| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157115 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/05/2021 |
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| E0000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 494.62 for Medicare Home Health providers.<br><br>Survey Date: 9/27/2021 to 10/5/2021<br><br>Facility #: IN005306<br><br>Provider #: 157115<br><br>Medicaid #: 100263840<br><br>At this Emergency Preparedness survey, Kindred at Home was found to have been in compliance with 42 CFR Emergency Preparedness Requirements, including staffing and implementation of staffing, for Medicare participating Provider and Suppliers.<br><br>Quality Review Completed on 10/25/2021 by Area 3 | E0000 | | |
| G0000 | INITIAL COMMENTS<br><br>This visit was for a Federal Recertification and State Re-Licensure Survey of a Medicare Home Health provider.<br><br>Survey Date: 9/27/2021 to 10/5/2021<br><br>Facility #: IN005306<br><br>Provider #: 157115<br><br>Medicaid #: 100263840<br><br>These deficiencies reflects State Findings cited in accordance with 410 IAC 17.<br><br>Quality Review Completed on 10/25/2021 by Area 3 | G0000 | | |
| G0528 | Health, psychosocial, functional, cognition | G0528 | | |

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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| G0528 | Continued from page 1<br><br>CFR(s): 484.55(c)(1)<br><br>The patient's current health, psychosocial, functional, and cognitive status;<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on record review, and interview the agency failed to ensure the comprehensive assessments were complete and accurately reflected the patient's current health status in 2 of 12 active records reviewed. (Patient #5, 9)<br><br>Findings Include:<br><br>1. Review of an agency policy revised date of 6/2021 titled, "Initial and Comprehensive Assessment" policy number 03-05 indicated, "Policy: Assessments will be performed by a clinician who has demonstrated verbal/written knowledge of specific skills needed to perform assessments, including specialty assessments (such as infusion and wound care)…Each patient's physical (including vital signs), nutritional, and psychosocial status will be assessed… patient's condition…Review of Patient Medications…prescription, over the counter…adverse reactions, allergies, contradictions, and significant side effects. A review will include viewing bottles and labels of drugs the patient has…Agency staff will contact the PCP (Primary Care Physician) as appropriate regarding any possible changes in medications…The assessment is the basis for planning patient care and is the baseline against which progress toward stated goals and outcomes is measured…Each discipline will assess patients based on their respective scope of practice. Goals and outcomes will be established as a result of the assessment process…"<br><br>2. During a home visit at patient #5's on 9/28/21 at 9:10 AM to 9:55 AM observed patient #5 show Non-Employee Y, social worker of the sister company, a bandage covering patient #5's right lower extremity, and a bandage covering the right elbow. Patient #5 was tearful explaining the fall that happened three weeks ago. Patient #5 stated, "I have anxiety." Patient #5 talked about living alone and worried about her caregiver who was just diagnosed with liver cancer.<br><br>The clinical record of patient #5 was reviewed on | G0528 | | |

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| G0528 | Continued from page 2<br>10/4/21 and contained a physician visit noted from Entity EE, the physician's office, dated 9/9/21, which indicated the patient's allergies as follows; Codeine, Erythromycin, Meperidine, Sulfa, and Demerol.<br><br>A review of the initial comprehensive assessment dated 9/17/21, indicated the patient has no known allergies; the integumentary/ skin assessment indicated the patient has a closed laceration from a fall on the right leg. The genitourinary assessment indicated the patient was incontinent. The patient's goal indicated "Get Stronger and Control BP (Blood Pressure)." The comprehensive assessment failed to complete the wound assessment, including measurements, appearance, signs, or symptoms of infection, on the patient's right leg laceration, and right elbow or any treatments if any.<br><br>3. Review of clinical record #9, start of care date 8/24/20, contained a recertification comprehensive assessment dated 8/18/21. The comprehensive assessment included but was not limited to the following diagnoses: Non-pressure Chronic Ulcer Left Foot (an open sore of the foot), Type 2 Diabetes Mellitus with Diabetic Neuropathy (a type of nerve damage caused from high blood sugar levels), Non-rheumatic Valve Stenosis (a narrowing of a valve in the heart), Paralytic Syndrome (a loss or impairment of motor/sensory function in a part due to a lesion of the neural or muscular mechanism), Dependence on Renal Dialysis(dependent on treatment to replace the filtering function of the kidneys), Type 2 Diabetes with Foot Ulcer ( a full thickness wound of a person with diabetes that can often lead to lower limb amputations), End-Stage Renal Disease ( the kidneys are unable to function to meet the body's needs to filter wastes and excess fluid from the blood) , Diastolic Heart Failure ( the heart cannot relax between beats causing the heart not to pump efficiently during each contraction filling the left ventricle of the heart), and History of Falling. The comprehensive assessment failed to evidence that a diabetic foot assessment, and assessment of the left arm AV (Arteriovenous) fistula dialysis shunt for a bruit ("swishing" indicating patency of blood flow), thrill (vibration that indicates arterial and venous blood flow patency/ by palpating pulses distal to vascular access to ensure patency), capillary refill in the patient's fingers, assessing the patient for numbness, tingling, | G0528 | | |

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| G0528 | Continued from page 3<br>altered sensation, coldness, pallor in the affected extremity, or assess vascular access for signs and symptoms of infection, failed to address fluid and diet restrictions for renal patients.<br><br>A review of a document Entity GG, the skilled facility patient #9 was discharged to home care from, titled, “Progress Note” dated 8/14/20 indicated, “…End stage renal disease/dependent on renal dialysis. Dialysis on Tuesday, Thursday, and Saturday. Fistula to left forearm with thrill/bruit…”<br><br>A review of an agency document titled “Client Coordination Note Report” dated 9/1/21 indicated, a skilled nurse had a missed visit due to the patient having an appointment at the wound clinic. The assessment failed to evidence care coordination in regards to wound care services received from the wound care center,<br><br>A review of a faxed document from Entity K, the dialysis facility, titled “Home Medication” dated 10/5/21, indicated the patient has an allergy to Lisinopril. The assessment failed to indicate the patient was allergic to or address the allergy to Lisinopril (a mediation used to treat high blood pressure).<br><br>During an interview on 10/5/21 at 12:40 PM, patient #9 indicated there were receiving dialysis at Entity K.<br><br>During an interview on 10/5/21 at 12:46 PM Person L, an assistant, at Entity K (the dialysis facility), confirmed patient #9 was a dialysis patient and had a fluid restriction of 32 ounces. The assessment failed to evidence care coordination or information regarding the patient was receiving services dialysis at the dialysis center.<br><br>4. During an interview on 10/4/21 at 11:15 AM, the administrator confirmed care coordination with other physicians and agencies providing services should be in the Focus of Care statement of the comprehensive assessment. | G0528 | | |
| G0530 | Strengths, goals, and care preferences<br><br>CFR(s): 484.55(c)(2)<br><br>The patient's strengths, goals, and care preferences, including information that may be | G0530 | | |

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| G0530 | Continued from page 4<br>used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the agency failed to ensure a complete and accurate assessment of the patient's strengths, and care preferences in 12 of 12 active patient record reviewed. (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12)<br><br>Findings included:<br><br>1. Review of an agency policy revised date of 6/2021 titled, “Initial and Comprehensive Assessment” policy number 03-05 indicated, “Policy: Assessments will be performed by a clinician who has demonstrated verbal/written knowledge of specific skills needed to perform assessments, including specialty assessments (such as infusion and wound care)…Each patient’s physical(including vital signs), nutritional, and psychosocial status will be assessed…"<br><br>2. The clinical record of patient #1 was reviewed on 09/29/2021 with a start of care of 09/04/19, evidenced a certification comprehensive assessment dated 09/04/2021. The comprehensive assessment failed to evidence the patient’s strengths and care preferences.<br><br>3. The clinical record of patient #2 was reviewed on 09/29/2021 with a start of care of 08/30/2021, evidenced a certification comprehensive assessment dated 08/30/2021. The comprehensive assessment failed to evidence the patient's strengths and care preferences.<br><br>4. The clinical record of patient #3 was reviewed on 09/29/2021 with a start of care of 06/29/2021, evidenced a certification comprehensive assessment dated 06/29/2021. The comprehensive assessment failed to evidence the patient's strengths and care preferences.<br><br>5. The clinical record of patient #4 was reviewed on 09/29/2021 with a start of care of 08/30/2021, evidenced a certification comprehensive assessment dated 08/30/2021. The comprehensive assessment failed to evidence the patient's strengths and care preferences. | G0530 | | |

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| G0530 | Continued from page 5<br><br>6. The clinical record of patient #10 was reviewed on 10/04/2021 with a start of care of 02/08/2021, evidenced a recertification comprehensive assessment dated 08/06/2021. The recertification comprehensive assessment failed to evidence the patient's strengths and care preferences.<br><br>7. The clinical record of patient #11 was reviewed on 10/04/2021 with a start of care of 06/14/2021, evidenced a certification comprehensive assessment dated 06/14/2021. The comprehensive assessment failed to evidence the patient's strengths and care preferences.<br><br>8. A review of clinical record #5, start of care date 9/17/21, evidenced a start of care comprehensive assessment dated 9/17/21. The comprehensive assessment failed to address specific patient-centered goals for skin breakdown due to incontinence and right leg wound and failed to evidence patient strengths, and care preferences.<br><br>9. A review of clinical record #6, start of care date 7/23/21, evidenced a recertification comprehensive assessment dated 9/16/21.The comprehensive assessment failed to evidence patient strengths and care preferences.<br><br>10. A review of clinical record #7, start of care date 9/9/21, evidenced a start of care comprehensive assessment dated 9/9/21. The comprehensive assessment failed to address specific patient-centered goals for skin breakdown due to incontinence, weights for heart failure and lymphedema, and failed to evidence patient strengths, and care preferences.<br><br>11. A review of clinical record #8, start of care date 8/14/21, evidenced a resumption of care comprehensive assessment dated 8/29/21. The comprehensive assessment failed to address specific patient-centered goals for skin breakdown due to incontinence, cellulitis of the lower limb, and high nutritional risk and failed to evidence patient strengths, and care preferences.<br><br>12. A review of clinical record #9, start of care date 8/24/20, evidenced a recertification comprehensive assessment dated 8/18/21. The comprehensive assessment failed to evidence patient strengths and care preferences. | G0530 | | |

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| G0530 | Continued from page 6<br><br>13. A review of clinical record #12, start of care date 5/3/21, evidenced a resumption comprehensive assessment dated 8/16/21. The comprehensive assessment failed to evidence patient strengths and care preferences. | G0530 | | |
| G0536 | A review of all current medications<br><br>CFR(s): 484.55(c)(5)<br><br>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.<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on observation, record review and interview the agency failed to ensure a registered nurse reconciled all medications with the patient, health care representative, outside agencies and ordering physicians in 3 of 12 active records reviewed. (Patient #2, 4, 6)<br><br>Findings Include:<br><br>1. Review of an agency policy revised date of 6/2021 titled, “Medication Documentation” policy number 03-41indicated, “Policy: All medication will be evaluated for adverse events, duplication of medication therapy, contraindications, and other medication effects. All drugs and treatments ordered by the physician/allowed practitioner will be recorded on the medication profile in the patient’s clinical record…The office will assess all medications the patient is taking…record them on the Plan of Care…”<br><br>2. During a home visit at patient #6’s home on 9/28/21 at 11:00 AM to 11:40 AM observed Employee D, the Speech therapist, review the medication planner on the kitchen counter review with patient medications and ask about medications that remained in the day before still in the planner. The Speech therapist then made the patient aware of a pill on the counter. The Speech therapist confirmed she would contact the RN (Registered Nurse) who does patient #6’s medication set up to come to a reset up medications. Patient #6 confirmed meds were not taken yesterday and did not know what the pill was on the counter. | G0536 | | |

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| G0536 | Continued from page 7<br><br>The clinical record of patient #6 was reviewed on 9/28/21 and 9/29/21 indicated a start of care date of 7/23/21. The record contained a plan of care for recertification period of 9/21/21 to 11/19/21 that indicated, " Medications: Acetaminophen 325 mg (milligrams) capsule 2 capsules as needed every 6 hours oral reason pain; Amlodipine 10 mg tablet 0.5mg tablet daily oral reason HTN (hypertension); Aspirin Low Dose 81mg tablet, delayed release 1 tablet daily reason blood thinner; Atorvastatin 40mg tablet 1 tablet oral at bedtime reason cholesterol; Folic Acid 1mg tablet 1 oral daily reason supplement; Incruse Ellipta 62.5 mcg (micrograms) /Actuation powder for inhalation 1 inhalation daily reason lungs; Levothyroxine 112 mcg capsule1 capsule daily reason thyroid; Melatonin 3 mg tablet 1 tablet oral at bedtime reason sleep; Meloxicam 15 mg tablet 1 tablet oral daily reason pain; Methotrexate Sodium 2.5mg tablet 8 tablets oral weekly on Fridays reason cervical ca; Metoprolol Succinate ER 50 mg tablet , Extended Release 24 hr (hour) 1 tablet oral daily reason HTN (Hypertension); Mirtazapine 7.5 mg 1 tablet oral daily reason depression; Tizanidine 4 mg capsule 1 capsule oral daily reason muscle pain; Venlafaxine 37.5 mg tablet 1 tablet oral 2 times daily reason depression."<br><br>Review of an agency document titled, "Client Medication Report" with a review date of 9/16/21 and electronically signed by the RN indicated the following, " Medications: Acetaminophen 325mg (milligrams) capsule 2 capsules as needed every 6 hours oral reason pain; Amlodipine 10 mg tablet 0.5 mg tablet daily oral reason hypertension; Aspirin Low Dose 81 mg tablet, delayed release 1 tablet daily reason blood thinner; Atorvastatin 40 mg tablet 1 tablet oral at bedtime reason cholesterol; Folic Acid 1mg tablet 1 oral daily reason supplement; Incruse Ellipta 62.5 mcg (micrograms)/Actuation powder for inhalation 1 inhalation daily reason lungs; Levothyroxine 112 mcg capsule1 capsule daily reason thyroid; Melatonin 3 mg tablet ( a supplement used to help you fall asleep) 1 tablet oral at bedtime reason sleep; Meloxicam 15 mg tablet 1 tablet oral daily reason pain; Methotrexate Sodium 2.5 mg ( a chemotherapy agent used to treat cancer) tablet 8 tablets oral weekly on Fridays reason cervical ca; Metoprolol Succinate ER 50 mg tablet (A medication used to treat high blood pressure) , Extended Release 24 hr (hour) 1 tablet oral daily reason HTN (Hypertension); Mirtazapine 7.5 mg 1 tablet | G0536 | | |

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| G0536 | Continued from page 8<br>oral daily reason depression; Tizanidine 4 mg capsule 1 capsule oral daily reason muscle pain; Venlafaxine 37.5 mg tablet 1 tablet oral 2 times daily reason depression.<br><br>Review of a document titled “Medication List” received from Entity A dated 9/29/21 indicated the following medications and dates refilled at Entity V and Entity W: "...Melatonin 3mg 1 tablet orally at bedtime PRN (as needed) for insomnia with a refill at Entity W on 9/21/1; Atorvastatin 40mg 1 tablet orally at bedtime; Aspirin 81 mg oral capsule 1capsule orally; Alprazolam 1 mg 1 tablet orally at bedtime with a refill at Entity V on 8/26/21; Amlodipine 10 mg oral tablet 5 mg 0.5 tablet orally daily, Metoprolol succinate 50 mg 1 tablet orally daily; Levothyroxine 112 mcg oral 1 tablet by mouth 6 days per week; Clotrimazole topical 1% 1 app ( application) topical twice a day with a refill at Entity V on 8/16/21, Venlafaxine 37.5mg 1 tablet twice daily orally; Methotrexate 2.5 mg 8 tablets orally every Friday; Incruse Ellipta 62.5mcg ( a drug used to control and prevent symptoms such as wheezing and shortness of breath) 1 inhalation every 24 hours; Calcium carbonate 1,250mg orally three times daily; and Folic acid 0.4mg 1 tablet orally daily..."<br><br>The medication list failed to be consistent with what the physician ordered, failed to be consistent with the plan of care, and failed to be appropriately reconciled.<br><br>During a phone interview on 9/29/21 at 12:19 PM with Person B, the medical assistant for Entity A confirmed a current medication list was on file for patient #6 and that patient is a current patient at Entity A. Person B provided patient #6’s current medication list from the physician.<br><br>During an interview on 10/4/21 at 11:19 AM the administrator and clinical manager confirmed all meds are reconciled and to be confirmed with the physician for the plan of care.<br><br>3. During a home visit on 09/28/2021 at 10:30 AM with employee J, Occupational Therapist (OT), was reviewing patient #2’s medications with the patient’s caregiver Person U, stating the patient is no longer receiving Melatonin (for sleep) 1 mg sublingual (under the tongue) and hadn’t been taking it since admission to the agency, and that the primary doctor was aware. Upon further review, | G0536 | | |

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| G0536 | Continued from page 9<br>Person U stated patient #2 is receiving a nasal spray and a stool softener. Person U stated the start date of the nasal spray was 04/05/2021 and the start date of the stool softener was in October of 2020.<br><br>The clinical record of patient #2, start of care 8/30/21, was reviewed on 9/29/2021. The record contained a plan of care for a certification period of 08/30/2021 through 10/28/2021. The plan of care included, but was not limited to, the patient's prescribed medications: Acetaminophen Pain Relief 500 mg (milligram) tablet, 2 tablets daily orally for pain; Eliquis 2.5 mg, 1 tablet 2 times daily orally for blood thinner to help prevent stroke or heart attack; Melatonin 1 mg sublingual tablet at bedtime for sleep; Omeprazole 20 mg capsule, 1 capsule daily orally for reflux; and Guaifenesin 100 mg/5ml (milliliter) oral liquid, 10 ml as needed daily orally for cough.<br><br>A review of the patient's medication list provided from entity E, physician's office, on 10/5/21, revealed the following medications prescribed to the patient: Apixaban (Eliquis) 75 mg 1 tablet 2 times a day; Famotidine 40 mg/5 ml oral suspension, 20 mg, 2.5 ml 2 times a day orally; Omeprazole 2 mg/ml oral suspension, 10 ml daily orally; Diclofenac Topical 2 gm, 4 times daily as needed for joint pain; Polyethylene glycol 3350 oral powder, daily/prn (as needed) orally for constipation; lidocaine 5% topical patch, apply topically at bedtime for pain; Guaifenesin 600 mg oral tablet, 1 tablet 2 times a day; Docusate-Senna 50 mg-8.6 mg, 2 tablets 2 times a day for constipation; fluticasone nasal Spray 50 mcg, 2 spray each nostril daily and as needed for nasal congestion; and acetaminophen 650 mg tablet, 2 tablets every AM daily.<br><br>The plan of care failed to evidence a consistent and accurate account of all medications prescribed to the patient.<br><br>The agency failed to review all the medications with the primary physician.<br><br>4. During a home visit on 09/29/2021 at 9 AM with patient #4 with employee H reviewing the patient's medications. Patient #4 stated they were told to stop taking Aspirin Low Dose 81 mg tablet in August they couldn't remember who or when they were told to stop taking the Aspirin. During this time, the Registered nurse, employee H, stated | G0536 | | |

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| G0536 | Continued from page 10<br>they would get the medication list updated and notify the physician.<br><br>A review of patient #4's clinical record on 09/29/2021 evidenced a plan of care with a start date of 08/30/2021 for a certification period of 08/30/2021 through 10/28/2021. The patient's diagnoses include but are not limited to Type 2 Diabetes Mellitus (an impairment with the way the body regulates and uses sugar for fuel) with a foot ulcer (an open sore that's difficult to heal), Cellulitis (potentially serious bacterial skin infection) of left lower limb, Thrombocytopenia (low platelet count), and Hypertensive Chronic Kidney Disease (damage to the kidney due to long term high blood pressure).<br><br>A review of the patient's medication profile revealed that Aspirin Low Dose 81 mg tablet, 1 tablet daily orally for heart health continued to be listed.<br><br>During a telephone interview on 09/30/2021 with Person D at entity C regarding the patient's aspirin usage. Other Person D stated that patient #4 aspirin was put on hold 08/16/2021 after it was discovered during the patient's hospitalization period of 08/08/201 through 08/11/2021, the patient's platelet counts were dangerously low.<br><br>The agency failed to ensure they reviewed the patient's medications with each contact and verified changes with the primary physician.<br><br>410 IAC 17-14-1(a)(1)(B) | G0536 | | |
| G0574 | Plan of care must include the following<br><br>CFR(s): 484.60(a)(2)(i-xvi)<br><br>The individualized plan of care must include the following:<br><br>(i) All pertinent diagnoses;<br><br>(ii) The patient's mental, psychosocial, and cognitive status;<br><br>(iii) The types of services, supplies, and equipment required;<br><br>(iv) The frequency and duration of visits to be made; | G0574 | | |

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| G0574 | Continued from page 11<br>(v) Prognosis;<br><br>(vi) Rehabilitation potential;<br><br>(vii) Functional limitations;<br><br>(viii) Activities permitted;<br><br>(ix) Nutritional requirements;<br><br>(x) All medications and treatments;<br><br>(xi) Safety measures to protect against injury;<br><br>(xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.<br><br>(xiii) Patient and caregiver education and training to facilitate timely discharge;<br><br>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;<br><br>(xv) Information related to any advanced directives; and<br><br>(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and interview the agency failed to evidence the individualized plan of care included all DME (Durable Medical Equipment) and supplies, all accurate medications and allergies and treatments, care preferences, strengths, nutritional requirements, all safety measures, all necessary interventions to address underlying risk factors with measurable goals, services being provided by outside facilities and agencies, and orders may be received/accepted by outside physicians in 10 of 12 active record records reviewed. (Patient #1, 2, 3, 4, 5, 8, 9, 10, 11, 12)<br><br>Findings Include:<br><br>1. Review of an agency policy revised date of 6/2021 titled, “Care Planning” policy number 03-11 indicated, “Policy: Each patient must receive an individualized written Plan of Care (POC) | G0574 | | |

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| G0574 | Continued from page 12<br>including any revisions or additions. The individualized POC must specify: Care and services to meet the patient- specific needs as identified in the comprehensive assessment including identification of the responsible disciplines and measurable outcomes the Home Health Agency (HHA) anticipates will occur as a result of implementing and coordination the POC…services must be furnished in accordance with accepted standards of practice…The clinical manager or designee will review the POC prior to submission for the physician…The individualized POC must include: All pertinent diagnosis… supplies, and equipment required…Nutritional requirements…All medications and treatments…Patient-specific interventions and education; measurable outcomes and goals identified by the Home Health Agency and the patient …. "<br><br>2. During a home visit at patient #5's on 9/28/21 at 9:10 AM to 9:55 AM observed patient #5 show Non-Employee Y, social worker of the sister company, a bandage covering patient #5's right lover extremity and a bandage covering the right elbow. Patient #5 was tearful explaining the fall that happened three weeks ago. Patient #5 stated, " I have anxiety." Patient #5 confirmed she had a wound on her right leg with a bandage on it..<br><br>The clinical record of patient #5 was reviewed on 10/4/21 and contained a physician visit noted at Entity EE, dated 9/9/21, which indicated patient's allergies as follows; Codeine, Erythromycin, Meperidine, Sulfa, and Demerol.<br><br>Review of an agency document titled, "Client Medication Report" dated 9/27/21, indicated, "Client Allergies: NKA (No Known Allergies)" with RN (Registered Nurse) electronic signatures and the review dates of 9/17/21 and 9/27/21.<br><br>Review of the initial comprehensive assessment dated 9/17/21, diagnoses included but not limited to Hypertensive Chronic Kidney Disease (over time untreated high blood pressure narrowing the blood vessels of the kidneys) , Chronic Kidney Disease Stage 3A (a stage indicating moderate kidney damage and noticeable loss of kidney function), Parkinson's Disease (a progressive nervous disorder that affects body movements), Olecranon Bursitis Left Elbow (the pointy bone at the tip of the elbow is filled with extra fluid causing swelling and pain), Anxiety Disorder, Major Depressive Disorder, Dorsalgia (low back pain and | G0574 | | |

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| G0574 | Continued from page 13<br>mid back pain), and Hypothyroidism (a condition in which the thyroid does not produce enough of certain hormones that if untreated can cause obesity, joint pain, and heart disease). The comprehensive assessment further indicated, "…Allergies: NKA… Indicate Other Integumentary Issue: Closed laceration from fall on right leg…Patient's Goal: Get Stronger and Control BP (Blood Pressure) …Genitourinary: Incontinence..."<br><br>A review of the plan of care for the certification period of 9/17/21 to 11/15/21 indicated "…Allergies: NKA(No Known Allergies)…." The plan of care failed to list the patient's allergies, failed to evidence patient-specific interventions addressing anxiety, major depression, and underlying risk factors, skin integrity due to incontinence and right leg and elbow lacerations, and patient-specific nutrition.<br><br>During an interview on 9/28/21 at 9:55 AM, patient #5 confirmed she had a wound on her right leg with a bandage on it. Patient #5 was tearful stated, "I am worried about my daughter who has liver cancer. I live here all alone and am worried. I fell hitting the entertainment center letting the dog out when I lost my balance."<br><br>3. Review of clinical record #8, start of care date 8/14/21, evidenced a resumption of care comprehensive assessment dated 8/29/21. The resumption of care indicated, "Diagnoses: Other Pulmonary Embolism, Anemia, Major Depressive Disorder, Generalized Anxiety Disorder, Obstructive Sleep Apnea, Cellulitis of Lower Limb…Vital signs: … Oxygen saturation 90…Indicate Safety Hazards: …Oxygen in use, Pets, Smoking in the home… Endocrine/ Hematopoietic…Patient is incontinent…Patient is taking an anticoagulant…Patient is at a High Nutritional Risk…Chair fast. Patient refused to stand from motorized wheelchair fear for fear of falling…"<br><br>Review of the plan of care for the initial certification period 8/14/21 to 10/12/21 diagnoses included but were not limited to: Pulmonary Embolism ( a blockage in one of the arteries of the lungs caused by a blood clot), Anemia, Obstructive Sleep Apnea ( throat muscles intermittently relax and blocks the airway during sleep), Cellulitis of Lower Limb (the lower extremities appear red and swollen and usually painful and warm to touch caused by a bacterial skin infection). The plan of care included orders | G0574 | | |

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| G0574 | Continued from page 14<br>for Skilled Nursing to obtain specimen for PT/INR (Prothrombin Time/International Normalized Ratio), (a blood test that measures how long it takes blood to clot to verify therapeutic doses of medication to thin the blood), via fingerstick/INR ratio machine and report results to MD (Doctor of Medicine).<br><br>The plan of care interventions failed to be individualized with specific goals addressing nutritional risk and wounds, failed to list INR strips, lancets, oxygen supplies, failed to include smoking with oxygen in safety measures, failed to include the anticoagulation clinic/ physician involved with patient care needs and collaborate goals.<br><br>4. Review of clinical record #9, start of care date 8/24/20, contained a plan of care for the recertification period of 8/19/21 to 10/17/21, diagnoses included but were not limited to: Non-pressure Chronic Ulcer Left Foot (an open sore of the foot), Type 2 Diabetes Mellitus with Diabetic Neuropathy (a type of nerve damage caused from high blood sugar levels), Long Term Use of Insulin, Long Term Use of Antithrombotic/Antiplatelet (a medication is required to regulate the blood and prevent the blood from clotting), Dependence on Renal Dialysis (dependent on treatment to replace the filtering function of the kidneys), Type 2 Diabetes with Foot Ulcer (a full thickness wound of a person with diabetes that can often lead to lower limb amputations), End Stage Renal Disease (the kidneys are unable to function to meet the body's needs to filter wastes and excess fluid from the blood), and unspecified Diastolic Heart Failure (the heart cannot relax between beats causing the heart not to pump efficiently during each contraction filling the left ventricle of the heart). The plan of care interventions failed to evidence all DME and supplies necessary for diabetic blood glucose testing, and supplies for insulin administration.<br><br>A review of a faxed document from Entity K, a dialysis facility, titled, "Home Medication" dated 10/5/21, indicated the patient had an allergy of Lisinopril. The plan of care failed to evidence an allergy to Lisinopril<br><br>A review of an agency document titled "Client Coordination Note Report" dated 9/1/21, indicated, a skilled nurse missed a visit on 9/1/21, due to the patient having an appointment at the wound | G0574 | | |

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| G0574 | Continued from page 15<br>clinic. The plan of care failed to evidence acceptance of orders/coordination with the wound care center.<br><br>During an interview on 10/5/21 at 12:40 PM, patient #9 stated he receives dialysis at entity K. The plan of care failed to evidence acceptance of orders/ coordination with the dialysis center.<br><br>During an interview on 10/5/21 at 12:46 PM Person L, a Nurse at Entity K, confirmed patient #9 was a patient there and doing dialysis at this time. Person L confirmed patient #9 had a fluid restriction of 32 ounces. The plan of care failed to evidence a daily 32-ounce fluid restriction and nutritional requirements failed to list<br><br>During an interview on 10/4/21 at 11:15 AM, the administrator confirmed care coordination with other physicians and agencies providing services should be in the "Focus of Care" statement of the Plan of Care.<br><br>5. Review of clinical record #12, start of care date 5/3/21, contained a plan of care for the certification period of 8/31/21 to 10/29/21 indicated diagnoses of but were not limited to COVID-19, Pulmonary Fibrosis, Dependence on Renal Dialysis, and Dependence on Supplemental Oxygen. The plan of care further indicated Safety measures: Emergency Plan, Fall precautions, O2 (Oxygen) precautions, universal precautions, and Nutritional Requirements: Renal.<br><br>Review of a document titled, “Discharge Summary” from Entity FF, a hospital, dated 8/12/21 to 8/14/21 indicated, “Patient was admitted requiring dialysis. Patient could not get into outpatient dialysis because of COVID positive status…AV Fistula Comments: LUE AV fistula… diet 3-4 grams Na(Sodium),3 gram K (Potassium)” The plan of care failed to evidence a daily 32-ounce fluid restriction, failed to evidence diet restrictions, and failed to evidence safety measures for no blood pressure in the left arm due to the fistula.<br><br>During a phone interview on 10/4/21 at 9:30 AM, Person I, patient #12’s caregiver confirmed patient #12 was to receive dialysis treatment at Entity G, dialysis center. Person I further confirmed Entity DD was the oxygen company who provided them with patient #12’s oxygen supplies. The plan of care failed to evidence coordination and information of care delivery with the dialysis | G0574 | | |

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| G0574 | Continued from page 16<br>center, where the patient receives oxygen supplies and failed to evidence the names and approval of orders of all physicians active in the patient's care.<br><br>During a phone interview on 10/4/21 at 2:19 PM with Employee K, Registered Nurse, for patient #12, when queried about issues patient #12 had with getting dialysis stated, "I did not talk to the facility."<br><br>6. During an interview on 10/4/21 at 4:00 PM, the administrator confirmed all plans of care are to be patient-specific with all elements supported by the comprehensive assessment.<br><br>7. During a home visit on 08/28/2021 at 9 AM, patient #1 was observed to have the following DME (durable medical equipment): an elevated toilet seat, toilet grab rails, rolling walker, shower chair, shower grab bars, and a laundry rolling cart.<br><br>The clinical record of patient #1, start of care 09/04/21, was reviewed on 09/29/2021. The clinical record contained an initial comprehensive assessment dated 09/04/2021 which revealed DME supplies of an elevated toilet seat, grab bars, long handle reacher, tub chair, rolling walker, upright walker, rails for toilet, long handle shoehorn, and a laundry rolling cart.<br><br>The record contained a plan of care for the certification period of 09/4/2021 through 11/02/2021. The plan of care indicated the following DME supplies: grab bars, reacher, shower/tub equipment, and rolling walker. The plan of care failed to evidence all DME supplies.<br><br>8. During a home visit on 09/28/2021 at 10:30 AM with employee J, Occupational Therapist (OT), was reviewing patient #2's medications with the patient's caregiver Person U, stating the patient is no longer receiving Melatonin (for sleep) 1 mg sublingual (under the tongue) and hadn't been taking it since admission to the agency, and that the primary doctor was aware. Upon further review, Person U stated patient #2 is receiving a nasal spray and a stool softener. Person U stated the start date of the nasal spray was 04/05/2021 and the start date of the stool softener was in October of 2020.<br><br>The clinical record of patient #2, start of care | G0574 | | |

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| G0574 | Continued from page 17<br>8/30/21, was reviewed on 9/29/2021. The record contained a plan of care for a certification period of 08/30/2021 through 10/28/2021. The plan of care included, but was not limited to, the patient's prescribed medications: Acetaminophen Pain Relief 500 mg (milligram) tablet, 2 tablets daily orally for pain; Eliquis 2.5 mg, 1 tablet 2 times daily orally for blood thinner to help prevent stroke or heart attack; Melatonin 1 mg sublingual tablet at bedtime for sleep; Omeprazole 20 mg capsule, 1 capsule daily orally for reflux; and Guaifenesin 100 mg/5ml (milliliter) oral liquid, 10 ml as needed daily orally for cough.<br><br>A review of the patient's medication list provided from entity E, physician's office, on 10/5/21, revealed the following medications prescribed to the patient: Apixaban (Eliquis) 75 mg 1 tablet 2 times a day; Famotidine 40 mg/5 ml oral suspension, 20 mg, 2.5 ml 2 times a day orally; Omeprazole 2 mg/ml oral suspension, 10 ml daily orally; Diclofenac Topical 2 gm, 4 times daily as needed for joint pain; Polyethylene glycol 3350 oral powder, daily/prn (as needed) orally for constipation; lidocaine 5% topical patch, apply topically at bedtime for pain; Guaifenesin 600 mg oral tablet, 1 tablet 2 times a day; Docusate-Senna 50 mg-8.6 mg, 2 tablets 2 times a day for constipation; fluticasone nasal Spray 50 mcg, 2 spray each nostril daily and as needed for nasal congestion; and acetaminophen 650 mg tablet, 2 tablets every AM daily.<br><br>The plan of care failed to evidence a consistent and accurate account of all medications prescribed to the patient.<br><br>9. During a home visit on 09/28/2021 at 12:15 PM, DME supplies observed in patient #3 home were a wheelchair and a pressure-relieving walking boot, and an elevated toilet seat.<br><br>The clinical record of patient #3, start of care 6/29/21, was reviewed on 09/29/2021. The record contained a plan of care for a certification period of 08/28/2021 through 10/26/2021. DME supplies listed on the plan of care were rails/grab bars and a wheelchair. The plan of care failed to evidence all DME supplies.<br><br>10. During a home visit on 09/29/2021 at 9 AM, patient #4 stated, "I test my blood sugar 3 times a day and record them in a notebook". Patient #4 stated they were told to stop taking Aspirin Low | G0574 | | |

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| G0574 | Continued from page 18<br>Dose 81 mg tablet in August but couldn't remember who or when they were told to stop it. The registered nurse, employee H asked the patient about upcoming medical appointments, in which they responded they had a bone marrow test to be performed on 10/15/2021.<br><br>The clinical record of patient #4, start of care 08/30/2021, was reviewed on 09/29/2021. The record contained an initial comprehensive assessment dated 08/30/2021, noted the patient checks blood sugars three times a day with a “meter”.<br><br>A review of the plan of care for the certification period of 08/30/2021 through 10/28/2021, the DME supplies listed on the plan of care failed to evidence any diabetic supplies. The medications on the plan of care continue to include Aspirin Low Dose 81 mg tablet, 1 tablet daily orally for heart health.<br><br>During a phone interview with Person E from entity C, blood clinic, on 09/30/2021 at 10:30 AM, stated the patient was taken off Aspirin effective 08/16/2021. Person E stated the aspirin was discontinued because of the patient’s low platelet counts, and this is why the patient is scheduled for the bone marrow testing on 10/15/2021.<br><br>11. The clinical record of patient #10, start of care 02/08/2021, was reviewed on 10/04/2021. The record contained a comprehensive recertification assessment dated 08/06/2021, which revealed there were daily caregivers and aides in the home to assist the family with the care of the patient, the patient uses a Roho cushion when sitting in a wheelchair/recliner, and a “meter” to check blood sugars. DME supplies revealed: a powered wheelchair, hospital bed, a Hoyer lift, a long-handled reacher, and a specialty mattress.<br><br>A review of the plan of care for a certification period of 08/11/2021 through 10/09/2021. The DME supplies failed to evidence the powered wheelchair, hospital bed, a Hoyer lift, a long-handled reacher, a specialty mattress, and the diabetic supplies.<br><br>During a phone interview on 10/05/2021 at 10:37 AM with the patient’s #10 family member Person M, stated there are other companies in the home to help take care of the patient but could not remember the name of companies. | G0574 | | |

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| G0574 | Continued from page 19<br>During a phone interview on 10/05/2021 at 1:30 PM with the registered nurse, Employee K stated that entity Q, a Medicaid Home Health Agency, was currently in the home providing daily care for the patient. When queried whether Employee K, Registered Nurse, coordinates care with entity Q, Employee K stated, “I never have talked to other companies about the patient’s care”. Employee K stated the primary physician and a podiatrist makes home visits to the patient.<br><br>During a phone interview with Person R at entity Q, Person R stated the agency had never contacted entity Q. Person R stated they called Kindred at Home to inquire about the care of the patient on 09/10/2021, 09/14/2021, and on 09/17/2021. On 09/17/2021, Person R was able to talk to an individual at Kindred at Home about the patient’s care the agency was providing.<br><br>The agency failed to record all DME supplies, identify all physicians and other entities involved with the care of the patient.<br><br>12. The clinical record of patient #11, start of care 06/14/2021, was reviewed on 10/04/2021. The record contained a resumption of care assessment dated 09/29/2021, which indicated the patient was incontinent of bowel and bladder, required assistance with commode, has a manual wheelchair, and a motorized wheelchair, hospital bed, tub chair, and wheelchair cushion.<br><br>A review of the plan of care for the certification period of 08/13/2021 through 10/11/2021 failed to evidence all DME supplies.<br><br>13. During an interview on 10/04/2021 at 11:20 AM, when queried as to what is considered DME supplies, the Administrator indicated anything “from supplies, equipment, 02, incontinent supplies, anything that's used for the patient.”<br><br>410 IAC 17-13-1(a)(1)(D)(ii)(viii)(ix)(x)(xiii) | G0574 | | |
| G0608 | Coordinate care delivery<br><br>CFR(s): 484.60(d)(4)<br><br>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. | G0608 | | |

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| G0608 | Continued from page 20<br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the agency failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs for 4 of 6 (Patients #4, 9, 10, 12) active patient records reviewed of patients receiving outside services.<br><br>Findings Include:<br><br>1. Review of an agency policy revised date of 6/2021 titled, “Care Planning” policy number 03-11 indicated, “Policy: …The clinician or clinical manager will communicate with all physicians or allowed practitioners involved …. ”<br><br>2. During a home visit on 09/29/2021 at 9 AM, patient #4 stated they were told to stop taking Aspirin Low Dose 81 mg tablet in August but couldn't remember who or when they were told to stop it. The registered nurse, employee H asked about upcoming medical appointments, they stated they had a wound clinic appointment on 10/08/2021 and were to have a bone marrow test performed on 10/15/2021.<br><br>The clinical record of patient #4, start of care 08/30/2021, was reviewed on 09/29/2021. The clinical record failed to evidence any coordination of care with the wound clinic and entity C.<br><br>During a phone interview with Person E from entity C, blood clinic, on date and time, stated the patient was taken off Aspirin effective 08/16/2021. Person E stated the aspirin was discontinued because of the patient’s low platelet counts, and this is why the patient is scheduled for the bone marrow testing on 10/15/2021.<br><br>3. The clinical record of patient #10, start of care 02/08/2021, was reviewed on 10/04/2021. The record contained a comprehensive recertification assessment dated 08/06/2021, which revealed there were daily caregivers and aides in the home to assist the family with the care of the patient.<br><br>During a phone interview on 10/05/2021 at 10:37 AM with the patient’s #10 family member Person M, stated there are other companies in the home to help take care of the patient but could not | G0608 | | |

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| G0608 | Continued from page 21<br>remember the name of companies.<br><br>During a phone interview on 10/05/2021 at 1:30 PM with the registered nurse, Employee K stated that entity Q, a Medicaid Home Health Agency, was currently in the home providing daily care for the patient. When queried whether Employee K, Registered Nurse, coordinates care with entity Q, Employee K stated, “I never have talked to other companies about the patient’s care”. Employee K stated the primary physician and a podiatrist makes home visits to the patient.<br><br>During a phone interview with Person R at entity Q, Person R stated the agency had never contacted entity Q. Person R stated they had to call Kindred at Home to inquire about the care of the patient on 09/10/2021, 09/14/2021, and on 09/17/2021.<br><br>4. A Review of clinical record #9, start of care date 8/24/20, evidenced a recertification comprehensive assessment dated 8/18/21. The comprehensive assessment diagnoses included but were not limited to: Non-pressure Chronic Ulcer Left Foot, Dependence on Renal Dialysis, Type 2 Diabetes with Foot Ulcer. The clinical record failed to evidence care coordination or information regarding the patient was receiving services dialysis at the dialysis center, wound care services received from the wound care center.<br><br>5. Review of clinical record #12, start of care date 5/3/21, contained a document titled, “Discharge Summary” from Entity FF, a hospital, dated 8/12/21 to 8/14/21 indicated, “Patient was admitted requiring dialysis. Patient could not get into outpatient dialysis because of COVID positive status…AV Fistula Comments: LUE AV fistula…”<br><br>During a phone interview on 10/4/21 at 9:30 AM, Person I, patient #12’s caregiver confirmed patient #12 was to receive dialysis treatment at Entity G, dialysis center. The plan of care failed to evidence coordination and information of care delivery with the dialysis center.<br><br>During a phone interview on 10/4/21 at 2:19 PM with Employee K, Registered Nurse, for patient #12, when queried about issues patient #12 had with getting dialysis stated, “I did not talk to the facility.”<br><br>6. During an interview on 10/4/21 at 11:15 AM, the | G0608 | | |

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| G0608 | Continued from page 22<br>administrator confirmed care coordination with other physicians and agencies providing services should be in the Focus of Care statement of the comprehensive assessment and plan of care.<br><br>410 IAC 17-12-2(h) | G0608 | | |
| G0616 | Patient medication schedule/instructions<br><br>CFR(s): 484.60(e)(2)<br><br>Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on interviews, the agency failed to ensure the patient and/ or patient representative was provided a medication schedule/ instructions, including the medication name, dosage, and frequency and whom medication will be administered by for 5 of 7 home visits conducted. (Patient #1, 2, 3, 4, 5)<br><br>Findings include:<br><br>1. A review of an agency policy revised date of 6/2021 titled, “Care Planning” policy number 03-11 indicated, “Policy: Each patient must receive an individualized written Plan of Care (POC) including any revisions or additions … The patient or caregiver will be provided a copy of the POC and/or other form of written instructions outlining: Visit schedule, disciplines, and frequency of visits. Patient medication schedule/instructions, to include medication name, dosage, frequency …. “<br><br>2. During a home visit on 08/28/2021 at 9 AM, when queried about a medication list and/ or plan of care provided by the agency, patient #1 stated they didn’t have either.<br><br>3. During a home visit on 09/28/2021 at 10:30 AM, when queried about a medication list and/ or plan of care provided by the agency, patient #2 stated they had their list but nothing from the agency.<br><br>4. During a home visit on 09/28/2021 at 12:15, when queried about a plan of care and/or medication list and/ or plan of care provided by | G0616 | | |

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| G0616 | Continued from page 23<br>the agency, patient #3 stated they didn't have them.<br><br>5. During a home visit on 09/28/2021 at 9 AM, when queried about a plan of care and/or medication list and/ or plan of care provided by the agency, patient #4 stated they didn't have or received a plan of care or a medication list.<br><br>6. During a home visit on 9/28/21 at 9:55 AM,. when queried about a plan of care and or medication list and or plan of care provided by the agency, patient #5 stated they didn't have them. | G0616 | | |
| G0682 | Infection Prevention<br><br>CFR(s): 484.70(a)<br><br>Standard: Infection Prevention.<br><br>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, record review, and interview, Employees failed to ensure they practiced proper hand hygiene while providing wound care to a patient for 1 of 2 patient's observed receiving wound care services by a Registered Nurse (Patient #4).<br><br>Findings Include:<br><br>1. Review of an agency policy revised date of 8/2021 titled, "Standard Precautions" policy number 10-03 indicated, "Policy: All clinicians performing job-related responsibilities will observe standard precautions…Use of Standard Precautions: …Standard Precautions include: hand hygiene…Clinicians are to follow CDC (Center for Disease Control and Prevention) recommendations…"<br><br>2. Centers for Disease Control last updated January 2021. When to Perform Hand Hygiene. Retrieved from cdc.gov/hand hygiene/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 | G0682 | | |

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| G0682 | Continued from page 24<br>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 soiled...moving from work on a soiled body site to a clean body site on the same patient or in another..."<br><br>During a home visit with patient #4 on 09/29/2021 at 9:00 AM, for the observation of skilled nursing services for wound care along with employee B, the alternate administrator. Employee H, a registered nurse had performed hand hygiene, applied gloves, picked up iPad off the floor to take pictures of a wound on the bottom of the foot, placed the iPad back on the floor, placed a dressing on the wound, and secured dressing. Employee H failed to use proper hand hygiene and practice universal precautions.<br><br>During an interview on 09/29/2021 at 4:15 PM, employee B stated she was aware of employee H not using proper hand hygiene with patient #4.<br><br>410 IAC 17-12-1(m) | G0682 | | |
| G0684 | Infection control<br><br>CFR(s): 484.70(b)(1)(2) | G0684 | | |

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| G0684 | Continued from page 25<br><br>Standard: Control.<br><br>The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include:<br><br>(1) A method for identifying infectious and communicable disease problems; and<br><br>(2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, record review and interview, the agency failed to ensure all Employees complete the patient prescreening for COVID-19 in patients 5 out of 7 home visits. (Patient #1, 3, 5, 6, 7)<br><br>Findings Include:<br><br>1. Review of an agency policy revised date of 9/3/2020 titled, “COVID-19 Pandemic: Communication and Coordination” policy number 10-13 indicated, “Guidelines…screening questions as recommended by the Centers for Disease Control and Prevention (CDC) guidance and state requirements will be conducted regarding symptoms and exposure to COVID-19…”<br><br>2. During a home visit at patient #5’s home on 9/28/21 from 9:10 AM to 9:58 AM, the social worker, Employee Y, failed to complete COVID-19 prescreening questions with patient #5 prior to services.<br><br>3. During a home visit at patient #6’s home on 9/28/21 from 10:55 AM to 11:45 AM, the speech therapist, Employee D, failed to complete COVID-19 prescreening questions with patient #6 prior to care and services.<br><br>During an interview on 9/28/21 at 11:45 AM when queried about how the staff prescreens patients for COVID-19, the speech therapist stated, “We take the patient’s temperature and if it is high, | G0684 | | |

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| G0684 | Continued from page 26<br>we call the nurse, office, and physician to report COVID-19."<br><br>4. During a home visit at patient #7's home on 9/28/21 from 12:45 PM to 1:20 PM, the RN (Registered Nurse), Employee E, failed to complete COVID-19 prescreening questions with patient #7 prior to providing care and services.<br><br>5. During an interview on 9/29/21 at 4:15 PM the administrator and clinical manager confirmed the agency staff was to ask COVID-19 prescreening questions. The administrator stated, " We need to do some retraining."<br><br>6. During a home visit with patient #1 on 9/28/21 at 9:00 AM, Employee G, certified occupational therapist assistant, failed to complete the COVID-19 prescreening evaluation prior to providing care and services.<br><br>7. During a home visit with patient #3 on 09/28/2021 at 12:15 PM, Employee I, physical therapist, failed to complete the COVID-19 prescreening evaluation prior to providing care and services.<br><br>During an interview on 09/29/2021 at 4:15 PM, employee B stated they were aware of COVID screenings not being completed on patient's #1 and #3. | G0684 | | |
| G0718 | Communication with physicians<br><br>CFR(s): 484.75(b)(7)<br><br>Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care;<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on observation, record review, and interview the agency failed to ensure the clinician communicated with all the patient's physicians to establish plans of care, review medications and allergies, and coordinate care in 3 of 12 active patients. (Patient # 4, 9, 12)<br><br>Findings Include:<br><br>6. During a home visit on 09/29/2021 at 9 AM with patient #4, the patient was queried by the | G0718 | | |

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| G0718 | Continued from page 27<br>registered nurse, employee H about their current medications, patient #4 stated they were told to stop taking Aspirin Low Dose 81 mg tablet in Aug. The patient was queried about upcoming medical appointments, they stated they had a wound clinic appointment on 10/08/2021 and was to have a bone marrow test performed on 10/15/2021.<br><br>A review of the clinical record of patient #4 on 09/29/2021 evidenced a plan of care with a start date of 08/30/2021 for a certification period of 08/30/2021 through 10/28/2021. The patient's diagnoses include but are not limited to are Type 2 Diabetes Mellitus (an impairment with the way the body regulates and uses sugar for fuel) with a foot ulcer (an open sore that's difficult to heal), Cellulitis (potentially serious bacterial skin infection) of left lower limb, Thrombocytopenia (low platelet count), and Hypertensive Chronic Kidney Disease (damage to the kidney due to long term high blood pressure).<br><br>A review of the comprehensive assessment dated 08/30/2021, a note written by the registered nurse, employee H, the patient had been to their primary physician and was referred to a wound clinic.<br><br>During a phone interview with patient #4 on 09/29/2021 at 3 PM, the patient stated they were going to entity C, blood clinic, for frequent platelet testing, and that's where they're going on 10/15/2021 to have a bone marrow test.<br><br>During a phone interview with person E from entity C, stating the patient was a patient there due to his low platelet counts since August 2021, and will continue to monitor the patient.<br><br>The agency failed to communicate/ coordinate with all physicians involved in the plan of care.<br><br>410 IAC 17-14-1(a)(1)(G)-RN<br><br>1. Review of an agency policy revised 3/2021titled, "Coordination of Care-Case Conferences" policy number 03-17 indicated, "Policy: Interdisciplinary personnel, internal and external to the Company, must maintain close communication to ensure the patient receives coordinated complimentary care that meets their needs…Case Conferences: …The clinical record or minutes of the meeting will document coordination of care…" | G0718 | | |

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| G0718 | Continued from page 28<br><br>2. Review of clinical record #9, start of care date 8/24/20, evidenced a recertification comprehensive assessment dated 8/18/21.The comprehensive assessment indicated the following but not limited to, “Diagnoses: Non-pressure Chronic Ulcer Left Foot, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Long Term Use of Antithrombotic/Antiplatelet, Dependence on Renal Dialysis, Type 2 Diabetes with Foot Ulcer, End-Stage Renal Disease, unspecified Diastolic Heart Failure, and History of Falling…” The comprehensive assessment failed to evidence care coordination or information regarding the patient’s nephrologist, wound physician, and endocrinologist.<br><br>3. Review of clinical record #12, start of care date 5/3/21, and a resumption of care date 8/16/21, evidenced a resumption of care comprehensive assessment dated 8/16/21. The resumption of care diagnoses indicated but was not limited to COVID-19, Pulmonary Fibrosis, Dependence on Renal Dialysis, and Dependence on Supplemental Oxygen. The comprehensive assessment failed to evidence care coordination or information regarding the other physicians that was involved in patient #12’s care including the nephrologist, pulmonologist.<br><br>Review of an agency document dated 8/16/21 titled, “Client Coordination Notes Report” failed to evidence care coordination and information regarding Entity G from the ESRD facility.<br><br>During a phone interview on 10/4/21 at 2:19 PM with Employee K, RN (Registered Nurse) for patient #12, when queried about issues patient #12 had with getting dialysis stated, “I did not talk to the facility.”<br><br>During an interview on 10/4/21 at 11:15 the administrator confirmed care coordination with other physicians and agencies providing services should be in the "Focus of Care" statement of the comprehensive assessment and Plan of Care. | G0718 | | |
| G0948 | Responsible for all day-to-day operations<br><br>CFR(s): 484.105(b)(1)(ii)<br><br>(ii) Be responsible for all day-to-day operations of the HHA; | G0948 | | |

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| G0948 | Continued from page 29<br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the Administrator failed to ensure they were responsible for day to day operation of the home health agency in regards to the agency failing to evidence all services provided (the office will be available on call 24 hours a day 7 days a week), and services not provided by the office employees arranged under agreement.<br><br>Findings Include:<br><br>A. Regarding all services provided (the office will be available on call 24 hours a day 7 days a week).<br><br>1. Review of an agency policy revised 5/2021 titled, “Services Provided” policy number 02-18 indicated, “Policy: …The office will be available on call 24 hours a day seven days a week to patients, physicians, and other referral sources…”<br><br>2. On 10/5/21 at 7:45 AM a call was placed to Kindred At Home. The surveyor spoke to Person J, the Entity Z answering service for Kindred At Home. Surveyor gave name and phone number and stated, “My mother has had a change in condition and that I needed to speak to the nurse right away.” Person J was given patient #12’s name. Person J was to let a nurse know and the call was disconnected. The surveyor did not receive a call back from an agency nurse.<br><br>During an interview on 10/5/21 at 8:51 AM when queried about the on-call process, the administrator confirmed the agency had used Entity Z answering service and response time should be 15 to 20 minutes.<br><br>During an interview on 10/5/21 at 10:50 AM when queried about on call response and call backs or disconnections, the administrator stated, “Absolutely. You should have received a call back if the call was not transferred.”<br><br>B. Regarding services not provided by the office employees arranged under agreement.<br><br>Based on record review and interview the administrator failed to ensure contracts were arranged by Non-Employee Y, a social worker of a sister agency, and Kindred At Home which outlines who has the overall responsibility for all | G0948 | | |

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| G0948 | Continued from page 30<br>services provided.<br><br>During an interview on 10/5/21 at 9:35 AM, the administrator stated there was no written agreement with their sister company, Entity P, for the use of Non-Employee Y, the social worker.<br><br>410 IAC 17-12-1(b)(3)<br><br>410 IAC 17-12-1(c)(1) | G0948 | | |
| G0962 | Coordinate patient care<br><br>CFR(s): 484.105(c)(2)<br><br>Coordinating patient care,<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the clinical manager failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs for 4 of 6 (Patients #4, 9, 10, 12) active patient records reviewed of patients receiving outside services.<br><br>Findings Include:<br><br>1. Review of an agency policy revised date of 6/2021 titled, “Care Planning” policy number 03-11 indicated, “Policy: …The clinician or clinical manager will communicate with all physicians or allowed practitioners involved …. ”<br><br>2. A Review of clinical record #9, start of care date 8/24/20, evidenced a recertification comprehensive assessment dated 8/18/21. The comprehensive assessment diagnoses included but were not limited to: Non-pressure Chronic Ulcer Left Foot, Dependence on Renal Dialysis, Type 2 Diabetes with Foot Ulcer. The clinical record failed to evidence care coordination or information regarding the patient was receiving services dialysis at the dialysis center, wound care services received from the wound care center.<br><br>3. Review of clinical record #12, start of care date 5/3/21, contained a document titled, “Discharge Summary” from Entity FF, a hospital, dated 8/12/21 to 8/14/21 indicated, “Patient was admitted requiring dialysis. Patient could not get into outpatient dialysis because of COVID positive | G0962 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157115 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/05/2021 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINDRED AT HOME | 8606 ALLISONVILLE RD STE 350 , INDIANAPOLIS, Indiana, 46250 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| G0962 | Continued from page 31<br>status…AV Fistula Comments: LUE AV fistula…"<br><br>During a phone interview on 10/4/21 at 9:30 AM, Person I, patient #12's caregiver confirmed patient #12 was to receive dialysis treatment at Entity G, dialysis center. The plan of care failed to evidence coordination and information of care delivery with the dialysis center.<br><br>During a phone interview on 10/4/21 at 2:19 PM with Employee K, Registered Nurse, for patient #12, when queried about issues patient #12 had with getting dialysis stated, "I did not talk to the facility."<br><br>4. During a home visit on 09/29/2021 at 9 AM, patient #4 stated they were told to stop taking Aspirin Low Dose 81 mg tablet in August but couldn't remember who or when they were told to stop it. The registered nurse, employee H asked about upcoming medical appointments, they stated they had a wound clinic appointment on 10/08/2021 and were to have a bone marrow test performed on 10/15/2021.<br><br>The clinical record of patient #4, start of care 08/30/2021, was reviewed on 09/29/2021. The clinical record failed to evidence any coordination of care with the wound clinic and entity C.<br><br>During a phone interview with Person E from entity C, blood clinic, on date and time, stated the patient was taken off Aspirin effective 08/16/2021. Person E stated the aspirin was discontinued because of the patient's low platelet counts, and this is why the patient is scheduled for the bone marrow testing on 10/15/2021.<br><br>5. The clinical record of patient #10, start of care 02/08/2021, was reviewed on 10/04/2021. The record contained a comprehensive recertification assessment dated 08/06/2021, which revealed there were daily caregivers and aides in the home to assist the family with the care of the patient.<br><br>During a phone interview on 10/05/2021 at 10:37 AM with the patient's #10 family member Person M, stated there are other companies in the home to help take care of the patient but could not remember the name of companies.<br><br>During a phone interview on 10/05/2021 at 1:30 PM with the registered nurse, Employee K stated that | G0962 | | |

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| G0962 | Continued from page 32<br>entity Q, a Medicaid Home Health Agency, was currently in the home providing daily care for the patient. When queried whether Employee K, Registered Nurse, coordinates care with entity Q, Employee K stated, “I never have talked to other companies about the patient’s care”. Employee K stated the primary physician and a podiatrist makes home visits to the patient.<br><br>During a phone interview with Person R at entity Q, Person R stated the agency had never contacted entity Q. Person R stated they had to call Kindred at Home to inquire about the care of the patient on 09/10/2021, 09/14/2021, and on 09/17/2021.<br><br>410 IAC 17-12-2(h) | G0962 | | |
| G0978 | Must have a written agreement<br><br>CFR(s): 484.105(e)(2)(i-iv)<br><br>An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been:<br><br>(i) Denied Medicare or Medicaid enrollment;<br><br>(ii) Been excluded or terminated from any federal health care program or Medicaid;<br><br>(iii) Had its Medicare or Medicaid billing privileges revoked; or<br><br>(iv) Been debarred from participating in any government program.<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, the Administrator failed to ensure they had written agreements with agencies with who they share employees and patients for 1 of 1 active records reviewed of patients receiving social worker services from a sister agency. (Patient #5)<br><br>Findings Include: | G0978 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157115 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/05/2021 |
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|---|---|---|---|---|
| G0978 | Continued from page 33<br>1. Review of an agency policy revised date of 3/2021 titled, “Contractor Files” policy number 02-20 indicated, “Policy: …Contractor Responsibilities: The contractor will maintain a personnel file on all staff assigned to provide service under an agreement with the office…”<br><br>2. Review of an agency policy revised 3/2021titled, “Services Under Arrangement” policy number 02-19 indicated, “Policy: Services not provided by the office employees will be arranged under agreements. Services will be evaluated for compliance with contract terms, state and federal requirements. Company policy, professional and accreditation standards…Contract Requirements: …Services provided under arrangements are subject to a current, signed agreement between the office and contractor. The agreement will specify the following information: …Services to be provided…The manner in which services will be controlled, coordinated, and evaluated by the office staff…”<br><br>3. During a home visit at patient #5’s on 9/28/21 at 9:10 AM, Non-Employee Y, the social worker, confirmed she was an employee of Entity P and also does visits for this Kindred At Home. The agency failed to evidence a contract between Entity P for Non-Employee Y to provide services to the patients at Kindred At Home.<br><br>During an interview on 10/5/21 at 9:45 AM, Employee L, human resources, confirmed employee Non-Employee Y’s file came from Entity P. Employee L confirmed that there is not a contract between the Kindred At Home and Non-Employee Y, in Non-Employee Y’s file during review.<br><br>During an interview on 10/5/21at 11:42 AM, the administrator stated, “Non-Employee Y, the social worker is a shared employee from Entity P and there is not a contract.”<br><br>410 IAC 17-12-2(d) | G0978 | | |