standard: Accuracy of encoded OASIS data. The encoded OASIS data must accurately reflect the patient's status at the time of assessment.</p> <p>Plan:</p> <ul style="list-style-type: none"> ·All professional, clinical staff (Registered Nurses, Physical Therapists, Occupational Therapists and Speech Therapists) will be provided with education regarding accuracy of OASIS assessments including required timeframes and methods for data collection. ·Education will be provided by agency Administrator or designee by August 13, 2021 ·Education will be provided through mandatory in-service training and attendance will be tracked with sign-in sheets. Individual meetings will be provided for any clinicians unable to participate in the in-service training session(s). ·Quality Assurance colleagues will be provided with education 	08/13/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(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	
	<p>(FU): This information is collected at Recertification and Other Follow-up ... M0090 ... Date assessment completed should reflect the last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including the OASIS items ... (M1242) [requires patient assessment] ... Frequency of Pain Interfering with patient's activity or movement ... (M1340) ... [requires patient assessment] ... Does this patient have a Surgical Wound? ... ITEM INTENT ... Identifies the presence of a wound resulting from a surgical procedure ... (M1342) ... [requires patient assessment] ... Status of Most Problematic Surgical Wound that is Observable ... (M1400) ... [requires patient assessment] ... When is the patient dyspneic or noticeably Short of Breath? ... Response 0 would apply if the patient has not been short of breath during the day of assessment...."</p> <p>Review of a web-based reference site: http://www.fazzi.com/tl_files/pages/oasis/Appendix%20A-G.pdf, titled "APPENDIX A - OASIS AND THE COMPREHENSIVE ASSESSMENT" stated "... Follow-up assessments must be completed every 60 days that a patient is under care ... For Medicare and Medicaid patients, when a follow-up assessment is due, it must be completed no earlier than four calendar days before, and no later than the day marking the end of the 60-day period (i.e., day 56 through day 60 of the period)"</p> <p>Record review for patient #3 was completed on 7/15/2021, start of care date 3/9/2021, for re-certification period 7/7/2021 - 9/4/2021, and failed to evidence direct patient contact/assessment by a clinician occurred after 7/2/2021 and prior to 7/7/2021 at 8:56 AM, to substantiate the changes made to OASIS items</p>		<p>regarding accuracy of OASIS assessments including required timeframes and methods for data collection.</p> <ul style="list-style-type: none"> ·Education will be provided by Quality Assurance Director or designee by August 13, 2021 ·Education will be provided through mandatory in-service training and attendance will be tracked with sign-in sheets. Individual meetings will be provided for any clinicians unable to participate in the in-service training session(s). ·The Clinical Manager or designee will review all active patient records to ensure OASIS assessments are accurate and OASIS date reflect the patient's health status during the time the assessment was completed. <p>·Specific action taken for clinical record #3:</p> <ul style="list-style-type: none"> ·Assessing clinician will be provided with individual education by Administrator or designee by August 27, 2021 regarding accuracy of OASIS assessments including required timeframes and methods for data collection and clinician responsibility for reviewing and approving or declining QA recommendations to ensure accurate OASIS encoding. ·Agency will recall the Recertification OASIS, correct the corresponding OASIS items to reflect the patient's status at the 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(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
	<p>which included M1242 (pain), M1340 (presence of a surgical wound), M1342 (status of the surgical wound), and M1400 (presence of shortness of breath), and failed to evidence the amended data entered on 7/7/2021, accurately reflected the patient's health status during the time the assessment was completed on 7/2/2021.</p> <p>Review of a document titled "PT [physical therapy] Recert with Skill" stated "... (M0090) Date assessment completed: 7/2/2021 ... Pain ... Was [patient] able to completely discuss his/her pain assessment? ... Yes, [patient] was able to completely discuss his/her pain ... [patient] reports no pain at any time during the 24 hour day ... (M1242) ... 0- Patient has no pain ... (M1340) Does this patient have a surgical wound? ... 0- No ... Indicate integumentary [skin] assessment findings: ... No problems identified ... Was Respiratory system addressed? ... Yes ... (M1400) When is the patient ... short of breath? ... 0- Patient is not short of breath"</p> <p>The document also evidenced it was last modified on 7/7/2021 at 8:56 AM, by RN [registered nurse] J, and stated "... ADDENDUM ... Question: M1242 [pain] ... Pre-edit answer: 0- No ... Post-edit answer: 1 [yes] ... Question: M1400 ... Pre-edit answer: 0 [not short of breath] ... Post-edit answer: 1- when walking more than ... Question: M1340 ... Pre-edit answer: 0- No [patient did not have a surgical wound] ... Post-edit answer: 1- Yes , patient has at least [one surgical wound] ... Question M1342 ... status of ... surgical wound ... Pre-edit answer: [not applicable] ... Post-edit answer: 3- Not healing...."</p> <p>Review of a document dated 7/7/2021, titled "PT Subsequent Visit" evidenced the visit was completed from 5:53 PM - 6:37 PM, and stated "...</p>		<p>time the assessment was completed and resubmit the corrected OASIS to CMS.</p> <ul style="list-style-type: none"> Record cited during the survey will be brought into compliance by August 6, 2021. <p>Person Responsible: Administrator</p> <p>Date of Completion: August 13, 2021</p> <p>Compliance:</p> <ul style="list-style-type: none"> Beginning August 9, 2021, 100% of admissions, resumptions of care, and recertifications will be audited weekly to ensure compliance with this standard. Audits will be continued until 95% compliance is met for 2 weeks. Once met, weekly audits will continue at 50% of the admissions, resumptions of care, and recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0546 Bldg. 00	<p>Integumentary assessment findings ... no problems identified ... patient concerned about open area on anterior [front] side of stump ... speculation [of] shear [injury created by friction] between silicone [sic] and skin upon prosthesis [artificial limb] wearing ... reports no pain" The wound was identified after the addendum was made to the OASIS item set, was identified as an injury created by friction, not a surgical wound, and failed to evidence it was not healing.</p> <p>During an interview on 7/15/2021 9:40 AM, the administrator indicated addendums to the assessments (including OASIS items) were made with approval of the assessing clinician, clinicians had 5 days to complete recertification assessments, she would argue there might be at least some shortness of breath since the patient used oxygen at night, and agreed an assessment of the wound was not completed until after addendums were already made.</p> <p>484.55(d)(1)(i,ii,iii) Last 5 days of every 60 days unless: The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode.</p> <p>Based on record review and interview, the agency failed to ensure all clinicians completed the comprehensive re-assessment during the last 5 days of every 60 day certification episode for 1 of 3 clinical records reviewed (#3).</p> <p>Findings include:</p> <p>Review of a policy dated 4/2020 titled "Care Management and the Plan of Care" stated "...</p>	G 0546	<p>scheduled meetings.</p> <p>G 546 "Last 5 days of every 60 days unless" CFR(s) 484.55(d)(1)(i,ii,iii) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due</p>	08/13/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(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
	<p>Recertification/Subsequent Episode ... Ensure the Re-cert OASIS assessment is completed during a visit on the 56th to the 60th day of the current episode", The document evidenced the recertification visit note, orders, and a summary of clinical findings for the past plan of care episode must be submitted within 24-48 hours of the actual visit made, and the documentation must be completed and submitted to the agency by the end of day 60.</p> <p>Review of a web-based reference site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D-Guidance-Manual-final.pdf, titled "OASIS-D Guidance Manual ... Effective 1/1/2019 ... Centers for Medicare & Medicaid Services" stated "... For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient ... [comprehensive re-assessment] and other follow-up ... the assessments must be completed on, or within 48 hours ... Follow-Up (FU): This information is collected at Recertification and Other Follow-up ... M0090 ... Date assessment completed should reflect the last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including the OASIS items"</p> <p>Review of a web-based reference site: http://www.fazzi.com/tl_files/pages/oasis/Appendix%20A-G.pdf, titled "APPENDIX A - OASIS AND THE COMPREHENSIVE ASSESSMENT" stated "... Follow-up assessments must be completed every 60 days that a patient is under care ... For Medicare and Medicaid patients, when a follow-up assessment is due, it must be completed no earlier than four calendar days before, and no later than the day marking the end</p>		<p>to a major decline or improvement in the patient's health status, but not less frequently than--</p> <p>484.55(d)(1) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a--</p> <p>484.55(d)(1)(i) Beneficiary elected transfer;</p> <p>484.55(d)(1)(ii) Significant change in condition; or</p> <p>484.55(d)(1)(iii) Discharge and return to the same HHA during the 60-day episode.</p> <p>Plan:</p> <ul style="list-style-type: none"> -All professional, clinical staff (Registered Nurses, Physical Therapists, Occupational Therapists and Speech Therapists) will be provided with education regarding required timeframes for data collection and completion of OASIS assessments. -Education will be provided by agency Administrator or designee by August 13, 2021 -Education will be provided through mandatory in-service training and attendance will be tracked with sign-in sheets. Individual meetings will be provided for any clinicians unable to participate in the in-service training session(s). -The Clinical Manager or designee will review all active patient records to ensure OASIS assessments are accurate and 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(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
	<p>of the 60-day period (i.e., day 56 through day 60 of the period)"</p> <p>Record review for patient #3 was completed on 7/15/2021, start of care date 3/9/2021, re-certification period 7/7/2021 - 9/4/2021, and failed to evidence the comprehensive re-assessment was completed during the last 5 days of the certification episode (7/2/2021 - 7/6/2021).</p> <p>Review of a document titled "PT [physical therapy] Recert with Skill" stated "... (M0090) Date assessment completed: 7/2/2021. The document evidenced it was last modified on 7/7/2021 at 8:56 AM, by RN [registered nurse] J. The completion date was 7/7/2021, not 7/2/2021, which was the last date the assessing clinician received any input used to complete the comprehensive assessment, including the OASIS items.</p> <p>During an interview on 7/15/2021 9:40 AM, the administrator indicated addendums to the comprehensive re-assessments (including OASIS items) were made with approval of the assessing clinician, and clinicians had 5 days to complete recertification assessments.</p> <p>17-14-1(a)(1)(B)</p>		<p>OASIS date reflect the patient's health status during the time the assessment was completed.</p> <p>Specific action taken for clinical record #3:</p> <ul style="list-style-type: none"> Assessing clinician will be provided with individual education by Administrator or designee by August 27, 2021 on required timeframes for data collection and completion of OASIS assessments. Record cited during the survey will be brought into compliance by August 6, 2021. <p>Person Responsible: Administrator</p> <p>Date of Completion: August 13, 2021</p> <p>Compliance:</p> <ul style="list-style-type: none"> Beginning August 9, 2021, 100% of recertifications will be audited weekly to ensure compliance with this standard. Audits will be continued until 95% compliance is met for 2 weeks. Once met, weekly audits will continue at 50% of the recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(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 0592 Bldg. 00	<p>484.60(c)(2) Revised plan of care</p> <p>A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.</p> <p>Based on record review and interview, the agency failed to ensure all revised plans of care included a summary of the patients' progress toward measurable outcomes and goals for 2 of 2 clinical records reviewed with services that were provided for greater than 60 days (#1, 3).</p> <p>Findings include:</p> <p>1. Review of a policy dated 4/2020 titled "Care Management and the Plan of Care" stated "... During visits and other patient contacts, the clinician regularly reevaluates the [patient's] medical condition ... the achievement or lack of achievement of goals and outcomes ... A summary of care (clinical findings) provided by all disciplines is included with each 60-day plan of care for physician review ... Any revisions to the plan of care reflect current information ... and the patient progress toward goals and measurable outcome...."</p>	G 0592	<p>audits will resume quarterly as part of the quarterly record review.</p> <ul style="list-style-type: none"> These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings. <p>G 592 Revised Plan of Care CFR(s) 484.60(c)(2) Standard: A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.</p> <p>Plan:</p> <ul style="list-style-type: none"> All professional, clinical staff (Registered Nurses, Physical Therapists, Occupational Therapists and Speech Therapists) will be provided with education regarding appropriate revision and required content of the home health plan of care. Education will be provided 	08/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(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	
	<p>2. Record review for patient #1 was completed on 7/15/2021, start of care date 5/5/2019, for re-certification period 6/23/2021 - 8/21/2021, which evidenced a document titled "Home Health Certification and Plan of Care" and failed to evidence a summary of the patients' progress toward measurable outcomes and goals for the previous 60 day certification period.</p> <p>3. Record review for patient #3 was completed on 7/15/2021, start of care date 3/9/2021, for re-certification period 7/7/2021 - 9/4/2021, which evidenced a document titled "Home Health Certification and Plan of Care" and failed to evidence a summary of the patients' progress toward measurable outcomes and goals for the previous 60 day certification period.</p> <p>4. During an interview on 7/15/2021 9:40 AM, when queried if a summary of the patients' progress toward measurable outcomes and goals for the previous certification period should be included on recertification plans of care, the administrator indicated she wasn't sure if it was required.</p>		<p>by agency Administrator or designee by August 13, 2021</p> <ul style="list-style-type: none"> ·Education will be provided through mandatory in-service training and attendance will be tracked with sign-in sheets. Individual meetings will be provided for any clinicians unable to participate in the in-service training session(s). ·The Clinical Manager or designee will review all active patient records to ensure plans of care are revised at all appropriate timepoints and are both accurate and reflective of the patient's current status at the time of revision. <p>·Specific action taken for clinical record #1:</p> <ul style="list-style-type: none"> ·Assessing clinician will be provided with individual education by Administrator or designee by August 27, 2021 on appropriate revision and content of the plan of care. ·Agency will enter addendum to the plan of care to provide missing information related to patient's current status (at time plan of care was written). ·Record cited during the survey will be brought into compliance by August 6, 2021. <p>·Specific action taken for clinical record #3:</p> <ul style="list-style-type: none"> ·Assessing clinician will be provided with individual education by Administrator or designee by August 27, 2021 on appropriate 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			<p>revision and content of the plan of care.</p> <ul style="list-style-type: none"> -Agency will enter addendum to the plan of care to provide missing information related to patient's current status (at time plan of care was written). -Record cited during the survey will be brought into compliance by August 6, 2021. <p>Person Responsible: Administrator Date of Completion: August 13, 2021</p> <p>Compliance:</p> <ul style="list-style-type: none"> -Beginning August 9, 2021, 100% of the plans of care developed in conjunction with resumptions of care, recertifications and significant change in condition assessments will be audited weekly to ensure compliance with this standard. Audits will be continued until 95% compliance is met for 2 weeks. -Once met, weekly audits will continue at 50% of the plans of care developed in conjunction with resumptions of care, recertifications and significant change in condition assessments for 3 months or until 95% compliance is reached for 4 consecutive weeks. -Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. -If compliance falls below 90%, 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(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
N 0000 Bldg. 00	<p>This visit was a State re-licensure revisit of a deemed home health agency.</p> <p>Facility ID: IN005248</p> <p>Provider # 157005</p> <p>Dates of Survey: 7/14, 7/15/2021</p> <p>Current Census: 207</p> <p>Unduplicated census: 1932</p> <p>Sample Selection: Record review for 3 active patients with 1 home visit, and focused record reviews for 2 discharged patients who required 15 days' notice of discharge.</p> <p>Refer to Federal Form for additional State Findings.</p>	N 0000	<p>staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review.</p> <p>·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings.</p>	
N 0541 Bldg. 00	<p>410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
	<p>services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.</p> <p>Based on record review and interview, the agency failed to ensure all clinicians regularly reevaluated the patient's nursing needs for 1 of 3 clinical records reviewed (#3).</p> <p>Findings include:</p> <p>Review of a policy dated 4/2020 titled "Care Management and the Plan of Care" stated "... Recertification/Subsequent Episode ... Ensure the Re-cert OASIS assessment is completed during a visit on the 56th to the 60th day of the current episode", The document evidenced the recertification visit note, orders, and a summary of clinical findings for the past plan of care episode must be submitted within 24-48 hours of the actual visit made, and the documentation must be completed and submitted to the agency by the end of day 60.</p> <p>Review of a web-based reference site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D-Guidance-Manual-final.pdf, titled "OASIS-D Guidance Manual ... Effective 1/1/2019 ... Centers for Medicare & Medicaid Services" stated "... For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient ... [comprehensive re-assessment] and other follow-up ... the assessments must be completed on, or within 48 hours ... Follow-Up (FU): This information is collected at Recertification and Other Follow-up ... M0090 ...</p>	N 0541	<p>N0541/G 546 "Last 5 days of every 60 days unless" CFR(s) 484.55(d)(1)(i,ii,iii) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than-- 484.55(d)(1) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a-- 484.55(d)(1)(i) Beneficiary elected transfer; 484.55(d)(1)(ii) Significant change in condition; or 484.55(d)(1)(iii) Discharge and return to the same HHA during the 60-day episode. Plan: -All professional, clinical staff (Registered Nurses, Physical Therapists, Occupational Therapists and Speech Therapists) will be provided with education regarding required timeframes for data collection and completion of OASIS</p>	08/13/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(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	
	<p>Date assessment completed should reflect the last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including the OASIS items"</p> <p>Review of a web-based reference site: http://www.fazzi.com/tl_files/pages/oasis/Appendix%20A-G.pdf, titled "APPENDIX A - OASIS AND THE COMPREHENSIVE ASSESSMENT" stated "... Follow-up assessments must be completed every 60 days that a patient is under care ... For Medicare and Medicaid patients, when a follow-up assessment is due, it must be completed no earlier than four calendar days before, and no later than the day marking the end of the 60-day period (i.e., day 56 through day 60 of the period)"</p> <p>Record review for patient #3 was completed on 7/15/2021, start of care date 3/9/2021, re-certification period 7/7/2021 - 9/4/2021, and failed to evidence the comprehensive re-assessment was completed during the last 5 days of the certification episode (7/2/2021 - 7/6/2021).</p> <p>Review of a document titled "PT [physical therapy] Recert with Skill" stated "... (M0090) Date assessment completed: 7/2/2021. The document evidenced it was last modified on 7/7/2021 at 8:56 AM, by RN [registered nurse] J. The completion date was 7/7/2021, not 7/2/2021, which was the last date the assessing clinician received any input used to complete the comprehensive assessment, including the OASIS items.</p> <p>During an interview on 7/15/2021 9:40 AM, the administrator indicated addendums to the comprehensive re-assessments (including OASIS items) were made with approval of the assessing</p>		<p>assessments.</p> <ul style="list-style-type: none"> ·Education will be provided by agency Administrator or designee by August 13, 2021 ·Education will be provided through mandatory in-service training and attendance will be tracked with sign-in sheets. Individual meetings will be provided for any clinicians unable to participate in the in-service training session(s). ·The Clinical Manager or designee will review all active patient records to ensure OASIS assessments are accurate and OASIS date reflect the patient's health status during the time the assessment was completed. <p>·Specific action taken for clinical record #3:</p> <ul style="list-style-type: none"> ·Assessing clinician will be provided with individual education by Administrator or designee by August 27, 2021 on required timeframes for data collection and completion of OASIS assessments. ·Record cited during the survey will be brought into compliance by August 6, 2021. <p>Person Responsible: Administrator Date of Completion: August 13, 2021 Compliance:</p> <ul style="list-style-type: none"> ·Beginning August 9, 2021, 100% of recertifications will be audited weekly to ensure compliance with this standard. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(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	
N 0542 Bldg. 00	<p>clinician, and clinicians had 5 days to complete recertification assessments.</p> <p>410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.</p> <p>Based on record review and interview, the agency failed to ensure all revised plans of care included a summary of the patients' progress toward measurable outcomes and goals for 2 of 2 clinical records reviewed with services that were provided</p>	N 0542	<p>Audits will be continued until 95% compliance is met for 2 weeks.</p> <ul style="list-style-type: none"> ·Once met, weekly audits will continue at 50% of the recertifications for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings. <p>N0542/G 592 Revised Plan of Care CFR(s) 484.60(c)(2) Standard: A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and</p>	08/13/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/15/2021
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE			STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545		
(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	
	<p>for greater than 60 days (#1, 3).</p> <p>Findings include:</p> <p>1. Review of a policy dated 4/2020 titled "Care Management and the Plan of Care" stated "... During visits and other patient contacts, the clinician regularly reevaluates the [patient's] medical condition ... the achievement or lack of achievement of goals and outcomes ... A summary of care (clinical findings) provided by all disciplines is included with each 60-day plan of care for physician review ... Any revisions to the plan of care reflect current information ... and the patient progress toward goals and measurable outcome...."</p> <p>2. Record review for patient #1 was completed on 7/15/2021, start of care date 5/5/2019, for re-certification period 6/23/2021 - 8/21/2021, which evidenced a document titled "Home Health Certification and Plan of Care" and failed to evidence a summary of the patients' progress toward measurable outcomes and goals for the previous 60 day certification period.</p> <p>3. Record review for patient #3 was completed on 7/15/2021, start of care date 3/9/2021, for re-certification period 7/7/2021 - 9/4/2021, which evidenced a document titled "Home Health Certification and Plan of Care" and failed to evidence a summary of the patients' progress toward measurable outcomes and goals for the previous 60 day certification period.</p> <p>4. During an interview on 7/15/2021 9:40 AM, when queried if a summary of the patients' progress toward measurable outcomes and goals for the previous certification period should be included on recertification plans of care, the</p>		<p>contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.</p> <p>Plan:</p> <ul style="list-style-type: none"> -All professional, clinical staff (Registered Nurses, Physical Therapists, Occupational Therapists and Speech Therapists) will be provided with education regarding appropriate revision and required content of the home health plan of care. -Education will be provided by agency Administrator or designee by August 13, 2021 -Education will be provided through mandatory in-service training and attendance will be tracked with sign-in sheets. Individual meetings will be provided for any clinicians unable to participate in the in-service training session(s). -The Clinical Manager or designee will review all active patient records to ensure plans of care are revised at all appropriate timepoints and are both accurate and reflective of the patient's current status at the time of revision. -Specific action taken for clinical record #1: -Assessing clinician will be provided with individual education by Administrator or designee by August 27, 2021 on appropriate 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(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
	administrator indicated she wasn't sure if it was required.		<p>revision and content of the plan of care.</p> <ul style="list-style-type: none"> ·Agency will enter addendum to the plan of care to provide missing information related to patient's current status (at time plan of care was written). ·Record cited during the survey will be brought into compliance by August 6, 2021. <p>·Specific action taken for clinical record #3:</p> <ul style="list-style-type: none"> ·Assessing clinician will be provided with individual education by Administrator or designee by August 27, 2021 on appropriate revision and content of the plan of care. ·Agency will enter addendum to the plan of care to provide missing information related to patient's current status (at time plan of care was written). ·Record cited during the survey will be brought into compliance by August 6, 2021. <p>Person Responsible: Administrator Date of Completion: August 13, 2021</p> <p>Compliance:</p> <ul style="list-style-type: none"> ·Beginning August 9, 2021, 100% of the plans of care developed in conjunction with resumptions of care, recertifications and significant change in condition assessments will be audited weekly to ensure compliance with this standard. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH VNA HOME CARE	STREET ADDRESS, CITY, STATE, ZIP COD 3838 N MAIN STREET, SUITE 100 MISHAWAKA, IN 46545
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
N 9999 Bldg. 00		N 9999	<p>Audits will be continued until 95% compliance is met for 2 weeks.</p> <ul style="list-style-type: none"> ·Once met, weekly audits will continue at 50% of the plans of care developed in conjunction with resumptions of care, recertifications and significant change in condition assessments for 3 months or until 95% compliance is reached for 4 consecutive weeks. ·Once the threshold is met, review of this standard will continue with a quarterly record review of 20% of patient records. ·If compliance falls below 90%, staff will be re-educated, weekly audits will continue at 50% until compliance is maintained at 95% for 4 consecutive weeks then audits will resume quarterly as part of the quarterly record review. ·These findings will be reviewed by the clinical team monthly and quarterly to the Quality Committee, Administrator and Governing Body during regularly scheduled meetings. 	08/13/2021