STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HOME CARE PLUS	**1275 N JACKSON STREET , GREENCASTLE, Indiana, 46135**

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G0000	INITIAL COMMENTS This visit was for a Federal Recertification Survey of a Home Health Provider. A fully extended survey was announced on 03/15/2021 at 12:00 PM. Survey dates: 3/8/2021 to 3/22/2021 Facility ID: IN005304 Provider #: 157113 Medicaid #: 100263820A Census: 110 An Immediate Jeopardy was identified on 3/15/2021 at 9:45 AM. The Immediate Jeopardy began on 3/15/2021, when it was identified that the agency failed to appropriately screen surveyors for COVID 19 upon entry from 3/08/21 to 3/12/21 and for home visits, the clinicians failed to screen patients. The Administrator confirmed that they had no formal tracking or contact tracing in place and infection control policies had not been updated to include screening, education, staffing, and respiratory precautions in relation to COVID 19. These deficient practices have the potential to affect all 110 patients who are receiving services from this agency. The Administrator was notified of the Immediate Jeopardy on 3/15/2021 at 12:00 PM. The agency submitted a removal plan for the Infection Control on 3/17/2021, in which the removal plan was found to be unacceptable. The agency resubmitted removal plans x2 on 3/19/21. The Immediate Jeopardy was not abated by the end	G0000		

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	TITLE	(X6) DATE

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G0000	Continued from page 1 of the exit conference on 03/22/2021 4:15 PM. Indiana Home Care Plus is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning March 22, 2021 to March 21, 2023 for being found out of compliance with the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment; 484.60 Care Planning, coordination, quality of care; 484.65 Quality Assessment Performance Improvement; 484.70 Infection Prevention and Control; 484.80 Home Health Aide services; 484.105 Organization and administrative of services; and 484.110 Clinical Records. These deficiencies reflects State Findings cited in accordance with 410 IAC 17. See the State Form for State only deficiency. Quality Review Completed on 03/25/2021 for the IJ findings by Area 3 Quality Review Completed on 4/22/2021 for the remaining deficiencies by Area 3 IDR Committee met on 09/14/2021. Tags G0750, G0798, G0800, G0802 modified. Tag G1008 deleted.	G0000		
G0374	Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all Outcome and Assessment Information Set (OASIS) questions were answered accurately in 5 out 7 records reviewed. (#3, 5, 12, 19, 22) Findings Include: 1. Review of an agency policy dated May 2003 titled, "Administration/Operations OASIS Data	G0374		

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G0374	Continued from page 2 Collection" stated, "3.0 Policy/Procedure 3.1.1 OASIS data are collected on all Medicare and Medicaid patients receiving skilled nursing or therapy services except for those ...3.2 The agency incorporates OASIS, agency-specific, discipline-specific data elements into assessment tools for 3.2.1 Start of care. 3.2.2 Resumption of care. 3.3.3 Follow-up for recertification and major change in health status ..." 2. The clinical record of patient #3 was reviewed on 3/11/21 and indicated a start of care date of 2/22/21. The record contained a plan of care for certification period 2/22/21 to 4/22/21. The comprehensive initial assessment failed to ensure all OASIS data was accurately submitted. Review of an initial comprehensive assessment dated 2/22/21, indicated, on OASIS question M2001 "Drug regimen Review 0-No issues found during review." Review of patient #3 medications on Drugs.com interactions indicate, 3 major drug interactions with Bupropion and Donepezil, Tramadol and Donepezil, and Itraconazole and Fluticasone Nasal. 3. The clinical record of patient #5 was reviewed on 3/15/21 and indicated a start of care date of 9/18/29. The record contained a plan of care for the certification period of 9/18/20 to 11/16/20. The comprehensive initial assessment failed to ensure all OASIS data was accurately submitted. Review of an initial comprehensive assessment dated 9/18/20 indicated, on OASIS questions M2001 "Drug regimen Review 0-No issues found during review, M2030 Management of Injectable Medications NA-No injectable medications prescribed." Review of a plan of care for the certification period 9/18/20 to 11/16/20 indicates, "Medication ... Betaseron 0.3mg subcutaneous solution take 250 mcg by subcutaneous route every 2 days..." Review of patient #5 medications on Drugs.com interactions indicate, 8 major drug interactions,	G0374		

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G0374	Continued from page 3 Atorvastatin and Aubagio, Tizanidine and Aubagio, Bupropion and Betaseron, Betaseron and Aubagio, Bupropion and Aubagio, Amlodipine and Tizanidine, Naprosyn and Aubagio, and Losartan and Tizanidine. 4. The clinical record of patient #12 was reviewed 3/18/21 and indicated a start of are date 5/5/20. The record contained a plan of care for a recertification period of 12/31/20 to 2/28/21. The comprehensive assessment failed to ensure all OASIS data was accurately submitted. Review of the comprehensive assessment dated 2/24/21 indicated, on OASIS question M2030 "Management of injectable Medications NA-No injectable medications prescribed." Review of a plan of care for a recertification period of 12/31/20 to 2/28/21 indicates, "Medication ...Liraglutide 0.6mg/o.1ml (18mg/3ml) subcutaneous inject 1.8mg by subcutaneous route everyday Reason: type 2 diabetes mellitus ..." 5. The clinical record of patient #19 was reviewed on 3/18/21 and indicated a start of care date 1/28/21. The record contained a plan of care for an initial certification period of 1/2821 to 3/28/21. The initial comprehensive assessment failed to ensure all OASIS data was accurately submitted. Review of the initial comprehensive assessment dated 1/28/21 indicated, on OASIS question M2001 "Drug Regimen Review 0-No issues found during review." Review of patient #19 medications on Drugs.com interactions indicate, 16 moderate interactions, Aspirin and Prednisone, Senna and MiraLAX, Prednisone and MiraLAX, Carvedilol and Novolog, Prednisone and Novolog, Aspirin and Novolog, Carvedilol and Lantus, Prednisone and Lantus, Aspirin and Lantus, Multivitamin and Sevelamer, Cholecalciferol and Sevelamer, Omeprazole and Atorvastatin, Carvedilol and Midodrine, Prednisone and Carvedilol, Prednisone and Lactobacillus, and Prednisone and Senna.	G0374		

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G0374	Continued from page 4 6. The clinical record of patient #22 was reviewed 3/17/21 and indicated a start of are date 7/12/18. The record contained a plan of care for a recertification period of 12/28/20 to 2/25/21. The comprehensive assessment failed to ensure all OASIS data was accurately submitted. Review of the comprehensive assessment dated 2/25/21 indicated, on OASIS question M1033 "Currently taking 5 or more medications 7-Currently taking 5 or more medications." Review of a plan of care for a recertification period of 12/28/20 to 2/25/21indicates, "Medications: lisinopril 2.5 mg tablet take 1 tablet (2.5mg) by oral route Everyday Reason: hypertension metoprolol succinate ER 100mg tablet, extended rel take 1 tablet (100mg) by oral route Everyday Reason: hypertension." 7. During an interview with the administrator and alternate clinical director on 3/12/21 at 4:10 PM, when quired about review of comprehensive assessment, notes and plan of care accuracy review, stated, "The nurses audit each other's charts." When asked for reviews or audit tools nothing was provided. 8. During an interview on 3/22/21 at 3:25, the administrator was made aware and stated, "I have nothing to say."	G0374		
G0434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care;	G0434		

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G0434	Continued from page 5 (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure patients were informed of changes in care to be furnished in relation to being discharged for 3 out of 3 interviews conducted. (Patients #25, 29, 30) Findings include: 1. Review of the agency's undated policy titled "Transfer/ Discharge From Services" indicated " ... 3.0 Policy/ Procedure. 3.1 The agency plans and prepares for the patient's discharge. ... 3.1.2 The patient participates in planning the discharge or transfer. The agency notifies the patient about 3.1.2.1 Changes in the plan as they affect the discharge plans. ... 3.1.3 Staff educates the patient and family in self care, management of medical and health needs, use of community resources and other appropriate information. .... " 2. On 3/22/21 at 1:49 PM, patient #29, a VA patient with unsigned orders, was called and queried concerning their discharge. Patient #29 stated he was unaware he had been discharged and had received no call from the agency stating such. 3. On 3/22/21 at 2 PM, patient #30, a VA patient with unsigned orders, was queried concerning discharge. Patient #30 denied knowing he was discharged but stated his nurse called him and told him she was not coming today because she had somewhere else to go, however his aide had called as well and stated she could not come because he was discharged. Patient #30 stated he did not know what she meant because no one told him he was discharged.	G0434		

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G0434	Continued from page 6 4. On 3/22/21 at 2:10 PM, patient #25 was called and queried concerning discharge. Patient #25 stated she was unaware she had been discharged and had not received a call from the agency stating such. 5. On 3/22/21 at 3:30 PM, during an interview, the administrator was queried whether all patients with outstanding orders had been notified of their discharge. The administrator stated she had notified all patients who required discharge. When queried why patients #29, #30, and #25 were unaware they were discharged, the administrator remained silent and did not provide an explanation.	G0434		
G0480	Treatment or care CFR(s): 484.50(e)(1)(i)(A) (i)(A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure they documented their efforts in describing how complaints were investigated, ensuring no other patients are being affected by the lack of care being provided by staff members for 3 out of 8 complaints reviewed about the lack of care being provided. (Patients #7, 37, 72) Findings include: 1. A review of an agency policy titled "Patient Complaints and Grievances", dated May 2003, revealed "3.1.2 ... the agency must investigate a complaint and document the complaint and resolution; ... 3.2 The agency investigates and attempts to resolve all complaints; 3.2.1 Established procedures describe how the agency receives, records, investigates and resolves complaints; 3.2.2 The administrator and/or registered nurse monitor complaint investigation; 3.2.3 The Administrator is ultimately accountable for receiving and resolving complaints which cannot be resolved at the staff level; 3.2.4 If	G0480		

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G0480	Continued from page 7 resolution was not possible, the agency documents its actions and outcomes; 3.2.5 The agency implements necessary actions to correct the situation and/or prevent recurrence of problems." 2. A review of a "Grievance Report" for patient #7, date reported 1/2/21, revealed a "Nature of Grievance" entry which evidenced "Patient [name of patient #7] was not on the schedule for the holiday 1/1/2021. [Name of employee F, home health aide] sees the patient that day." An undated, untimed, unsigned "Disposition of Grievance" entry revealed "Had order/auth. (authorization). Pt (Patient) requires a shower." The grievance failed to evidence an investigation was completed to determine the nature of the complaint, including whether the complainant was alleging the patient received no services, received partial care, or why the patient was not on the schedule. On 3/18/21 at 3 PM the administrator was queried as to whether there was additional information for the complaint log and whether the information could be found in the clinical record. The administrator stated there was no additional information and the agency documents all complaint information in the complaint log, not the clinical record. 3. A review of a "Grievance Report" for patient #37, reported on 2/9/21, revealed a "Nature of Grievance" entry which evidenced "See attached. [Remainder of the description was illegible."]" No attachment was available. Review of "Disposition of Grievance" entry revealed "3/2/21 Resolved. Now very happy with services. I realized this was a delivery issue." The document failed to evidence the nature of the grievance or that an investigation was conducted. 4. A review of a "Grievance Report" for patient #72, reported on 1/20/21, revealed a "Nature of Grievance" entry which evidenced "Patient called into the office, stated they do not call before aide shows up. Aide only stayed 45 min (had a very packed day) should have stayed 2hr. No bath given, also stated [Name of alternate clinical manager] threatened to take nurse away if he didn't straighten up HHA (home health aide) 'the office overloaded me and I don't have time to stay' and the registered nurse told him to 'straighten up and quit complaining or I'll take your nurse	G0480		

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G0480	Continued from page 8 away.'" The "Disposition of Grievance" entry revealed "[Name of administrator] called patient and resolved issues with the patient." The document failed to evidence the complaint was investigated, including care and service received and whether the patient was threatened with removal of services. 5. On 3/8/21 at 10:18 AM, during an interview, the alternate clinical manager was queried concerning the agency process for managing complaints, incidents, or grievances. The alternate clinical manager stated the agency tracked complaints, grievances, and incidences together in the same log. When asked who oversaw handling complaints, the alternate clinical manager stated, "both of us". When queried further, the alternate clinical manager stated complaints were managed by herself and the administrator, with the administrator ultimately responsible for ensuring investigation and resolution of all complaints. She stated complaints were documented on a paper grievance form that included a "description of the complaint, who was involved, and the resolution.". At 10:18 AM the surveyor requested to view the complaint/incident/grievance log for January 1, 2020-present. The alternate clinical manager stated she would go get the log but failed to return with the complaint log. 6. On 3/18/21 at 3 PM the administrator was queried as to whether there was additional information for the complaint log and whether the information could be found in the clinical record. The administrator stated there was no additional information and the agency documents all complaint information in the complaint log, not the clinical record. When queried on the complaint log and the agency's process for managing complaints and grievances, the administrator stated they keep the information in a binder and all complaints are investigated. The administrator stated the agency was unable to locate the binder containing grievance documentation for the previous 12 months. 410 IAC 17-12-3(c)(1)(A)	G0480		
G0484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii)	G0484		

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G0484	Continued from page 9 (ii) Document both the existence of the complaint and the resolution of the complaint; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure they documented the resolution for all complaints 5 of 8 grievances reviewed about the lack of care being provided. (Patient's #7, 37, 72, 117, 120) Findings include: 1. A review of an agency policy titled "Patient Complaints and Grievances", dated May 2003, revealed "3.1.2 ... the agency must investigate a complaint and document the complaint and resolution; ... 3.2 The agency investigates and attempts to resolve all complaints; 3.2.1 Established procedures describe how the agency receives, records, investigates and resolves complaints; 3.2.2 The administrator and/or registered nurse monitor complaint investigation; 3.2.3 The Administrator is ultimately accountable for receiving and resolving complaints which cannot be resolved at the staff level; 3.2.4 If resolution was not possible, the agency documents its actions and outcomes; 3.2.5 The agency implements necessary actions to correct the situation and/or prevent recurrence of problems." The agency failed to evidence established procedures for investigation and resolution of complaints and failed to follow its policy "Patient Complaints and Grievances", including completion and documentation of an investigation and resolution of complaints and actions implemented to correct or prevent recurrence of the complaints, including follow-up with the patient, patient representative, and/or physician. 2. A review of a document titled "Grievance Report" for patient #7, date reported 1/2/21, revealed a "Nature of Grievance" entry which evidenced "Patient [name of patient #7] was not on the schedule for the holiday 1/1/2021. [Name of employee F, home health aide] sees the patient that day." A "Disposition of Grievance" entry evidenced "Had order/auth. (authorization). Pt (Patient) requires shower." The document failed to evidence any action or resolution, including	G0484		

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G0484	Continued from page 10 contact with the patient, confirmation of resolution, how it would be prevented in the future, and whether the patient and/or patient's physician was notified. 3. A review of a "Grievance Report" for patient #37, reported on 2/9/21, revealed a "Nature of Grievance" entry which evidenced "See attached. [Remainder of the description was illegible."]" No attachment was available. Review of the "Disposition of Grievance" entry evidenced "3/2/21 Resolved. Now very happy with services. I realized this was a delivery issue." The document failed to evidence any action or resolution, how it would be prevented in the future, and whether the patient's physician was notified. 4. A review of a "Grievance Report" for patient #72, reported on 1/20/21, revealed a "Nature of Grievance" entry which evidenced "Patient called into the office, stated they do not call before aide shows up. Aide only stayed 45 min (had a very packed day) should have stayed 2hr. No bath given, also stated [Name of employee B] threatened to take nurse away if he didn't straighten up HHA (home health aide) 'the office overloaded me and I don't have time to stay' and the registered nurse told him to 'straighten up and quit complaining or I'll take your nurse away.'" Review of the "Disposition of Grievance" entry evidenced "[Name of Administrator] called patient and resolved issues with patient." The document failed to evidence any action or resolution to ensure services would be provided as ordered and not cut due to lack of staffing, failed to evidence any action or counseling with the alternate clinical manager in regards to retaliation and possible verbal abuse, and whether the patient's physician was notified. 5. Review of a "Grievance Report" for patient #117, reported 2/24/20, revealed a "Nature of Grievance" entry which evidenced "[Name of patient #117] request [sic] to cancel HHA (Home Health Agency or home health aide) Services due to HHA (home health aide) accidentally [sic] letting his dog outside. States he doesn't want or need services at this time." Review of the "Disposition of Grievance entry evidenced "Notified MD of pt requesting to cx [sic. cancel] HHA services." A follow-up entry revealed "Called pt to discuss	G0484		

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G0484	Continued from page 11 concern. [Illegible] desire to cx [sic. cancel] services. The report evidenced a resolution date of 2/26/20. The document failed to evidence documentation showing how the complaint was resolved and the outcome of the physician notification. 6. Review of a "Grievance Report" for patient #120, reported 11/23/20, revealed a "Nature of Grievance entry which evidenced "[Name of patient #120] called to complain about [name of employee L, home health aide] moving things around at her apartment. She states that things have to be left where they are due to her blindness." Review of the Disposition of Grievance" revealed "Spoke with [name of employee L] and reminded her of pts disability and asked that she put things where pt has them." A follow-up entry was illegible. The document failed to include evidence of a resolution, including notification to the patient that her items would not be moved. 7. On 3/18/21 at 3 PM the administrator was queried as to whether there was additional information for the complaint log and whether information could be found in the clinical record. The administrator stated there was no additional information and the agency documents all complaint information in the complaint log, not the clinical record. 410 IAC 17-12-3-(c)(2)	G0484		
G0510	Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This CONDITION is NOT MET as evidenced by:	G0510		

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G0510	Continued from page 12 Based on record review and interview the agency failed to evidence the comprehensive assessments were complete and accurately reflected the patient's status, including current health, psychosocial, functional, and cognitive status to ensure the patients needs are being met (See G528); failed to ensure comprehensive assessments contained patient goals, strengths, and care preferences (See G530); and failed to ensure the medication list included indications for all PRN/ as needed medications and failed to evidence the location of application of topical medications was correct (See G536). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of health care for all 110 patients who are receiving services from this provider.	G0510		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to evidence the comprehensive assessments were complete and accurately reflected the patient's status, including current health, psychosocial, functional, and cognitive status to ensure the patients needs are being met in 6 of 9 complete records reviewed. (#1, 3, 5, 6, 12, 19) Findings Include: 1. Review of an agency policy titled, "Service Delivery Scope of Services" dated April 2004, revealed the following: "1.0 Purposes ... The registered nurse 3.4.1 Makes the initial evaluation and assessment visit and complete the comprehensive assessment except in those circumstances where the physician ordered only therapy services. 3.4.2 Regularly reevaluates the patient's nursing needs and updates the comprehensive assessment ... 3.4.5 Initiates appropriate preventive and rehabilitative skilled nursing procedures. ... 3.4.14 Follows the nursing	G0528		

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G0528	Continued from page 13 process in identifying nursing-prescribed actions such as assessment and teaching ..." 2. During a home visit on 3/9/21 from 2:15 PM to 3:05 PM, patient #1 was observed completing a nebulizer treatment upon arrival. The patient was observed to have a nasal cannula in her nose with oxygen infusing. The alternate clinical manager was observed obtaining the patient's blood pressure while the patient was sitting up in bed, oxygen saturation, but failed to obtain a temperature. During this time, the patient reported to the Alternate Clinical Manager that she had burning upon urination. The patient appeared to be emaciated and underweight. The alternate clinical manager failed to obtain further information from the patient such as when did the burning start, if the patient has been running a temperature, odor, and if there was an increased frequency and urgency. During this visit, the alternate clinical manager was observed completing the medication set up but failed to reference a medication list during this time. The alternate clinical manager asked the patient if she was eating in which the patient responded that she had eggs in the morning. No other questions were asked about the patient's diet. The alternate clinical manager failed to check the patient's feet for bilateral pedal pulses, failed to assess capillary refill, failed to complete the fall risk time up and go the assessment, failed to take a blood pressure while standing and lying for orthostatic changes, failed to assess the fall risk gait and balance for gait deviation, failed to appropriately assess the patient's diet and weight, and failed to assess the patient lungs posteriorly. Per the medication list, the patient is prescribed and taking fentanyl for the chronic pain due to scoliosis. The alternate clinical manager failed to complete a pain assessment using the pain scale of 1 to 10 (1 being no pain and 10 being excruciating pain) or if the medication was effective. No education was provided during this visit. The only documentation left in the home was the home health aide care plan, which was not reviewed with the patient. A review of a recertification comprehensive assessment that was completed by the alternate clinical manager from the observation visit dated 3/9/21, revealed the patient had burning upon urination by conditions affecting genitourinary	G0528		

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G0528	Continued from page 14 status, the temperature was blank and no further documentation regarding follow up. The blood pressure assessment inaccurately indicated that a blood pressure was taken standing and lying by indicating "Fall Risk orthostatic changes: 0 - No noted drop in blood pressure between lying and standing. No changes in cardiac rate." Further review of the recertification assessment failed to give weight, oxygen liter flow rate amount, address pain medication management, and the effectiveness of pain medication or other alternatives for pain relief. The recertification assessment revealed, "Safety Measures teach proper/ safe use of medications..." no education was observed completed verbally or written during home visit. Recertification assessment indicated that the alternate clinical manager conducted the following which was inconsistent with the above observations: "Follow-Up Notes ...Instructions/ Materials..1 - Patient Bill of Rights - Discussed, Copy left in the home, 2 - State home health hotline number - Discussed, Copy left in the home, 3 - Verification of benefits-Discussed, Copy left in the home, 4 - Advance Directives-Discussed, Copy left in the home, 5 - Home care service agreement -Discussed, Copy left in home 6 - Home health visit schedule-Discussed, Copy left in the home,7-Home health agency phone numbers (Regular hours/ after-hours/ weekends/ holidays) - Discussed, Copy left in the home, 8 - Emergency medical response plan -Discussed, Copy left in the home, 9 - Fire/ Evacuation response plan-Discussed, Copy left in the home, Hospice care option - Discussed, Copy left in-home ... Materials given to Patient. .... " The alternate clinical manager failed to conduct a complete a thorough assessment and accurately document the education provided. A review of the recertification comprehensive assessment dated 1/17/21, indicated the alternate clinical manager visit was made from 3:30 PM to 3:45 PM. The diagnosis included: Pressure Ulcer of Right Upper Back, Stage 2, Methicillin-Resistant Staphylococcus Aureus Infection, Unspecified Site, Encounter for Change or Removal of Nonsurgical wound Dressing, Chronic Obstructive Pulmonary disease, unspecified, Dependence on Supplemental Oxygen, and Difficulty in Walking, Not Elsewhere Classified. The assessment revealed a Stage 2 pressure ulcer to the right upper back, which had slight, green, drainage. The vital sign assessment failed to evidence that a temperature was obtained	G0528		

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G0528	Continued from page 15 (the entry line was left blank). The skin assessment identified the patient as a high-risk score for skin breakdown/ impairment by identifying "Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contracture, or agitation leads to almost constant friction." The assessment revealed dyspnea (shortness of breath) with minimal exertion, oxygen-dependent, and chronic pain location back. The assessment failed to include details related to pain management and relief, failed to include education reflective to treating moderate to severe pain, and failed to ensure medication was taken accurately. The assessment failed to address oxygen flow rate left blank and oxygen saturation level left blank being monitored, and nebulizer treatments. The patient #1 assessment identified the patient was immunocompromised and is a nutritional risk. The assessment failed to evidence a height and weight, as they were left blank. The assessment failed to include safety, fall risk, emotional Psychosocial, and DME (durable medical equipment). The alternate clinical manager visit note indicated a 15-minute visit was, therefore, the alternate failed to conduct a thorough comprehensive assessment of the patient During an interview 3/9/21 at 2:55 PM, when queried regarding the frequency of one time weekly for wound care, the alternate clinical manager indicated that the spouse did the dressing changes and she would complete them once a week with the medication set-up. When queried about the home folder containing the agency information and state hotline, the alternate clinical director stated," They had to throw that away a while back when their water heater broke and flooded the back bedroom." 3. The clinical record of patient #3 was reviewed on 3/11/21 and contained an initial comprehensive assessment dated 2/22/21. Patient diagnosis included: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, History of Falling, Repeated Falls, and Presence of Cardiac Pacemaker. The assessment failed to evidence the patient's that the temperature was	G0528		

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G0528	Continued from page 16 taken (entry was blank) in the vital sign section. 4. The clinical record of patient #5 was reviewed on 3/15/21 and contained an initial comprehensive assessment dated 9/18/20 revealed diagnoses of Abscess of Bursa, Left Elbow, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Change or Removal of Nonsurgical Wound Dressing, Disorder of White Blood Cells, and Multiple Sclerosis. The assessment failed to evidence that the patient's temperature had been checked as part of a vital sign assessment, and failed to assess wounds on left elbow and right knee. 5. The clinical record of patient #6 was reviewed on 3/12/20 and contained an initial comprehensive assessment dated 8/15/20 which revealed patient diagnoses as "Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Therapeutic Drug Level Monitoring, Essential Hypertension, and Long Term Use of Insulin" A review of the initial comprehensive assessment failed to evidence the patient's temperature (left blank) as part of the vital sign assessment for a patient who is being treated for a septic infection. The assessment revealed patient is insulin-dependent but failed to evidence an assessment or documentation of the patient's blood sugars nor of a diabetic foot assessment. The RN documented the patient had a right chest tunneled catheter but failed evidence documentation of the appearance of the site, measurement of the catheter for purposes to ensure the catheter does not come loose or dislodged. 6. The clinical record of patient #12 was reviewed 3/18/21, and contained a medication list which revealed liraglutide 0.6mg/0.1ml (18mg/3ml) subcutaneous inject 1.8 g by subcutaneous route every day for Type 2 Diabetes Mellitus. A review of a recertification comprehensive assessment dated 2/24/21, indicated an RN visit was made from 3:55 PM to 4:15 PM. The patient's diagnoses included: Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without	G0528		

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G0528	Continued from page 17 Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. The endocrine system section was left blank and failed to evidence that an assessment, including a diabetic foot care assessment, had been completed. The assessment revealed the patient had a condition of the inability to leave home due to a seizure disorder, mental health impairment, unsteady gait, and safety. The Neurological and Muscular System was left blank and failed to evidence that an assessment had been completed. The assessment failed to address seizures and patient mood and medication effects being therapeutic. The assessment failed to evidence the patient's acceptable lab values ranges for effective drug monitoring. The assessment failed to include details related to pain management and relief, failed to include education reflective to treating moderate to severe pain, and failed to ensure medication was taken accurately. The Medication assessment section indicated "Not Applicable (NA) - No injectables medications prescribed" upon answering the question of "Management of injectable medications." 7. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns. The medication list revealed silver sulfadiazine 1% cream was being applied to the skin/ end of toes daily. The note indicated for home care services "Evaluate and Treat" and indicated the patient had a left below the knee amputation, required dialysis 3 to 4 times a week, and requires skilled nursing for medication management and monitoring of dialysis. A review of the initial comprehensive assessment dated 1/28/21 revealed the patient's diagnoses of Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. The assessment revealed the patient had chronic back pain but failed to evidence the details related to pain	G0528		

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G0528	Continued from page 18 management and relief, and failed to ensure medication was taken accurately. The assessment indicated a dialysis shunt in the left upper extremity (LUE). The assessment failed to give details on appearance, bruit/ thrill of shunt, coordination, and documentation details of dialysis facility and times. The assessment indicated the patient had diabetes, the endocrine system section was left blank and failed to evidence that an assessment, including a diabetic foot care assessment, had been completed. The assessment indicated the patient has intermittent confusion short, long-term memory varies throughout the day, and forgetful. The assessment further revealed the management of injectable medications as the patient was able to independently take the correct medications and proper dosage at correct times. The assessment failed to evidence a correct detail of the patient's functional capacity of giving insulin. The assessment inaccurately indicated the skin was intact with no open areas. During an interview on 3/17/21 at 11:35 AM, the caregiver of patient #19 indicated they go to the wound care clinic. When queried about what the case manager does for the client stated, "She sets up his meds, checks his blood pressure, and checks out any complaints he may have." During an interview on 3/19/2021 at 10:45 AM, employee B, alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I am not in there for wound care I am doing just med set up, so I don't monitor dialysis or wound care." The comprehensive assessment failed to evidence the patient received a complete and accurate assessment including the primary reason for home health admission, previous hospitalizations, the risk for hospitalization, endocrine/ hematology, integumentary, diabetic foot care/assessment, neurological/emotional, psychosocial, functional abilities/ limitations, urological, medication management and reconciliation, including the ability to take and set up medications properly, DME, therapy needs, education/ knowledge of patient and caregivers with demonstrations, care coordination of other agencies provided wound care and dialysis set up, secondary diagnosis, and	G0528		

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G0528	Continued from page 19 infection control. 8. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 9. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-14-1(a)(1)(B)	G0528		
G0530	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure comprehensive assessments contained patient goals, strengths, and care preferences for 7 of 7 active records reviewed. (1, 2, 3, 8, 12, 19, 22) Findings Include: 1. The clinical record of patient #1 was reviewed on 3/16/2021 and indicated a start of care of 5/21/19. The record contained a plan of care for a recertification period of 1/11/21 to 3/11/21. Patient diagnosis included: Pressure Ulcer of Right Upper Back, Stage 2, Methicillin Resistant Staphylococcus Aureus Infection, Unspecified Site, Encounter for Change or Removal of Nonsurgical wound Dressing, Chronic Obstructive Pulmonary disease, unspecified, Dependence on Supplemental Oxygen, Difficulty in Walking, Anemia in other Chronic Diseases, Cardiac Murmur, Atherosclerosis	G0530		

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G0530	Continued from page 20 of Aorta, Other Abnormalities of Breathing, Gastro-Esophageal Reflux Disease Without Esophagitis, Scoliosis (curvature of the spine) Unspecified. The recertification comprehensive assessment dated 1/7/21 failed to evidence patient strengths, goals, and care preferences. 2. The clinical record of patient #2 was reviewed 3/10/21 and indicated at start of care date of 8/19/19. The record contained a plan of care for a recertification period of 2/9/21 to 4/9/21. Patient diagnosis included: Need for Assistance with Personal Care, Difficulty Walking, Hypertensive Chronic Kidney Disease with Stage 2, Chronic Obstructive Pulmonary Disease, Unspecified Macular Degeneration (center vision loss), Gastro-Esophageal Reflux Disease without Esophagitis, and Hyperlipidemia. The recertification comprehensive assessment dated 2/4/21 failed to evidence patient strengths, goals, and care preferences. 3. The clinical record of patient #3 was reviewed on 3/11/21 and indicted a start of care of 2/22/21. The record contained a plan of for an initial certification period of 2/22/21 to 4/22/21. Patient diagnosis included: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, History of Falling, Repeated Falls, Presence of Cardiac Pacemaker, and Personal History of Malignant Neoplasm of Prostate. The initial comprehensive assessment dated 2/22/21 failed to evidence patient strengths, goals, and care preferences. 4. The clinical record of patient #8 was reviewed on 3/16/21 and indicated a start of care of 7/15/20. The record contained a plan of care for a recertification period of 1/11/21 to 3/11/2. Patient diagnosis included: Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease, or End Stage Renal	G0530		

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G0530	Continued from page 21 Disease, End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Unspecified, Car Passenger Injured in Non-collision Transport Accident in Non-traffic Accident, Subsequent Encounter, Multiple Fractures of Ribs, Right Side, Subsequent Encounter for Fracture with Routine Healing, Unspecified Laceration of Spleen, Subsequent Encounter, Critical Illness Myopathy, Difficulty Walking, Not Elsewhere Classified, Wegener's Granulomatosis (condition that causes inflammation of the blood vessels) with Renal involvement, Dependence on Renal Dialysis, Anemia in Chronic Kidney Disease, Old Myocardial Infarction (heart attack), Dependence on Supplemental Oxygen, Presence of Coronary Angioplasty Implant and Graft, Hypersensitivity Angiitis (purpuric lesions most often on the lower extremities and sometimes associated with multiple organ involvement), and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms. The recertification comprehensive assessment dated 1/7/21 failed to evidence strengths, goals, and care preferences. 5. The clinical record of patient #12 was reviewed 3/10/21 and indicated a start of care of 5/5/2020. The record contained a plan of care for a recertification period of 12/23/20 to 2/28/21. Patient diagnosis included: Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy (seizures), Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. An order for discipline and treatment indicated, "SN 1 Every Other Week 10 Assess and evaluate vital signs, mentation, respiratory and cardiovascular status. Assess nutrition and hydration, bowel and bladder functioning, skin integrity. Teach actions, s/s of side effects and proper administration of medications. Assess safety of home environment. Draw CBC with diff (complete blood count with differential)/platelets q o week (every other week)., next draw due 1/11/21. Draw q o month (every other month) labs next due 1/2021: BMP (Basic Metabolic Panel), Phosphorous, Magnesium as ordered by Dr (Doctor)." Patient diagnosis include: Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring.	G0530		

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G0530	Continued from page 22 The recertification comprehensive assessment dated 2/24/21 failed to evidence patient strengths, goals, and care preferences. 6. The clinical record of patient #19 was reviewed on 3/16/2021 and indicated a start of care of 1/28/21. The record contained a plan of care for an initial certification period of 01/28/21 to 3/28/21. Patient diagnosis included: Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. The start of care comprehensive assessment dated 1/28/21 failed to evidence patient strengths, goals, and care preferences. 7. The clinical record of patient #22 was reviewed 3/17/21 and indicated a start of care date of 7/12/18. The record contained a plan of care for a recertification 2/26/21 to 4/26/21. Patient diagnosis included: Need for Personal Assistance with Personal Care, Essential Hypertension, and Unspecified Intellectual Disabilities. The recertification comprehensive assessment dated 2/25/21 failed to evidence patient strengths, goals, and care preferences. 8. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 9. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say."	G0530		
G0536	A review of all current medications	G0536		

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G0536	Continued from page 23 CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on observation, interview, and record review the agency failed to ensure the medication list included indications for all PRN/ as needed medications and failed to evidence the location of application of topical medications was correct in 2 out of 7 active records reviewed. (#1 and 19) Findings Include: 1. Review of an agency policy titled, "Service Delivery Medications" dated April 2004, revealed the following: "3.0 Policy/Procedure 3.1 The clinical record includes appropriate physician orders for all medications, parental nutrition therapy and/or blood products prescribed by the physician(s) for the patient and for all (over the counter) OTC medications that staff administers and/or prepours. 3.1.1 Orders for medications include 3.1.1.1 Name, dose, route, and frequency of administration. 3.1.1.2 Start and stop dates, if known. 3.1.1.3 Indication or reason for PRN medications ..." 2. The clinical record of patient #1 was reviewed on 3/16/2021 and indicated a start of care of 5/21/19. The record contained a plan of care for a recertification period of 1/11/21 to 3/11/21. The plan of care contained a section titled, " Medications" which stated, "Wound Wash Saline 0.9% Spray take 1 sm [small] amt [amount] by topical route Every day as needed qd-qod prn [every day-every other day as needed]...Medi-Honey [treatment for skin impairments] 100% topical paste take sm amt by topical route Every day qd-qod..Mupirocin 2% topical [antibiotic ointment] ointment take 1 sm amt by topical route 3 times per day as needed ...Ropinirole 1 mg [milligrams] tablet take 1-2 tabs by oral route 2 times per day 1 tab in am, 2 tabs in pm; also 0.25 mg-3 tabs in	G0536		

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G0536	Continued from page 24 evening prn ...". The medication list failed to evidence indications for all PRN/ as needed medications listed and failed to evidence the location of application of topical medications. 3. The clinical record of patient #19 was reviewed on 3/16/2021 and indicated a start of care of 1/28/21. The record contained a plan of care for initial certification 1/28/21 to 3/28/21. The plan of care contained a section titled, "Medications" which stated, "Midodrine 2.5 mg tablet take 1 tab by oral route 4 times per day as needed ...". The clinical record failed to evidence indications for all "as needed" medications listed on the agency plan of care. 4. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 5. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-14-1(a)(1)(B) 410 IAC 17-15-1(a)(3)	G0536		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the	G0570		

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G0570	Continued from page 25 comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is NOT MET as evidenced by: In regards to services being put on hold due to COVID-19 exposure 4. The closed record of clinical record of former patient #9 was reviewed on 3/19/2021 at 10:16 AM. The clinical record contained a document titled "Case Communication Report" entered 12/4/2020 at 3:42 PM by Employee B, "Subject: COVID +11/19/20-Wife and son are COVID positive, requesting to hold ALL visits at this time. 11/24/20-Patient is now COVID positive. Patient reported that he, wife, and son are just very tired at this point. Continues to request to hold ALL visits at this time." The discharged record failed to evidence any further documentation of the agency following up. During an interview on 3/19/2021 at 11:51 AM, when queried former patient #9 about his request not to have services while he and his family had COVID 19 he stated, "My wife and son tested positive on 11/18/2020 then I tested positive on 11/24/2020. I went to Entity I, a Hospital for that infusion, but I was not admitted I came back home. I then was in the hospital 12/30/2020 with fluid retention they put me on that IV Lasix and kept me. I was back in on 1/4/2021 had to have the dialysis catheter put in my neck and received 1 treatment. I got to come home on 1/7/2021." When asked about his home care services he stated, "A lady came out here once to give me a bath and when we let her know that we have had COVID she left, and no one ever came back." When asked if he requested services to be on hold, patient #9 stated "No, I needed help." The clinical record failed to evidence any documentation that the agency followed up with this former patient when the agency put the patient's services on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19.	G0570		

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G0570	Continued from page 26 5. The clinical record of patient #14 was reviewed on 3/19/2021 at 10:21 AM. The clinical record contained a document titled "Case Communication Report" entered 12/4/2020 at 4:15 PM by Employee B, "Subject: COVID +11/13/20-Not feeling well, IV next Week. 11/20/20-Not administering IV this week, COVID present in home. 11/27/20 -IV next week, patient/family out of quarantine on 11/30/20. Patient still has not recovered taste/smell, no temp." During an interview on 3/19/2021 at 12:03 PM with patient #14, when queried about if the staff call and prescreen for COVID 19, she stated, "Not the nurse who is coming this week my regular nurse calls that week and does ask the prescreening questions." When queried about requesting services to be put on hold, Patient #14 stated she did not request services to be put on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19. 6. The clinical record of patient #23 was reviewed on 3/19/2021 at 10:26 AM. The clinical record contained a document titled "Case Communication Report" entered 1/11/2021 at 7:45 AM by Employee B, Subject: COVID +1/7/21-Hold COVID in home 1/7/21. Patients son in law tested + for COVID, will be out of quarantine on 1/18/21, as long as no else tests +, requesting to hold visits until then. Patient to have MD home visit on 1/19/21." During an interview on 3/19/2021 at 12:15 PM with individual H, caregiver of patient #23, when queried about services being put on hold, Individual H stated the agency told the patient that they (patient/ family) were in quarantine for 14 days and the agency will resume care after quarantine. Individual H stated they did not request to be put on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19. 7. The clinical record of patient #24 was reviewed on 3/19/2021. The clinical record contained a document titled "Case Communication Report" entered 12/26/2020 at 10:31 AM by Employee B, "Subject: COVID - Spoke with patient, is COVID +	G0570		

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G0570	Continued from page 27 hold visits at this time MD aware, he sent her for testing." During interview on 3/19/2021 at 1:08 PM with patient #24, when queried about requesting services to be put on hold, Patient #24 stated she did not ask for her services to be placed on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19. In regards to hands on personal care and services 8. Review of the plan of care for patient #3, start of care 2/22/21, for the certification period of 2/22/21 to 4/22/21, revealed orders for homemaker services 5 times a week for 8 weeks then 4 times a week for 1 week to assist with personal care, light housekeeping, meal prep. The agency failed to ensure they met the needs of the patient by failing to provide personal care services as evidenced by the following: Review of an agency document titled "Home Health Aide Assignment" last dated 2/22/21, indicated the patient was up with help (if needed), assist to the bathroom (if needed), the patient has rollator x2, shower chair, handrails, tall toilet, canes, stairs chair, and reachers. bath: shower bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn (as needed), prepare, and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 2/22/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 2/23/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot	G0570		

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G0570	Continued from page 28 care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 2/24/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 2/26/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 3/1/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. Trash that was not ordered on the plan of care. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/2/21, the home health aide note indicated a visit was made from 1:10 to 3:10, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes.	G0570		

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G0570	Continued from page 29 Review of a home health aide visit note dated 3/3/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 3/4/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 3/5/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. 9. Review of a signed plan of care for patient #8, the start of care 7/15/20, with a recertification period of 1/11/21 to 3/11/21 the order for discipline and treatment revealed, "Aide 2 week 9 HHA to assist with personal care, light housekeeping, meal prep. Visits may last up to 6 hours." The agency failed to meet the needs of the patient by failing to ensure bathing and hygiene were provided as ordered by the plan of care as evidenced by the following: Review of an agency document titled "Home Health Aide Assignment" last dated on 1/7/21, appliances: walker, walk-in shower, grab bars, handheld shower, SPC (single-point cane), hospital bed. Duties: bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, wash	G0570		

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G0570	Continued from page 30 dishes, laundry (in-home only), clean bathroom, and handwritten in housekeeping Review of a home health aide visit note dated 1/12/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), clean bathroom, and housekeeping. Review of a home health aide visit note dated 1/14/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 1/19/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 1/21/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 1/26/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve meals, keep kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated	G0570		

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G0570	Continued from page 31 1/28/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 2/2/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 2/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 2/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 2/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 2/18/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping.	G0570		

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G0570	Continued from page 32 Review of a home health aide visit note dated 2/20/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 2/23/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 2/25/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 3/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 3/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. Review of a home health aide visit note dated 3/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave,	G0570		

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G0570	Continued from page 33 up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. 10. During an interview on 3/18/21 at 2:20 PM, when queried about the comprehensive assessment and plan of care matching process, the administrator stated, "The nurse seeing the patient is responsible to ensure the HHA care plan and visit notes match." 11. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-13-1(a) Based on observation, record review, and interview, the agency failed to ensure patients received all care and services according to the written plan of care and that they were not placed on hold due to COVID-19 exposure, positive COVID-19 test in 4 out of 5 interviews conducted (Patients #9, 14, 23, 24), failed to ensure services were not placed on hold due to bedbugs and fleas for 3 out of 3 grievances documented (Patient #58, 92, 98); failed to ensure they provided home health aide services to meet the personal care needs of a patient in 1 of 1 record reviewed of personal care services being assigned to a home maker (Patient #3); and failed to ensure a home health aide provided hands on personal care as ordered in 1 out of 3 complete records reviewed of patients only receiving home health aide services (Patient #8) (See G570); failed to ensure nursing and personal care services were provided according to the written plan of care (See G572); failed to ensure the individualized plan of care was supported by the comprehensive assessment and included all interventions and measurable goals identified by the agency and patient, all durable medical equipment (DME) and supplies, all treatment orders, diet, safety measures, diagnoses being supported by the comprehensive assessment, and call parameters individualized to the patients cardiopulmonary, endocrine, pain, and nutritional assessments, include nutritional requirements,	G0570		

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G0570	Continued from page 34 indications for use and locations of topical medications, infection control precautions, patient-specific education and training provided, and the acceptance of orders that may be received/accepted by an outside physician, and ranges of hours per day were short in range and specific to patient needs (See G574); failed to ensure their physician order were returned with date and signature of the ordering physician within a timely manner; failed to have a system and policy in place to ensure outstanding orders were followed up on within a timely manner so that services were not provided without a physicians signature; failed to address continued acceptance of patients from physicians with a documented history of failing to sign orders; failed to follow its own current policy for physician orders, including having verbal orders countersigned by a physician, maintaining open communication, obtaining complete orders for care; and the director of clinical services failed to maintain a liaison with the physician/ representative to ensure timely receipt of orders (See G584); failed to promptly alert the physician of changes in patient conditions (See G590); failed to ensure they communicated with all physicians involved in the patient's plan of care and documented those efforts within the patients' clinical record (See G602); and failed to coordinate care and delivery with wound care centers, dialysis facilities, and outside company/ facilities to meet the patient's needs (See G608). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of health care for all 110 patients who are receiving services from this provider. In regards to G570, findings include: In regards to services being put on hold due to bedbugs and fleas 1. Review of a "Grievance Report" for patient #58, reported 7/22/20, revealed a "Nature of Grievance" entry which evidenced "[Name of employee V, home health aide] called to report that she found bed bugs in [name of patient #58]'s bed." Review of the "Disposition of Grievance" revealed "Spoke	G0570		

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G0570	Continued from page 35 with patient and his brother. Informed them that until home was treated we could not return." A follow up entry revealed "Home cleaned." The document revealed a resolution date of 8/15/20. The patient went without services for nearly 24 days. 2. Review of a "Grievance Report" for patient #92, reported 9/9/20, revealed a "Nature of Grievance" entry which evidenced "HHA [name of employee Q, home health aide] called in to report that [name of patient #92] had bed bugs." Review of the "Disposition of Grievance" entry evidenced "Spoke with pt/family. Informed them that home would have to be treated professionally before we could return." A follow up entry revealed "Home Cleaned." The document revealed a resolution date of 9/16/20. The patient went without services for nearly 7 days. 3. Review of a "Grievance Report" for patient #98, reported 12/1/20, revealed a "Nature of Grievance" entry which evidenced "[Name of employee F, home health aide] called to report that [name of patient #98] house was full of fleas." Review of the "Disposition of Grievance" entry evidenced "Spoke with pt [patient], informed him that home would have to be treated for fleas before we could return for visits...." A follow up entry revealed "Home Cleaned." The document revealed a resolution date of 12/10/20. The patient went without services for nearly 9 days.	G0570		
G0572	Plan of care CFR(s): 484.60(a)(1) 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. This STANDARD is NOT MET as evidenced by:	G0572		

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G0572	Continued from page 36 Based on record review and interview, the agency failed to ensure nursing and personal care services were provided according to the written plan of care for 7 of 7 complete records reviewed. (Patients #1, 2, 3, 8, 12, 19, 22) Findings Include: 1. Review of an agency policy titled, "Service Delivery Scope of Services" dated April 2004, revealed the following: "... 3.0 Policy/ Procedure ...3.4 The agency provides skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care and established policies and procedures...." 2. During a home visit patient #1, on 3/9/21 from 2:15 PM to 3:05 PM, the clinical manager was observed skilled nurse obtaining blood pressure, pulse, pulse oximeter, respirations, and listened to anterior right upper field, mid apical area, and then right upper and mid-region and lower field of the chest. The skilled nurse failed to listen to the posteriorly for cardiopulmonary assessment and temperature as ordered on the plan of care. The alternate clinical manager failed to obtain a temperature. During this time, the patient reported to the Alternate Clinical Manager that she had to burn upon urination. The patient appeared to be emaciated and underweight. The alternate clinical manager failed to obtain further information from the patient such as when did the burning start, if the patient has been running a temperature, odor, and if there was an increased frequency and urgency. During this visit, the alternate clinical manager was observed completing the medication set up but failed to reference a medication list during this time. The alternate clinical manager asked the patient if she was eating in which the patient responded that she had eggs in the morning. No other questions were asked about the patient's diet. The alternate clinical manager failed to check the patient's feet for bilateral pedal pulses, failed to assess capillary refill, failed to complete the fall risk time up and go the assessment, failed to take a blood pressure while standing and lying for orthostatic changes, failed to assess the all risk gait and balance for gait deviation, failed to	G0572		

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G0572	Continued from page 37 appropriately assess the patient's diet and weight, and failed to assess the patient lungs posteriorly. Per the medication list, the patient is prescribed and taking fentanyl for the chronic pain due to scoliosis. The alternate clinical manager failed to complete a pain assessment using the pain scale of 1 to 10 (1 being no pain and 10 being excruciating pain) or if the medication was effective. No education was provided during this visit. The only documentation left in the home was the home health aide care plan, which was not reviewed with the patient. A review of the plan of care for a recertification period of 1/11/21 to 3/11/21, the plan of care indicated, "Orders for disciplines and Treatment: 1/11/2021-3/11/21-SN 1 week 9 Assess and evaluate vital signs, mentation, respiratory and cardiovascular status. Assess nutrition and hydration, bowel and bladder functioning, skin integrity. Teach s/s of side effects and proper administration of medication. Assess safety of home environment ... Aide 1 week 9 HHA (home health aide) to assist with personal care, visits may last up to 2 hours one weekly." Review of an agency document titled "Home Health Aide Assignment" last dated 1/7/21, indicated the patient was up with help, assistance to the bathroom, the patient has a walker, wheelchair, hospital bed, bedside commode, handheld shower, reachers, shower chair, bath: bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn (when necessary), prepare and serve the meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom. Review of a skilled nursing visit note dated 2/17/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care. Review of a skilled nursing visit note dated 2/24/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care.	G0572		

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G0572	Continued from page 38 Review of the home health aide visit note dated 2/26/21, failed to evidence the patient had a bath: bed, dress, nail & foot care, skin care, oral hygiene, shave, change linen, up with help, assist to the bathroom, prepare, and serve the meals, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a skilled nursing visit note dated 3/2/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care. Review of a home health aide visit dated 3/5/2021, failed to evidence that the patient had a bath, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve the meals, keep the kitchen clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visit dated 3/9/21, failed to evidence the patient had nail & foot care, oral hygiene, shave, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a skilled nursing visit note dated 3/9/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care. 4. Review of the plan of care for patient #2, the start of care 5/22/19, with a recertification period of 2/9/21 to 4/9/21 the order for discipline and treatment indicated, "Aide 2 week 1; 3 weeks 8 HHA to assist with personal care, light housekeeping, meal prep." Review of an agency document titled "Home Health	G0572		

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G0572	Continued from page 39 Aide Assignment" last dated on 2/4/21, indicated the patient was to receive a bath/ shower: bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom. Review of a home health aide visits notes dated 2/15/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/17/21, failed to evidence the patient was up with help, hair comb, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/19/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/22/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide note dated 2/24/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered.	G0572		

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G0572	Continued from page 40 Review of a home health aide visits notes dated 2/26/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 3/1/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 3/3/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. 5. Review of the plan of care for patient #3, the start of care 2/22/21, with an initial certification period of 2/22/21 to 4/22/21 the order for discipline and treatment revealed, "SN 2 week 2; 1 week 2. Assess and evaluate vital signs, mentation, respiratory and cardiovascular status...HM (Homemaker) 5 week 8, 4-week 1 Homemaker to assist with personal care, light housekeeping, meal prep. May run errands per pt (patient) request per private pay services. Visits to last up to 2 hours. Review of an agency document titled "Home Health Aide Assignment" last dated 2/22/21, indicated the patient was up with help (if needed), assist to the bathroom (if needed), the patient has rollator x2, shower chair, handrails, tall toilet, canes, stairs chair, and reachers. bath: shower bed, dress, comb hair, nail & foot care, skincare, oral hygiene, shave, change linen prn, prepare, and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated	G0572		

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G0572	Continued from page 41 2/22/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/23/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to the plan of care as ordered. Review of a skilled nursing visit notes dated 2/24, 3/5, and 3/10/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. Review of a home health aide visit note dated 2/24/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/26/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered.	G0572		

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G0572	Continued from page 42 Review of a home health aide visit note dated 3/1/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/2/21, the home health aide note indicated a visit was made from 1:10 to 3:10, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/3/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/4/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/5/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if	G0572		

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G0572	Continued from page 43 needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a skilled nursing visit note dated 3/10/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. 6. Review of a signed plan of care for patient #8, the start of care 7/15/20, with a recertification period of 1/11/21 to 3/11/21 the order for discipline and treatment revealed, "Aide 2 week 9 HHA to assist with personal care, light housekeeping, meal prep. Visits may last up to 6 hours." The range of "up to 6 hours" were large and failed to be specific to the patient's needs. Review of an agency document titled "Home Health Aide Assignment" last dated on 1/7/21, appliances: walker, walk-in shower, grab bars, handheld shower, SPC (single-point cane), hospital bed. Duties: bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, wash dishes, laundry (in-home only), clean bathroom, and handwritten in housekeeping Review of a home health aide visit note dated 1/12/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), clean bathroom, and housekeeping. The aide failed to follow the plan of care. Review of a home health aide visit note dated 1/14/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan	G0572		

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G0572	Continued from page 44 of care as ordered. Review of a home health aide visit note dated 1/19/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/21/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/26/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve meals, keep kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/28/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/2/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered.	G0572		

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G0572	Continued from page 45 Review of a home health aide visit note dated 2/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/18/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/20/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered.	G0572		

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G0572	Continued from page 46 Review of a home health aide visit note dated 2/23/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/25/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. 7. Review of the plan of care for patient #12, the	G0572		

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G0572	Continued from page 47 start of care 5/5/20, with a recertification period of 12/31/20 to 2/28/21 the order for discipline and treatment revealed, "SN 1 Every Other Week 10 Assess and evaluate vital signs, mentation, respiratory and cardiovascular status. Assess nutrition and hydration, bowel and bladder functioning, skin integrity. Teach actions, s/s of side effects, and proper administration of medications. Assess the safety of the home environment. Draw CBC with diff (complete blood count with differential)/platelets q o week (every other week)., next draw due 1/11/21. Draw q o month (every other month) labs next due 1/2021: BMP (Basic Metabolic Panel), Phosphorous, Magnesium as ordered by Dr (Doctor)." Patient diagnosis includes Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. Review of a skilled nursing visit note dated 12/29/20, failed to evidence the patient had temperature checked during comprehensive recertification assessment visit. The nurse failed to assess temperature as a part of vital signs as ordered in the plan of care. Review clinical record failed to evidence a physician order or communication note to the physician indicating the reason for a missed skilled visit for date 1/11/21 and the reason for the blood not being obtained for a CBC with diff and Platelets, as ordered on the plan of care. Review of a skilled nursing visit note dated 1/13/21, failed to evidence the patient had temperature checked during the visit. The nurse failed to assess and evaluate vital signs as ordered in the plan of care. A review of the clinical record failed to evidence an order for labs, CBC with diff and Platelets, that were drawn during this visit. Review of a skilled nursing visit note dated 1/27, 2/10, and 2/24/21 failed to evidence the patient had temperature checked as a vital sign assessment as ordered on the plan of care.	G0572		

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G0572	Continued from page 48 During an interview on 3/17/21 at 1:05 PM, patient #12 stated, "I have had a terrible cough and I am on my second dose of antibiotics that I had to go to the doctor to get treated for." When queried about nurse visiting patient #12 stated, "They have been short-staffed, I had to go get my labs done at the hospital and see my doctor for this cough." 8. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns. The medication list revealed silver sulfadiazine 1% cream was being applied to the skin/ end of toes daily. The note indicated for home care services "Evaluate and Treat" and indicated the patient had a left below the knee amputation, required dialysis 3 to 4 times a week, and requires skilled nursing for medication management and monitoring of dialysis. A review of the plan of care for the certification period of 01/28/21 to 3/28/21, with orders for skilled nursing to conduct a general assessment, assess disease process compliance, and disease management. The patient's diagnoses include but not limited to Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Long Term Use of Insulin. Review of the comprehensive assessment dated 1/28/21, revealed the patient was going to dialysis three times a week. Review of a skilled nurse visit note dated 2/3, 2/14, 2/24, 3/4, 3/13/21, failed to evidence the patient had dialysis shunt assessed. The nurse failed to assess the patient's wound(s) and complete a skin assessment. The nurse failed to provide a general assessment and tasks as ordered on the plan of care.	G0572		

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G0572	Continued from page 49 During an interview on 3/19/2021 at 10:45 AM, with the alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I am not in there for wound care I am doing just med set up, so I don't monitor dialysis or wound care." 9. Review of a signed plan of care for patient #22, the start of care 7/12/18, with a recertification period of 12/28/20 to 2/25/21 the order for discipline and treatment indicated, "AC (Attendant care) 2 week 8; 1 week 1. Attendant care to assist with personal care, light housekeeping, and meal prep, visits may last up to 2 hours, twice weekly. HM (homemaker) 1 week 9 Homemaker services to perform light housekeeping, meal prep. Visits may last up to 2 hours." A review of an agency document titled "Home Health Aide Assignment" last dated 12/24/20, indicated keep kitchen clean, wash dishes, laundry (in-home only) clean bathrooms handwritten in housekeeping. Review of a home health aide visit note dated 12/2820, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 12/29/20, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 12/30/20, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/5/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide	G0572		

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G0572	Continued from page 50 failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/6/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/8/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/11/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/13/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/15/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/18/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/20/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as	G0572		

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G0572	Continued from page 51 ordered. Review of a home health aide visit note dated 1/22/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/25/21, the home health aide note indicated a visit was made from 7:40 to 9:40, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/27/21failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. On 1/29/21, 2/1/21, 2/3/21, 2/5/21, and 2/8/21, the visit notes were marked as missed visits and documented by the aide as "no answer." Review of a home health aide visit note dated 2/10/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. 10. During an interview with the alternate clinical manager on 3/12/2021 at 4:05 PM, when queried about vital signs and regarding temperatures being considered a vital sign and not being done during a home visit or in clinical note reviews, the administrator stated to the alternate clinical manager, "No, temperatures are to be taken, I have told you about that!" 11. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for	G0572		

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G0572	Continued from page 52 reviews or audit tools, nothing was provided. 12. During an interview on 3/18/21 at 2:20 PM, when queried about the plan of care, home health aide care plan and their visit notes matching process, the administrator stated, "The nurse seeing the patient is responsible to ensure the HHA care plan and visit notes match." 13. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-13-1(a)	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for	G0574		

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G0574	Continued from page 53 emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the individualized plan of care was supported by the comprehensive assessment and included all interventions and measurable goals identified by the agency and patient, all durable medical equipment (DME) and supplies, all treatment orders, diet, safety measures, diagnoses being supported by the comprehensive assessment, and call parameters individualized to the patients cardiopulmonary, endocrine, pain, and nutritional assessments, include nutritional requirements, indications for use and locations of topical medications, infection control precautions, patient-specific education and training provided, and the acceptance of orders that may be received/accepted by an outside physician, and ranges of hours per day were short in range and specific to patient needs in 9 of 9 complete records reviewed. (Patients #1, 2, 3, 5, 6, 8, 12, 19, 22) Findings include: 1. Review of an agency policy titled, "The Physician Role," dated April 2004, revealed the following: "1.0 Purposes 1.1 Establish guidelines for interaction with physicians that promote appropriate care planning, delivery of care, orders, and physician certification; and coordination of services ...2.0 Definitions 2.1 Plan of care is a written plan developed with the participation of professional staff and the	G0574		

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G0574	Continued from page 54 patient, in consultation with and authorizes by the physician, that supports the patient's medical, nursing and social needs in the home setting and serves as the basis of care delivery,. 2.1.1 The plan includes all pertinent diagnoses, mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications, treatments, safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items ...2.1.3 The plan is individualized to the patient's needs, strengths, limitations, goals and environment..." 2. During a home visit on 3/9/21 from 2:15 PM to 3:05 PM, patient #1 was observed completing a nebulizer treatment upon arrival. The patient was observed to have a nasal cannula in her nose with oxygen infusing. The alternate clinical manager was observed obtaining the patient's blood pressure, oxygen saturation, but failed to obtain a temperature. During this time, the patient reported to the Alternate Clinical Manager that she had to burn upon urination. The patient appeared to be emaciated and underweight. The alternate clinical manager failed to obtain further information from the patient such as when did the burning start, if the patient has been running a temperature, odor, and if there was an increased frequency and urgency. During this visit, the alternate clinical manager was observed completing the medication set up but failed to reference a medication list during this time. The alternate clinical manager asked the patient if she was eating in which the patient responded that she had eggs in the morning. No other questions were asked about the patient's diet. The alternate clinical manager failed to check the patient's feet for bilateral pedal pulses, failed to assess capillary refill, failed to complete the fall risk time up and go the assessment, failed to take a blood pressure while standing and lying for orthostatic changes, failed to assess the all risk gait and balance for gait deviation, failed to appropriately assess the patient's diet and weight, and failed to assess the patient lungs posteriorly. Per the medication list, the patient is prescribed and taking fentanyl for the chronic pain due to scoliosis. The alternate clinical manager failed to complete a pain assessment using the pain scale of 1 to 10 (1 being no pain and 10	G0574		

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G0574	Continued from page 55 being excruciating pain) or if the medication was effective. No education was provided during this visit. The only documentation left in the home was the home health aide care plan, which was not reviewed with the patient. The clinical record of patient #1 was reviewed on 3/16/2021 and indicated a start of care of 5/21/19. The record contained a plan of care for a recertification period of 1/11/21 to 3/11/21. Patient diagnosis included: Pressure Ulcer of Right Upper Back, Stage 2, Methicillin-Resistant Staphylococcus Aureus Infection, Unspecified Site, Encounter for Change or Removal of Nonsurgical wound Dressing, Chronic Obstructive Pulmonary disease, unspecified, Dependence on Supplemental Oxygen, Difficulty in Walking, Anemia in other Chronic Diseases, Cardiac Murmur, Atherosclerosis of Aorta, Other Abnormalities of Breathing, Gastro-Esophageal Reflux Disease Without Esophagitis, Scoliosis Unspecified. The plan of care indicated, skilled nursing to provide services 1 time a week for 9 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status, nutrition and hydration, bowel and bladder functioning, skin integrity, and safety of the home environment. Other interventions for skilled nursing are to teach signs and symptoms of side effects and proper administration of medication, fill medication set weekly, reinforce right upper back wound care. The wound care treatment orders indicated to cleanse with normal saline or soap and water as needed, apply calmoseptine (moisture barrier to prevent skin irritation), obtain wound care culture with the next visit. The goals revealed the following: "Patient will remain safe and comfortable in the home. The patient will receive necessary assistance ...Can demonstrate the aseptic performance of the prescribed procedure... " The plan of care failed to evidence the DME (durable medical equipment)/ Supplies specific wound care dressing supplies being used, nebulizer and nebulizer, oxygen nasal cannulas, tubing, and the name of oxygen company for coordination of care. Treatment of wound care is not specific in times dressing changes are to be completed and who completes wound care if dressing comes off, as well as caregiver willingness. The plan of care also failed to evidence call parameters on when to call the physician with abnormal ranges of vital signs.	G0574		

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G0574	Continued from page 56 During an interview on 3/9/21 at 10:39 AM, the alternate clinical manager stated the patient has a dressing change weekly by a skilled nurse and the caregiver does it the other days. 3. The clinical record of patient #2 was reviewed 3/10/21 and indicated the start of care date of 8/19/19. The clinical record contained a signed plan of care dated 10/12/20 to 12/10/20 with corrections made on the medication list. A dark black line was made through Magnesium and a dark black line was made through the dose of Tamsulosin and typed stated, "two capsules..." A review of the current plan of care for a recertification period of 2/9/21 to 4/9/21 revealed skilled nursing to set up patient #2's medications weekly. The medications listed on the plan of care revealed, "Magnesium 400 mg (as magnesium oxide) tablet take 1 tab by oral route every evening ...Tamsulosin 0.4 mg capsule take 1 capsule (0.4 MG) by oral route every day...". The clinical record failed to evidence any interim orders that would indicate the Magnesium was resumed and the Tamsulosin was back to 1 capsule. The plan of care failed to evidence that the medication list was updated as the physician indicated on the previous plan of care. The plan of care failed to evidence call parameters for blood sugars or abnormal ranges of vital signs. 4. The clinical record of patient #3 was reviewed on 3/11/21 and indicted a start of care of 2/22/21. The record contained a start of care comprehensive assessment dated 2/22/21. Patient diagnosis included: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, History of Falling, Repeated Falls, and Presence of Cardiac Pacemaker. The assessment revealed a wound to the left foot, 3rd digit, measuring 0.5 centimeters (cm) length, 1.25 cm width, and 0.1 cm depth, serosanguinous drainage, surrounding tissue described as being red and inflamed. The assessment further revealed a surgical wound to the left chest but was not observable due to the non-removable dressing due to pacemaker placement.	G0574		

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G0574	Continued from page 57 A review of the plan of care for the initial certification period of 2/22/21 to 4/22/21, revealed diagnoses of Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, History of Falling, Repeated Falls, Presence of Cardiac Pacemaker, and Personal History of Malignant Neoplasm of Prostate. The goals indicated "Patient will remain safe and comfortable in the home. The patient will receive the necessary assistance. Describe s/s of associated potential complication. Will demonstrate appropriate use of interventions. Can describe energy conservation. Techniques and activities which reduce the workload of the heart. Can describe s/s decreased cardiac output and how to modify activities accordingly." The plan of care failed to identify the cardiac physician for coordination and the pacemaker company for pacemaker checks, failed to evidence interventions and measurable goals for the skin impairments, and failed to evidence call parameters on when to call the physician for abnormal ranges of vital signs and weight. 5. The clinical record of patient #5 was reviewed on 3/15/21 and contained a comprehensive assessment dated 9/18/20 which revealed diagnoses of Abscess of Bursa, Left Elbow, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Change or Removal of Nonsurgical Wound Dressing, Disorder of White Blood Cells, and Multiple Sclerosis. A review of a visit note dated 9/28/20 indicated, "Assessed right knee: 2.5 cm x 3 cm with 1.5 cm undermining at 12 o'clock ..." A Review of a visit note dated 10/9/20 indicated, "measurements right knee 3 cm x 3 cm with 1 cm undermining at 12 o'clock ... left elbow dressing removed a small amount of orange-tinged drainage Wound bed pink, marked outer edges of redness around the wound with marker, no warmth, increase in pain in elbow up to shoulder measurement 3 cm x 1 cm x 0.5 cm ..." A review of the plan of care for the certification period of 9/18/20 to 11/16/20. The orders for	G0574		

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G0574	Continued from page 58 skilled nursing were to provide services 1 time a week for 1 week then 2 times a week for 2 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status, change central line dressing and caps weekly, and as needed utilizing sterile technique. Other orders included drawing/ obtain a CBC (complete blood count) with diff/ platelets, BMP (basic metabolic profile), ESR (erythrocyte sedimentation rate), and CRP (c-reactive protein)quantitative on 9/23/20..." The plan of care and the clinical record failed to evidence how the skilled nurse was to obtain the blood specimen and failed to evidence wound care treatment orders that were to be completed on the right knee and left elbow. 6. The clinical record of patient #6, the start of care dated 8/15/20, was reviewed on 3/12/202. The record contained a plan of care for the certification period of 8/15/20 to 10/13/20 which indicated the following diagnoses: "Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Therapeutic Drug Level Monitoring, Essential Hypertension, and Long Term Use of Insulin." The services to be provided indicated skilled nursing 1 time a week for 7 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status, teach and reinforce proper infusion technique, teach and reinforce the proper flush technique utilizing a SASH (saline, administer medication, saline, heparin) method, change the central line dressing and caps every week and as needed utilizing sterile technique. The DME and Supplies included the central line/ infusion supplies. Further orders indicated starting on 8/17/20, to draw weekly labs: CBC diff/platelets and BMP. The goals indicated "Patient will remain safe and comfortable in the home. The patient receives necessary assistance. Describe s/s of associated potential complications Verbalizes name, purpose, the function of parenteral access device/infusion therapy. Demonstrates cognitive skills and manual dexterity adequate to administer infusion therapy; demonstrates proper handling, storage, and disposal of supplies and hazardous wastes. Demonstrates safe use of DME. Demonstrates correct procedure for clamping parenteral access device. Verbalizes the importance of maintaining a clean area for setting up infusion therapy. Will describe and/or dosages, purpose and times of administration." The plan of care failed to	G0574		

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G0574	Continued from page 59 evidence how the skilled nurse was to obtain the blood specimen for labs, name of the lab where specimens were to be sent to, name of infusion company for coordination of care, failed to evidence how to complete the vascular dressing change and the supplies to be used, failed to evidence the glucometer, glucometer strips, lancets, insulin syringes and needles under the DME, failed to evidence call parameters on when to call the physician with blood sugars, or abnormal ranges of vital signs, and abnormal lab results. The goals failed to be measurable. 7. Review of a signed plan of care for patient #8, the start of care 7/15/20, with a recertification period of 1/11/21 to 3/11/21 the order for discipline and treatment revealed, "Aide 2 week 9 HHA to assist with personal care, light housekeeping, meal prep. Visits may last up to 6 hours." The agency failed to ensure the large range of hours per day were short ranges and specific to the patient's needs. 8. The clinical record for patient #12, the start of care 5/5/20, was reviewed on 3/18/21. The record contained a plan of care for the recertification period of 12/31/20 to 2/28/21, with orders for discipline and treatment of skilled nursing 1 time every other week for 10 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status, nutrition, and hydration, bowel and bladder functioning, skin integrity, and safety of the home environment. Teach actions and signs/ symptoms of side effects and proper administration of medications, draw CBC with differential/platelets every other week, and the next draw was due on 1/11/21, then draw BMP, Phosphorous, and Magnesium labs every other month with the next one due 1/2021 and as ordered by the Doctor. The patient diagnoses include Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. The DME and Supplies indicated N/A (not applicable). The nutritional requirements revealed a regular diet and medications included Viibryd 10 mg tablet - take 1 tablet (10mg) orally daily for major depressive disorder, furosemide 20 mg tablet - take 2 tablets (40mg) orally every day for edema, magnesium 64 - 64 mg tablet delay release -	G0574		

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G0574	Continued from page 60 take 1 tab orally 2 times per day for hypomagnesemia, Liraglutide 0.6mg/0.1ml (18mg/3ml) inject 1.8 mg by subcutaneous injection daily for type 2 diabetes. The goals indicated "Patient will remain safe and comfortable in the home. The patient will receive the necessary assistance. Will describe and/or demonstrate appropriate behaviors to comply with prescribed medication regimens. Can name medications, dosages, purpose and times of administration." The plan of care failed to evidence Type 2 Diabetes as a diagnosis. The DME failed to evidence a glucometer, glucometer supplies, insulin needles, insulin syringes. The plan of care failed to evidence how the skilled nurse was to obtain the blood specimen for the labs ordered. The plan of care also failed to evidence call parameters on when to call the physician with blood sugars or abnormal lab results. The goals failed to be measurable. A review of a skilled visit note dated 1/13/21 revealed the patient reports compliance with c-pap, CPAP has oxygen. The plan of care failed to be updated to include that the patient had a c-pap in the home with oxygen. 9. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns. The medication list revealed silver sulfadiazine 1% cream was being applied to the skin/ end of toes daily. The note indicated for home care services "Evaluate and Treat" and indicated the patient had a left below the knee amputation, required dialysis 3 to 4 times a week, and requires skilled nursing for medication management and monitoring of dialysis. A review of the initial comprehensive assessment dated 1/28/21 revealed the patient's diagnoses of Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. The assessment	G0574		

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G0574	Continued from page 61 revealed the patient had chronic back pain. The assessment indicated a dialysis shunt in the left upper extremity (LUE). The assessment indicated the patient had diabetes. The assessment indicated the patient has intermittent confusion short, long-term memory varies throughout the day, and forgetful. The assessment failed to identify the skin impairments as indicated the 1/13/21 progress note. Review of a skilled nursing visit note dated 3/13/21 revealed," Going to dialysis now on Mondays, Tuesdays, Thursdays, Saturday; Monday is 0800 then rest of week it is 1430 running for two hours." During an interview on 3/17/21 at 11:35 AM with the family member of patient #19, revealed that the family member performed the wound care for patient #19 and that patient goes to Entity #L for wound care assessments. When queried about what the case manager did for the client, the family member stated, "She sets up his meds, checks his blood pressure, and checks out any complaints he may have." During an interview on 3/19/2021 at 10:45 AM, employee B, alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I am not in there for wound care I am doing just med set up, so I don't monitor dialysis or wound care." Review of the plan of care for the initial certification period of 01/28/21 to 3/28/21, included orders for skilled nursing to provide services 2 to 2 times a week for 9 weeks then 1 time a week for 1 week for safety, general assessment, medication set as needed, disease process compliance, and disease management. The patient diagnoses include Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. The goals indicated "Patient will remain safe and comfortable in the home. The patient will receive the necessary assistance.	G0574		

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G0574	Continued from page 62 Describe s/s of associated potential complications Will describe and/or demonstrate appropriate behaviors to comply with prescribed medication regiment. Will implement measures to prevent/minimize skin breakdown. Can name medications, dosages, purpose and times of administration." The plan of care failed to identify the patient's wound and that the family member was competent in the management of the wound, treatment that is being conducted by the family member, weekly assessments by the RN, failed to evidence that the patient goes to dialysis or type of dialysis received at home, days/ times of the week for treatment, the name of the dialysis facility for coordination purposes if the dialysis facility manages the patient's access site, and if the agency was to assess for bruit during visits, the DME section failed to evidence insulin pen needles, insulin syringes, diabetic glucometer, glucometer lancets, glucometer strips, wound care supplies, failed to evidence call parameters on when to call the physician with blood sugars, abnormal ranges vital signs, concerns with the patient's wound. The goals failed to be measurable. 10. The clinical record of patient #22 was reviewed on 3/17/21 and indicated a start of care date of 7/12/18. Review of a recertification assessment dated 2/25/21, indicates "patient has a single point cane, grab bars (toilet/shower/tub)." The patient diagnosis included, but not limited to, essential hypertension. A review of the plan of care for the recertification period of 2/26/21 to 4/26/21 revealed "DME and Supplies: NA." The plan of care failed to evidence all DME equipment and call parameters on when to notify the physician with abnormal ranges of vital signs. 11. During an interview on 3/12/21 at 4:10 PM, when queried if the plan of care should include call parameters, the administrator stated, "The nurse is to call and get call orders for parameters of blood sugars, blood pressure, oxygen saturation, temperatures, and pulse if the physician does not already provide parameters." When queried about the review of the plan of care for accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for	G0574		

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G0574	Continued from page 63 reviews or audit tools, nothing was provided. 12. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-13-1(a)(1)(D)(iii) 410 IAC 17-13-1(a)(1)(D)(viiii) 410 IAC 17-13-1(a)(1)(D)(ix) 410 IAC 17-13-1(a)(1)(D)(xiii)	G0574		
G0584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is NOT MET as evidenced by: 7A. On 3/22/21, the administrator provided an updated list of outstanding physician orders that failed to be signed. The following clinical records were reviewed for outstanding orders which were inconsistent with the list provided on 3/17/21:	G0584		

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G0584	Continued from page 64 Review of patient #2, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the recertification period 9/13/2020-11/10/2020. Review of patient #4, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the recertification period 12/9/2020-2/6/2021 and a verbal order dated 12/10/2021. Review of patient #7, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the recertification period 10/2/2020-11/30/2020. Review of patient #32, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the initial certification period 4/28/2020-6/26/2020. Review of patient #37, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the initial certification period 12/16/2020-2/13/2021. Review of patient #42, an active clinical record, on 3/22/21, failed to evidence a signed and a verbal order dated 8/31/2020 and verbal order dated 12/28/20. Review of patient #61, an active clinical record on 3/22/21, failed to evidence a signed plan of care for the recertification period 8/14/2020-10/12/2020. Review of patient #111, an active clinical record on 3/22/21, failed to evidence a signed plan of care for the recertification period 10/20/2020-12/18/2020. 7B. The following clinical records reviewed for outstanding orders that were not part of the list provided on 3/17/21:	G0584		

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G0584	Continued from page 65 Review of patient #1, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the recertification period 8/13/2020-10/11/2020. Review of patient #12, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the initial certification period 5/5/2020-7/3/2020, the recertification 7/4/2020-9/1/2020, and the recertification 9/2/2020-10/31/2020. Review of patient #31, an active clinical record, on 3/22/21, failed to evidence a signed verbal order dated 7/16/2020. Review of patient #35, an active clinical record, on 3/22/21, failed to evidence signed verbal orders dated: 12/14/20, 1/13/21, and 2/1/21. Review of patient #38, an active clinical record, on 3/22/21, failed to evidence a signed plan of care for the recertification period 12/23/2020-2/20/2021. Review of patient #46, an active clinical record on 3/22/21, failed to evidence a signed plan of care for the recertification period 1/6/2021-3/6/2021 and a verbal order dated 10/27/2020. Review of patient #112, an active clinical record on 3/22/21, failed to evidence a signed plan of care for the recertification period 10/2/2020-11/30/2020. Review of patient #113, an active clinical record on 3/22/21, failed to evidence a signed plan of care for the initial certification period 8/28/2020-10/26/2020 and a verbal order dated 10/20/2020. Review of patient #114, an active clinical record on 3/22/21, failed to evidence a signed plan of	G0584		

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G0584	Continued from page 66 care for the recertification period 12/10/2020-2/2/2021. Review of patient #115, an active clinical record on 3/22/21, failed to evidence a signed plan of care for the recertification period 7/31/2020-9/28/2020, the recertification 9/29/2020-11/27/2020, and the recertification 11/28/2020-1/26/2021. 410 IAC 17-14-1(a)(1)(F) 410 IAC 17-14-1(a)(1)(H) 410 IAC 17-15-1(a)(7) Based on observation, record review, and interview the agency failed to ensure they had a system in place to accurately reflect outstanding orders in need of signature; failed to ensure their physician order policy specified a time frame of when physician orders must be returned with the date and signature of the ordering physician; failed to ensure verbal orders were obtained in advance of providing care; failed to ensure outstanding orders were followed up on frequently so that services were not provided without a physicians signature; failed to follow its current policy for physician orders, including having verbal orders countersigned by a physician, maintaining open communication, obtaining complete orders for care; and the director of clinical services failed to maintain a liaison with the physician/ representative to ensure timely receipt of orders. (VA [Veterans Administration] patient #s 2, 8, 10, 21, 23, 29, 30, 32, 33, 37, 62 to 111) (Non-VA patient #s 4, 7, 18, 36, 37, 40 to 47, 49, 50, 52 to 61) (Random sample patient #s 1, 12, 31, 35, 38, 46, 112, 113, 114, 115) The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of health care for all 110 patients who are receiving services from this provider. Findings include:	G0584		

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G0584	Continued from page 67 1. A review of an undated agency policy titled "Clinical Record" indicated " ... 3.0 Policy. 3.1 The written documentation of professional and paraprofessional staff in the clinical record reflects professional and clinical standards and established policies and procedures. ... 3.1.3.3 The agency obtains the physician's signature on plans of care and verbal orders as promptly as possible. .... " 2. A review of an agency policy, including "Sample Letter to Inform Physicians of Responsibilities", titled "Service Delivery: The Physician's Role", dated April 2004, revealed the following: Definitions: 2.1 Plan of care is a written plan developed with the participation of professional staff and the patient, in consultation with and authorized by the physician ... and serves as the basis of care delivery. ... 2.2 Verbal order is an order communicated from the physician prior to rendering services, recorded and signed by a registered nurse ... and countersigned by the physician. ... Policy/ Procedure: ... 3.2 The agency and the physician maintain open mutual communication to facilitate a cooperative working arrangement to meet patients' needs. ... 3.2.2 The agency notifies all physician of: ... 3.2.2.2 The requirements and time frames applying to the plan of care and verbal orders. ... 3.4 Staff develops and maintains the plan of care in consultation with the physician. ... 3.4.1.2 If the physician refers a patient under a plan of care that cannot be completed until after the initial evaluation visit, the RN (Registered Nurse) Case Manager consults with the physician to approve any modifications or additions to the plan of care and documents orders according to established procedure. ... 3.4.3 Professional staff and the attending physician review the plan of care as often as the severity of the patient's condition indicates, but at least every 60 days. ... 3.5 The agency obtains complete orders for care, which are clearly written and transcribed accurately. ... 3.5.5 The agency obtains the physician's countersignature on plans of care and verbal orders before submitting a claim for services, for medicare services. ... 3.5.5.2 The agency has a process for tracking verbal orders to ensure timely physician signature. ... 3.9 The Director of Clinical Services: 3.9.1 Maintains liaison with physicians .... "	G0584		

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G0584	Continued from page 68 A review of the sample letter that was attached to the policy to inform the physician of responsibilities dated April 2004, stated "Home Health Agency Expectations: Physician's providing care to home health agency patients are requested to: Evaluate the patient's need for home care at least every 60 days; Review, update, renew and sign orders as required by state and federal regulations; Communicate to the agency accurate and complete clinical information." The agency policy failed to evidence a specific time frame in which orders must be signed, failed to include a policy for how to proceed should orders remain outstanding and failed to address the continued acceptance of patients from physicians with a documented history of failing to sign orders. The agency failed to follow its policy for physician orders, including having verbal orders countersigned by a physician, maintaining open communication, obtaining complete orders for care. The agency failed to have a process for tracking verbal orders to ensure timely physician signatures, and the director of clinical services failed to maintain a liaison with the physician/ representative to ensure timely receipt of orders. 3. On 3/10/21 at 3:38 PM, the administrator provided an untitled and undated 5-page digital document, in which she stated it was the list of VA patients whose orders remained unsigned. A review of the document revealed patient number, name in the first column; address, the title of order for the second column; the word outstanding and payer source in the third column, date of orders in the fourth column, another set of dates in the fifth column, then a random two-three digit number in the sixth column. A review of this document revealed 206 unsigned orders from 4/15/20 - present. 4. On 3/12/21 at 2 PM, the administrator and alternate clinical manager were interviewed concerning the process for obtaining signed orders. The alternate clinical manager stated orders must be obtained via the VA patient's social worker, and all communication initially goes through a non-clinical triage line, where a message or request is given to the operator, who forwards it to the physician's office. The	G0584		

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G0584	Continued from page 69 alternate clinical manager stated if calls are made to the VA after 4 PM, there is no method to leave a message or obtain orders and the caller is instructed to send the patient to the emergency room, regardless of the reason for the call. The administrator and alternate clinical manager confirmed the agency continues to provide services while waiting for orders to come back signed. The alternate clinical manager stated it is the agency practice to complete the comprehensive assessment and complete a plan of care to send to the physician, without contacting the physician, because it is not possible to confirm findings with a VA physician or designee after the assessment is completed. When queried how the clinician knows what services, treatments, medications, and teaching to provide if no orders are signed, the alternate clinical manager stated the VA sends orders in the authorization that include the number of visits authorized and any wound care orders. When queried as to what she would do if the comprehensive assessment revealed a new wound or a medication discrepancy, she stated they would continue services while trying to reach someone. The administrator stated, "We don't stop services just because we can't get orders signed. That would leave a patient without care." When queried how long the agency had to obtain signatures on verbal orders the administrator stated there was no specific time frame. When queried whether the agency used some form of documentation to keep track of orders until they are returned signed, the administrator stated, "I have a list of all the patients I call about." The administrator stated there was no tracking tool used and there was no documentation available other than emails 5. On 3/12/21 at 3:55 PM, the administrator provided another undated and untitled single-page document and stated this was the list of non -VA patients with unsigned orders. A review of the document revealed patient number, name in the first column; address, the title of order for the second column; the word outstanding and payer source in the third column, date of orders in the fourth column, another set of dates in the fifth column, then a random two-three digit number in the sixth column. The document evidenced 50 unsigned orders. 6A. On 3/17/21 at 2 PM, the administrator	G0584		

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G0584	Continued from page 70 clarified that a date typed in untitled column #5 indicated when orders were returned and should not have been included on the report that was provided on 3/10/21. The administrator stated she did not know why the report included returned/ signed orders. A review of the updated report revealed the following VA patients with unsigned initial certification, recertification, treatment, and frequency orders: Patient #2: recertifications dated 6/14/20, 8/13/20, 12/11/20, and 2/9/21 Patient #8: recertifications dated 1/11/21 and 9/13/20 Patient #10: recertification dated 1/3/21 Patient #23: initial certification dated 10/13/20 Patient #29: recertification dated 10/23/20 Patient #30: recertifications dated 9/26/20, 11/25/20, and 1/24/21 Patient #32: recertifications dated 6/9/20, 10/25/20, and 12/24/20 Patient #33: initial certification dated 6/29/20; recertifications dated 8/28/20, 12/26/20; treatment orders dated 7/20/20, 8/5/20, and 9/8/20 Patient #37: initial certification 1/28/21 Patient #62: recertification 9/9/20 and 7/11/20 Patient #63: two treatment orders each dated 2/1/21; two treatment orders each dated 2/2/21; recertifications dated 12/28/20, 7/1/20, and 5/2/20 Patient #64: initial certification dated 1/6/21;	G0584		

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G0584	Continued from page 71 frequency dated 1/20/21 Patient #65: initial certifications each dated 9/25/20 and 12/11/20 Patient #66: recertifications dated 7/18/20 and 9/16/20 Patient #67: frequency dated 6/9/20 Patient #68: recertifications dated 4/16/20, 6/15/20 and 8/14/20 Patient #69: treatment dated 6/16/20 and 8/31/20 Patient #70: frequency dated 5/4/20 Patient #71: recertifications dated 11/26/20 and 1/25/21; frequency dated 1/26/21 and 5/13/20; treatment ordered dated 6/22/20, and two orders each dated 12/28/20, 1/5/21, and 1/25/21. Patient #72: two frequency orders each dated 11/3/20 and one dated 1/5/21, two frequency orders dated 1/25/21; recertifications dated 4/25/20, 6/24/20, 8/23/20 and 12/21/20 Patient #73: recertifications dated 5/2/20, 7/1/20, 8/30/20, 10/29/20 and 12/28/20 Patient #75: recertification dated 6/15/20; frequency orders dated 4/27/20, 5/11/20 Patient #76: two treatment orders each dated 1/7/21 Patient #77: initial dated 5/22/20 and recertification dated 1/17/21 Patient #78: initial certification dated 8/10/20; two frequency orders each dated 8/24/20; and a	G0584		

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G0584	Continued from page 72 treatment order dated 9/14/20 Patient #79: recertification 7/11/20 Patient #80: initial certification dated 6/24/20; frequency order dated 9/28/20; two frequency orders each dated 1/29/21, and recertification dated 10/9/20 Patient #81: initial certification dated 6/5/20 and frequency order dated 6/22/20 Patient #82: recertification dated 8/16/20 Patient #83: initial certification dated 9/11/20 Patient #84: recertifications dated 6/14/20 and 2/9/21; frequency orders dated 4/15/20, 9/3/20 and 1/11/21 Patient #85: recertifications dated 6/5/20 and 10/3/20; frequency orders dated 6/15/20, 7/8/20, 8/6/20, and six frequency orders each dated 9/18/20 Patient #86: recertifications dated 6/2/20 and 8/1/20; frequency order dated 4/29/20 Patient #87: recertifications dated 8/28/20, 10/27/20 and 12/26/20 Patient #88: initial certification dated 7/16/20 Patient #89: recertifications dated 5/21/20, 7/20/20 and 9/18/20 Patient #90: initial certification dated 6/19/20 and recertification dated 12/16/20 Patient #91: recertification dated 7/4/20 and frequency order dated 6/22/20	G0584		

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G0584	Continued from page 73 Patient #92: recertifications dated 7/5/20 and 9/3/20 Patient #93: initial certification dated 10/28/20 and recertification dated 12/27/20 Patient #94: recertification dated 1/26/21 Patient #95: recertification dated 7/8/20 Patient #96: initial certification dated 6/26/20 Patient #97: frequency orders dated 9/9/20 and 9/23/20; recertification dated 9/21/20 Patient #99: initial certification dated 9/26/20; two frequency orders each dated 10/12/20 and 10/24/20, and one order dated 10/23/20 Patient #100: recertifications dated 6/13/20, 8/12/20, 10/11/20 and 12/10/20 Patient #101: initial certification dated 7/15/20 Patient #102: two frequency orders each dated 9/9/20 and one dated 9/16/20 Patient #103: initial certification dated 9/8/20; two treatment orders each dated 9/18/20; recertification dated 2/6/21 Patient #104: initial certification dated 8/17/20 Patient #105 initial certification dated 5/11/20 and recertification dated 7/10/20 Patient #106: recertifications 9/9/20 and 1/7/21; two treatment orders each dated 10/9/20; and two frequency orders each dated 12/23/20	G0584		

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G0584	Continued from page 74 Patient #107: recertifications dated 9/29/20 and 11/28/20 Patient #108: recertification dated 6/28/20 Patient #109: frequency order dated 5/18/20 Patient #110: recertification dated 1/9/21; treatment dated 12/1/20; initial dated 11/10/20 Patient #111: initial certifications dated 10/20/20 and 12/19/20 6B. On 3/17/21 at 2 PM, the administrator stated the date in the untitled column 5 of the form indicated orders returned, and that order should not have been included on the report that was provided on 3/12/21. A review of the updated report revealed the following non - VA patients with unsigned initial certification, recertification, treatment, and frequency orders: Patient #4: frequency orders dated 12/10/20 and 1/5/21; recertification dated 1/30/21 Patient #7: frequency orders dated 12/18/20 and 2/4/21 Patient #17: initial certification dated 12/30/20 Patient #18: initial certification 1/31/21; frequency orders dated 2/2/21, 2/3/21, and 2/8/21; treatment order dated 2/8/21 Patient #36: recertification dated 12/17/20 Patient #37: initial certification dated 12/16/20 Patient #40: recertification dated 12/31/20	G0584		

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G0584	Continued from page 75 Patient #41: treatment orders dated 12/22/21, 1/5/21 Patient #42: frequency order dated 12/28/20; recertification dated 1/10/21 Patient #43: treatment order dated 12/28/20 Patient #44: recertification dated 1/3/21 Patient #45: initial certification dated 12/31/2; treatment order dated 1/25/21; frequency order dated 1/27/21 Patient #46: recertification dated 1/6/21 Patient #47: initial certification dated 1/5/21; treatment order dated 1/14/21; frequency order dated 1/29/21 Patient #49: recertification dated 1/18/21 Patient #50: treatment order dated 1/18/21 Patient #52: recertification dated 1/19/21 Patient #53: recertification dated 1/22/21 Patient #54: initial certification dated 1/16/21; treatment order dated 2/3/21 Patient #55: initial certification dated 1/20/21 Patient #56: initial certification dated 1/15/21 Patient #57: recertification dated 2/3/21 Patient #58: initial certification dated 2/1/21	G0584		

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G0584	Continued from page 76 Patient #59: recertification dated 2/4/21 Patient #60: recertification dated 2/8/21 Patient #61: recertification dated 2/10/21	G0584		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the agency failed to promptly alert the physician of changes in patient conditions in 6 of 9 complete records reviewed. (Patients #1, 3, 5, 6, 12, 19). Findings Include: 1. A review of an agency policy, titled "Service Delivery: The Physician's Role", dated April 2004, revealed the following: " ... 3.6 Staff notifies the physician, if required, and documents accordingly about ... 3.6.2 Changes in the patient's condition that suggest a need to modify the plan of care..." 2. The clinical record of patient #1 was reviewed on 3/16/2021 and indicated a start of care of 5/21/19. The record contained a plan of care for a recertification period of 1/11/21 to 3/11/21. Patient diagnosis included: Pressure Ulcer of Right Upper Back, Stage 2, Methicillin-Resistant Staphylococcus Aureus Infection, Unspecified Site, Encounter for Change or Removal of Nonsurgical wound Dressing, Chronic Obstructive Pulmonary disease, unspecified, Dependence on Supplemental Oxygen, Difficulty in Walking, Anemia in other Chronic Diseases, Cardiac Murmur, Atherosclerosis of Aorta, Other Abnormalities of Breathing, Gastro-Esophageal Reflux Disease Without	G0590		

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G0590	Continued from page 77 Esophagitis, Scoliosis Unspecified. Review of a recertification assessment dated 3/9/21, recertification assessment revealed the patient was burning on urination burning to conditions affecting genitourinary status. The assessment and clinical record failed to evidence that the RN notified the physician of the patient's burning upon urination. 3. The clinical record of patient #3 was reviewed on 3/11/21 and contained an initial comprehensive assessment dated 2/22/21. Patient diagnosis included: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, History of Falling, Repeated Falls, and Presence of Cardiac Pacemaker. The initial comprehensive assessment revealed a wound to the left foot - 3rd digit, measuring 0.5 centimeters (cm) length, 1.25 cm width, and 0.1 cm depth with serosanguinous drainage, and the surrounding tissue described as being red and inflamed. The assessment further revealed a surgical wound to the left chest but was not observable due to a non-removable dressing. The assessment note revealed that the alternate the admitting RN instructed the patient's family members to obtain orders for wound treatment. The assessment identified a referral for speech and occupational therapy, but the clinical record failed to evidence that this service was initiated. The comprehensive assessment and clinical record failed to evidence the physician was notified of the patient's wound are red and inflamed, and failed to contact the physician herself to obtain treatment orders. A review of an RN visit note dated 2/26/21, revealed the patient's weight was 197 pounds, lung sounds clear, and respirations 20. A review of an RN visit noted dated 3/10/21 revealed the client weighed 202 pounds (increase in 5 pounds), had a trace of edema in bilateral lower extremities, and the patient stating he has mild shortness of breath with overexertion and breath sounds diminish. The visit note and clinical record failed to evidence that the RN notified the physician of the 5-pound increase in the patient's weight.	G0590		

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G0590	Continued from page 78 The clinical record failed to evidence that occupational therapy was initiated, and/ or communication with the physician to discontinue the referral need. During an interview on 3/11/21 at 3:40 PM, when required about the patient not receiving speech or occupation therapy, the alternate clinical director indicated patient's caregiver refused speech and occupational therapy services. The alternate clinical manager verified there was no order in the clinical record to discontinue the referral need for speech and occupational services nor was there a communication note of the patient's caregiver stating they were refusing speech and occupational therapy services. 4. The clinical record of patient #5 was reviewed on 3/15/21 and contained a comprehensive assessment dated 9/18/20, which revealed diagnoses of Abscess of Bursa, Left Elbow, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Change or Removal of Nonsurgical Wound Dressing, Disorder of White Blood Cells, and Multiple Sclerosis. Review of a visit note dated 9/23/20 revealed that the vascular insertion site was slightly red, and also revealed that the wife had changed elbow dressing on this day. The visit note revealed the wife described the elbow wound as macerated and the patient complained of pain as a 5 (pain level on a scale of 1 - 10 with 1 being very little pain and 10 being worse pain) primarily in the elbow. The visit note and clinical record failed to evidence that the RN notified the physician of the insertion site is red, and the spouse reporting of the elbow wound being macerated and pain in the elbow. Review of a visit note dated 9/28/20 indicated, "Assessed right knee: 2.5 cm x 3 cm with 1.5 cm undermining at 12 o'clock ..." Review of a visit note dated 10/9/20 indicated, "measurements right knee 3 cm x 3 cm with 1 cm undermining at 12 o'clock ... left elbow dressing removed - a small amount of orange-tinged drainage Wound bed pink, marked outer edges of redness around the wound with marker, no warmth, increase in pain in elbow	G0590		

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G0590	Continued from page 79 up to shoulder measurement 3 cm x 1 cm x 0.5 cm ..." The visit note and clinical record failed to evidence that the RN notified the physician of the increase in wound measurement from 9/28/20 to 10/9/20. 5. The clinical record of inactive patient #6 was reviewed on 3/12/2021 and contained a plan of care with the start of care date 8/15/20, which revealed the following diagnoses: Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Therapeutic Drug Level Monitoring, Essential Hypertension, and Long Term Use of Insulin. A review of a skilled nurse visit dated 8/24/20 indicated SN documented, "Had received a call from patient last evening stating that her dressing was wet, came loose, she changed it and reported used the last one she had in her home. No other dressing change kits in the home reported that she went to ER to have it changed." The skilled note further indicated the patient stopped their Flagyl due to it was causing loose stools. The skilled nursing visit note and the clinical record failed to evidence the RN notified the physician of the patient's trip to the Emergency Room and stopping the Flagyl due to the patient-reported loose stools. 6. Review of the plan of care for patient #12, the start of care 5/5/20, with a recertification period of 12/31/20 to 2/28/21, with patient diagnoses of Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. The plan of care included orders for skilled nursing to draw a CBC with diff (complete blood count with differential)/platelets every other week, next draw to be due on 1/11/21 and to draw BMP (Basic Metabolic Panel), Phosphorous, Magnesium every other month labs, next due on 1/2021. Review clinical record failed to evidence that a skilled nursing visit was provided on 1/11/21. The clinical record failed to evidence a physician order or communication note to the physician	G0590		

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G0590	Continued from page 80 indicating the reason for a missed skilled visit and the reason for the blood not being obtained, as ordered on the plan of care. A review of the clinical record revealed a skilled nursing visit note dated 1/13/21, which revealed the CBC with diff and Platelets were drawn during this visit. The clinical record failed to evidence an order for labs to be obtained on this date. During an interview on 3/17/21 at 1:05 PM, when queried about the nurse visits, patient #12 stated, "They have been short-staffed, I had to go get my labs done at the hospital and see my doctor for this cough." Patient #12 went on to state, "I have had a terrible cough and I am on my second dose of antibiotics that I had to go to the doctor to get treated for." 7. The clinical record of patient #19 was reviewed on 3/16/2021 contained an initial comprehensive assessment dated 1/28/21, with diagnoses of Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. A review of an RN visit note dated 2/3/21 revealed the patient's blood pressure of 172/80, pulse 74, and the family reported they were having difficulties with the dialysis company because the dialysis machine will not fill the pack, so they are using travel bags for dialysis exchanges. The skilled nursing visit note and the clinical record failed to evidence that the dialysis physician was notified of the patient and family having difficulty with home dialysis equipment and the patient not completing dialysis and the patient's elevated blood pressure. Review of RN visit note dated 2/14/21 reveals patient's blood pressure 170/80, pulse 72, respirations 20 lungs sound diminished has improved, patient reports that he does have a productive cough at the present with thick clear phlegm, +2 edema in the right lower extremity,	G0590		

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G0590	Continued from page 81 fasting blood sugar was 187, the family used the travel bags Thursday night for dialysis and that the patient has not let family hook him/her up since then due to reporting that he felt too "zapped for any more yet." The skilled nursing visit note and the clinical record failed to evidence the dialysis physician was notified of elevated blood pressure, diminished lung sounds, +2 edema, and not being dialyzed. A review of an RN visit note dated 3/13/21 reveals patient's blood pressure 118/68, pulse 72, respirations 18, 2+ edema in right lower extremity, fasting blood sugar of 21 (normal blood sugar ranges 80-140), reported loose stools, and the patient reported "they zapped" him on Thursday. The assessment indicated the patient's skin color was slightly pale. The skilled nursing visit note and the clinical record failed to evidence the primary care and dialysis physician was notified of the patient's fasting blood sugar of 21, loose stools, 2+ edema, and not completing dialysis. During an interview on 3/19/21 at 10:45 AM when queried about patient's dialysis and physician notification, the alternate clinical manager stated, "I am only doing medication set up for this client." 410 IAC 17-13-1(a)	G0590		
G0602	Communication with all physicians CFR(s): 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. This ELEMENT is NOT MET as evidenced by: 6. The clinical record of patient #25, the start of care date 12/14/2020, was reviewed on 3/22/2021. The record contained a plan of care for the recertification period of 2/21/2021-4/14/2021. Diagnosis included, but not limited to: Encounter for Fitting and Adjustment of Urinary Device, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Long Term Use of Insulin, Chronic Obstructive Pulmonary Disease, Unspecified, Essential	G0602		

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G0602	Continued from page 82 Hypertension, History of Falling, Arthrodesis status, Fusion of Spine, Cervical Region, Personal History of Urinary (Tract) Infections. Orders for skilled nursing (SN) 1 time every 4 weeks for 10 weeks for changing suprapubic (sp) catheter (cath) every 4 weeks next change due 3/3/2021. The clinical record contained a document titled "Case Communication Report" dated 3/19/2021 at 10:45 PM by the alternate clinical manager, which stated "Subject: Discharge Note-Patient had to be discharged on the day, d/t [due to] IHCP [Indiana Home Care Plus] not having received signed Doctor of Medicine (MD) orders for more than 30 days. Had received SN services for sp [suprapubic] cath [catheter] changes every 4 weeks and [as needed]. Verbalized understanding that once orders are received, we will be able to restart services." The clinical record failed to evidence any case communication notes of attempts of notification to the physician to obtain outstanding orders or plan of care. 7. The clinical record of patient #26, the start of care date 9/3/2015, was reviewed on 3/22/2021. The record contained a plan of care for the recertification period 2/3/2021-4/3/2021, diagnoses included: Chronic Inflammatory Demyelinating Polyneuritis, Encounter for Adjustment and Management of Vascular Access Device with orders for SN 1 time every 8 weeks to start a peripheral intravenous line (PIV) to administer IVIG [Intravenous Immunoglobulin - and infusions of antibodies that helps your body fight infections]. The clinical record further contained a document titled "Case Communication Report" dated 3/19/2021 at 10:27 PM by the alternate clinical manager, which stated "Subject: Discharge Note-Patient had to be discharged on the day, d/t IHCP not having received signed MD orders for more than 30 days. The clinical record failed to evidence any case communication notes of attempts of notification to the physician to obtain outstanding orders or plan of care. 8. The review of the record of patient #27, the start of care date 10/19/2020, was reviewed on 3/22/2021. The record contained a plan of care for	G0602		

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G0602	Continued from page 83 the recertification period 2/16/2021-4/16/2021, diagnoses included: Chronic Inflammatory Demyelinating Polyneuritis, Encounter for Adjustment and Management of Vascular Access Device, and Mild Intellectual Disabilities with orders for SN 1 time weekly for 4 weeks for monitoring effects, vital signs before and after infusion, and teaching subcutaneous infusion of Hizentra [used in patients whose blood does not contain enough antibodies to fight infections]. The clinical record further contained a document titled "Case Communication Report" dated 3/19/2021 at 10:06 PM by the alternate clinical manager, which stated "Subject: Discharge Note-Patient had to be discharged on the day, d/t IHCP not having received signed MD orders for more than 30 days. Had received SN services for infusions, the wife is now independent with them. Verbalized understanding that once orders are received, we will be able to restart services if he needs them." The clinical record failed to evidence any case communication notes of attempts of notification to the physician to obtain outstanding orders or plan of care. 9. The review of the clinical record of patient #28, the start of care date12/30/2020, was reviewed on 3/22/2021. The record contained a plan of care for the recertification period 2/28/2021-4/28/2021, diagnoses included, but not limited to: Malignant Neoplasm of Head of Pancreas, Encounter for Adjustment and Management of Vascular Access Device, Neoplasm of unspecified behavior of Bone, Soft Tissue, and Skin, Post-Traumatic Stress Disorder, Chronic, Abdominal Aortic Aneurysm, Without Rupture, and Diverticulosis of Intestine, part unspecified, with orders for SN 1 time every other week for 9 weeks for chemotherapy (chemo) infusion completion, flush port a cath (IV access that is surgically placed under the skin), administer heparin, deaccess port, assess the site. The clinical record further contained a document titled "Case Communication Report" dated 3/19/2021 at 10:29 PM by the alternate clinical manager, which stated "Subject: Discharge Note-Patient had to be discharged on the day, d/t IHCP not having received signed MD orders for more than 30 days. Had received SN services for chemo disconnects.	G0602		

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G0602	Continued from page 84 Verbalized understanding that once orders are received, we will be able to restart services if he needs them." The clinical record failed to evidence any case communication notes of attempts of notification to the physician to obtain outstanding orders or plan of care. Agency. 10. The review of the clinical record of patient #29, the start of care date 8/24/2020, was reviewed on 3/22/2021. The record contained a plan of care for the recertification period 2/20/2021-4/20/2021, diagnoses included: Type 2 Diabetes Mellitus with unspecified Complications, Essential Hypertension, Difficulty in Walking, not elsewhere classified, Hyperlipidemia, and Benign Prostatic Hyperplasia without lower Urinary Tract Symptoms, with orders for a home health aide 1 time a week for 10 weeks for assistance with personal care, light housekeeping, meal prep, up to 2 hours a visit. The clinical record further contained a document titled "Case Communication Report" dated 3/19/2021 at 10:14 PM by the alternate clinical manager, which stated "Subject: Discharge Note-Patient had to be discharged on the day, d/t IHCP not having received signed MD orders for more than 30 days. Had received home health aide (HHA) services for assistance with personal care. Verbalized understanding that once orders are received we will restart services." The clinical record failed to evidence any case communication notes of attempts of notification to the physician to obtain outstanding orders or plan of care. 11. The review of the clinical record of patient #30, start of care date 2/25/2015, was reviewed on 3/22/2021. The record contained a plan of care for the recertification period 1/24/2021-3/24/2021, diagnoses included: Legal Blindness as Defined in the USA, Heart Failure unspecified, Essential Hypertension, Chronic Atrial Fibrillation, unspecified, with orders for a home health aide 4 times a week for 8 weeks, 2 times a week for 1 week, to assist with personal care, light housekeeping, meal prep, visits may last up to 2 hours. The clinical record further contained a document titled "Case Communication Report" dated 3/19/2021	G0602		

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G0602	Continued from page 85 at 10:11 PM by the alternate clinical manager, which stated "Subject: Discharge Note-Patient had to be discharged on the day, d/t IHCP not having received signed MD orders for more than 30 days. Had received HHA services for assistance with personal care. Verbalized understanding that once orders are received we will be able to restart services." The clinical record failed to evidence any case communication notes of attempts of notification to the physician to obtain outstanding orders or plan of care. 410 IAC 17-14-1(a)(1)(G) Based on record review and interview, the agency failed to ensure they communicated with all physicians involved in the patient's plan of care and documented those efforts within the patients' clinical record for 6 of 6 random sample of focused records reviewed of patients who were to be discharged due to unsigned verbal orders. Findings include: 1. A review of an agency policy, titled "Service Delivery: The Physician's Role", dated April 2004, revealed the following: " ...3.6 Staff notifies the physician, if required, and documents accordingly about ...3.6.1 The patient's condition, treatment, outcomes and response. 3.6.2 Changes in the patient's condition that suggest a need to modify the plan of care..." 2. A review of an undated agency policy titled "Clinical Record" indicated " ... 3.0 Policy. 3.1 The written documentation of professional and paraprofessional staff in the clinical record reflects professional and clinical standards and established policies and procedures. ... 3.1.4 The record reflects coordination of services through and/ or caregiver communication ... in the visit notes, progress notes or minutes of case conferences. ... 3.1.6 Dcoumentation is precise. Staff ... 3.1.6.4 Identifies the patient on each piece of documentation with name and medical record number as needed. 3.1.6.5 Includes the date, time and place or circumstance of the entry, such as telephone call, home visit, case conference, progress note, summary report, etc.	G0602		

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G0602	Continued from page 86 3.1.6.6 Signes all entries with first initial and last name and title and date. ... 3.2 The clinical record includes essential components ... 3.2.4 Plans of care, verbal orders, changes in orders and documentation of physician contact. .... " 3. On 3/10/21 at 3:47 PM, the administrator submitted a 2-page document to the surveyor which evidenced an email thread dated January 21, 2021. A review of the email thread beginning at 9:44 PM evidenced a message sent to Individual J, a physician's representative which stated, " You talked with [Name of Administrator] today regarding our outstanding documents. She asked me to send you the outstanding documents for [physician name]." The email thread further evidenced a request for completed escalation forms, followed by a response by Individual J who stated forms had previously been completed but would be resent. The email provided failed to evidence what documents/ orders that were outstanding, which patients were affected, which patients were receiving care from a said physician, or whether the documents were received signed. The administrator submitted further documents, including a 3-page untitled, undated spreadsheet of patient names, which she stated were proof of tracking for unsigned orders. The emails, dated 11/30/21, 1/21/21 (repeat of above email), and 1/25/21, failed to address any specific orders, failed to evidence which patients were affected, which orders were being tracked, which orders were not signed, and whether the situation was resolved, and signed orders were received. 4. On 3/12/21 at 2 PM, the administrator, and alternate clinical manager were interviewed concerning the process for obtaining signed orders. The administrator stated that the VA hospital had a long history of difficulty receiving signed orders and the agency was not the only agency affected. The administrator stated the agency emails and calls frequently but it was very difficult to speak with the physician's representative. The administrator stated she has emails to prove she has been in contact with the VA. The alternate clinical manager stated orders must be obtained via the VA patient's social worker, and all communication initially goes through a non-clinical triage line, where a message or request is given to the operator, who	G0602		

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G0602	Continued from page 87 forwards it to the physician's office. When queried whether the agency used some form of documentation to keep track of orders until they are returned signed, the administrator stated, "We don't document all those calls in the patient's chart. I have a list of all the patients I call about." The administrator stated there was no tracking tool used and there was no documentation available other than emails. 5. During an interview on 3/22/21 at 3:30 PM, the administrator stated all patients with unsigned orders had been notified they were discharged effective 3/22/21.	G0602		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to coordinate care and delivery with wound care, dialysis, cardiac, and infusion centers to meet the patient's needs in 4 of 4 complete clinical records reviewed of patients receiving outside services. (Patients #3, 6, 8, 19) Findings Include: 1. Review of an agency policy titled, "Service Delivery Scope of Services" dated April 2004, revealed the following: "1.0 Purposes 1.1 Identify the patient population which the agency serves to ensure that the patients' medical, and social needs can be met adequately in the home ...1.3 Describe the responsibilities of services ...3.0 Policy/Procedure ...3.4 The agency provides skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care and established policies and procedures. The registered nurse ... 3.4.7 Coordinates services ... " 2. The clinical record of patient #3, the start of	G0608		

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G0608	Continued from page 88 care dated 2/22/21, was reviewed on 3/11/21 and contained a plan for the certification period of 2/22/21 to 4/22/21. The patient's diagnoses included but were not limited to: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, and Presence of Cardiac Pacemaker. Review of an initial assessment dated 2/22/21 revealed a wound to the left foot - 3rd digit, that measured 0.5 centimeters (cm) length, 1.25 cm width, and 0.1 cm depth, with having serosanguinous drainage, and a description of the surrounding tissue is red and inflamed. The assessment further revealed a surgical wound to the left chest but was not observable due to a non-removable dressing due to a pacemaker placement. The comprehensive assessment/ clinical record failed to evidence if the RN notified the cardiologist regarding pacemaker coordination of care and pacemaker checks as well as treatment orders to the surgical wound and left foot. 3. The clinical record of patient #6 was reviewed on 3/12/2021. The record contained a plan of care for the certification period of 8/15/20 to 10/13/20. The plan of care, included, but was not limited to the following diagnoses: Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, and Long Term Use of Antibiotics." A review of a skilled nurse visit dated 8/24/20 indicated "Had received a call from patient last evening stating that her dressing was wet, came loose, she changed it and reported used the last one she had in her home. No other dressing change kits in the home reported that she went to ER to have it changed." The document/ clinical record failed to evidence the coordination of care with the infusion company of needed supplies. 4. The clinical record of patient #8, the start of care 1/11/21, was reviewed on 3/16/21 and contained a plan of care for a recertification period of 1/11/21 to 3/11/2. The patient's diagnoses, included, but not limited to Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney	G0608		

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G0608	Continued from page 89 Disease, or End-Stage Renal Disease, End-Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Wegener's Granulomatosis with Renal involvement, Dependence on Renal Dialysis, Anemia in Chronic Kidney Disease, Old Myocardial Infarction, and the Presence of Coronary Angioplasty Implant and Graft. Review of the comprehensive reassessment dated 3/9/21 revealed the patient was receiving dialysis 3 days per week. The record failed to evidence coordination of care with the dialysis center to verify medications received during treatment, medications prescribed by the dialysis to take at home, fluid and diet restrictions, as well as any call orders for changes in condition. 6. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns and that the patient was receiving dialysis 3 to 4 times a week. Review of the plan of care for the certification period of 1/28/21 to 3/28/21, failed to evidence any information in relation to the patient's dialysis facility nor the wound clinic. The patient's diagnoses included but were not limited to the following diagnoses: Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. A review of an RN visit note dated 2/3/21 revealed the patient's blood pressure was 172/80, and documentation revealed the family reported they were having difficulties with the dialysis company because the machine would not fill the pack, and they were using travel bags. The record fails to evidence that the RN coordinated care with the dialysis center. During an interview on 3/17/21 at 11:35 AM, the	G0608		

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G0608	Continued from page 90 caregiver of patient #19 indicated the patient goes to a wound care center. The clinical record failed to evidence any coordination with the wound care center for treatment orders, call orders. During an interview on 3/19/2021 at 10:45 AM, employee B, alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I don't do anything with his dialysis or wound care." 7. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 8. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-12-2(h)	G0608		
G0640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.	G0640		

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G0640	Continued from page 91 This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to develop and maintain documented evidence of a Quality Assessment and Performance Improvement (QAPI) program that involved all agency services; failed to identify, measure, analyze, and track improvement indicators; failed to address the frequency with which measurement and analysis occurred; failed to maintain a coordinated, agency-wide program for surveillance, investigation, identification, prevention, control, and investigation of infectious and communicable diseases as an integral part of the program; failed to use measures derived from OASIS and other relevant data; failed to utilize the data collected to monitor the effectiveness and safety of services and the quality of care and identify opportunities for improvement; failed to identify incidence, prevalence, and severity of problems in high risk, high volume, or problem-prone areas; failed to develop performance improvement activities to track adverse events; failed to measure and document the success of performance improvement activities and track performance improvement to ensure improvements were sustained; and failed to document the quality improvement projects undertaken and the reasons for conducting specific projects, and the measurable progress achieved. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of health care for all 110 patients who are receiving services from this provider. Findings include: 1. A review of a 5 page agency policy titled "Quality Assessment and Performance Improvement" (QAPI), dated April 2004, revealed the purpose of QAPI was to "provide a planned, organized, systematic, ongoing and organization-wide process to ensure delivery of high quality, consistent, safe and patient specific care ... Assure compliance with agency policy and procedures ... and local, State and Federal laws and regulations ... Improve patient care outcomes and patient	G0640		

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G0640	Continued from page 92 satisfaction ... Ensure that quality assessment and performance improvement activities ... meet regulatory and accreditation requirements ... reflect the complexity of the agency's organizations and services." The document evidenced "A quality assessment and performance improvement program is a planned, systematic and organization-wide program designed to assess and evaluate ... patient care. Identify and pursue opportunities to improve patient care and service delivery; resolve identified problems ...; take actions that result in improvements ...; sustaining the improvements." Further review of the policy revealed "Components of the quality assessment and performance improvement program include, but are not limited to ... Use of objective measures to demonstrate improved performance with regard to quality indicator data derived from patient assessments ...; Current clinical practice guidelines and professional standards ...; Effectiveness and safety of services ...; Case-mix and adverse event outcome, risk-adjusted and descriptive outcome ...; National patient safety goals ...; Monitoring performance improvement, including taking actions that result in performance improvement ...; Tracking performance improvement to assure that improvements are sustained ...; Reviews and analyzes case-mix and adverse event outcome reports ...; Considers prevalence and severity of problems ...; gives priority to improvement activities that affect clinical outcomes ...; Immediately identifies, analyzes and corrects undesirable patterns and trends ...; Identifies changes that will lead to improved performance and reduce the risk." The document further revealed "Duties of the quality assessment and performance improvement committee include ... staff education ...; Communication of quality assessment and performance improvement activities ...; the use of appropriate statistical techniques ... Comparison of data on processes and outcomes ...; Evaluation of the agency's [QAPI] program ...; The quality assessment and performance improvement committee develops and implements a methodology for quality assessment and performance improvement activities ...; The agency systematically collects, aggregates, displays and analyzes data, as appropriate, on important processes and outcomes related to ... patient care ...; Assessment and reassessment ...; Undesirable patterns or trends ...; Processes that involve risks ...; Deficiencies and opportunities for improvement...;	G0640		

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G0640	Continued from page 93 The agency failed to evidence compliance with its QAPI policy, including failure to provide a planned, organized, systematic, ongoing and organization-wide process; Assure compliance with agency policy and procedures ... and local, State and Federal laws and regulations ... Improve patient care outcomes and patient satisfaction ... Ensure that quality assessment and performance improvement activities ... meet regulatory and accreditation requirements; Use objective measures to demonstrate improved performance with regard to quality indicator data derived from patient assessments ...; develop and maintain documentation of a QAPI program; collect, aggregate, display, and analyze data; identify trends or patterns that can lead to changes. 2. On 3/18/21 at 10:30 AM the surveyor requested for the alternate clinical manager to provide all QAPI information, including the QAPI plan, any improvement plans, and all tracking and documentation showing trends, improvement indicators, and high risk, high volume, problem prone areas. At 10:36 PM the alternate administrator submitted a binder and 5-page, 2 sided document titled "Oral Medication Management" and subtitled "QAQI (Quality Assurance Quality Improvement): Improving Patient Quality of Care" and stated, "Here's the QAPI." (Quality Assurance Performance Improvement) When queried whether there were any additions to the QAPI, such as other performance improvement plans, a QAPI program, or a binder, the alternate clinical manager stated, "That's what the administrator told me to give you." No other information was provided. An undated, un-numbered first page revealed the document was developed by the administrator, alternate clinical manager, and employees G, W, and X. and focused on improving patient care by increasing and improving the management of oral medication. An un-numbered second page, dated/ labeled as "Started February 2020 Executive Summary" revealed "the objective of this report is simply to establish an ongoing quality improvement program that will focus on the improvement of patient care by assessing the oral medication management for the patients and teaching the oral medication management in all care planning. The RN's (Registered Nurse) teaching content should include	G0640		

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G0640	Continued from page 94 medications, both prescribed and over the counter, including herbal remedies." The goal was to "Establish a team that can review our current plan while also identify and implement a program for improving patient care by increasing ... the medication management of patients." An un-numbered third page, dated July 17, 2020 and titled "QAQI Team Formation", evidenced "the premise of a quality improvement program consists of systematic and continuous actions that lead to measurable improvement" and stated the team met "to start process of creating of a QI program" and "decided that this team should first focus on the review of our current Oral Medication Management. Thus, the goal for the next meeting is to have each member identify their own interaction with the patient and his/her medications." No further information was available. The agency failed to show why members were not able to identify their interaction with patients and their medications at this meeting, failed to clearly identify a high risk, high volume, problem prone area and how it was determined, failed to outline a plan that included a planned, organized, systematic, ongoing, and organization-wide process for medication management that leads to measurable improvement as stated in the document. An un-numbered fourth page, dated October 16, 2020 and titled "QAQI Team Meeting" evidenced the meeting was "to review the findings of its team members with respect to the goals set fourth[sic]in the previous meeting. While also looking more into the principles of the QI (Quality Improvement) program and their relationship to Indiana Home Care Plus." Review of a section subtitled "Previous Meeting Goal Review" revealed "Team Members current medication involvement: [Name of alternate clinical manager] - in home review of current medication and submission to the Dr. office; [name of employee W] - in home review of current medication and reports to [name of alternate clinical manager]; [name of administrator] - Administrative Auditor; [name of employee X] - in home review of current medication and reports Administration; [name of employee G] - Submission of medication to Dr. Office." No further information was provided. The document failed to explain how the goal supports the performance improvement plan, failed to identify the high risk, high volume, problem prone area	G0640		

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G0640	Continued from page 95 related to medication management is, failed to provide data collection, statistics, analysis, or summary, or plan for change. No further information was available since the July 17, 2020 meeting, including clinical record audits, OASIS data concerning medication, or individualized medication review. An un-numbered fifth page, dated January 15, 2021, revealed the objective of the meeting "is to review the findings of its team members with respect to the goals set fourth [sic] in the previous meeting. After understanding what data exists and what still needs to be collected we will start into our planning phase of the QI Program." Review of goals from the last meeting revealed the team was to "identify types of data already be [sic] collected that we can you [sic] in the QI program to help us determine current performance of the process in place now." The document revealed "It was determined in this meeting that no data is currently being collect. [sic] Two ways to collect data for [sic. to] be used in this program are a) send a nurse to every pt (patient) home to review current meds (medications) and see how many have all medications shown; start logging the returned changes from the Dr. Office." Further review of the documentation revealed team findings of 'We believe for this QI Program to be effective the program must make changes at both the organizations [sic] cultural level and the infrastructure level. In this meeting the team members present reviewed the information located on the U.S. Department of Health and Human Services website under the Health Resources and Services Administration (HRSA). The team felt that it was important to focus on oral medication because adverse [sic. adverse] drug events cause so many emergency visits ...." The goals for the next meeting stated the team "would like to have actual data for review. It was decided that in an effort to be more efficient [name of employee D (office manager)] would drive [name of employee W] around to pt homes for Oral medication review. The team has requested that [name of employee W] see pt's that are not her own and would like 100% pt reviewed." The agency failed to explain why a performance improvement plan was initiated in February 2020, but failed to show any data, analysis, summary, or plan over an 11-month period. The agency failed to include the specific information that was reviewed on the U.S.	G0640		

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G0640	Continued from page 96 Department of Health and Human Services website or how it was utilized and applied to a performance improvement plan related to oral medication. The agency states it failed to collect any data but failed to specify what category of data and for what purpose. The document mentions 2 ways to collect data for this program, but failed to state what program, and stated they could send a nurse to every pt home to review current medications but failed to address why this wasn't already being completed, at a minimum, on admission and every 60 days with recertification as required in CFR 484.55(c)(5). The agency failed to explain the purpose of having a non-clinical employee drive the clinician to each patient's home, how 100% of patients would be seen if the RN was only seeing patients that were not her own, how she would collect data, and how that data would be analyzed and interpreted, and presented. Review of an un-numbered and undated sixth page titled "Workflow of Oral Medication Tracking" evidenced a flowchart which revealed 3 categories of "Source: Oral medications are either received from Dr. Office or from the patient and then inputed [sic] into the EMR. (electronic medical record); Activities: Medication are reviewed on a by visit bases [sic] and then submitted to DON (Director of Nursing} and then to the Dr. Office for reconciliation; Results: Reconciliation of any discrepancies between EMR and Dr. Office." The document evidenced "This is one of the most important areas to focus. Data will me [sic] the main indicator of the performance of our QI program. It will give us the feed back [sic] we need to determine how much better the process is working, what happens when we apply our changes and will document the success of our performance." Goals for the next meeting included "Identify types of data already be [sic] collected that we can you [sic] in the QI program to help us determine current performance of the process in place now." The document failed to include a clear plan for implementing, tracking, analyzing, and interpreting data gathered, who would gather the information, the expected timeline for reconciliation, how medications are reviewed and the "submitted to the DON", and failed to explain what it means to identify types of data already be[ing] collected that can be used in the QI program.	G0640		

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G0640	Continued from page 97 Review of an undated and un-numbered seventh page of the document revealed another workflow process titled "Principles of this QI and how they relate to IHCP (Indiana Home Care Plus). The document revealed "Resources: Office staff, Administration, field Staff, Field Input Device; Activities: Medication input, Report to Admin (Administrator), Submission to Dr.; Results: Health Services Delivered, Change in Health, Patient Satisfaction" but failed to evidence an actual plan for investigating, analyzing, interpreting, and summarizing data to use in development of an actual plan. No further data, statistics, audits, or tracking tools were available to show a QAPI plan was active and in place. No information was available to evidence how this workflow and the previous workflow are connected. Review of an undated and un-numbered eighth page titled "QI Work as Systems and Presses" [sic] revealed a single large circle with 4 smaller circles labeled PT (referred); PT Assessed; PT Admitted; PT Visit; PT discharge [sic] and arrows pointing clockwise between the circles. No further documentation or explanation was available to explain the meaning of the eighth page. 3. On 3/8/21 at 11:16 AM the surveyor queried the alternate clinical manager concerning whether QAPI was ready as requested during the entrance interview. The alternate clinical manager stated, "I gave it to you" and indicated the "Oral Medication Management packet. The surveyor asked if the agency utilized a binder, or QAPI book and clarified that QAPI is all tracking, patient record and any other audits, or anything for performance improvement. The alternate clinical manager stated she had provided what the administrator instructed her to provide and no further information was available until the administrator arrived. 4. On 3/8/21 at 11:30 AM, the administrator was queried concerning QAPI. When questioned as to where the tracking documentation was, such as weekly/quarterly chart audits, OASIS compliance tracking, performance improvement plans, the actual QAPI program and policy, or any tools used to gather and analyze data, the administrator indicated the "Oral Medication Management" packet and stated, "That's one of two that we are working	G0640		

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G0640	Continued from page 98 on." When the surveyor repeated the request the administrator stated, "I don't know what that means but I'll figure it out." The surveyor attempted to clarify the request, however the administrator stated, "I know that" and offered no further information. When queried as to what the second performance improvement plan was about and where it was located, the administrator stated, "We have an EMR (electronic medical record) PIP we're working on. There's a lag time between documentation in the field and other individuals having access to that information because it was necessary to sync. When asked if there was anything showing audits, data gathering, tracking, or statistics related to the EMR PIP the administrator responded, "No. There isn't." No further information was provided and there were no other PIPs given for review. During continued interview, the administrator was queried as to how the agency determined QAPI needs. The administrator stated the information was obtained through OASIS summaries, chart audits, and "sometimes from something being out of normal." The administrator stated, "For instance, we began to suspect on supervisory visits the RNs weren't updating medications" and this suspicion was what prompted the agency to develop the "Oral Medication Management" PIP. When asked for evidence supporting investigation, analysis, QAPI plan and any formal tracking method(s) used for gathering data, the administrator stated, "I don't know what it is that you want. I don't know what you mean by formal tracking." Upon clarifying and to the administrator that we were looking for the agency audits, audit tools, documentation of findings, anything that describes the agency's QAPI program that shows what the agency identified as high risk, high volume, problem prone areas, as well as the measures put into place to show how the agency's plan to correct the problem, and how often are audits completed, the administrator responded, "We begin the audits in the quarter following the quarter we are reviewing" but denied any specific timeframe requirements for completion of the audits. When asked the requirement for number of charts to be audited, the administrator stated, "We've done 100% or 50%. It's rare to do less than 50%. When asked who completes audits the administrator responded, "The nurses audit each other's charts." When asked if any specialized training was given to the nurses concerning the QA process or use of an audit tool, no further	G0640		

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G0640	Continued from page 99 information was offered. In reference to data gathering and analysis the administrator stated, "We don't keep that. Too much paper. Once the audit is done, we throw all that away." The administrator stated they do keep summary information. When asked to provide all summary information for audits completed during the last year, the administrator stated she would have to look for it. When asked why the agency did not keep audit information and how they determined what to measure to monitor the effectiveness of the program, the administrator remained silent and failed to provide any further information. When asked who was in charge of the QAPI program, the administrator responded she was the QAPI director. 410 IAC 17-12-2(a)	G0640		
G0680	Infection prevention and control CFR(s): 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. This CONDITION is NOT MET as evidenced by: 10. During an interview on 3/22/2021 at 12:10 PM, with employee E, physical therapist, when queried about if she calls her patients and prescreen them for COVID 19 symptoms prior to her arrival, employee E, a physical therapist, stated "No, the patients call me if something is wrong, for they know ahead of time when I am coming, so I do not call them before my visit. As far as the in services I received last Thursday they were on handwashing, infection control, and COVID-19 about wearing your mask, handwashing and social distancing." 11. During an interview on 3/22/2021 at 12:39 PM with employee H, registered nurse, when queried about if a client reports any symptoms of COVID 19 she stated, "If a client has COVID 19 we are told not to see them and report it to the supervisor."	G0680		

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G0680	Continued from page 100 12. During an interview on 3/22/2021 at 1:50 PM, with patient #7, when queried if office calls her before aide visits or staff call before visits, she stated, "No, why should they? The aide texts me when she is on her way." The agency failed to evidence COVID 19 prescreening calls as indicated on the agency plan for resolution. In regards to Covid prescreening and education to patients 13. During a home visit with patient #1, on 3/9/2021 at 2:15 PM, upon arrival employee B, the alternate clinical manager, who manages patient #1, failed to complete COVID 19 screening questions for prevention and control of COVID 19. 14. During a home visit with patient #2, on 3/10/2021 at 11:05 AM, upon arrival employee B, failed to complete COVID 19 screening questions for prevention and control of COVID 19. Employee F, the home health aide, arrived at 11:11am and failed to complete COVID 19 screening questions for prevention and control of COVID 19. 15. During a home visit with Patient #3 on 3/11/21 at 12 PM, employee E, a physical therapist (PT), was queried concerning the current process for self-screening and screening the patient for symptoms of Covid. Employee E stated, "I have been vaccinated so it isn't something I have to do." Employee E denied any process for pre-screening any patients or other individuals in the home prior to entering or prior to the start of therapy. When queried how patients are screened prior to a visit she denied any screening process and stated, "We rely on the patient's to tell us if they have symptoms if they aren't feeling well." When asked what she would do if the patient stated he had positive Covid symptoms she stated, "I wouldn't go in." When asked if there was anything else she would do she stated she would probably call the agency. Upon entering the patient home, the PT was observed in the kitchen washing her hands with soap and water for less than 15 seconds, tapping her wet hands against the edge of the sink to knock off excess water, and drying with a hand towel she obtained on the countertop. No other hand hygiene was observed throughout the visit. The therapist failed to	G0680		

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G0680	Continued from page 101 question the patient concerning nausea/ vomiting, diarrhea, cough, loss of taste/smell, fever, known exposure, travel, and failed to obtain a patient temperature prior to the start of the therapy, and failed to request the patient wear a mask throughout the visit. Review of the patient's plan of care did not reveal the patient had a mask exception. The clinical record of patient #3, start of care date 2/22/2021, was reviewed on 3/11/202. The comprehensive assessment dated 2/22/2021 failed to evidence any COVID 19 prevention and control education or caregiver/ patient response to education. 16. During an interview on 3/17/2021 at 11:35 AM, individual E, Power of Attorney (POA) of patient #19, stated, the nurse comes twice a week and she calls or texts when she is in the area with no prescreening done. Individual E further indicated they had not received any education or information from the nurse on COVID 19. The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. 17. During an interview on 3/17/2021 at 12:30 PM, with the caregiver for patient #10. Individual C indicated that they did not receive any information or education on COVID 19 from the nurse. Individual C further indicated the only time the nurse calls is when she is going to be late. Individual C stated, "COVID 19 prescreening what is that?" The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. 18. During an interview on 3/17/2021 at 12:10 PM, patient #11 indicated she does not receive any prescreening calls from her nurse, she only receives a text message on her cell phone letting her know that her nurse is on her way. When queried about information and education on COVID 19, during the past year during the pandemic, the patient stated, "No." The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19.	G0680		

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G0680	Continued from page 102 19. During an interview on 3/17/2021 at 12:38 PM, patient #12, quarried about COVID 19 education and information she could not recall. Patient #12 indicated the agency staff do not call and ask prescreen questions before they visit. The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. 20. During an interview on 3/17/2021 at 1:00 PM, patient #21 stated that the nurse did not call and prescreen for COVID 19 and he did not receive any information or education on COVID 19. The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. 21. During an interview on 3/17/2021 at 2:28 PM, individual B, POA for patient #22, stated the staff do not call and prescreen for COVID 19 and they have not received education and information on COVID 19 from the nurse. The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. In regards to patients being placed on hold per request of the patient or caregiver due to Covid-19 exposure: 22. The closed record of clinical record of former patient #9 was reviewed on 3/19/2021 at 10:16 AM. The clinical record contained a document titled "Case Communication Report" entered 12/4/2020 at 3:42 PM by Employee B, "Subject: COVID +11/19/20-Wife and son are COVID positive, requesting to hold ALL visits at this time. 11/24/20-Patient is now COVID positive. Patient reported that he, wife, and son are just very tired at this point. Continues to request to hold ALL visits at this time." The discharged record failed to evidence any further documentation of the agency following up. During an interview on 3/19/2021 at 11:51 AM, when queried former patient #9 about his request not to have services while he and his family had COVID 19	G0680		

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G0680	Continued from page 103 he stated, "My wife and son tested positive on 11/18/2020 then I tested positive on 11/24/2020. I went to Entity I, a Hospital for that infusion, but I was not admitted I came back home. I then was in the hospital 12/30/2020 with fluid retention they put me on that IV Lasix and kept me. I was back in on 1/4/2021 had to have the dialysis catheter put in my neck and received 1 treatment. I got to come home on 1/7/2021." When asked about his homecare services he stated, "A lady came out here once to give me a bath and when we let her know that we have had COVID she left, and no one ever came back." When asked if he requested services to be on hold, patient #9 stated "No, I needed help." The clinical record failed to evidence any documentation that the agency followed up with this former patient when the agency put the patient's services on hold. 23. The clinical record of patient #14 was reviewed on 3/19/2021 at 10:21 AM. The clinical record contained a document titled "Case Communication Report" entered 12/4/2020 at 4:15 PM by Employee B, "Subject: COVID +11/13/20-Not feeling well, IV next Week. 11/20/20-Not administering IV this week, COVID present in home. 11/27/20 -IV next week, patient/family out of quarantine on 11/30/20. Patient still has not recovered taste/smell, no temp." During an interview on 3/19/2021 at 12:03 PM with patient #14, when queried about if the staff call and prescreen for COVID 19, she stated, "Not the nurse who is coming this week my regular nurse calls that week and does ask the prescreening questions." When queried about requesting services to be put on hold, Patient #14 stated she did not request services to be put on hold. The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. 24. The clinical record of patient #23 was reviewed on 3/19/2021 at 10:26 AM. The clinical record contained a document titled "Case Communication Report" entered 1/11/2021 at 7:45 AM by Employee B, Subject: COVID +1/7/21-Hold COVID in home 1/7/21. Patients son in law tested + for COVID, will be out of quarantine on 1/18/21, as long as no else tests +, requesting to hold visits until then. Patient to have MD home visit on	G0680		

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G0680	Continued from page 104 1/19/21." During an interview on 3/19/2021 at 12:15 PM with individual H, caregiver of patient #23, when queried about prescreening indicated no one ever calls and prescreens until yesterday. Individual H stated "That was the first time and they told me they had to start calling." Individual H stated the agency told them that they were in quaratine for 14 days and will resume care after quarantine. Individual H stated they did not request to be put on hold. The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. 25. The clinical record of patient #24 was reviewed on 3/19/2021 at 10:33 AM. The clinical record contained a document titled "Case Communication Report" entered 12/26/2020 at 10:31 AM by Employee B, "Subject: COVID - Spoke with patient, is COVID + hold visits at this time MD aware, he sent her for testing." During interview on 3/19/2021 at 1:08 PM with patient #24, she indicated the staff do not call and prescreen before visits. Patient #24 when queried about infection control stated, "Some of the home health aides do not wear masks which concerns me. They said they do not have enough masks." When queried about requesting services to be put on hold, Patient #24 stated she did not ask for her services to be placed on hold. The agency failed to use safe infection control practices by prescreening the patient prior to visits during the pandemic of COVID 19. 410 IAC 17-12-1(m) 410 IAC 17-12-2(a) An Immediate Jeopardy (IJ) related to the Condition of Participation 42 CFR 484.70 Infection Control was identified on 03/15/2021 at 9:45 AM. The Administrator was notified of the IJ on 3/15/2021 at 12:00 PM. The Immediate Jeopardy was not abated by the end of the exit conference on 3/22/2021 at 4:15 PM.	G0680		

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G0680	Continued from page 105 Based on observation, record review, and interview, the agency failed to maintain an infection control program with the goal of prevention and control, and investigation of infectious and communicable diseases, failed to keep adequate records of Covid infections among staff, patients, and respective families, including analysis of data to determine trends and provided direction for follow up/ contact tracing to infected individuals in relation to the Covid-19 pandemic, failed to follow current standards of practice for prevention and screening of Covid, failed to ensure staff were educated and followed infection control standards and policies, failed to have a system in place to ensure staff have the appropriate PPE (personal protective equipment) to wear when patients are exposed/ diagnosed with Covid-19, so patient services are not put on hold during their/ household exposure, and the program failed to include written policies and procedures which were compliant with requirements of local, state, and federal rules and regulations including the Centers for Disease Control and Prevention (CDC) (See G 680) and failed to ensure proper hand hygiene was conducted while providing wound care to a patient (See G682) . The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for all 110 patients who are receiving services from this provider In regards to G680, findings include: 1. A review of a policy dated April 2004 revealed the following: 3.0 Policy/Procedure: 3.1 The agency defines and implements an infection control program to reduce the risks for infection in patients, families, caregivers, and staff, based on: ... 3.1.2 Current scientific methods for surveillance and prevention. 3.1.3 Epidemiological issues relevant for both patients and staff. 3.1.3.1 Current standards of practice. 3.1.5 Current clinical references. 3.2 The agency follows a process to decrease the risk of infection for staff and patients. 3.2.1 The agency ensures that staff complies with all infection control policies and procedures including health,	G0680		

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G0680	Continued from page 106 education training, and competency requirements. 3.2.2 The agency requires that all staff meet infection control program requirements. 3.2.3 The infection control program defines employee health issues. 3.2.4 The agency uses the Centers for Disease Control (CDC) and Prevention's guidelines for: 3.2.4.1 Prevention of infection with staff and with patient care. 3.2.4.3 Drug and medication preparation and administration. 3.3 The infection control program includes written policies and procedures related to 3.3.1 Compliance with documentation and reporting requirements of local, State, and Federal rules and regulations including: 3.3.1.1 Centers for Disease Control and Prevention, including the hand hygiene guidelines. 3.3.2 Compliance with accepted professional standards, principles, and practice requirements for employee health and patient care including State specific requirements. 3.3.3 Surveillance systems to track occurrence and transmission of infection. 3.3.4 Prevention and control processes including: 3.3.4.4 Personal protective precautions for staff and patients. ... 3.3.4..7 Communicable diseases. 3.4 The agency ensures staff knows and follows infection control policies and procedures by: 3.4.1 Providing orientation and annual continuing education programs for staff in prevention and control of infections including: ... 3.4.1.6 Record keeping 3.4.1.7 Incident investigating. 3.4.1.8 Local, State and Federal infection control requirements. 3.4.3 Providing ongoing staff education. ... 3.5 The agency's process for identification of infections among patients, families, caregivers, and staff: 3.5.1 Defines types of infections in patients and staff that must be reported. 3.5.1.1 Specific reportable infections include those defined in local, State and Federal regulations. 3.5.2 Reviews and analyzes infection data identifying unusual patterns and trends. 3.5.3 Determines the impact of infection and appropriate action to be taken. ... 3.5.5 Acts on infection findings to decrease the risk of infection. 3.6 To comply with reporting requirements, the agency: ... 3.6.1 Monitors incidents of infection in staff, patients and families. 3.6.2 Reports patient or staff illness to public health agencies as required by law. 3.6.3 Completes incident reports and infection control logs to document all exposure incidents and evidence of infection: 3.7 To control infection, the agency: 3.7.1 Documents and maintains records of infection occurrences and findings for staff and patients. ... 3.7.3 Provides education and educational resources on	G0680		

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G0680	Continued from page 107 prevention and control of infection for patients, families, and caregivers. 3.7.4 Documents patient education in the clinical record. Review of the infection control policy revealed no specific instructions or mention of Covid. The agency failed to define and implement an infection control program that utilized scientific methods for surveillance and prevention of infection, address current epidemiological issues and current standards of practice, failed to follow current standards of practice for prevention and screening of Covid, failed to ensure staff knew and followed infection control standards and policies, failed to develop a program that decreased the risk of infection and ensured staff were trained and knowledgeable in infection control measures, failed to keep adequate records of Covid infections among staff, patients, and respective families, including analysis of data to determine trends and provided direction for follow up to infected individuals. The program failed to include written policies and procedures which were compliant with requirements of local, state, and federal rules and regulations including the Centers for Disease Control and Prevention (CDC), and failed to report required infections to appropriate entities. 2. On March 17, 2021, at 2:39 PM, the administrator submitted a single-page document titled "Board of Directors Meeting, Emergency Meeting, Crawfordsville", and dated Tuesday, March 17, 2021. Review of the document revealed the members present. The meeting was called to order and the members reviewed the agency's current infectious control policies. The document evidenced " ...we purchased a new Briggs distributed Infectious Control Plan. Reviewed the new plan and its ability to meet required specifications." The document revealed the new infectious control policy met the required specification and was approved. The document also evidenced "Approved policy change from ISDH [Indiana Stated Department of Health] plan of correction 484.60." The meeting was then adjourned. The last sentence of this meeting note is not accurate for the removal plan (plan of correction as the agency indicates) was not approved on 3/17/19, and had to be revised and resubmitted by the agency 2 more times on 3/19/21. A review of the new infection control policy and	G0680		

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G0680	Continued from page 108 procedure manual revealed overlapping policies that contradicted with the original infection control policy and procedure manual. The Governing Body Minutes was requested and provided on 3/18/21 at 2:39 PM by the administrator. A review of the Governing Body Minutes dated 1/12/20, under the "Meeting adjourned" revealed an entry indicating "- Reviewed Emergency Preparedness Plan - Reviewed Infectious Control Plan." A review of the Governing Body Minutes dated 9/18/20, under the "Meeting adjourned" revealed an entry indicating "- Reviewed Emergency Preparedness Plan - Reviewed Infectious Control Plan - Reviewed CDC recommendation as well as Governors Executive Orders regarding Covid-19." 3. In regards to prescreening before entering the parent and branch offices and home visits: On 3/8/2, 3/9/21, and 3/10/21, on or around 9:00 AM each day, the Public Health Nurse Surveyors arrived at the parent agency of Indianapolis Home Care Plus and entered through the unlocked front entrance doors. The surveyors observed signage for hours of operation but failed to observe signage which stated instructions for prevention and/or protection of Covid such as mask, symptom screening, or hand hygiene. Agency staff were observed appropriately wearing face masks each day but failed to conduct an infection control screening for Covid, including symptom and exposure screening questions and a temperature. On 3/10/21 at 1:00 PM, during an interview with the alternate clinical manager, when asked about what tools she used to track prescreening of Covid calls, she stated "I take the home health aide schedule and call from it." When asked about prescreening the patients who are receiving skilled services, she stated "the home health aides go out the most." On 3/10/21 at 2:00 PM, upon arrival to the branch agency, the surveyor observed a sign on the locked front door of the agency which stated "We are open by phone or email only" followed by agency phone number and email. Employee I, Director of	G0680		

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G0680	Continued from page 109 Reimbursement, admitted the surveyors into the building but failed to complete Covid screening for symptoms and exposure and failed to give directions for the expectation of a mask. Employee I failed to conduct an appropriate infection control screening for Covid, including symptom and exposure screening questions and a temperature. On 3/12/21 and 3/15/21 on or around 9 AM each day, the surveyor observed the parent agency doors were locked. Employee B answered the door and obtained a temperature using a no touch forehead thermometer which initially registered each day between 94 and 95 degrees. After multiple attempts employee B obtained a temperature greater than 95, which was accepted, and asked the surveyor, "Are you having any symptoms or anything?" Employee B failed to log the screening results. Employee B failed to conduct an appropriate infection control screening for Covid, including symptom and exposure screening questions and failed to recognize and/ or address an inappropriate temperature. On 3/16/21 at 9 AM, employee B made 4 attempts to obtain a temperature reading on the surveyor, using a no-touch forehead thermometer, but was unable to obtain a result greater than 95 degrees. On the 5th attempt employee B obtained a result of 95.3 and stated, "Are you having any nausea/ vomiting/ diarrhea or have you been around others?" Employee B failed to log the screening results. Employee B failed to log the screening results. Employee B failed to conduct an appropriate infection control screening for Covid, including symptom and exposure screening questions and failed to recognize and/ or address an inappropriate temperature. After 3/16/21, employee B continued to screen the surveyors daily upon entry by completing a temperature and asking if the surveyors had "any symptoms" or "anything? nausea? vomiting?" Employee B failed to log any screening results between 3/12/21 and 3/22/21. Employee B failed to log the screening results. Employee B failed to conduct an appropriate infection control screening for Covid, including symptom and exposure screening questions and failed to recognize and/ or address an inappropriate temperature.	G0680		

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G0680	Continued from page 110 On 3/19/21 at 10:39 AM, when asked if they were documenting the prescreening for visitors, the alternate clinical manager tapped her head and stated "In my brain." In regards to the Infection Control Program: 4. On 3/8/21 at 10 AM, during the entrance interview, the surveyor announced a focused infection control survey related to Covid and requested all information related to employee education for Covid, agency policy/ procedure for Covid infection control, employee and patient tracking logs, and the agency's infection control and in-service program for Covid. The administrator provided an untitled binder which she referred to as the "Covid book" which revealed communication notes and that evidenced the agency had 8 Covid positive patients, 5 Covid positive employees, and 3 Covid positive employee family members in the last 12 months. The administrator stated she had provided all infection control and Covid information to the surveyor and no further information was available. A. Review of the "Employee Infection report summary log 2020" included dates, patient number, Infection type and description, date of notification to physician and family, type of actions and description, and follow-up comments. The log revealed the following: On 11/11, employee N, HHA, indicated the infection type was "R" for respiratory, infection description indicated a spouse was Covid +, dates of notification to physician and family were blank, actions indicated "T" [test] for type, description indicated "isolation for spouse", and follow-up/ comments indicated a "low grade tem [temp]." On 11/11, employee L, HHA, indicated the infection type was "R" for respiratory, infection description indicated "possible Covid exposure", dates of notification to physician and family were blank, action indicated "T" for type, description indicated negative, and follow-up/ comments indicated "isolation."	G0680		

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G0680	Continued from page 111 On 12/25, employee M, HHA, indicated the infection type was "R" for respiratory, infection description indicated "possible Covid exposure", dates of notification to physician and family were blank, action indicated "T" for type, description indicated "tested on 12/28, 12/27-body aches, te [temp]." The binder failed to evidence documentation that the agency followed up with patients/ and or caregivers, whom the employees were in contact with, to ensure they were not experiencing symptoms due to clinician exposure and failed to notify the patients physician to inform them of their patients exposure to the clinicians. B. Review of the "Patient Infection report summary log 2020" included dates, patient number, Infection type and description, date of notification to physician and family were blank, type of actions and description, and follow-up/ comments. The log revealed the following [entries were not documented in date order]: On 11/11, Patient # 67, indicated the infection type was "R" for respiratory, infection description indicated "Covid", "date notified/ physician and family" were blank, type of action and description indicated "HHA requests hold" and follow-up/ comments were blank. On 11/19, Patient #65, indicated the infection type was "R" for respiratory, infection description indicated "Covid-family +", date notified under physician and family "11/19 pt 11/24", type of action and description indicated "HHA, SN, PT requests hold" and follow-up/ comments were blank. On 11/16, Patient #116, indicated the infection type was "R" for respiratory, infection description indicated "Covid in home, date notified under physician indicated 11/16, date of family was blank, of action and description indicated "SN hold" and follow-up/ comments indicated "pt c symptomatic."	G0680		

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G0680	Continued from page 112 On 11/20, Patient #14, indicated the infection type was "R" for respiratory, infection description indicated "Covid in home" date notified under physician indicated 11/20, date notified under family was 11/27 , of action and description indicated "SN hold" and follow-up/ comments indicated "pt +" On 11/30, Patient #101, indicated the infection type was "R" for respiratory, infection description indicated "possible exposure", date notified under physician indicated 11/30, date of family was blank, of action and description indicated "HHA hold" and follow-up/ comments were left blank. On 12/25, Patient 24, indicated the infection type was "R" for respiratory, infection description indicated Covid + 12/25", date notified under physician indicated 12/25, date of family was blank, type of action and description indicated "hold HHA" and follow-up/ comments were left blank. The binder failed to evidence documentation that the agency followed up with all their employees who provided services to these patients to see if they have symptoms and quarantine due to exposure, and failed to include all the employees who were exposed on the employee 2020 Infection report summary log. C. Review of the "Patient Infection report summary log 2021" included dates, patient number, Infection type and description, date of notification to physician and family were blank, type of actions and description, and follow-up/ comments. The log revealed the following: On 1/07, Patient #23, indicated the infection type was "R" for respiratory, infection description indicated "Covid in Home ... ", date of notification to physician and family were blank, action indicated "T" for type, description indicated "family held services", and follow-up/ comments "pt [patient] negative."	G0680		

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G0680	Continued from page 113 The binder failed to evidence documentation that the agency followed up with all their employees who provided services to these patients to see if they have symptoms and quarantine due to exposure, and failed to include all the employees who were exposed on the employee 2020 Infection report summary log. 5. During an interview on 3/10/21 at 1:50 PM, the Administrator and Alternate Clinical Manager were queried concerning the agency's infection control program and Covid screening. When queried concerning the screening process, the Administrator stated she stayed "in tune with the CDC guidelines and listened to Dr. Faucci." The Administrator stated there was a note on the door that stated the agency was open but please call or email. The surveyor stated no note was observed other than hours of operation and the administrator stated she was referring to the branch agency and agreed that no signage was present on the parent agency door "because the agency doesn't have the foot traffic the other office has so it isn't necessary." When queried concerning current practices for Covid screening the Administrator stated, "The process is still the same. But everyone except one person has been vaccinated so we will re-evaluate that agency on April 1st." When asked for clarification concerning what will be re-evaluated, the Administrator stated she was referring to the branch and that Dr. Faucci said if all parties are vaccinated they do not have to wear masks in their work area or in small groups of vaccinated individuals. During further interview with the administrator and alternate clinical manager, the Administrator stated the Alternate Clinical Manager calls all patients the morning of the visit and asks Covid questions for patients and all individuals in the home. When asked what the "Covid questions" are, the administrator stated, "I don't know that the questions have really changed. Do you have any changes, cough, chills, fever?" The administrator and alternate clinical manager confirmed there is not a formal process in place to document the calls. The alternate clinical manager stated, "I don't know that there is documentation. I just started with the home health aide list and called." The Administrator stated, "We ask staff to self-report and we talk to everyone every day." The Administrator stated the staff contacted employee G, the Home Care Coordinator located at the branch. The	G0680		

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G0680	Continued from page 114 Administrator stated there is no tracking/ documentation of those calls but knew the process was working because there has been no cross infection between infected employees and patients and those not infected. When queried whether there was tracking/ documentation to support the absence of cross infection, the administrator asked the alternate clinical manager, "Do you have that handy?" The alternate clinical manager did not respond and no further information was available concerning tracking/ documentation related to cross infection. The administrator stated that there was no documentation available because they know their patients and employees and they talk to them every day. When asked if they knew how many patients, household members, and employees were reported positive over the last 12 months the administrator stated she did not know for sure but thought 5 or less for patients and less than 5 for employees. During further interview, the administrator and alternate clinical manager were queried concerning the process if a patient received a positive Covid test. The administrator stated she would remove any employees from the patient's home. When asked if they would contact the patient's physician, the administrator stated if a patient was able to handle his/her own affairs, they would encourage the patient to call the physician. If a patient was unable to handle his/her own affairs, the agency would contact the representative/POA. (Power of Attorney) The Administrator confirmed no formal tracking or contact tracing was in place and stated no policies for infection control had been added or modified in the last 12 months. In regards to the removal of the Immediate Jeopardy 7. On 3/22/21 at 10:09 AM, the administrator provided an untitled spreadsheet which revealed columns with titles of date, P/S (patient/staff), name, doctor, status/ symptoms, contacts, and status of household. The administrator stated this was their new Covid-19 tool to track screening. This document failed to include a level of detail that would allow contact tracing and follow-up. 8. On 3/22/21 10:11 AM, the administrator provided a single page, undated, document titled "Plan of Correction Response." The document revealed the	G0680		

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G0680	Continued from page 115 following: "On 3/16, the signs on the door had additional worded added. On 3/17, the daily Covid 19 screening calls that are made to the patient and staff ... are not documented on the visit schedule calendars. On 3/17, a revised spreadsheet was created to add to our current tracking and contact tracing activities. On 3/17, a new infection control policy and procedure manual was added to the existing manual. On 3/18, the clinical and clerical staff were updated on the new and revised infectious control policies." This was presented by the administrator to the following employees: employee K, E, I, O, G, C, D, alternate clinical manager, and administrator. On 3/18, [Name of alternate clinical manager] educated and updated home health aide staff about changes in policies and procedures" to employees P, Q, R, S, T, F, and N. The document failed to evidence the content of the education, which revised infection control policies that were mentioned, failed to evidence what additional wording was added for both offices, failed to evidence who would make the prescreening calls, failed to include the specific questions that would be asked for prescreening, how that information would be documented, and who to provide information to when calls indicate possible exposure. The new infection control policy and procedure manual revealed overlapping policies that contradicted with the original infection control policy and procedure manual. The agency also failed to ensure all 23 employees listed on the employee roster, that was completed by the administrator on 3/9/21, were included in the education provided on this document. 9. On 3/22/21 at 11:15 AM, per the agency's Immediate Jeopardy removal plan, the tracking tool/ form for Covid prescreening from 3/19/21 to 3/22/21 was requested to the alternate clinical manager. The alternate clinical manager stated they print out the employee schedules and write on it. The clinical manager provided 24 employee schedules from 3/17/21 to 3/27/21. A review of 21 home health aide schedules (calendar), revealed inconsistent prescreening. Some dates on the schedules either had a check mark under the last listed patient's name, handwritten "no symptoms" and an employee initials	G0680		

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G0680	Continued from page 116 on one day, then the next day the word "OK" handwritten next to each patient name listed on the schedule, and a check mark under the last patient name, handwritten "no symptoms" and employee initials. There were also schedules with no indication that the patient/ or caregiver have been prescreened prior to visits. A review of the alternate clinical supervisor schedule (calendar), failed to evidence any notation that patients were prescreened for Covid on Friday 3/19, Saturday 3/20 and Monday 3/22/21. A review of employee KK, RN revealed no patient names on the schedule, but had a hand written check mark on 3/19 and on 3/22, the schedule revealed a check mark and the alternate clinical supervisor initials only. The schedule failed to evidence any notation or provide any indication that the patients were prescreened for Covid. A review of employee H, RN, calendar revealed a list of patients to be seen on 3/22, with a checked mark and the alternate clinical supervisor initials only. The schedule failed to evidence any notation or provide any indication that the patients were prescreened for Covid.	G0680		
G0682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the alternate clinical manager failed to ensure she practiced proper hand hygiene while providing wound care to a patient for 1 of 1 patient's observed receiving wound care services by the agency. (Patient #1) Findings include: Review of an agency policy titled, "Administration/Operations Infection Control," dated April-04, revealed "3.0 POLICY/PROCEDURE 3.1	G0682		

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G0682	Continued from page 117 The agency has policies and procedure to ensure that staff provides patient care and services according to consistent standards of practice adopted and approved by the agency ...3.2 The agency follows a process to decrease the risk of infection for staff and patients ...3.3.2 Compliance with accepted professional standards, principles, and practice requirements for employee health and patient care including State specific requirements ...3.3.4 Prevention and control processes including 3.3.4.1 Personal hygiene, handwashing and attire. 3.4.4.2 Standard and universal precautions. 3.3.4.3 Aseptic procedures. 3.3.4.4 Personal protective precautions for staff and patients ..." Centers for Disease Control last updated January, 2021. When to Perform Hand Hygiene. Retrieved from cdc.gov/handhygiene/providers/index.html indicated "Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient. Before performing an aseptic task [e.g., placing an indwelling device] or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids or contaminated surfaces. Immediately after glove removal. Wash with Soap and Water: When hands are visibly soiled. ... After known or suspected exposure to spores.... When using alcohol-based hand sanitizer: Put product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. ... The CDC Guideline for Hand Hygiene in Healthcare Settings recommends: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product ... and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet. ... Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right time. ... When and How to Wear Gloves: Wear gloves ... when ... contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur ... Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly	G0682		

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G0682	Continued from page 118 soiled ... moving from work on a soiled body site to a clean body site on the same patient or in another .... " During a home visit observation on 8/9/21 at 2:15 PM, with patient #1, employee B, alternate clinical manager, was observed providing skilled care. Employee B put nursing bag on couch, without placing a barrier under bag. After obtaining the patient's blood pressure, Employee B then paced equipment back into bag without cleaning it. Employee B stated, "I clean my equipment in my trunk after I leave this is my dirty side of my bag. Employee B obtained wound supplies out of plastic bin, laid them on the coffee table without a barrier, was observed to remove old dressing, discarded into trash container. Employee B removed gloves discarded them in the trash and applied new gloves from sweater pocket without washing or sanitizing hands between glove changes. After Employee B was observed to cleanse wound with saline and gauze, threw gauze in the trash, discarding gloves in the trash, applied new gloves without washing or sanitizing hands between glove changes. After Employee B took wound measurements with a paper tape measuring tool. Employee B removed gloves discarded in the trash, applied new gloves from sweater pocket without washing or sanitizing hands between glove changes picked up the tube of Calmoseptine cream and applied cream to wound with gloved fingertip and not an applicator. Employee B removed gloves discarding into trash, applied new gloves from sweater pocket, without washing or sanitizing hands between glove changes opened gauze dressing with boarder adhesive dressing applied to Stage 2 open wound on area on right shoulder, removed gloves, applied new gloves from sweater pocket, without washing or sanitizing hands between glove changes opened foam dressing, applied, and secured with 2-inch paper tape down the middle of the dressing to adhering tape to skin. Employee B removed gloves discarding in trash assisted repositioning patient with pillows, before applying alcohol gel to hands. Employee B went to the kitchen and washed her hands. Employee B then opened a heart box containing brown prescription bottles with labels, took the old broken medication planner with bare hands took pills out of broken medication planner and placed in new one obtained from caregiver. Employee B then took the prescription bottles and continued to take pills out of the bottles and place them in the	G0682		

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G0682	Continued from page 119 medication planner with her bare fingers and hands. Employee B failed to take a temperature of patient #1 to ensure no signs or symptoms of infection. Employee B failed to pre-screen patient #1 for COVID-19. During an interview with the administrator on 3/12/21 at 3:55 PM, when queried about process of glove changing and hand hygiene during wound care stated, "Hand hygiene is to be done after gloves are removed and new gloves are applied, when you remove old dressing, when you open packages of dressings, before you touch the patient and after." 410 IAC 17-12-1(m)	G0682		
G0706	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the skilled nurses failed to appropriately assess patients temperatures, skin impairments, and renal access in 4 (Patients #1, 3, 12, 19) out of 4 active records reviewed of receiving skilled nursing services and failed to ensure all clinicians assess vital signs and pain assessments at each visit for 1 (Patient #3) out of 1 home visit with physical therapy. Findings Include: 1. A review of an agency policy, titled "Service Delivery: The Physician's Role", dated April 2004, revealed the following: " 2.0 Definitions: 2.1 Plan of care is a written plan developed with the participation of the professional staff and the patient, in consultation with and authorized by the physician, that supports the patient's medical, nursing, and social needs in the home setting and serves aa the basis of care delivery ...2.1.3 The plan is individualized to the patient's needs, strengths, limitations, goals and environment ...3.6 Staff notifies the physician,	G0706		

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G0706	Continued from page 120 if required, and documents accordingly about ...3.6.1 The patient's condition, treatment, outcomes and response. 3.6.2 Changes in the patient's condition that suggest a need to modify the plan of care..." 2. During a home visit patient #1 on 3/9/21 at 2:20 PM, the alternate clinical manager was not observed to obtain the patient's temperature, nor did the skilled nurse assess the patients lung sounds posteriorly as ordered per the plan of care. A review of the plan of care for the recertification period of 01/11/21 to 3/11/21 revealed orders for skilled nursing to assess and evaluate vital signs and cardiovascular status. The patient's diagnoses included but not limited to Pressure Ulcer of Right Upper Back, Stage 2, Methicillin-Resistant Staphylococcus Aureus Infection, Unspecified Site, Encounter for Change or Removal of Nonsurgical wound Dressing, Chronic Obstructive Pulmonary disease, unspecified, and Dependence on Supplemental Oxygen. Review of a skilled nursing visit note dated 2/17/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. Review of a skilled nursing visit note dated 2/24/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. Review of a skilled nursing visit note dated 3/2/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. Review of a skilled nursing visit note dated 3/9/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. 3. Review of plan of care for patient #3, start of care 2/22/21, contained a plan of care for the	G0706		

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G0706	Continued from page 121 certification period of 02/22/21 to 4/22/21, with orders for skilled nursing to assess and evaluate vital signs. The patient's diagnoses included but not limited to Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, Presence of Cardiac Pacemaker due to recent placement. Review of a skilled nursing visit note dated 2/22, 2/24, 3/5, and 3/10/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. 4. The clinical record of patient #5 was reviewed on 3/15/21 and contained an initial comprehensive assessment dated 9/18/20 revealed diagnoses of Abscess of Bursa, Left Elbow, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Change or Removal of Nonsurgical Wound Dressing, Disorder of White Blood Cells, and Multiple Sclerosis. The assessment failed to evidence that the patient's temperature had been checked as part of a vital sign assessment, and failed to assess wounds on left elbow and right knee. A review of the plan of care for the certification period of 9/18/20 to 11/16/20, with orders for skilled nursing to provide services 1 time a week for 1 week then 2 times a week for 2 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status, A review of skilled visit notes dated 9/23 and 9/28/20, failed to evidence the patient had temperature checked as part of a vital sign assessment, and failed to assess wounds on left elbow and right knee. Review of a skilled visit note dated 10/9/20, failed to evidence the patient had temperature checked as part of a vital sign assessment. 5. The clinical record of inactive patient #6 was reviewed on 3/12/202 contained a discharge/transfer summary dated 8/27/20. The	G0706		

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G0706	Continued from page 122 record further contained an electronically signed plan of care for 8/15/21 to 10/13/20. The plan of care with start of care date 8/15/20, indicated the following: "Diagnosis included: Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Therapeutic Drug Level Monitoring, Essential Hypertension, and Long Term Use of Insulin and further indicated Orders for Discipline and Treatment SN 1 week 7 Assess and evaluate vital signs, mentation, respiratory and cardiovascular status...Teach and reinforce proper infusion technique. Teach and reinforce proper flush technique utilizing SASH method ...Change central line dressing and caps every week (qwk) and prn utilizing sterile technique and supplies ..." A review of a skilled nursing visit note dated 8/15/20, failed to evidence the patient had temperature checked as part of a vital sign assessment, review of blood sugars as patient # 6 is insulin dependent and has sepsis following a procedure during initial comprehensive assessment visit. A review of skilled visit notes dated 8/17 and 8/24/20, failed to evidence a temperature was checked as part of the vital sign assessment. 6. Review of plan of care for patient #12, start of care 5/5/20, with a recertification period of 12/31/20 to 2/28/21 the order for discipline and treatment indicated, "SN 1 Every Other Week 10 Assess and evaluate vital signs, mentation, respiratory and cardiovascular status. Assess nutrition and hydration, bowel and bladder functioning, skin integrity. Teach actions, s/s of side effects and proper administration of medications. Assess safety of home environment. Draw CBC with diff (complete blood count with differential)/platelets q o week (every other week)., next draw due 1/11/21. Draw q o month (every other month) labs next due 1/2021: BMP (Basic Metabolic Panel), Phosphorous, Magnesium as ordered by Dr (Doctor)." Patient diagnosis include: Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring.	G0706		

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G0706	Continued from page 123 Review clinical record failed to evidence a physician order or communication note to the physician indicating the reason for missed skilled visit for date 1/11/21 and the reason for the blood not being obtained for a CBC with diff and Platelets, as ordered on the plan of care. Review of a skilled nursing visit note dated 1/13/21, failed to evidence the patient had temperature checked during visit. The nurse failed to assess and evaluate vital signs as ordered per the plan of care. Review of clinical record failed to evidence order for labs that were drawn during this visit. Review of a skilled nursing visit note dated 1/27, 2/10, and 2/24/21 failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. 7. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns. The medication list revealed silver sulfadiazine 1% cream was being applied to the skin/ end of toes daily. The note indicated for home care services "Evaluate and Treat" and indicated the patient had a left below the knee amputation, required dialysis 3 to 4 times a week, and requires skilled nursing for medication management and monitoring of dialysis. A review of the plan of care for the certification period of 01/28/21 to 3/28/21, with orders for skilled nursing to conduct a general assessment, assess disease process compliance, and disease management. The patient's diagnoses include but not limited to Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Long Term Use of Insulin.	G0706		

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G0706	Continued from page 124 Review of the comprehensive assessment dated 1/28/21, revealed the patient was going to dialysis three times a week. Review of a skilled nurse visit note dated 2/3, 2/14, 2/24, 3/4, ans 3/13/21, failed to evidence the patient had dialysis shunt assessed. The nurse failed to assess the patient's wound(s) and complete a skin assessment. The nurse failed to provide a general assessment and tasks as ordered on the plan of care. During an interview on 3/19/2021 at 10:45 AM, with the alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I am not in there for wound care I am doing just med set up, so I don't monitor dialysis or wound care." 8. During an interview with the alternate clinical manager on 3/12/2021 at 4:05 PM, when queried about vital signs and regarding temperatures being considered a vital sign and not being done during a home visit or in clinical note reviews, the administrator stated to the alternate clinical manager, "No, temperatures are to be taken, I have told you about that!" 9. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 10. During a home visit on 3/11/21 at 11:30 AM at patient #3's home with physical therapy, the therapist failed to conduct any form of an assessment such as vital signs and pain assessment prior to starting therapy exercises. The clinical record of patient #3 was reviewed on 3/11/21 and contained an initial comprehensive assessment dated 2/22/21. Patient diagnosis included: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, History of Falling, Repeated Falls, and Presence of Cardiac Pacemaker that was recently placed. The medication list identified that the patient was	G0706		

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G0706	Continued from page 125 taking tramadol 50 mg twice a day as needed for chronic pain and acetaminophen 325 mg two tablets every 6 hours as needed for arthritic pain. On 3/11/21 at 4:00 PM, the administrator and alternate clinical manager were questioned concerning when therapists perform vital signs on patients, in which the alternate clinical manager responded "if a patient is in distress, beyond a shadow of a doubt we do them." Upon verifying "if a patient is in distress", the administrator and alternate clinical manager both stated, "Yes." When asked about the expectation for a patient to have a pain assessment, the administrator stated, "We do pain assessments every visit on patients who have pain medication. If they don't take pain meds (medication) then maybe monthly. If there is a diagnosis that has pain in it, then every visit." 11. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-12-2(g)	G0706		
G0750	Home health aide services CFR(s): 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. This CONDITION is NOT MET as evidenced by: Based on observation, record review and interview, the Case Manager failed to ensure the aide care plan was individualized with patient specific instructions of all duties to be performed (See G798); failed to ensure they provided home health aide services to provide personal care services and not be assigned to a homemaker and failed to ensure all personal care services and housekeeping duties were provided as ordered on the plan of	G0750		

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G0750	Continued from page 126 care (See G800); and failed to ensure all home health aides provided hands on personal care as ordered in the plan of care (See G802). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of health care for all patients who are to be receiving personal care services from this provider.	G0750		
G0798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the Case Manager failed to ensure the aide care plan was individualized with patient specific instructions of all duties to be performed for 1 (Patients #1) out of 3 active records reviewed of patient's receiving home health aide only services Findings Include: 1. A review of an agency policy, titled "Service Delivery: The Physician's Role", dated April 2004, revealed the following: "2.0 Definitions: 2.1 Plan of care is a written plan developed with the participation of the professional staff and the patient, in consultation with and authorized by the physician, that supports the patient's medical, nursing, and social needs in the home setting and serves a the basis of care delivery ...2.1.3 The plan is individualized to the patient's needs .... " 2. Review of plan of care for patient #1, start of care 5/22/19, with a recertification period of	G0798		

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G0798	Continued from page 127 1/11/21 to 3/11/21 the order for discipline and treatment indicated, "Aide 1 week 9 HHA (home health aide) to assist with personal care, visits may last up to 2 hours one weekly." Review of an agency document titled "Home Health Aide Assignment" last dated on 1/7/21, indicated the patient was up with help, assist to bathroom, the patient has walker, wheelchair, hospital bed, bedside commode, handheld shower, reachers, shower chair, bath: bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn (when necessary), prepare and serve meals, keep kitchen clean, wash dishes, laundry (in home only), and clean bathroom. Review of the home health aide visit note dated 2/26/21, revealed the home health aide shampooed the patient's hair and clean the patient area that was not ordered on the plan of care. The aide care plan failed to be updated to meet the patient's ongoing care needs. Review of a home health aide visit note dated 3/5/21, revealed the home health aide shampooed the patient's hair and clean the patient area that was not ordered on the plan of care. The aide care plan failed to be updated to meet the patient's ongoing care needs. Review of a home health aide visit dated 3/9/21, revealed the home health aide shampooed the patient's hair and clean the patient area that was not ordered on the plan of care. The aide care plan failed to be updated to meet the patient's ongoing care needs. 3. During an interview on 3/18/21 at 2:20 PM, when queried about the plan of care, aide care plans, and aide visit notes matching process, the administrator stated, "The nurse seeing the patient is responsible to ensure the HHA care plan and visit notes match." 4. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance	G0798		

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G0798	Continued from page 128 before the surveyors departed, in which the administrator responded "I have nothing to say."	G0798		
G0800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure they provided home health aide services as ordered on the plan of care for 3 (Patients #1, 2, 8) out of 3 active records reviewed of patients receiving home health aide services only. Findings include: 1. Review of an agency policy titled; "Service Delivery Scope of Services" dated April 2004, revealed the following: "3.6 The agency provides home health aide services by qualified home health aides under the supervision of a registered nurse (or established qualified therapist) and in accordance with the plan of care established policies and procedure ..3.6.5 Home health aide duties include 3.6.5.1 Hands -on personal care. 3.6.5 The performance of simple procedures as an extension of nursing or therapy services. 3.6.5.3 Assisting with ambulation or exercise. 3.6.5.4 Reporting changes in the patient's condition and needs. 3.6.5.5 Completing appropriate records. 3.6.5.6 Household services essential to health care at home. 2. The clinical record of patient #1 was reviewed and contained a plan of care for the recertification period of 1/11/21 to 3/11/21, with orders for home health aide services to be provided 1 day a week for 9 weeks to assist with personal care.	G0800		

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G0800	Continued from page 129 A review of an agency document titled "Home Health Aide Assignment" dated 1/7/21, indicated the patient was up with help, assistance to the bathroom, the patient has a walker, wheelchair, hospital bed, bedside commode, handheld shower, reachers, shower chair, bath: bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn (when necessary), prepare and serve the meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom. Review of the home health aide visit note dated 2/26/21, failed to evidence the patient had a bath: bed, dress, nail & foot care, skin care, oral hygiene, shave, change linen, up with help, assist to the bathroom, prepare, and serve the meals, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visit dated 3/5/2021, failed to evidence that the patient had a bath, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve the meals, keep the kitchen clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visit dated 3/9/21, failed to evidence the patient had nail & foot care, oral hygiene, shave, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. 3. The clinical record for patient #2 was reviewed and contained a plan of care for the recertification period of 2/9/21 to 4/9/21, with orders for home health aide services to be provided 2 days a week for 1 week then 3 days a week for 8 weeks to assist with personal care, light housekeeping, meal prep. Review of an agency document titled "Home Health Aide Assignment" last dated 2/4/21, indicated the patient was to receive a bath/ shower: bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare and serve meals,	G0800		

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G0800	Continued from page 130 keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom. Review of a home health aide visits notes dated 2/15/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/17/21, failed to evidence the patient was up with help, hair comb, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/19/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/22/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide note dated 2/24/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/26/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 3/1/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom,	G0800		

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G0800	Continued from page 131 prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 3/3/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. 4. The clinical record of patient #8 was reviewed and contained a plan of care for the recertification period of 1/11/21 to 3/11/21, with orders for home health aide services to be provided 2 days a week for 9 weeks to assist with personal care, light housekeeping, meal prep. Visits may last up to 6 hours." Review of an agency document titled "Home Health Aide Assignment" last dated on 1/7/21, appliances: walker, walk-in shower, grab bars, handheld shower, SPC (single-point cane), hospital bed. Duties: bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, wash dishes, laundry (in-home only), clean bathroom, and handwritten in housekeeping Review of a home health aide visit note dated 1/12/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), clean bathroom, and housekeeping. The aide failed to follow the plan of care. Review of a home health aide visit note dated 1/14/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/19/21, failed to evidence the patient had a	G0800		

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G0800	Continued from page 132 bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/21/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/26/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/28/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/2/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered.	G0800		

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G0800	Continued from page 133 Review of a home health aide visit note dated 2/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/18/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/20/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/23/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/25/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave,	G0800		

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G0800	Continued from page 134 change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. 5. During an interview on 3/18/21 at 2:20 PM, when queried about the plan of care, aide care plans, and aide visit notes matching process, the administrator stated, "The nurse seeing the patient is responsible to ensure the HHA care plan and visit notes match." 6. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-13-1(a)	G0800		
G0802	Duties of a HH aide CFR(s): 484.80(g)(3) The duties of a home health aide include:	G0802		

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G0802	Continued from page 135 (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all home health aides provided hands on personal care as ordered in the plan of care for 2 of 5 records reviewed of patients who were to receive personal care services. (Patients #3 and 8) Findings Include: 1. Review of an agency policy titled; "Service Delivery Scope of Services" dated April 2004, revealed the following: "3.6 The agency provides home health aide services by qualified home health aides under the supervision of a registered nurse (or established qualified therapist) and in accordance with the plan of care established policies and procedure ... 3.6.5 Home health aide duties include 3.6.5.1 Hands -on personal care. ... " 2. The clinical record for patient #3, start of care 2/22/21, was reviewed and contained a plan of care for the certification period of 2/22/21 to 4/22/21, with orders for homemaker services 5 days a week for 8 weeks then 4 days a week for 1 week to assist with personal care. Review of an agency document titled "Home Health Aide Assignment" last dated on 2/22/21, indicated the patient was to have a shower, assist with dressing, combing of hair, nail & foot care, skin care, oral hygiene, and shave. Review of a home health aide visit note dated 2/22/21, the home health aide note indicated a visit was made from 1:00 to 3:00, the visit note	G0802		

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G0802	Continued from page 136 was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 2/23/21, the home health aide note indicated a visit was made from 12:48 to 2:18, the visit note was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 2/24/21, the home health aide note indicated a visit was made from 12:50 to 2:50, the visit note was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 2/26/21, the home health aide note indicated a visit was made from 2:50 to 4:50, the visit note was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 3/1/21, the home health aide note indicated a visit was made from 12:10 to 2:10, the visit note was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 3/2/21, the home health aide note indicated a visit was made from 1:10 to 3:10, the visit note was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 3/3/21, the home health aide note indicated a visit was made from 1:10 to 3:10, the visit note	G0802		

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G0802	Continued from page 137 was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 3/4/21, the home health aide note indicated a visit was made from 3:00 to 5:00, the visit note was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. Review of a home health aide visit note dated 3/5/21, the home health aide note indicated a visit was made from 12:55 to 3:55, the visit note was blank and failed to evidence that a home health aide was provided for personal hands on care: bath shower bed, dress, comb hair, nail & foot care, oral hygiene, and shave. 4. The clinical record of patient #8, 7/15/20, contained a plan of care for the recertification period of 1/11/21 to 3/11/21, with orders for home health aide services to be provided 2 days a week for 9 weeks to assist with personal care. Review of an agency document titled "Home Health Aide Assignment" last dated on 1/7/21, indicated the patient was to receive a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. Review of a home health aide visit note dated 1/12/21, the home health aide note indicated a visit was made from 11:18 to 5:00, failed to evidence that the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 1/14/21, the home health aide note indicated a visit was made from 8:00 to 2:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care.	G0802		

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G0802	Continued from page 138 Review of a home health aide visit note dated 1/19/21, the home health aide note indicated a visit was made from 12:40 to 5:40, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated on 1/21/21, the home health aide note indicated a visit was made from 7:10 to 8:10, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 1/21/21, the home health aide note indicated a visit was made from 8:40 to 1:45, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 1/26/21, the home health aide note indicated a visit was made from 7:00 to 1:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 1/28/21, the home health aide note indicated a visit was made from 8:50 to 2:50, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 2/2/21, the home health aide note indicated a visit was made from 7:00 to 1:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care.	G0802		

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G0802	Continued from page 139 Review of a home health aide visit note dated 2/4/21, the home health aide note indicated a visit was made from 9:00 to 3:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 2/9/21, the home health aide note indicated a visit was made from 8:00 to 10:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 2/9/21, the home health aide note indicated a visit was made from 2:30 to 5:30, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 2/11/21, the home health aide note indicated a visit was made from 7:30 to 12:30, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 2/18/21, the home health aide note indicated a visit was made from 8:20 to 1:20, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 2/20/21, the home health aide note indicated a visit was made from 10:00 to 3:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care.	G0802		

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G0802	Continued from page 140 Review of a home health aide visit note dated 2/23/21, the home health aide note indicated a visit was made from 8:05 to 1:05, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 2/25/21, the home health aide note indicated a visit was made from 8:00 to 1:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 3/4/21, the home health aide note indicated a visit was made from 11:58 to 4:58, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 3/9/21, the home health aide note indicated a visit was made from 8:00 to 1:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. Review of a home health aide visit note dated 3/11/21, the home health aide note indicated a visit was made from 12:40 to 5:00, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, and shave. The aide failed to provider hands-on personal care. 5. During an interview on 3/18/21 at 2:20 PM, when queried about the plan of care, aide care plans, and aide visit notes matching process, the administrator stated, "The nurse seeing the patient is responsible to ensure the HHA care plan and visit notes match."	G0802		

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G0802	Continued from page 141 6. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say." 410 IAC 17-14-1(h)(9)(A) 410 IAC 17-14-1(h)(9)(B) 410 IAC 17-14-1(h)(9)(C) 410 IAC 17-14-1(h)(9)(D) 410 IAC 17-14-1(h)(9)(E) 410 IAC 17-14-1(h)(9)(F) 410 IAC 17-14-1(h)(10) 410 IAC 17-14-1(h)(14)	G0802		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is NOT MET as evidenced by:	G0940		

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G0940	Continued from page 142 Based on record review and interview, the Administrator failed ensure they were responsible for all day to day operations of the parent and branch home health agency in regards to infection control; careplanning, coordination, quality of care; comprehensive assessments; complaints/ grievances; QAPI (quality assessment performance improvement); and clinical records (See G948); failed to ensure that a qualified, pre-designated person could act in the absence of the administrator/ clinical manager to assume the same responsibilities and obligations, was knowledgeable to their job title and duties and responsibilities, knowledgeable to the titles and duties of the administrative staff and failed to ensure the job descriptions match the title of the alternate administrator/ clinical manager (See G954); the Clinical Manager (also the Administrator) and Alternate Clinical Manager failed to ensure the coordination care and delivery with wound care, dialysis, cardiac, and infusion centers to meet the patient's needs (See G962); failed to ensure intital and recertification comprehensive assessments were complete and accurately reflected the patient's status, in order to ensure patient needs are completely met (See G966); failed to ensure patients received all care and services according to the written plan of care and that they were not placed on hold due to COVID-19 exposure, positive COVID-19 test, failed to ensure services were not placed on hold due to bedbugs and fleas, and failed to ensure nursing and personal care services were provided according to the written plan of care (See G968); and failed to ensure all nurses appropriately and accurately assess patients according to professional standards (See G984). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of health care for all 110 patients who are receiving services from this provider.	G0940		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA;	G0948		

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G0948	Continued from page 143 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the Administrator failed ensure they were responsible for all day to day operations of the parent and branch home health agency in regards to infection control; care planning, coordination, quality of care; comprehensive assessments; complaints/ grievances; QAPI (quality assessment performance improvement); and clinical records. Findings include: In regards to Infection Control 1. The administrator failed to maintain an infection control program with the goal of prevention and control, and investigation of infectious and communicable diseases, failed to keep adequate records of Covid infections among staff, patients, and respective families, including analysis of data to determine trends and provided direction for follow up/ contact tracing to infected individuals in relation to the Covid-19 pandemic, failed to follow current standards of practice for prevention and screening of Covid, failed to ensure staff were educated and followed infection control standards and policies, failed to have a system in place to ensure staff have the appropriate PPE (personal protective equipment) to wear when patients are exposed/ diagnosed with Covid-19, so patient services are not put on hold during their/ household exposure, and the program failed to include written policies and procedures which were compliant with requirements of local, state, and federal rules and regulations including the Centers for Disease Control and Prevention (CDC) (See G 680) and failed to ensure proper hand hygiene was conducted while providing wound care to a patient (See G682) . In regards to Care planning, coordination, quality of care 2. The administrator failed to ensure patients received all care and services according to the written plan of care and that they were not placed on hold due to COVID-19 exposure, positive	G0948		

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G0948	Continued from page 144 COVID-19 test; failed to ensure services were not placed on hold due to bedbugs and fleas; failed to ensure they provided home health aide services to meet the personal care needs of a patient; failed to ensure a home health aide provided hands on personal care as ordered (See G570); failed to ensure nursing and personal care services were provided according to the written plan of care (See G572); failed to ensure the individualized plan of care was supported by the comprehensive assessment and included all interventions and measurable goals identified by the agency and patient, all durable medical equipment (DME) and supplies, all treatment orders, diet, safety measures, diagnoses being supported by the comprehensive assessment, and call parameters individualized to the patients cardiopulmonary, endocrine, pain, and nutritional assessments, include nutritional requirements, indications for use and locations of topical medications, infection control precautions, patient-specific education and training provided, and the acceptance of orders that may be received/accepted by an outside physician, and ranges of hours per day were short in range and specific to patient needs (See G574); failed to ensure their physician orders were returned with date and signature of the ordering physician within a timely manner; failed to have a system and policy in place to ensure outstanding orders were followed up on within a timely manner so that services were not provided without a physicians signature; failed to address continued acceptance of patients from physicians with a documented history of failing to sign orders; failed to follow its own current policy for physician orders, including having verbal orders countersigned by a physician, maintaining open communication, obtaining complete orders for care; and the director of clinical services failed to maintain a liaison with the physician/ representative to ensure timely receipt of orders (See G584); failed to promptly alert the physician of changes in patient conditions (See G590); failed to ensure they communicated with all physicians involved in the patient's plan of care and documented those efforts within the patients' clinical record (See G602); and failed to coordinate care and delivery with wound care centers, dialysis facilities, and outside company/ facilities to meet the patient's needs (See G608). In regards to comprehensive assessments	G0948		

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G0948	Continued from page 145 3. The administrator failed to ensure the comprehensive assessments were complete and accurately reflected the patient's status, including current health, psychosocial, functional, and cognitive status to ensure the patients needs are being met (See G528); failed to ensure comprehensive assessments contained patient goals, strengths, and care preferences (See G530); and failed to ensure the medication list included indications for all PRN/ as needed medications and failed to evidence the location of application of topical medications was correct (See G536). In regards to complaints/ grievances being protected and kept in a safe area 4. On 3/8/21 at 10:18 AM, during an interview, the alternate clinical manager was queried concerning the agency process for managing complaints, incidents, or grievances. The alternate clinical manager stated the agency tracked complaints, grievances, and incidences together in the same log. When asked who oversaw handling complaints, the alternate administrator stated, "both of us", then clarified complaints were managed by herself and the administrator. She stated complaints were documented on a paper grievance form that included a "description of the complaint, who was involved, and the resolution." When asked who ultimately oversaw complaints, the alternate clinical manager stated it was the administrator. At 10:18 AM the surveyor requested to view the complaint/ incident/ grievance log for January 1, 2020-present. The alternate administrator stated she would bring the log but failed to return with the complaint log. 5. On 3/8/21 at 11:16 AM the surveyor asked the alternate clinical manager if she could obtain the complaint log. The alternate clinical manager stated the log was in the Greencastle office. When queried concerning why the log was not at the parent agency the alternate clinical manager had no further answer. At 11:17 AM the administrator arrived in the building, and immediately assumed the primary role for interviews. 6. At 11:17 AM the administrator arrived in the building, and immediately assumed the primary role	G0948		

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G0948	Continued from page 146 for interviews. At 11:20 AM, during an interview with the administrator, the surveyor asked if the administrator would like to repeat the entrance conference. She stated, "I don't want to answer all those questions." The surveyor requested the complaint log, and the administrator stated she would bring the log after the interview was over. The administrator failed to provide the complaint log when the interview was over. 7. On 3/8/21 at 1:17 PM the surveyor spoke with the administrator and requested the complaint log. The administrator stated, "I'll get it right now." The administrator failed to return with the complaint log. 8. On 3/8/21 at 1:45 PM the administrator was asked why no one had been able to provide the complaint log, despite answering at least 3 times that they were getting the log. The administrator stated, "We are just 2 people and we are getting everything as fast as we can." The surveyor stated that providing the log would allow the agency to focus on gathering other materials requested while the surveyor continued reviewing required items. The administrator stated she would bring the complaint log shortly. She failed to return with the complaint log. 9. On 3/8/21 at 2:35 PM the alternate clinical manager submitted a binder titled "OASIS Submission" and stated. "Here is the complaint log." When asked why the binder was labeled "OASIS Submission" she stated, "This is what the administrator told me to give you." 10. On 3/9/21 at 9:27 AM the administrator was asked if there were further grievance reports for 1/1/20 - present. The administrator stated, "We can't find the complaint log. We thought it fell behind a desk, or we took it to Greencastle. But we just can't find it. We think it accidentally got placed in storage and we are looking for it." 11. On 3/18/21 the administrator provided copies of grievance reports with dates reported of 2/24/20, 7/20/20, 7/22/20, 7/24/20, 9/9/20, 11/23/20, 12/1/20, and 12/30/20 and stated she had found them in storage but had not located the full	G0948		

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G0948	Continued from page 147 grievance log. In regards to QAPI 12. The Administrator failed to develop and maintain documented evidence of a Quality Assessment and Performance Improvement (QAPI) program that involved all agency services; failed to identify, measure, analyze, and track improvement indicators; failed to address the frequency with which measurement and analysis occurred; failed to maintain a coordinated, agency-wide program for surveillance, investigation, identification, prevention, control, and investigation of infectious and communicable diseases as an integral part of the program; failed to use measures derived from OASIS and other relevant data; failed to utilize the data collected to monitor the effectiveness and safety of services and the quality of care and identify opportunities for improvement; failed to identify incidence, prevalence, and severity of problems in high risk, high volume, or problem-prone areas; failed to develop performance improvement activities to track adverse events; failed to measure and document the success of performance improvement activities and track performance improvement to ensure improvements were sustained; and failed to document the quality improvement projects undertaken and the reasons for conducting specific projects, and the measurable progress achieved. (See G640) In regards to clinical records 13. The Administrator failed to ensure documentation in the patients record were accurate and failed to ensure to clinical records had up to date information of the agency's efforts/ attempts to notify the prescribing physician to obtain verbal orders and signatures. 410 IAC 17-12-1(b)(3) 410 IAC 17-12-1(d)(1) 410 IAC 17-12-1(d)(6)	G0948		

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G0948 G0954	Ensures qualified pre-designated person CFR(s): 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the Administrator failed to ensure that a qualified, pre-designated person could act in the absence of the administrator/ clinical manager to assume the same responsibilities and obligations, was knowledgeable to their job title and duties and responsibilities, knowledgeable to the titles and duties of the administrative staff and failed to ensure the job descriptions match the title of the alternate administrator/ clinical manager. Findings include: 1. On 3/8/21 at 9:00 AM, the surveyors were met by employee C, who identified herself at that time as the office manager. Employee C stated she would call the administrator and let her know of our arrival. At 9:10 AM employee C stated the administrator was on the phone and wanted to speak to a surveyor. During a phone conversation, the administrator stated, "I'm having outpatient surgery today and can be there around 11:30 or 12, but [name of employee B, the alternate administrator] is on her way from Greencastle. The administrator was informed that they can survey with the alternate for her not to cancel her surgery. At 9:30 AM, employee B arrived. When asked who was the agency's clinical manager, employee B stated, "I am" and went on to state that she had been the clinical manager and alternate administrator for 17 years." Employee B was queried as to whether she knew the administrator would be off that day, in which she responded, "I talk to her every day between 9 and 10. (AM)". When asked again if she knew the administrator would be out of the office today due to outpatient surgery, she appeared to become flustered and eventually stated "No." During the	G0948 G0954		

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G0954	Continued from page 149 entrance conference, employee B was asked what employee C's title was and she stated, "[Name of employee C] staffs the office and answers phones." When asked again for her job title, employee B stated she did not know her actual title. When queried who the alternate clinical manager was, the alternate clinical manager responded, "I don't know that one. The previous alternate clinical manager left the area but she did not know who was currently in that role." When asked for the agency census, employee B stated she did not know the exact number. When asked for an estimate of the active patient census, employee B stated she had no idea what the census was. Employee B was then queried concerning speech services provided by the agency. Employee B stated the agency offers speech therapy, but it can be 4-6 weeks before a therapist is available. When asked what the agency process is when there is a significant delay in services such as that, employee B stated she would notify the physician and the administrator, who finds an alternate therapist or an alternate plan, such as another agency. Employee B stated, "But most of the time it doesn't come to that because the patient is still in the hospital so they deal with that there." When asked to explain her statement, specifically how the agency receives orders and prepares 4-6 weeks in advance of a patient discharging from the hospital, the alternate clinical manager had no further comment. When asked how the delay is managed for patients who may need speech therapy and are already on service, employee B stated, "It can take 4-6 weeks. But most of those patients would be ready to discharge by that time, so they wouldn't need a speech by then because they would be better." Employee B failed to evidence an understanding of the need to address the patient's need for speech therapy immediately and failed to evidence understanding Medicare requirements when a patient needs the addition of services. The surveyor asked employee B if she was aware of the administrator was going to be in today, to which she responded "I don't know her schedule. I talk to her every day between 9 AM and 10 AM." When the question was repeated, employee B continued to reply that she calls the administrator every day between 9 and 10 AM. When the surveyor clarified the question once again if she was aware of the administrator was going to be at the office on this day, the alternate clinical manager stated, "No."	G0954		

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G0954	Continued from page 150 3. During an interview on 3/8/21 at 11:30 AM, when asked who was the agency's clinical manager, the administrator stated, "That's me." When questioned why employee B stated she was the clinical manager the administrator stated, "I don't know why she said that. She is the alternate clinical manager and alternate administrator. I'm the administrator and clinical manager." 4. On 3/8/21 at 1:54 PM, employee B was asked who had access to personnel files. Employee B stated only the administrator and employee D, the office manager, who is based out of the Greencastle office. When asked if she had access to the locked cabinets, employee B stated, "No. I don't have a key." When asked what would happen if the administrator and office manager were not available and a personnel file was needed, employee B stated, "[Name of administrator] had a key in her office." When asked for clarification as to whether she could obtain the key if she needed access to the files, employee B stated, "Yes." During this time, employee B was asked to bring a personnel file, to which she responded, "The cabinets are locked and I don't have a key." When asked as the alternate clinical manager and alternate administrator, doesn't she have the ability to unlock and access personnel files, and reminded her that she had stated that she had access to the key in the administrator's office, employee B stated the surveyor would have to wait for the arrival of the administrator. 5. On 3/11/21 at 4:00 PM, after observing a physical therapist failing to conduct any form of a vital sign or pain assessment before providing therapy services, the administrator and alternate clinical manager were questioned concerning when to do vital signs on patients. The alternate clinical manager stated they do vital signs "if a patient is in distress, beyond a shadow of a doubt we do them." When asked by the surveyor "So only if a patient is in distress?" the administrator and alternate clinical manager both stated, "Yes." When asked about the expectation for a patient to have a pain assessment, the administrator stated, "We do pain assessments every visit on patients who have pain medication. If they don't take pain meds (medication) then maybe monthly. If there is a diagnosis that has pain in it, then every	G0954		

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G0954	Continued from page 151 visit." 6. On 3/18/21 at 2 PM, a review of the personnel file for employee B revealed a job description titled "Director of Clinical Services", dated 10/25/04, a job description titled "Administrator", dated 4/18/01, and a job description titled "Nursing Supervisor" dated 10/25/04, all signed by employee B. The personnel files failed to evidence any job descriptions for the alternate clinical manager or an alternate administrator. On 3/18/21 at 3 PM, during an interview, the administrator was queried concerning the absence of job descriptions for employee B being the alternate administrator and alternate clinical manager, in which she responded "It's the same thing, right? They do the same thing so I just had her sign the job description for administrator and clinical manager." 410 IAC 17-12-1(c)(8)	G0954		
G0962	Coordinate patient care CFR(s): 484.105(c)(2) Coordinating patient care, This ELEMENT is NOT MET as evidenced by: Based on record review and interview the Administrator (also the Clinical Manager) failed to ensure the coordination care and delivery with wound care, dialysis, cardiac, and infusion centers to meet the patient's needs in 4 of 4 complete clinical records reviewed of patients receiving outside services. (Patients #3, 6, 8, 19) Findings Include: 1. Review of an agency policy titled, "Service Delivery Scope of Services" dated April 2004, revealed the following: "1.0 Purposes 1.1 Identify the patient population which the agency serves to ensure that the patients' medical, and social needs can be met adequately in the home ...1.3	G0962		

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G0962	Continued from page 152 Describe the responsibilities of services ...3.0 Policy/Procedure ...3.4 The agency provides skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care and established policies and procedures. The registered nurse ... 3.4.7 Coordinates services ... " 2. The clinical record of patient #3, the start of care dated 2/22/21, was reviewed on 3/11/21 and contained a plan for the certification period of 2/22/21 to 4/22/21. The patient's diagnoses included but were not limited to: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, and Presence of Cardiac Pacemaker. Review of an initial assessment dated 2/22/21 revealed a wound to the left foot - 3rd digit, that measured 0.5 centimeters (cm) length, 1.25 cm width, and 0.1 cm depth, with having serosanguinous drainage, and a description of the surrounding tissue is red and inflamed. The assessment further revealed a surgical wound to the left chest but was not observable due to a non-removable dressing due to a pacemaker placement. The comprehensive assessment/ clinical record failed to evidence if the RN notified the cardiologist regarding pacemaker coordination of care and pacemaker checks as well as treatment orders to the surgical wound and left foot. 3. The clinical record of patient #6 was reviewed on 3/12/2021. The record contained a plan of care for the certification period of 8/15/20 to 10/13/20. The plan of care, included, but was not limited to the following diagnoses: Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, and Long Term Use of Antibiotics." A review of a skilled nurse visit dated 8/24/20 indicated "Had received a call from patient last evening stating that her dressing was wet, came loose, she changed it and reported used the last one she had in her home. No other dressing change kits in the home reported that she went to ER to have it changed." The document/ clinical record failed to evidence the coordination of care with	G0962		

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G0962	Continued from page 153 the infusion company of needed supplies. 4. The clinical record of patient #8, the start of care 1/11/21, was reviewed on 3/16/21 and contained a plan of care for a recertification period of 1/11/21 to 3/11/2. The patient's diagnoses, included, but not limited to Hypertensive Heart and Chronic Kidney Disease with Heart Failure and with Stage 5 Chronic Kidney Disease, or End-Stage Renal Disease, End-Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Wegener's Granulomatosis with Renal involvement, Dependence on Renal Dialysis, Anemia in Chronic Kidney Disease, Old Myocardial Infarction, and the Presence of Coronary Angioplasty Implant and Graft. Review of the comprehensive reassessment dated 3/9/21 revealed the patient was receiving dialysis 3 days per week. The record failed to evidence coordination of care with the dialysis center to verify medications received during treatment, medications prescribed by the dialysis to take at home, fluid and diet restrictions, as well as any call orders for changes in condition. 6. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns and that the patient was receiving dialysis 3 to 4 times a week. Review of the plan of care for the certification period of 1/28/21 to 3/28/21, failed to evidence any information in relation to the patient's dialysis facility nor the wound clinic. The patient's diagnoses included but were not limited to the following diagnoses: Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. A review of an RN visit note dated 2/3/21 revealed	G0962		

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G0962	Continued from page 154 the patient's blood pressure was 172/80, and documentation revealed the family reported they were having difficulties with the dialysis company because the machine would not fill the pack, and they were using travel bags. The record fails to evidence that the RN coordinated care with the dialysis center. During an interview on 3/17/21 at 11:35 AM, the caregiver of patient #19 indicated the patient goes to a wound care center. The clinical record failed to evidence any coordination with the wound care center for treatment orders, call orders. During an interview on 3/19/2021 at 10:45 AM, employee B, alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I don't do anything with his dialysis or wound care." 7. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 8. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say."	G0962		
G0966	Assure patient needs are continually assessed CFR(s): 484.105(c)(4) Assuring that patient needs are continually assessed, and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the Clinical Manager (also the Administrator) and Alternate Clinical Manager failed to ensure initial and recertification comprehensive assessments were complete and accurately reflected the patient's status, in order to ensure patient needs are completely met in 6 out of 9 complete records reviewed. (#1, 3, 5, 6, 12, 19)	G0966		

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G0966	Continued from page 155 Findings Include: 1. Review of an agency policy titled, "Service Delivery Scope of Services" dated April 2004, revealed the following: "1.0 Purposes ... The registered nurse 3.4.1 Makes the initial evaluation and assessment visit and complete the comprehensive assessment except in those circumstances where the physician ordered only therapy services. 3.4.2 Regularly reevaluates the patient's nursing needs and updates the comprehensive assessment ... 3.4.5 Initiates appropriate preventive and rehabilitative skilled nursing procedures. ... 3.4.14 Follows the nursing process in identifying nursing-prescribed actions such as assessment and teaching ..." 2. During a home visit on 3/9/21 from 2:15 PM to 3:05 PM, patient #1 was observed completing a nebulizer treatment upon arrival. The patient was observed to have a nasal cannula in her nose with oxygen infusing. The alternate clinical manager was observed obtaining the patient's blood pressure while the patient was sitting up in bed, oxygen saturation, but failed to obtain a temperature. During this time, the patient reported to the Alternate Clinical Manager that she had burning upon urination. The patient appeared to be emaciated and underweight. The alternate clinical manager failed to obtain further information from the patient such as when did the burning start, if the patient has been running a temperature, odor, and if there was an increased frequency and urgency. During this visit, the alternate clinical manager was observed completing the medication set up but failed to reference a medication list during this time. The alternate clinical manager asked the patient if she was eating in which the patient responded that she had eggs in the morning. No other questions were asked about the patient's diet. The alternate clinical manager failed to check the patient's feet for bilateral pedal pulses, failed to assess capillary refill, failed to complete the fall risk time up and go the assessment, failed to take a blood pressure while standing and lying for orthostatic changes, failed to assess the all risk gait and balance for gait deviation, failed to appropriately assess the patient's diet and weight, and failed to assess the patient lungs	G0966		

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INDIANA HOME CARE PLUS	**1275 N JACKSON STREET , GREENCASTLE, Indiana, 46135**

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G0966	Continued from page 156 posteriorly. Per the medication list, the patient is prescribed and taking fentanyl for the chronic pain due to scoliosis. The alternate clinical manager failed to complete a pain assessment using the pain scale of 1 to 10 (1 being no pain and 10 being excruciating pain) or if the medication was effective. No education was provided during this visit. The only documentation left in the home was the home health aide care plan, which was not reviewed with the patient. A review of a recertification comprehensive assessment that was completed by the alternate clinical manager from the observation visit dated 3/9/21, revealed the patient had burning upon urination by conditions affecting genitourinary status, the temperature was blank and no further documentation regarding follow up. The blood pressure assessment inaccurately indicated that a blood pressure was taken standing and lying by indicating "Fall Risk orthostatic changes: 0 - No noted drop in blood pressure between lying and standing. No changes in cardiac rate." Further review of the recertification assessment failed to give weight, oxygen liter flow rate amount, address pain medication management, and the effectiveness of pain medication or other alternatives for pain relief. The recertification assessment revealed, "Safety Measures teach proper/ safe use of medications..." no education was observed completed verbally or written during home visit. Recertification assessment indicated that the alternate clinical manager conducted the following which was inconsistent with the above observations: "Follow-Up Notes ...Instructions/ Materials..1 - Patient Bill of Rights - Discussed, Copy left in the home, 2 - State home health hotline number - Discussed, Copy left in the home, 3 - Verification of benefits-Discussed, Copy left in the home, 4 - Advance Directives-Discussed, Copy left in the home, 5 - Home care service agreement -Discussed, Copy left in home 6 - Home health visit schedule-Discussed, Copy left in the home,7-Home health agency phone numbers (Regular hours/ after-hours/ weekends/ holidays) - Discussed, Copy left in the home, 8 - Emergency medical response plan -Discussed, Copy left in the home, 9 - Fire/ Evacuation response plan-Discussed, Copy left in the home, Hospice care option - Discussed, Copy left in-home ... Materials given to Patient. .... " The alternate clinical manager failed to conduct a complete a thorough assessment and accurately document the	G0966		

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G0966	Continued from page 157 education provided. A review of the recertification comprehensive assessment dated 1/17/21, indicated the alternate clinical manager visit was made from 3:30 PM to 3:45 PM. The diagnosis included: Pressure Ulcer of Right Upper Back, Stage 2, Methicillin-Resistant Staphylococcus Aureus Infection, Unspecified Site, Encounter for Change or Removal of Nonsurgical wound Dressing, Chronic Obstructive Pulmonary disease, unspecified, Dependence on Supplemental Oxygen, and Difficulty in Walking, Not Elsewhere Classified. The assessment revealed a Stage 2 pressure ulcer to the right upper back, which had slight, green, drainage. The vital sign assessment failed to evidence that a temperature was obtained (the entry line was left blank). The skin assessment identified the patient as a high-risk score for skin breakdown/ impairment by identifying "Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contracture, or agitation leads to almost constant friction." The assessment revealed dyspnea (shortness of breath) with minimal exertion, oxygen-dependent, and chronic pain location back. The assessment failed to include details related to pain management and relief, failed to include education reflective to treating moderate to severe pain, and failed to ensure medication was taken accurately. The assessment failed to address oxygen flow rate left blank and oxygen saturation level left blank being monitored, and nebulizer treatments. The patient #1 assessment identified the patient was immunocompromised and is a nutritional risk. The assessment failed to evidence a height and weight, as they were left blank. The assessment failed to include safety, fall risk, emotional Psychosocial, and DME (durable medical equipment). The alternate clinical manager visit note indicated a 15-minute visit was, therefore, the alternate failed to conduct a thorough comprehensive assessment of the patient During an interview 3/9/21 at 2:55 PM, when queried regarding the frequency of one time weekly for wound care, the alternate clinical manager indicated that the spouse did the dressing changes and she would complete them once a week with the	G0966		

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G0966	Continued from page 158 medication set-up. When queried about the home folder containing the agency information and state hotline, the alternate clinical director stated," They had to throw that away a while back when their water heater broke and flooded the back bedroom." 3. The clinical record of patient #3 was reviewed on 3/11/21 and contained an initial comprehensive assessment dated 2/22/21. Patient diagnosis included: Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, History of Falling, Repeated Falls, and Presence of Cardiac Pacemaker. The assessment failed to evidence the patient's that the temperature was taken (entry was blank) in the vital sign section. 4. The clinical record of patient #5 was reviewed on 3/15/21 and contained an initial comprehensive assessment dated 9/18/20 revealed diagnoses of Abscess of Bursa, Left Elbow, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Change or Removal of Nonsurgical Wound Dressing, Disorder of White Blood Cells, and Multiple Sclerosis. The assessment failed to evidence that the patient's temperature had been checked as part of a vital sign assessment, and failed to assess wounds on left elbow and right knee. 5. The clinical record of patient #6 was reviewed on 3/12/20 and contained an initial comprehensive assessment dated 8/15/20 which revealed patient diagnoses as "Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Therapeutic Drug Level Monitoring, Essential Hypertension, and Long Term Use of Insulin" A review of the initial comprehensive assessment failed to evidence the patient's temperature (left blank) as part of the vital sign assessment for a patient who is being treated for a septic infection. The assessment revealed patient is insulin-dependent but failed to evidence an assessment or documentation of the patient's blood sugars nor of a diabetic foot assessment. The RN documented the patient had a right chest tunneled catheter but failed evidence documentation of the appearance of the site,	G0966		

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G0966	Continued from page 159 measurement of the catheter for purposes to ensure the catheter does not come loose or dislodged. 6. The clinical record of patient #12 was reviewed 3/18/21, and contained a medication list which revealed liraglutide 0.6mg/0.1ml (18mg/3ml) subcutaneous inject 1.8 g by subcutaneous route every day for Type 2 Diabetes Mellitus. A review of a recertification comprehensive assessment dated 2/24/21, indicated an RN visit was made from 3:55 PM to 4:15 PM. The patient's diagnoses included: Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. The endocrine system section was left blank and failed to evidence that an assessment, including a diabetic foot care assessment, had been completed. The assessment revealed the patient had a condition of the inability to leave home due to a seizure disorder, mental health impairment, unsteady gait, and safety. The Neurological and Muscular System was left blank and failed to evidence that an assessment had been completed. The assessment failed to address seizures and patient mood and medication effects being therapeutic. The assessment failed to evidence the patient's acceptable lab values ranges for effective drug monitoring. The assessment failed to include details related to pain management and relief, failed to include education reflective to treating moderate to severe pain, and failed to ensure medication was taken accurately. The Medication assessment section indicated "Not Applicable (NA) - No injectables medications prescribed" upon answering the question of "Management of injectable medications." 7. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns. The medication list revealed silver sulfadiazine 1% cream was being applied to the skin/ end of toes daily. The note indicated for home care services "Evaluate and Treat" and indicated the patient had	G0966		

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G0966	Continued from page 160 a left below the knee amputation, required dialysis 3 to 4 times a week, and requires skilled nursing for medication management and monitoring of dialysis. A review of the initial comprehensive assessment dated 1/28/21 revealed the patient's diagnoses of Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. The assessment revealed the patient had chronic back pain but failed to evidence the details related to pain management and relief, and failed to ensure medication was taken accurately. The assessment indicated a dialysis shunt in the left upper extremity (LUE). The assessment failed to give details on appearance, bruit/ thrill of shunt, coordination, and documentation details of dialysis facility and times. The assessment indicated the patient had diabetes, the endocrine system section was left blank and failed to evidence that an assessment, including a diabetic foot care assessment, had been completed. The assessment indicated the patient has intermittent confusion short, long-term memory varies throughout the day, and forgetful. The assessment further revealed the management of injectable medications as the patient was able to independently take the correct medications and proper dosage at correct times. The assessment failed to evidence a correct detail of the patient's functional capacity of giving insulin. The assessment inaccurately indicated the skin was intact with no open areas. During an interview on 3/17/21 at 11:35 AM, the caregiver of patient #19 indicated they go to the wound care clinic. When queried about what the case manager does for the client stated, "She sets up his meds, checks his blood pressure, and checks out any complaints he may have." During an interview on 3/19/2021 at 10:45 AM, employee B, alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I am not in there for wound care I am doing just med set up, so I don't monitor	G0966		

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G0966	Continued from page 161 dialysis or wound care." The comprehensive assessment failed to evidence the patient received a complete and accurate assessment including the primary reason for home health admission, previous hospitalizations, the risk for hospitalization, endocrine/ hematology, integumentary, diabetic foot care/assessment, neurological/emotional, psychosocial, functional abilities/ limitations, urological, medication management and reconciliation, including the ability to take and set up medications properly, DME, therapy needs, education/ knowledge of patient and caregivers with demonstrations, care coordination of other agencies provided wound care and dialysis set up, secondary diagnosis, and infection control. 8. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 9. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say."	G0966		
G0968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the Clinical Manager (also the Administrator) failed to ensure patients received all care and services according to the written plan of care and that they were not placed on hold due to COVID-19 exposure, positive COVID-19 test in 4 out of 5 interviews conducted (Patients #9, 14, 23, 24), failed to ensure services were not placed on hold due to bedbugs and fleas for 3 out of 3 grievances documented (Patient #58, 92, 98); and failed to ensure nursing and personal care services were provided	G0968		

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G0968	Continued from page 162 according to the written plan of care for 7 of 7 complete records reviewed. (Patients #1, 2, 3, 8, 12, 19, 22) Findings Include: 1. Review of an agency policy titled, "Service Delivery Scope of Services" dated April 2004, revealed the following: "... 3.0 Policy/ Procedure ...3.4 The agency provides skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care and established policies and procedures...." 2. During a home visit patient #1, on 3/9/21 from 2:15 PM to 3:05 PM, the clinical manager was observed skilled nurse obtaining blood pressure, pulse, pulse oximeter, respirations, and listened to anterior right upper field, mid apical area, and then right upper and mid-region and lower field of the chest. The skilled nurse failed to listen to the posteriorly for cardiopulmonary assessment and temperature as ordered on the plan of care. The alternate clinical manager failed to obtain a temperature. During this time, the patient reported to the Alternate Clinical Manager that she had to burn upon urination. The patient appeared to be emaciated and underweight. The alternate clinical manager failed to obtain further information from the patient such as when did the burning start, if the patient has been running a temperature, odor, and if there was an increased frequency and urgency. During this visit, the alternate clinical manager was observed completing the medication set up but failed to reference a medication list during this time. The alternate clinical manager asked the patient if she was eating in which the patient responded that she had eggs in the morning. No other questions were asked about the patient's diet. The alternate clinical manager failed to check the patient's feet for bilateral pedal pulses, failed to assess capillary refill, failed to complete the fall risk time up and go the assessment, failed to take a blood pressure while standing and lying for orthostatic changes, failed to assess the all risk gait and balance for gait deviation, failed to appropriately assess the patient's diet and weight, and failed to assess the patient lungs posteriorly. Per the medication list, the patient	G0968		

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G0968	Continued from page 163 is prescribed and taking fentanyl for the chronic pain due to scoliosis. The alternate clinical manager failed to complete a pain assessment using the pain scale of 1 to 10 (1 being no pain and 10 being excruciating pain) or if the medication was effective. No education was provided during this visit. The only documentation left in the home was the home health aide care plan, which was not reviewed with the patient. A review of the plan of care for a recertification period of 1/11/21 to 3/11/21, the plan of care indicated, "Orders for disciplines and Treatment: 1/11/2021-3/11/21-SN 1 week 9 Assess and evaluate vital signs, mentation, respiratory and cardiovascular status. Assess nutrition and hydration, bowel and bladder functioning, skin integrity. Teach s/s of side effects and proper administration of medication. Assess safety of home environment ... Aide 1 week 9 HHA (home health aide) to assist with personal care, visits may last up to 2 hours one weekly." Review of an agency document titled "Home Health Aide Assignment" last dated 1/7/21, indicated the patient was up with help, assistance to the bathroom, the patient has a walker, wheelchair, hospital bed, bedside commode, handheld shower, reachers, shower chair, bath: bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn (when necessary), prepare and serve the meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom. Review of a skilled nursing visit note dated 2/17/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care. Review of a skilled nursing visit note dated 2/24/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care. Review of the home health aide visit note dated 2/26/21, failed to evidence the patient had a	G0968		

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G0968	Continued from page 164 bath: bed, dress, nail & foot care, skin care, oral hygiene, shave, change linen, up with help, assist to the bathroom, prepare, and serve the meals, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a skilled nursing visit note dated 3/2/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care. Review of a home health aide visit dated 3/5/2021, failed to evidence that the patient had a bath, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve the meals, keep the kitchen clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visit dated 3/9/21, failed to evidence the patient had nail & foot care, oral hygiene, shave, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a skilled nursing visit note dated 3/9/21, failed to evidence the patient had temperature checked. The nurse failed to provide all vital signs tasks as ordered on the plan of care. 4. Review of the plan of care for patient #2, the start of care 5/22/19, with a recertification period of 2/9/21 to 4/9/21 the order for discipline and treatment indicated, "Aide 2 week 1; 3 weeks 8 HHA to assist with personal care, light housekeeping, meal prep." Review of an agency document titled "Home Health Aide Assignment" last dated on 2/4/21, indicated the patient was to receive a bath/ shower: bed, dress, comb hair, nail & foot care, skin care,	G0968		

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G0968	Continued from page 165 oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom. Review of a home health aide visits notes dated 2/15/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/17/21, failed to evidence the patient was up with help, hair comb, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/19/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/22/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide note dated 2/24/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 2/26/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the	G0968		

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G0968	Continued from page 166 bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 3/1/21, failed to evidence the patient had oral hygiene, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. Review of a home health aide visits notes dated 3/3/21, failed to evidence the patient had oral hygiene, change linen, up with help, assist to the bathroom, prepare, and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom. The aide failed to follow the plan of care as ordered. 5. Review of the plan of care for patient #3, the start of care 2/22/21, with an initial certification period of 2/22/21 to 4/22/21 the order for discipline and treatment revealed, "SN 2 week 2; 1 week 2. Assess and evaluate vital signs, mentation, respiratory and cardiovascular status...HM (Homemaker) 5 week 8, 4-week 1 Homemaker to assist with personal care, light housekeeping, meal prep. May run errands per pt (patient) request per private pay services. Visits to last up to 2 hours. Review of an agency document titled "Home Health Aide Assignment" last dated 2/22/21, indicated the patient was up with help (if needed), assist to the bathroom (if needed), the patient has rollator x2, shower chair, handrails, tall toilet, canes, stairs chair, and reachers. bath: shower bed, dress, comb hair, nail & foot care, skincare, oral hygiene, shave, change linen prn, prepare, and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), and clean bathroom, floor care, may clean cat boxes. Review of a home health aide visit note dated 2/22/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up	G0968		

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G0968	Continued from page 167 with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/23/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to the plan of care as ordered. Review of a skilled nursing visit notes dated 2/24, 3/5, and 3/10/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. Review of a home health aide visit note dated 2/24/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/26/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/1/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot	G0968		

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G0968	Continued from page 168 care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/2/21, the home health aide note indicated a visit was made from 1:10 to 3:10, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/3/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/4/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean cat boxes. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/5/21, failed to evidence the patient had bath shower bed, dress, comb hair, nail & foot care, oral hygiene, shave, change linen prn, up with help if needed, assist to the bathroom if needed prepare and serve the meal, keep the kitchen area clean, wash dishes, laundry (in the home), and clean bathroom, floor care, may clean	G0968		

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G0968	Continued from page 169 cat boxes. The aide failed to follow the plan of care as ordered. Review of a skilled nursing visit note dated 3/10/21, failed to evidence the patient had temperature checked as part of the vital sign assessment as ordered on the plan of care. 6. Review of a signed plan of care for patient #8, the start of care 7/15/20, with a recertification period of 1/11/21 to 3/11/21 the order for discipline and treatment revealed, "Aide 2 week 9 HHA to assist with personal care, light housekeeping, meal prep. Visits may last up to 6 hours." The range of "up to 6 hours" were large and failed to be specific to the patient's needs. Review of an agency document titled "Home Health Aide Assignment" last dated on 1/7/21, appliances: walker, walk-in shower, grab bars, handheld shower, SPC (single-point cane), hospital bed. Duties: bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, wash dishes, laundry (in-home only), clean bathroom, and handwritten in housekeeping Review of a home health aide visit note dated 1/12/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, laundry (in-home only), clean bathroom, and housekeeping. The aide failed to follow the plan of care. Review of a home health aide visit note dated 1/14/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered.	G0968		

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G0968	Continued from page 170 Review of a home health aide visit note dated 1/19/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/21/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/26/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve meals, keep kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/28/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/2/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated	G0968		

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G0968	Continued from page 171 2/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/18/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/20/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/23/21, failed to evidence the patient had a	G0968		

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G0968	Continued from page 172 bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 2/25/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/4/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/9/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, change linen prn, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 3/11/21, failed to evidence the patient had a bath: tub, shower, bed, dress, comb hair, nail & foot care, skin care, oral hygiene, shave, up with help, assist to the bathroom, prepare, and serve meals, keep the kitchen clean, wash dishes, clean bathroom, and housekeeping. The aide failed to follow the plan of care as ordered. 7. Review of the plan of care for patient #12, the start of care 5/5/20, with a recertification period of 12/31/20 to 2/28/21 the order for discipline and treatment revealed, "SN 1 Every	G0968		

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G0968	Continued from page 173 Other Week 10 Assess and evaluate vital signs, mentation, respiratory and cardiovascular status. Assess nutrition and hydration, bowel and bladder functioning, skin integrity. Teach actions, s/s of side effects, and proper administration of medications. Assess the safety of the home environment. Draw CBC with diff (complete blood count with differential)/platelets q o week (every other week)., next draw due 1/11/21. Draw q o month (every other month) labs next due 1/2021: BMP (Basic Metabolic Panel), Phosphorous, Magnesium as ordered by Dr (Doctor)." Patient diagnosis includes Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. Review of a skilled nursing visit note dated 12/29/20, failed to evidence the patient had temperature checked during comprehensive recertification assessment visit. The nurse failed to assess temperature as a part of vital signs as ordered in the plan of care. Review clinical record failed to evidence a physician order or communication note to the physician indicating the reason for a missed skilled visit for date 1/11/21 and the reason for the blood not being obtained for a CBC with diff and Platelets, as ordered on the plan of care. Review of a skilled nursing visit note dated 1/13/21, failed to evidence the patient had temperature checked during the visit. The nurse failed to assess and evaluate vital signs as ordered in the plan of care. A review of the clinical record failed to evidence an order for labs, CBC with diff and Platelets, that were drawn during this visit. Review of a skilled nursing visit note dated 1/27, 2/10, and 2/24/21 failed to evidence the patient had temperature checked as a vital sign assessment as ordered on the plan of care. During an interview on 3/17/21 at 1:05 PM, patient #12 stated, "I have had a terrible cough and I am on my second dose of antibiotics that I had to go	G0968		

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G0968	Continued from page 174 to the doctor to get treated for." When queried about nurse visiting patient #12 stated, "They have been short-staffed, I had to go get my labs done at the hospital and see my doctor for this cough." 8. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns. The medication list revealed silver sulfadiazine 1% cream was being applied to the skin/ end of toes daily. The note indicated for home care services "Evaluate and Treat" and indicated the patient had a left below the knee amputation, required dialysis 3 to 4 times a week, and requires skilled nursing for medication management and monitoring of dialysis. A review of the plan of care for the certification period of 01/28/21 to 3/28/21, with orders for skilled nursing to conduct a general assessment, assess disease process compliance, and disease management. The patient's diagnoses include but not limited to Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Long Term Use of Insulin. Review of the comprehensive assessment dated 1/28/21, revealed the patient was going to dialysis three times a week. Review of a skilled nurse visit note dated 2/3, 2/14, 2/24, 3/4, 3/13/21, failed to evidence the patient had dialysis shunt assessed. The nurse failed to assess the patient's wound(s) and complete a skin assessment. The nurse failed to provide a general assessment and tasks as ordered on the plan of care. During an interview on 3/19/2021 at 10:45 AM, with the alternate clinical manager, stated, "I am not doing wound care, the wound care center and his	G0968		

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G0968	Continued from page 175 daughter are. I am not in there for wound care I am doing just med set up, so I don't monitor dialysis or wound care." 9. Review of a signed plan of care for patient #22, the start of care 7/12/18, with a recertification period of 12/28/20 to 2/25/21 the order for discipline and treatment indicated, "AC (Attendant care) 2 week 8; 1 week 1. Attendant care to assist with personal care, light housekeeping, and meal prep, visits may last up to 2 hours, twice weekly. HM (homemaker) 1 week 9 Homemaker services to perform light housekeeping, meal prep. Visits may last up to 2 hours." A review of an agency document titled "Home Health Aide Assignment" last dated 12/24/20, indicated keep kitchen clean, wash dishes, laundry (in-home only) clean bathrooms handwritten in housekeeping. Review of a home health aide visit note dated 12/2820, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 12/29/20, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 12/30/20, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/5/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered.	G0968		

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G0968	Continued from page 176 Review of a home health aide visit note dated 1/6/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/8/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/11/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/13/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/15/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/18/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/20/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered.	G0968		

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G0968	Continued from page 177 Review of a home health aide visit note dated 1/22/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/25/21, the home health aide note indicated a visit was made from 7:40 to 9:40, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes and keep the kitchen clean. The aide failed to follow the plan of care as ordered. Review of a home health aide visit note dated 1/27/21failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. On 1/29/21, 2/1/21, 2/3/21, 2/5/21, and 2/8/21, the visit notes were marked as missed visits and documented by the aide as "no answer." Review of a home health aide visit note dated 2/10/21, failed to evidence the patient had a clean bathroom, housekeeping, laundry (in-home only), wash dishes, and keep the kitchen clean. The aide failed to follow the plan of care as ordered. 10. Review of a "Grievance Report" for patient #58, reported 7/22/20, revealed a "Nature of Grievance" entry which evidenced "[Name of employee V, home health aide] called to report that she found bed bugs in [name of patient #58]'s bed." Review of the "Disposition of Grievance" revealed "Spoke with patient and his brother. Informed them that until home was treated we could not return." A follow up entry revealed "Home cleaned." The document revealed a resolution date of 8/15/20. The patient went without services for nearly 24 days. 11. Review of a "Grievance Report" for patient #92, reported 9/9/20, revealed a "Nature of Grievance" entry which evidenced "HHA [name of	G0968		

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G0968	Continued from page 178 employee Q, home health aide] called in to report that [name of patient #92] had bed bugs." Review of the "Disposition of Grievance" entry evidenced "Spoke with pt/family. Informed them that home would have to be treated professionally before we could return." A follow up entry revealed "Home Cleaned." The document revealed a resolution date of 9/16/20. The patient went without services for nearly 7 days. 12. Review of a "Grievance Report" for patient #98, reported 12/1/20, revealed a "Nature of Grievance" entry which evidenced "[Name of employee F, home health aide] called to report that [name of patient #98] house was full of fleas." Review of the "Disposition of Grievance" entry evidenced "Spoke with pt [patient], informed him that home would have to be treated for fleas before we could return for visits...." A follow up entry revealed "Home Cleaned." The document revealed a resolution date of 12/10/20. The patient went without services for nearly 9 days 13. The closed record of clinical record of former patient #9 was reviewed on 3/19/2021 at 10:16 AM. The clinical record contained a document titled "Case Communication Report" entered 12/4/2020 at 3:42 PM by Employee B, "Subject: COVID +11/19/20-Wife and son are COVID positive, requesting to hold ALL visits at this time. 11/24/20-Patient is now COVID positive. Patient reported that he, wife, and son are just very tired at this point. Continues to request to hold ALL visits at this time." The discharged record failed to evidence any further documentation of the agency following up. During an interview on 3/19/2021 at 11:51 AM, when queried former patient #9 about his request not to have services while he and his family had COVID 19 he stated, "My wife and son tested positive on 11/18/2020 then I tested positive on 11/24/2020. I went to Entity I, a Hospital for that infusion, but I was not admitted I came back home. I then was in the hospital 12/30/2020 with fluid retention they put me on that IV Lasix and kept me. I was back in on 1/4/2021 had to have the dialysis catheter put in my neck and received 1 treatment. I got to come home on 1/7/2021." When asked about his homecare services he stated, "A lady came out here once to give me a bath and when	G0968		

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G0968	Continued from page 179 we let her know that we have had COVID she left, and no one ever came back." When asked if he requested services to be on hold, patient #9 stated "No, I needed help." The clinical record failed to evidence any documentation that the agency followed up with this former patient when the agency put the patient's services on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19. 14. The clinical record of patient #14 was reviewed on 3/19/2021 at 10:21 AM. The clinical record contained a document titled "Case Communication Report" entered 12/4/2020 at 4:15 PM by Employee B, "Subject: COVID +11/13/20-Not feeling well, IV next Week. 11/20/20-Not administering IV this week, COVID present in home. 11/27/20 -IV next week, patient/family out of quarantine on 11/30/20. Patient still has not recovered taste/smell, no temp." During an interview on 3/19/2021 at 12:03 PM with patient #14, when queried about if the staff call and prescreen for COVID 19, she stated, "Not the nurse who is coming this week my regular nurse calls that week and does ask the prescreening questions." When queried about requesting services to be put on hold, Patient #14 stated she did not request services to be put on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19. 15. The clinical record of patient #23 was reviewed on 3/19/2021 at 10:26 AM. The clinical record contained a document titled "Case Communication Report" entered 1/11/2021 at 7:45 AM by Employee B, Subject: COVID +1/7/21-Hold COVID in home 1/7/21. Patients son in law tested + for COVID, will be out of quarantine on 1/18/21, as long as no else tests +, requesting to hold visits until then. Patient to have MD home visit on 1/19/21." During an interview on 3/19/2021 at 12:15 PM with individual H, caregiver of patient #23, when queried about services being put on hold, Individual H stated the agency told the patient that they (patient/ family) were in quaratine for 14 days and the agency will resume care after	G0968		

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G0968	Continued from page 180 quarantine. Individual H stated they did not request to be put on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19. 16. The clinical record of patient #24 was reviewed on 3/19/2021. The clinical record contained a document titled "Case Communication Report" entered 12/26/2020 at 10:31 AM by Employee B, "Subject: COVID - Spoke with patient, is COVID + hold visits at this time MD aware, he sent her for testing." During interview on 3/19/2021 at 1:08 PM with patient #24, when queried about requesting services to be put on hold, Patient #24 stated she did not ask for her services to be placed on hold. The agency failed to meet the needs of the patient by failing to provide services after exposure to COVID-19. 17. During an interview with the alternate clinical manager on 3/12/2021 at 4:05 PM, when queried about vital signs and regarding temperatures being considered a vital sign and not being done during a home visit or in clinical note reviews, the administrator stated to the alternate clinical manager, "No, temperatures are to be taken, I have told you about that!" 18. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 19. During an interview on 3/18/21 at 2:20 PM, when queried about the plan of care, home health aide care plan and their visit notes matching process, the administrator stated, "The nurse seeing the patient is responsible to ensure the HHA care plan and visit notes match." 20. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the	G0968		

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G0968	Continued from page 181 administrator responded "I have nothing to say."	G0968		
G0984	In accordance with current clinical practice CFR(s): 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the Clinical Manager (also the Administrator) and Alternate Clinical Manager failed to ensure all nurses appropriately and accurately assess patients according to professional standards for 6 of 9 complete records reviewed. (#1, 3, 5, 6, 12, 19) Findings Include: 1. Review of an agency undated job description titled," Indiana Home Care Plus Registered Nurse" signed by the Administrator, revealed the following: "Definition: The registered Nurse is a highly skilled professional who, through education and experience, has developed a high level of sophistication in observation and judgement and can function independently on supervision to conform to the Nursing Care Plan per the physician's Plan of Treatment and the state's Nurse Practice Act ..." 2. Constantine, L., MSN, RN, C-FNP. (2004, June 15). Overview of Nursing Health Assessment. Retrieved January 16, 2019, from rn.com "... PULMONARY ASSESSMENT: When examining the pulmonary system ... Inspect the thoracic cage, palpate the thoracic cage, Auscultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth, Auscultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds. .... " 3. Nurse.org, dated April 7, 2020, indicated: "How to Conduct a Head-to-Toe Assessment : ... LENGTH OF ASSESSMENT ... the duration of the exam is	G0984		

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G0984	Continued from page 182 directly in correlation to the patient's overall health status. Health patients with limited health histories may be completed in less than 30 minutes" The Order of a Head-to-Toe Assessment: 1. GENERAL STATUS: Vital signs; ... Temperature; ... Pain. 2. HEAD, EARS, EYES, NOSE, THROAT ... 3. NECK ... 4. RESPIRATORY: Listen to lung sounds front and back; Assess respiratory expansion level; Ask about coughing; Palpate thorax. 5. CARDIAC: Palpate the carotid and temporal pulses bilaterally; Listen to heartbeat. 6. ABDOMEN: ... Ask about problems with bowel or bladder. 7. PULSES: Check pulses in arms/legs/feet including, Radial, Femora, Posterior tibial, Dorsalis pedis. 8. EXTREMITIES: ... Check capillary refill on fingernails/toenails. 9. SKIN: Check skin turgor; Check for lesions, abrasions, rashes; Check for tenderness, lumps, lesions; Check if patient is pale, clammy, dry, cold, hot, flushed. 10. NEUROLOGICAL: Oriented x3; Assess gait; Check coordination; Assess reflexes; Check Glasgow Coma Scale." 4. Quality of Nursing Practice in Arteriovenous Fistula Care at kidneyregistrylb.com/wp-content/uploads/2021/05/AVF-NursingCare dated 5/10/2012, indicated " ... Inspection: look for ecchymosis/discoloration, breaks in the skin, erythema, aneurysm, hematoma formations, curves/ flat spots ... hand or arm or limb swelling, discoloration of nail beds, presence of accessory veins. Palpation: Feel thrill or pulsation ... Vein diameter, flat spots, aneurysms, skin temperature [warm - infection? cold - steal syndrome]. Auscultation: listen quality and amplitude of bruit: sounds should be continuous. ... Vascular access remains the single most important and modifiable risk factor for death and illness in the hemodialysis population. Preserving vascular access patency strongly influences treatment outcomes for patients .... " 5. Diabetes Mellitus: Nursing Care Management at https://nurseslabs.com/diabetes-mellitus/#nursing_management dated 6/5/2020 indicated " ... The nurse should assess the following for patients with Diabetes Mellitus: Assess the patient's history. To determine if there is presence of diabetes, assessment of history of symptoms related to the diagnosis of diabetes, results of blood glucose monitoring, adherence to prescribed dietary, pharmacologic, and exercise regimen, the	G0984		

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G0984	Continued from page 183 patient's lifestyle, cultural, psychosocial, and economic factors, and effects of diabetes on functional status should be performed. Assess Physical Condition. Assess the patient's blood pressure while sitting and standing to detect orthostatic changes. Assess the body mass index and visual acuity of the patient. Perform examination of foot, skin, nervous system and mouth....risk for unstable blood glucose level ... risk for infection ... deficient knowledge ... risk for disturbed sensory perception ... impaired skin integrity ... ineffective peripheral tissue perfusion .... " 6. Caring for a Patient with a CVC (central venous catheter) at https://www.ausmed.com/cpd/articles/-central-venous-catheters Published 4/27/2020, indicated " ... How to perform a CVC assessment: ... 3. Perform a head -to-toe assessment. 4. Identify the CVC and inspect the insertion site. Look for any signs of infection [e.g. redness, swelling or pain"] ... 6. Identify how many lumens are present ... Measure the length of the line from the skin to the first hub - this clarifies how far the line is in the vein and indicates any potential displacement .... " 7. During a home visit patient #1, on 3/9/21 at 2:20 PM, the alternate clinical manager was observed assessing the patient. The alternate clinical manager failed to obtain a temperature and failed to listen to posterior for cardiopulmonary assessment. A review of patient's #1, start of care 5/22/19, contained a plan of care for the recertification period of 01/11/21 to 3/11/21, with orders for skilled nursing to provide services 1 time a week for 9 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status. A review of skilled nursing visit notes dated 2/17, 2/24, 3/2, and 3/9/21, failed to evidence the patient had temperature checked as part of the vital signs assessment as ordered on the plan of care. 8. The clinical record of patient #3 was reviewed	G0984		

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G0984	Continued from page 184 on 3/11/21 and contained an initial comprehensive assessment dated 2/22/21 indicating a RN visit was made 1:40 PM to 3:15 PM. Patient diagnosis included but not limited to Hypertensive Heart Disease with Heart Failure, Chronic Diastolic (Congestive) Heart Failure, Atrioventricular Block, First Degree, and Presence of Cardiac Pacemaker that was newly placed. The assessment revealed a wound to the left foot - 3rd digit, measuring 0.5 centimeters (cm) length, 1.25 cm width, and 0.1 cm depth, having serosanguinous drainage with surrounding tissue described as being red and inflamed. The vital sign assessment failed to evidence that a temperature was taken (left blank). A review of the plan of care for the initial certification period of 02/22/21 to 4/22/21, revealed orders for skilled nursing 2 times a week for 2 weeks then 1 time a week for 2 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status..." A review of skilled nursing visit notes dated 2/22, 2/24, 3/5, and 3/10/21, failed to evidence the patient had temperature checked as part of the vital signs assessment as ordered on the plan of care. 9. The clinical record of patient #5 was reviewed on 3/15/21 and contained an initial comprehensive assessment dated 9/18/20 revealed diagnoses of Abscess of Bursa, Left Elbow, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Change or Removal of Nonsurgical Wound Dressing, Disorder of White Blood Cells, and Multiple Sclerosis. The assessment failed to evidence that the patient's temperature had been checked as part of a vital sign assessment, and failed to assess wounds on left elbow and right knee. A review of the plan of care for the certification period of 9/18/20 to 11/16/20, with orders for skilled nursing to provide services 1 time a week for 1 week then 2 times a week for 2 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status,	G0984		

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G0984	Continued from page 185 A review of skilled visit notes dated 9/23 and 9/28/20, failed to evidence the patient had temperature checked as part of a vital sign assessment, and failed to assess wounds on left elbow and right knee. Review of a skilled visit note dated 10/9/20, failed to evidence the patient had temperature checked as part of a vital sign assessment. 10. The clinical record of patient #6 was reviewed on 3/12/202 and contained an initial comprehensive assessment dated 8/15/20 which revealed patient diagnoses as "Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Therapeutic Drug Level Monitoring, Essential Hypertension, and Long Term Use of Insulin" A review of the initial comprehensive assessment failed to evidence the patient's temperature (left blank) as part of the vital sign assessment for a patient who is being treated for a septic infection. The assessment revealed patient is insulin-dependent but failed to evidence an assessment or documentation of the patient's blood sugars nor of a diabetic foot assessment. The RN documented the patient had a right chest tunneled catheter but failed evidence documentation of the appearance of the site, measurement of the catheter for purposes to ensure the catheter does not come loose or dislodged. Review of the plan of care for the certification period of 8/15/20 to 10/13/20, with diagnoses of Sepsis following a Procedure, Encounter for Adjustment and Management of Vascular Access Device, Long Term Use of Antibiotics, Encounter for Therapeutic Drug Level Monitoring, Essential Hypertension, and Long Term Use of Insulin and further indicated Orders for Discipline and Treatment. The plan of care included orders for skilled nursing 1 day a week for 7 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status. A review of a skilled nursing visit note dated 8/15/20, failed to evidence the patient had temperature checked as part of a vital sign assessment, review of blood sugars as patient # 6	G0984		

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G0984	Continued from page 186 is insulin dependent and has sepsis following a procedure during initial comprehensive assessment visit. A review of skilled visit notes dated 8/17 and 8/24/20, failed to evidence a temperature was checked as part of the vital sign assessment. 7. The clinical record of patient #12 was reviewed 3/18/21, and contained a medication list which revealed liraglutide 0.6mg/0.1ml (18mg/3ml) subcutaneous inject 1.8 g by subcutaneous route every day for Type 2 Diabetes Mellitus. A review of a recertification comprehensive assessment dated 2/24/21, indicated an RN visit was made from 3:55 PM to 4:15 PM. The patient's diagnoses included: Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. The endocrine system section was left blank and failed to evidence that an assessment, including a diabetic foot care assessment, had been completed. The assessment revealed the patient had a condition of the inability to leave home due to a seizure disorder, mental health impairment, unsteady gait, and safety. The Neurological and Muscular System was left blank and failed to evidence that an assessment had been completed. The assessment failed to address seizures and patient mood and medication effects being therapeutic. The assessment failed to evidence the patient's acceptable lab values ranges for effective drug monitoring. The assessment failed to include details related to pain management and relief, failed to include education reflective to treating moderate to severe pain, and failed to ensure medication was taken accurately. The Medication assessment section indicated "Not Applicable (NA) - No injectables medications prescribed" upon answering the question of "Management of injectable medications." A review of plan of care for the recertification period of 12/31/20 to 2/28/21, revealed orders for skilled nursing 1 day every other week for 10 weeks to assess and evaluate vital signs, mentation, respiratory and cardiovascular status,	G0984		

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G0984	Continued from page 187 nutrition and hydration, bowel and bladder functioning, and skin integrity. The patient diagnoses include: Bipolar Disorder, Current Episode Manic Severe with Psychotic Features, Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus, and Encounter for Therapeutic Drug Level Monitoring. A review of a skilled nursing visit note dated 12/29/20, failed to evidence the patient had temperature checked during comprehensive recertification assessment visit. The nurse failed to take a temperature as part of the vital signs as ordered in the plan of care. A review clinical record failed to evidence a physician order or communication note to the physician indicating the reason for missed skilled visit for date 1/11/21 and the reason for the blood not being obtained for a CBC with diff and Platelets, as ordered on the plan of care. A review of a skilled nursing visit note dated 1/13/21, failed to evidence the patient had temperature checked during visit. The nurse failed to assess and evaluate vital signs as ordered in the plan of care. Review of clinical record failed to evidence order for labs, CBC with diff and Platelets, that were drawn during this visit as ordered on the plan of care. A review of skilled nursing visit notes dated 1/27 and 2/10/21 failed to evidence the patient had temperature checked during visit as part of the vital sign assessment as ordered on the plan of care. A review of a skilled nurse visit notes dated 2/24/21, failed to evidence the patient had temperature checked during a recertification visit. The nurse failed to assess and evaluate a temperature as part as vital sign assessment as ordered in the plan of care. 11. The clinical record of patient #19 was reviewed on 3/16/2021 and contained a progress note from the Veterans Administration dated 1/13/21. The progress note revealed that a wound	G0984		

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G0984	Continued from page 188 care consult was placed to the wound clinic for concerns related to the patient's left below the knee amputation and chronic skin breakdowns. The medication list revealed silver sulfadiazine 1% cream was being applied to the skin/ end of toes daily. The note indicated for home care services "Evaluate and Treat" and indicated the patient had a left below the knee amputation, required dialysis 3 to 4 times a week, and requires skilled nursing for medication management and monitoring of dialysis. A review of the initial comprehensive assessment dated 1/28/21 revealed the patient's diagnoses of Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End-Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. The assessment revealed the patient had chronic back pain but failed to evidence the details related to pain management and relief, and failed to ensure medication was taken accurately. The assessment indicated a dialysis shunt in the left upper extremity (LUE). The assessment failed to give details on appearance, bruit/ thrill of shunt, coordination, and documentation details of dialysis facility and times. The assessment indicated the patient had diabetes, the endocrine system section was left blank and failed to evidence that an assessment, including a diabetic foot care assessment, had been completed. The assessment indicated the patient has intermittent confusion short, long-term memory varies throughout the day, and forgetful. The assessment further revealed the management of injectable medications as the patient was able to independently take the correct medications and proper dosage at correct times. The assessment failed to evidence a correct detail of the patient's functional capacity of giving insulin. The assessment inaccurately indicated the skin was intact with no open areas. A review of the plan of care for the the initial certification period of 01/28/21 to 3/28/21, revealed orders for skilled nursing to be provided 1-2 times a week for 9 weeks then 1 time a week for 1 week, assess for safety, general assessment, medication set as needed, disease process	G0984		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HOME CARE PLUS	**1275 N JACKSON STREET , GREENCASTLE, Indiana, 46135**

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G0984	Continued from page 189 compliance, and disease management. The patient diagnoses include: Hypertensive Heart and Chronic Kidney Disease, Heart Failure, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Long Term Use of Insulin, Hyperlipidemia, and Gastro-Esophageal Reflux Disease without Esophagitis. Review of skilled nurse visit notes dated 2/3/21, 2/14, 2/24, 3/4, and 3/13/21 failed to evidence that the patient's dialysis shunt had been assessed. The nurse failed to assess wound and complete skin assessment. The nurse failed to provide a general assessment. During an interview on 3/17/21 at 11:35 AM, the caregiver of patient #19 indicated they go to the wound care clinic. When queried about what the case manager does for the client stated, "She sets up his meds, checks his blood pressure, and checks out any complaints he may have." During an interview on 3/19/2021 at 10:45 AM, employee B, alternate clinical manager, stated, "I am not doing wound care, the wound care center and his daughter are. I am not in there for wound care I am doing just med set up, so I don't monitor dialysis or wound care." The comprehensive assessment failed to evidence the patient received a complete and accurate assessment including the primary reason for home health admission, previous hospitalizations, the risk for hospitalization, endocrine/ hematology, integumentary, diabetic foot care/assessment, neurological/emotional, psychosocial, functional abilities/ limitations, urological, medication management and reconciliation, including the ability to take and set up medications properly, DME, therapy needs, education/ knowledge of patient and caregivers with demonstrations, care coordination of other agencies provided wound care and dialysis set up, secondary diagnosis, and infection control. 12. During an interview with the alternate clinical manager on 3/12/2021 at 4:05 PM, when	G0984		

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G0984	Continued from page 190 queried about vital signs and regarding temperatures being considered a vital sign and not being done during a home visit or in clinical note reviews, the administrator stated to the alternate clinical manager, "No, temperatures are to be taken, I have told you about that!" 13. During an interview on 3/12/21 at 4:10 PM, when queried about the review of the clinical records accuracy, the administrator stated, "The nurses' audit each other's charts." When asked for reviews or audit tools, nothing was provided. 14. The findings were reviewed on 3/22/2021 at 3:55 PM with the administrator. The administrator was asked if she had any further information or documentation to provide to demonstrate compliance before the surveyors departed, in which the administrator responded "I have nothing to say."	G0984		