STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157663	A. BUILDING 00 B. WING	12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOME HELPERS HOME HEALTH	630 NORTH GARDNER ST SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00		G 0000		

This visit was for a complaint investigation survey of a Deemed Home Health Agency.

Complaint #: IN00341660; substantiated with findings

Survey Dates: 11/18, 11/19, 11/20, 11/23, 11/30, 12/1, and 12/2, of 2020

Facility ID: 013118

A fully extended survey was announced on 11/20/2020 at 10:00 a.m.

An Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care was identified and announced on 11/20/2020 at 11:20 a.m. The agency's 2nd immediate jeopardy removal of immediacy plan and actions were determined to have removed the immediacy component of the immediate jeopardy on 12/02/2020, at 3:13 p.m.

Based on the Condition-level deficiencies identified during the 12-02-2020, survey, your home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act, on 12/02/2020 at 10:00 a.m. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for two years beginning 12/02/2020, and continuing through 12/01/2022.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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.

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G 0436 Bldg. 00	484.50(c)(5) Receive all services in plan of care Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure all patient's with bed bugs received services as ordered in 3 of 3 records reviewed. (Patient 2, 7, and 8) Findings include: 1. A 2015 dated policy titled, Discharge/Transfer Policy, was provided by employee B on 11/18/2020. The document indicated, but was not limited to, "Interruption of Services When an interruption of services/transfer occurs during a patient/client's certification period, a form is to be completed and placed in the clinical record with previous progress notes to clarify why visits have not occurred. This will apply to instances in which the patient/client has been admitted to the hospital or to any other situation that creates the need for a brief, temporary hold on Agency services. It does not apply to a one-time missed visit occurrence. 1. When an interruption of services occurs the following procedure should be followed: a. Complete the 'Interruption of Services/Transfer' form which includes an explanation as to why services must be temporarily halted and anticipated length of hold, if known." 2. A 2015 policy titled, 2.8 Care Plan, was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is	G 0436	100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021 Interruption of Services Form will be used when there is any situation that creates the need for a brief, temporary hold of agency services. Education will be done with all nurses and office staff by 1/29/2020. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient	01/29/2021

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	essential ... Continuing evaluation and service modifications is provided as indicated as an integral part of ongoing provision of Agency services ... 2. A review of current patient/client status vs. services rendered. 3. The Plan of Care reflects the participation of the client to the extent possible. The agency communicates the plan of care to the client/caregiver in a comprehensive way that the client/caregivers understands ... 5. Patient/Client Involvement in Care Planning and Decision-Making In order to optimize patient/family participation in care planning and decisions affecting patient/client care, including planning for transfer, referral or discharge ... i. The clinical record will contain evidence of Agency staff communication with the patient/caregiver, and/or periodic case conference documentation will reflect patient/caregiver issues during planning ... 11. Revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient/client ... Evaluation of the Care Plan ..." 3. A document titled Patient Bill of Rights was provided on 11/18/2020 at 10:30 a.m. by the Clinical Manager. The document indicated, but was not limited to, "The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the person are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law ... The Patient has the right: ... 7. To participate in, and be informed about ... a. Completion of all assessments ... c. Establishing and revising the plan of care ... Any factors that could impact treatment effectiveness ... any changes in the care to be furnished ...14. To		has been followed up with, and that the dr. and case manager are notified weekly. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of 12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy as of 12/1/2020. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician.	

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	receive and access services consistently, with continuity, and in a timely manner from the agency ... 24. To access necessary professional services 24 hours a day, 7 days a week ... 25. To be referred to another agency if ... the agency cannot meet the patient's needs ... 27. To education, instruction and a list of requirements for continuity of care when the services of the agency are terminated ... 31. To receive all services as ordered." 4. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification periods 9/1/2020 to 10/30/2020 and 10/31/2020 to 12/29/2020, and included, but was not limited to, diagnoses of Amnesia, Type 2 Diabetes Mellitus with diabetic neuropathy, and unspecified blindness right eye. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per day 5 days per week for all personal care including bathing, dressing, oral/hair/skin care, meal set-up, frequent skin assessments d/t (due to) incontinence and poor mobility, medication reminders, fall precautions, and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020 was reviewed on 11/19/2020. The document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13 would be missed related to the patient having bed bugs. 9 of these dates had not yet occurred		Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going to his home. Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including	

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	A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020 was reviewed on 11/19/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 of these dates had not yet occurred. A document titled Communication Note dated 11/10/2020 signed by employee A, Clinical manager, indicated the following: "12:42p Clients niece [sic] messaged that several of clients meds need refilled. She also inquired about resetting the medication tower. Writer explained process of medication refills and that med tower would have to be reset per agency nurse once re-entry allowed. Explained that if she planned to set up clients meds she could use medication cups in tower." A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee A was reviewed on 11/19/2020. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment or take patient 2 to the ER (Emergency Room)." Employee A failed to notify the physician of the change in the patient's condition. Employee F failed to document if patient 2's family was advised to contact the MD or go the hospital per employee B's recommendation. During an interview 11/19/2020 at 1:59 p.m., patient 2's case manager stated patient 2's caregiver had called her frantic and upset. The		home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	case manager stated the patient was forced to leave the home immediately by property management taking all belongings, the patient had no portable oxygen and is dependent on 2 liters, the patient is often confused, and the patient requires maximum assistance. The case manager stated patient 2's caregiver could not figure out the patient's medications, the patient's blood sugars were out of control, and that patient 2's caregiver stated she had made multiple attempts for medication assistance to the agency with no response. The case manager stated the patient also had homemaker and attendant care services which were also abruptly stopped. The case manager stated on 11/12/2020 she had emailed the agency begging if they would at the very least would fill the medications tower. The case manager received an email on 11/13/2020 from the agency indicating they would go fill the medication tower. When informed the agency did not refill the medication tower the case manager stated the agency failed to inform her that it had not occurred. The case manager stated she connected patient 2's caregiver with the company responsible for the medication tower to get it set up. The case manager stated patient 2's caregiver works a full time job, is unable to figure out the medications the patient needs, didn't know how to set up the patient's medication tower, and struggling as the patient is not able to move the patient independently. During an interview with the administrator on 11/19/2020 at 10:37 a.m. when asked why patient 2 failed to receive services as ordered and has failed to have a home health aide or skilled nurse provide care since 10/27/2020 the administrator stated services were placed on hold related to bed bugs and would resume once an all clear was provided by the property manager or pest control			

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	company. 5. The complete clinical record for patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20, and included, but was not limited to, a diagnosis of spastic quadriplegia cerebral palsy. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/18/20 for the certification period 10/18/20 to 11/19/20 was reviewed. The document indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. A document titled Initial Summary of Care dated 10/18/20. The document indicated but was not limited to, "Client's mother reports that they currently have bed bugs and humpback flies. She states she tries to spray for these pests with sprays she buys at the store. Writer has not seen any bed bugs or humpback flies at this time ...The office will contact client's case manager to have an exterminator come to client's house to spray for bed bugs and humpback flies." A document titled Communication Note dated 10/19/20. The document indicated, but was not limited to, "I (employee K) was contacted by employee F upon client's admission on 10/18/20 that the client's home has a bed bug infestation. Entity 1 was contacted and was made aware of the situation. After speaking to her immediate supervisor, they are going to be treating the home for the infestation immediately so we will be able to start serviced upon ...approval." A document titled Communication Note dated 10/19/20. The document indicated, but was not limited to, "I contacted non-employee BB from			

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	entity 1 concerning this client having bed bugs. At that time entity 1 was informed that we will be unable to send anyone into the home until the situation is taken care of. Entity 1 would pay for them to come and spray ...as soon as possible." A document titled Communication Note dated 11/13/20. The document indicated, but was not limited to, "Non-employee BB from entity 1 contacted me ...and gave me the trip ID# for transportation on the client ...It is scheduled for November 18th at 2:30 pm." A document titled Communication Note dated 11/17/20. The document indicated, but was not limited to, "Non-employee BB entity 1 contacted me late this afternoon to inform us that transportation service EE has refused to pick up the client because it is not considered a medical necessity. Non-employee BB from entity 1 has been made aware that we can not start services with the client until the home has been treated for bed bugs." A document titled Communication Note dated 11/17/20. The document indicated, but was not limited to, "Non-employee BB from entity 1 contacted me around 9:30 pm to inform that they were able to make arrangements for the client to be transported by a transportation service FF. Client is to be transported to a local church where he will stay for at least two hours or more so the home can be treated for bed bugs." A document titled Communication Note dated 11/19/20. The document indicated, but was not limited to, "Client's mother called me today saying that she talked to the man who came to spray for bed bugs Wednesday the 18th and he informed her that the back interior room was infested the			

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	worst and it would need to be sprayed again." The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received an all clear notification. 6. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20, and included, but was not limited to, diagnoses of Type 2 Diabetes Mellitus and Major depressive disorder. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days per week, for all personal care. A document titled 60 Day Summary/Case Conference dated 9/10/20. The document indicated, but was not limited to, "Pt has not had the HHA yet due to bed bugs in the home, that are being treated. Left a message with his case manager requesting an emergency button. Pt has had multiple falls and said he had to go to the ER last week and spent the night, due to a fall. " A document titled Communication Note dated 11/10/20. The document indicated, but was not limited to, "Pt says he has not seen any bed bugs, but he hasn't gotten the clear from the exterminator yet and they are supposed to come one more time." Missed visit notes for patient 8 indicated patient 8 failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21,			

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	9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. Patient was accepted on 07/16/2020 by the agency. The agency was aware the patient had bed bugs. The patient was first visited on 07/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 07/16/2020 to current and has only seen the patient 2 times for OASIS assessments. The agency failed to provide services as ordered to meet the patient's needs.			
G 0454 Bldg. 00	484.50(d)(1) HHA can no longer meet the patient's needs The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities; Based on record review and interview, the agency failed to transfer or discharge 3 of 3 patients with services on hold according to agency policy when unable to meet the patients needs, with the potential to affect all patients. (Patient 2, 7, and 8) Findings include: 1. A 2015 policy titled 2.17 Discharge/Transfer Policy was provided by employee B on 11/18/2020 at 12:20 p.m. The policy indicated, but was not limited to, "Discharge of Patients in Unsafe	G 0454	Professional nursing staff will be re-educated on transfer/discharge policy and that the HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHAs capabilities education will be completed by 1/29/2021. The Interruption of Services Form will be used when there is any situation that creates the need for a brief, temporary hold on agency services. Education will be done	01/29/2021

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	Situations ... The safety of field staff is of primary importance. If in any way this safety would be compromised, the case (after all efforts to resolve the issues have been exhausted) will close ... If there are ongoing unsafe situations in the home or area, which field staff observes ... examples of unsafe situations include ... Environmental issues,, e.g., vermin, open flames near oxygen cylinders, animal dropping, etc ... Documentation will include a description of the situation, any discussions, and communications with the patient, caregiver, organizational staff, community resources, etc ... Interruption of Services When an interruption of services/transfer occurs during a patient/client's certification period, a form is to be completed and placed in the clinical record with previous progress notes to clarify why visits have not occurred. This will apply to instances in which the patient/client has been admitted to the hospital or to any other situation that creates the need for a brief, temporary hold on Agency services. It does not apply to a one-time missed visit occurrence. 1. When an interruption of services occurs the following procedure should be followed: a. Complete the 'Interruption of Services/Transfer' form which includes an explanation as to why services must be temporarily halted and anticipated length of hold, if known." 2. The complete clinical record for patient 2 was reviewed on 11/19/2020 and indicated services had been placed on hold beginning 10/27/2020. The agency failed to follow their own policy by not discharging the patient if they were in an unsafe situation and/or by not completing an "Interruption of Services/Transfer" form. 3. The complete record of patient 7 was reviewed on 11/19/20 and indicated services had been		with all nurses and office staff by 1/29/2020. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020 100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager,	

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	placed on hold beginning 10/18/2020. The agency failed to follow their own policy by not discharging the patient if they were in an unsafe situation and/or by not completing an "Interruption of Services/Transfer" form. 4. The complete clinical record for patient 8 was reviewed on 11/19/20 and indicated services had been placed on hold beginning 7/16/2020 at the start of care. Patient was accepted on 07/16/2020 by the agency. The agency was aware the patient had bed bugs. The patient was first visited on 07/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 07/16/2020 to current and has only seen the patient 2 times for OASIS assessments. The agency failed to transfer or discharge patient's when unable to meet the patient's needs. The agency failed to follow their own policy by not discharging the patient if they were in an unsafe situation and/or by not completing an "Interruption of Services/Transfer" form. 5. During an interview with the administrator on 11/19/2020 at 10:37 a.m. when asked how long was a patient left on hold before being considered for transfer/discharge if the agency was unable to meet their needs, the administrator stated it really depended on what the patient preferred.		and HR Director to ensure no gaps in care. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up with and dr. and case manager notified weekly. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a	

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			permanent home health aide going to his home. Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified. 10% of all clinical records will be audited quarterly, including a discharge and transfer chart, for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care and if the HHA is no longer able to meet the patient's needs that a discharge and/or transfer is completed. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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G 0484 Bldg. 00	484.50(e)(1)(ii) Document complaint and resolution (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to document all complaints in the agency complaint log for 1 of 1 complaint log review. Findings include: A document titled 1.36 Patient/Client Grievance Procedure was provided on 11/18/2020 at 12:20 p.m. by employee B. The document indicated, but was not limited to, "3. When a grievance is received, whether written or verbal, it is to be documented in the patient/client's clinical record by the Administrator or his/her designee. It is also to be noted in a log kept by the Administrator. 4. The resolution of the problem is also to be documented in the same manner ... 7. Each written or verbal grievance received is to be responded to in writing by the Administrator within (10) days ... A copy of the outcome is to be filed in the clinical record and noted in the Administrator's log." A document titled Patient Bill of Rights was provided on 11/18/2020 at 10:30 a.m. by the Clinical Manager. The document indicated, but was not limited to, "The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the person are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law ... The Patient has the	G 0484	Professional nursing staff and office staff will be re-educated on the Complaint Policy, complaint log, and the proper procedure to follow for a complaint by 1/29/2020. Complaint log will be monitored and audited by the Administrator or a designee of the Administrator every two weeks for six months and then monthly to ensure that any complaints are handled per guidelines and documented with a documented resolution.	01/29/2021

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	right: ... 36. To voice grievances regarding treatment or care that is (or fails to be) furnish ... and the patient notified of the resolution within 30 days." The administrators/agency's complaint log was reviewed on 11/18/2020. The last complaint listed in the complaint log was dated 07/13/2020. A document titled Communication Note dated 11/13/2020 for Patient 2 signed by employee A, was provided by the administrator on 11/9/20. The document indicated, but was not limited to, "11-13-2020 at 441pm - (Caregiver) ... called again at this time ... She voiced unhappiness with patients nurse at this time and patient not being able to take her insulin as directed ... " The agency failed to log this complaint in the administrator's complaint log, failed to document a resolution, and failed to respond to the complaint in writing within 10 days. A document titled Communication Note dated 11/05/2020 was provided by the administrator on 11/19/2020. The document indicated, but was not limited to, "We had a complaint on (employee F). Entity 2 does NOT want her back on their property. She will be banned from there. Non-employee GG from Entity 2 claims she is spreading rumors that is damaging to their company and she has yelled at staff as well as disregards company rules." The agency failed to log this complaint in the administrator's complaint log and failed to respond to the complaint in writing within 10 days. During an interview with the administrator on 11/19/2020 at 10:37 a.m. the administrator stated all complaints should be in the complaint log and clinical record if applicable. The administrator			

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	said she would have to look further into the situation. No other information was provided.			
G 0570 Bldg. 00	484.60 Care planning, coordination, quality of care 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 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. An Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care was identified and announced on 11/20/2020 at 11:20 a.m. The agency's 2nd immediate jeopardy removal of immediacy plan and actions were determined to have removed the immediacy component of the immediate jeopardy on 12/02/2020, at 3:13 p.m. The immediate jeopardy began July 17, 2020 when the agency accepted a patient (patient 8) with a known infestation of bed bugs and subsequently	G 0570	100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager,	01/29/2021

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	placed the patient's services on hold after completing the initial comprehensive assessment failing to provide services as ordered by the physician The agency failed to follow their own policy titled Bed Bug and Other Pest Control Policy that was provided by employee B, assistant clinical manager. The document indicated, but was not limited to, "Staff is typically temporarily pulled from a client's home with bed bugs until after the client has been cleared by a pest company. The agency will discuss this with the client's family to ensure that the client is getting the care they need while services are suspended. If the client is unable to go without services, the agency will provide staff with gowns, shoe covers, and hair covers ... If regular staff is unwilling to return to the clients home due to bed bugs, other staff will be asked if willing to go into the client's home." The agency failed to notify the physician or perform a follow up assessment after unwitnessed falls and repeated hospitalizations for patient 8, failed to provide services as ordered for patient 2 and 8, failed to coordinate care with the patient's family while services were placed on hold related to a bed bug infestation (patient 2), failed to document a complaint in the agency complaint log in regards to patient 2, failed to provide a written medication schedule for patient 2's caregiver, failed to notify the physician of changes in the patient's condition (patient 2 and 8), and failed to notify the physician that services were placed on hold for 3 of 3 hold records reviewed. (patient 2, 7, and 8). The subsequent failures resulted in 2 of 3 patients with bed bugs being hospitalized related to adverse outcomes. Based on record review and interview, the agency failed to follow their own policy to prevent adverse outcomes for patients for 2 of 3 patients with services on hold related to a bed bug		and HR Director to ensure no gaps in care. Professional nursing staff will be re-educated on transfer/discharge policy and that the HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHAs capabilities education will be completed by 1/29/2021. An Interruption of Services Form will be used when there is any situation that creates the need for a brief, temporary hold on agency services. Education will be done with all nurses and office staff by 1/29/2020. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up with and dr. and case manager notified weekly. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as	

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	infestation and failed to coordinate care with the patient's family/caregiver while services where on hold (Patients 2 and 8) (See G570); failed to ensure each patient received services identified in their plan of care (See G572); failed to ensure care provided conformed with the physician's orders (See G578); failed to promptly alert relevant physicians of changes (G590); failed to ensure up to date written medication instructions were provided to all individuals included in a patients care including the patient's caregiver (See G616). The cumulative effect of this systemic problem resulted in the agency being out of compliance with §484.60 Condition of participation: Care planning, coordination of services, and quality of care. Findings include: 1. An undated policy titled Bed Bug and Other Pest Control Policy was provided by the employee B, assistant clinical manager. The document indicated, but was not limited to, "Staff is typically temporarily pulled from a client's home with bed bugs until after the client has been cleared by a pest company. The agency will discuss this with the client's family to ensure that the client is getting the care they need while services are suspended. If the client is unable to go without services, the agency will provide staff with gowns, shoe covers, and hair covers ... If regular staff is unwilling to return to the clients home due to bed bugs, other staff will be asked if willing to go into the client's home." 2. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification periods 9/1/2020 to 10/30/2020 and 10/31/2020 to 12/29/2020. The record indicated, but was not		of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going	

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	limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per day 5 days per week for all personal care and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed Visit dated on 11/3/2020. The document indicated, but was not limited to, "Missed skilled nursing visit for medication set up in medication tower and skilled nursing assessment. Client services placed on hold due to bed bug infestation." A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020. The document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13 would be missed related to the patient having bed bugs. 9 days that had not yet occurred. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020 was reviewed on 11/19/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. The agency failed to notify the physician patient 2's services were placed on hold 10/27/2020 and had remained on hold indefinitely until the agency received an all clear notification from a pest service agency.		to his home. Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be	

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	A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee B. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment of take patient 2 to the ER (Emergency Room)." Employee B failed to notify the physician of the change in the patient's condition. A document titled Skilled Nurse Visit Note for visit date 10/20/20 indicated, but was not limited to, "Appointment was not made last week (related to right lower extremity ulcer) due to client waiting on portable O2 (oxygen) tanks to be refilled to go to the MD (Medical Doctor). HHA to make appointment with podiatry for client to be seen in home. The document failed to evidence follow up on the patient's portable O2 tanks and the skilled nursing note for the subsequent visit on 10/27/2020 failed to document any information related to the empty 02 tanks. 3. Patient 2's caregiver indicated on 11/18/2020 that they had reached out to the agency on 11/6/2020 at 1:00 p.m. and 8:17 p.m. asking for assistance in identifying which medications the patient was supposed to take. On 11/10/2020 at 12:41 p.m. patient 2's caregiver sent pictures of the patient's medications and stated there were more medications in the home than the patient believes they are to take. Patient 2's caregiver also asked for assistance on refilling medications and setting up patient 2's medication tower. On 11/10/2020 at 2:56 p.m. the agency's nurse responded and told the caregiver to call the pharmacy and use the automated system for refills, stated to use a pill		audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	planner because the machine was quite a process. The nurse failed to identify which medications the patient was supposed to be receiving. 4. A document titled [Name of Hospital] Patient Visit information was provided by patient 2's caregiver on 11/19/2020. The document indicated patient 2 was hospitalized on 11/12/2020 and diagnosed with hyperglycemia and a urinary tract infection. The patient's blood sugar at the time of admittance was 513. 5. During a phone interview on 11/19/2020 patient 2's case manager stated that patient 2's caregiver had called her distraught not knowing which medications to give the patient and stated the agency would not assist her. The case manager stated patient 2 required maximum assistance and should have received 43 hours a month of personal care services along with the home health aide and skilled nursing services all of which had been abruptly suspended on 10/28/2020. She stated she had emailed the agency begging them to at the very least to refill the patient's medication dispenser. The agency responded to the case manager that they would send a nurse in on 11/13/2020 to refill the medications. 6. During an interview on 11/19/2020 at 10:37 am the administrator stated she would have to look into whether the physician was notified. She stated the case manager was notified. The administrator failed to find documentation indicating the physician had been notified the patient's services had been placed on hold, the patient's condition had changed, or the agency was unable to meet the goals set forth in the patient's plan of care. The administrator failed to find documentation evidencing other home health aides if they would be willing to assist patient 2			

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	with proper PPE. 7. During an interview with patient 2's caregiver on 11/19/2020 the caregiver stated no one from the agency had reached out to her about offering alternative nurses or aides for the patient. The caregiver stated she had never been provided a written medication list from the agency or instructions related to patient 2's care. Patient 2's caregiver stated when she had found the patient, the patient was connected to an empty oxygen canister (patient is dependent on 2L of continuous oxygen), the patient had no Lantus (a long acting insulin) available, the patient was confused about her blood sugars, and the patient was in a soiled brief. 8. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/2020 to 11/12/2020. The record indicated, but was not limited to the following: A document titled Home Health Certification and Plan of Care dated 9/10/2020 for the certification period 9/14/20 to 11/12/20 was reviewed. The document indicated, but was not limited to, orders for home health aide serviced two hours per day, three days per week for all personal care as well as pre meal set-up, medication reminders and frequent skin inspections ... Orders to Notify physician if vitals fall out of parameters: pulse >120 or <60. Respirations >22 or <10. Systolic BP (Blood Pressure) >170 or < 90. Diastolic >90 or < 60. O2 sat (percent) <90. Fasting blood sugar >250 or <60. A document titled Communication Note with a date of 8/17/20 signed by employee E. The document indicated, but was not limited to, "Spoke with (Non-Employee DD) his new case manager. Made him aware of bed bug situation			

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	and possible eviction. He said he would look into it." A document titled Missed or Changed Scheduled Visit with a date of 8/7/20. The document indicated, but was not limited to, visit dates 8/3, 8/5, and 8/7 would be missed due to no HHA being available. A document tilted Communication Note with a date of 9/10/20 signed by employee E. The document indicated, but was not limited to, "Left a message for ... pt's cm, requesting ER button and informing him of broken brake on rollator." A document titled Oasis D1 Recertification with a date of 9/10/20 signed by employee E. The certification was completed via telephone. The document indicated, but was not limited to, "He (patient 8) does say his neck and shoulders hurt and has neuropathy that causes him to not be able to write. Fell about a week ago and went to ER and spent night in hospital. Has had multiple falls. Tailbone feels like someone took a hammer to it. Legs, feet and hands numb due to neuropathy." "Has a couple cuts on his left forearm where he fell." "Pt [patient] BS [blood sugar] 230 fasting this AM [morning]." "Pt expresses depression. Pt denies suicidal thoughts." A document titled 60 Day Summary/Case Conference signed by employee E. The document indicated, but was not limited to, "A 60 day recertification was completed via phone due to bed bugs in home (being treated). Left a message with his case manager requesting an emergency button." A document titled Missed or Changed Scheduled			

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	Visit with a date of 8/28/20. The document indicated, but was not limited to, visit dates 8/24, 8/26, 8/28 and 8/31 would be missed related to the patient having bed bugs. A document titled Communication Note with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "(Case Manager), I have been trying to reach you. Do you know anything about the bed bug situation? He says the exterminator is coming one more time." A document titled 60 Day Summary/Case Conference with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "A 60 day recertification was completed via phone due to bed bugs in the home (being treated)." A document titled Communication Note with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "Pt AP (apical pulse) 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him the ER twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." Missed visit notes for patient 8 indicated patient 8 failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs. Patient was accepted on 07/16/2020 by the agency. The agency was aware the patient had			

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	bed bugs. The patient was first visited on 07/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 07/16/2020 to current and had only seen the patient 2 times for OASIS assessments. The agency failed to discharge the patient when they were unable to meet the patient's needs; failed to notify the physician when the patient's pulse rate fell below ordered parameters; and failed to notify the physician of patient's unwitnessed falls, hospitalizations, and feeling faint. During an interview on 11/20/20 at 9:41 am with the administrator, when asked about follow up and if the physician had been notified the administrator stated that their follow-up procedure in the situation and on exterminator visits was reaching out to case management. The patient's case manager takes it from that point.			
G 0572 Bldg. 00	484.60(a)(1) Plan of care 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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to follow the plan of care for 3 of 11 patients with services on hold. (Patients 2, 7, and 8)	G 0572	100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps	01/29/2021

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	Findings include: 1. An undated policy titled Policy on Missed Visits was provided by employee B on 11/18/2020 at 1:29 p.m. The policy indicated, but was not limited to, "When a missed visit is required due to staff being unable to complete shift with a client or due to client canceling, a missed visit form will be completed by office staff and turned into the agency. The missed visit form will then be faxed to the client's physician as well. Missed visits are monitored by the administrator. If there are a large amount of missed in a short amount of time, the administrator will follow up with office staff, the client, and the client's family to discuss a plan." 2. A 2015 policy titled 2.8 Care Plan was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential ... Continuing evaluation and service modifications is provided as indicated as an integral part of ongoing provision of Agency services ... 2. A review of current patient/client status vs. services rendered. 3. The Plan of Care reflects the participation of the client to the extent possible. The agency communicates the plan of care to the client/caregiver in a comprehensive way that the client/caregivers understands ... 5. Patient/Client Involvement in Care Planning and Decision-Making In order to optimize patient/family participation in care planning and decisions affecting patient/client care, including planning for transfer, referral or discharge ... i. The clinical record will contain evidence of Agency staff communication with the patient/caregiver,		in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes, the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up with and dr. and case manager notified weekly. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case	

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	and/or periodic case conference documentation will reflect patient/caregiver issues during planning ... 11. Revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient/client ... Evaluation of the Care Plan ..." 3. A job description titled Registered Nurse was provided by employee B on 11/18/2020. The document indicated but is not limited to, "Responsibilities ... Consult with the attending physician concerning alterations of Patient Care Plans ... Coordinate Patient Services ... Evaluate the patient, family member(s) and home situations to determine what health teaching will be required ... Observing signs and symptoms and reporting to the physician ... as well as changes in the patient's physical or emotional condition." 4. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification periods 9/1/2020 to 10/30/2020 and 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per day 5 days per week for all personal care including bathing, dressing, oral/hair/skin care, meal set-up, frequent skin assessments d/t (due to) incontinence and poor mobility, medication reminders, fall precautions, and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020 was reviewed on 11/19/2020. The		Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. decided to not continue services at this time. DCS and Physician were notified. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring	

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	document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13 would be missed related to the patient having bed bugs. 9 days that had not yet occurred. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020 was reviewed on 11/19/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. The clinical record failed to evidence an Interruption of Services/Transfer Form which includes an explanation as to why services must be temporarily halted and anticipated length of hold, if known per the agency's own policy. The agency failed to notify the physician and revise the plan of care to accurately reflect the services the patient was receiving. During an interview on 11/20/2020 at 10:37 a.m. the administrator stated employee K had discovered a bed bug while performing a recertification visit on 10/27/2020 and the decision was made to place patient 2's services on hold the same day the Case Conference/60 Day Summary was faxed to the physician indicating the patient was receiving services. The administrator stated the case manager for patient 2 was notified the same day. The administrator acknowledged the agency failed to notify the patient's physician that services were being placed on hold immediately and failed to revise the plan of care. 5. The complete clinical record for patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record indicated, but was not limited to, the following:		these corrective actions to ensure that this deficiency is corrected and will not reoccur. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going to his home. Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse	

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	A document titled Home Health Certification and Plan of Care dated 10/18/20 for the certification period 10/18/20 to 12/16/20 was reviewed. The document indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received and all clear notification. The agency failed to make revisions to the plan of care to accurately reflect the care the patient was receiving. 6. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days per week, for all personal care. A document titled 60 Day Summary/Case Conference dated 9/10/20. The document indicated, but was not limited to, "Pt has not had the HHA yet due to bed bugs in the home, that are being treated. Left a message with his case manager requesting an emergency button. Pt has had multiple falls and said he had to go to the ER last week and spent the night, due to a fall. " A document titled Communication Note dated 11/10/20. The document indicated, but was not limited to, "A 60 day recertification was completed via phone due to bed bugs in the home (being		called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified.	

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	treated) ...Pt wished to continue services through Home Helpers." The document failed to indicate services would be placed on hold, failed to evidence interventions for potential adverse outcomes, failed to reflect the patient would not be receiving services for an indefinite time period, and failed to identify how patient measurable goals and outcome would be measured and met. Missed visit notes for patient 8 indicated patient 8 failed to receive services 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. Patient was accepted on 07/16/2020 by the agency. The agency was aware the patient had bed bugs. The patient was first visited on 07/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 07/16/2020 to current and had only seen the patient 2 times for OASIS assessments. The agency failed to notify the physician of lack of services being received, failed to notify the physician of changes in patient's condition related to missed visits, failed to notify the physician of the patient reported adverse events that had occurred, and failed to modify the plan of care. During an interview on 11/20/2020 at 3:46 p.m. the administrator stated she was not aware missed visit notices were being sent in advance to the physician prior to the date of the scheduled visit. The administrator acknowledged the agency had no documentation to support the reasoning for sending missed visit notes dated in the future.			

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G 0578 Bldg. 00	484.60(b) Conformance with physician orders Standard: Conformance with physician orders. Based on record review and interview, the agency failed to provide services as ordered by the physician resulting in an adverse outcome in 2 of 3 patient records reviewed with services on hold related to bed bugs. (Patient 2 and 8) Findings include: 1. A document titled Patient Bill of Rights was provided on 11/18/2020 at 10:30 a.m. by the Clinical Manager. The document indicated, but was not limited to, "The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the person are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law ... The Patient has the right: ... 31. To receive all services as ordered." 2. The complete clinical record of patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record evidenced the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per day 5 days per week for all personal care including bathing, dressing, oral/hair/skin care, meal set-up, frequent skin assessments d/t (due to)	G 0578	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including communication with Physician. Education on revised Missed Visits Policy was done with nursing staff and office staff on 12/1/2020 which included reporting missed visits to physician. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. An audit is used to check all client timesheets to make sure all missed visit forms are accounted for and have been sent to the doctor. 10% of all clinical records will be audited quarterly for evidence that the physician ordered frequency is being followed and if a visit is missed that a missed visit note is faxed to the physician. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not	01/29/2021

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	incontinence and poor mobility, medication reminders, fall precautions, and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020 was reviewed on 11/19/2020. The document indicated patient 2 failed to receive ordered services visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13. A written prescription order from patient 2's physician dated 11/12/20 was provided on 11/19/20 by the administrator. The prescription included orders for the patient to be monitored related to their insulin, preferably a home health aide the patient was familiar with. The agency failed to follow the 11/12/20 order and failed to notify the physician they could not meet the patient's need in regards to this prescription. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020 was reviewed on 11/19/2020. The document indicated patient 2 failed to receive ordered services for scheduled visit dates 11/16, 11/17, 11/18, 11/19, and 11/20.3. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days per week, for all personal care. Missed visit notes for patient 8 indicated patient 8		reoccur.	

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	failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. During an interview on 11/20/20 at 9:41 am with the administrator, when asked about follow-up and if the physician had been notified the administrator stated that their follow-up procedure in the situation and on exterminator visits was reaching out to case management. The patient's case manager takes it from that point. Patient 8 was first visited on 7/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 7/16/2020 to current and has only seen the patient 2 times for OASIS assessments.			
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(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. Based on record review and interview, the agency failed to promptly alert the physician of changes in patient's condition and/or changes that would prevent the patient from meeting goals listed in the plan of care in 3 of 3 records reviewed for patients with bed bugs. (Patient 2, 7, and 8). Findings include: 1. An undated policy titled Policy on Missed	G 0590	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and	01/29/2021

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	157663	A. BUILDING 00 B. WING	12/02/2020

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	Visits was provided by employee B on 11/18/2020 at 1:29 p.m. The policy indicated, but was not limited to, "When a missed visit is required due to staff being unable to complete shift with a client or due to client canceling, a missed visit form will be completed by office staff and turned into the agency. The missed visit form will then be faxed to the client's physician as well." 2. A job description titled Registered Nurse was provided by employee B on 11/18/2020. The document indicated but is not limited to, "Responsibilities ... Consult with the attending physician concerning alterations of Patient Care Plans ... as well as changes in the patient's physical or emotional condition." 3. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee A was reviewed on 11/19/2020. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment of take patient 2 to the ER (Emergency Room)." Employee A failed to notify the physician of the change in the patient's condition. Employee F failed to document if patient 2's family was advised to contact the MD or go the hospital per employee B's recommendation. The agency failed to notify the physician on 11/11/2020 patient 2's blood sugars were out		all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	range, the patient was not doing well, and the patient's family believed the patient may have a UTI which subsequently resulted in the patient being taken to the emergency room by the caregiver the following day. 4. During an interview on 11/19/2020 at 10:37 a.m., the administrator failed to find documentation sent to the physician indicating the patient's services had been placed on hold, the patient's condition had changed, and the agency was unable to meet the goal's set forth in the patient's plan of care. The administrator was aware that patient had to be taken to the emergency room. 5. The complete record of patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record evidenced the following: A document titled Home Health Certification and Plan of Care dated 10/18/20 indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received an all clear notification. The agency failed to notify the patient's physician they would be unable to meet the patient's current goals and outcomes. 6. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for "home			

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	health aide services 2 hours per day, three days per week, for all personal care as well as pre meal set-up, medication reminders and frequent skin inspections ... Orders to Notify physician if vitals fall out of parameters: pulse >120 or <60. Respirations >22 or <10. Systolic BP (Blood Pressure) >170 or < 90. Diastolic >90 or < 60. O2 sat (percent) <90. Fasting blood sugar >250 or <60. A document titled Oasis D1 Recertification with a date of 9/10/20 signed by employee E. The certification was completed via telephone. The document indicated, but was not limited to, "He (patient 8) does say his neck and shoulders hurt and has neuropathy that causes him to not be able to write. Fell about a week ago and went to ER and spent night in hospital. Has had multiple falls. Tailbone feels like someone took a hammer to it. Legs, feet and hands numb due to neuropathy." "Has a couple cuts on his left forearm where he fell." "Pt BS 230 fasting this AM." "Pt expresses depression. Pt denies suicidal thoughts." Employee E failed to notify the physician of the patient's hospital visits and unwitnessed falls with injuries. A document titled Communication Note dated 11/10/20 was reviewed on 11/19/20. The document indicated, but was not limited to, "AP (apical pulse) pulse 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him up in the ER (emergency room) twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." Employee E failed to notify the physician of patient 8's apical pulse being out of physician prescribed parameters, failed to notify			

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	the physician of the patients deteriorating mental status, failed to notify the physician of the patient fainting, and failed to notify the physician of the patient's multiple unwitnessed falls. During an interview on 11/19/2020 at 10:37 a.m. the administrator failed to find documentation sent to the physician indicating the patient's services had been placed on hold, the patient's condition had changed, and the agency was unable to meet the goal's set forth in the patient's plan of care.			
G 0616 Bldg. 00	484.60(e)(2) Patient medication schedule/instructions 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. Based on record review and interview the agency failed to ensure the patient's power of attorney for 1 of 1 of patient's on hold with medication set up received a written copy of the patient's medication list including route, frequency, and dosage. (Patient 2) Findings include: A document titled Patient Bill of Rights was provided on 11/18/2020 at 10:30 a.m. by the Clinical Manager. The document indicated, but was not limited to, "The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the person are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to	G 0616	Medication Profiles are left in every patient binder and are reviewed upon admission, recertification, and notification of any changes. Medication Profiles are available upon request to the Patient and/or POA/Patient Representative. Audits are done on admission and every recertification reviewed to ensure the medications have been reviewed and are correct and updated if appropriate. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including communication with Physician. Education on revised Missed Visits Policy was done	01/29/2021

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	the extent permitted by law ... The Patient has the right: ... 7. To participate in, and be informed about ... a. Completion of all assessments ... c. Establishing and revising the plan of care ... Any factors that could impact treatment effectiveness ... any changes in the care to be furnished ...14. To receive and access services consistently, with continuity, and in a timely manner from the agency ... 24. To access necessary professional services 24 hours a day, 7 days a week ... 25. To be referred to another agency if ... the agency cannot meet the patient's needs ... 27. To education, instruction and a list of requirements for continuity of care when the services of the agency are terminated ... 31. To receive all services as ordered." A 2015 policy titled 2.8 Care Plan was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "The clinical record will contain evidence of Agency staff communication with the patient/caregiver, and/or periodic case conference documentation will reflect patient/caregiver issues during planning ..." The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, a diagnosis of amnesia and orders for home health aide services 3 hours per day 5 days per week for all personal care and orders for skilled nursing for 1 hour per week for medication set up.		with nursing staff and office staff on 12/1/2020 which included reporting missed visits to physician. 10% of all clinical records will be audited quarterly for evidence medication review is done upon admission, recertification, and upon notification of any changes. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur	

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	A document evidencing messages exchanged between patient 2's caregiver and employee K, RN, was provided by the patient's caregiver on 11/19/2020. The document evidenced patient 2's caregiver had asked for a phone call regarding patient 2's medications on 11/6/2020 at 1:00 p.m. Patient 2's caregiver asked a second time at 8:17 p.m. for clarification on which medications to give to the patient. The document evidenced on 11/10/2020 at 12:41 p.m. patient 2's caregiver asked for assistance on refilling medications and setting up medication tower. Employee K first responded on 11/10/2020 at 2:56 p.m. Employee K informed patient 2 to call the pharmacy and enter the Rx (Prescription) numbers through the pharmacy's automated system and to get a pill planner as the medication tower was a process. Employee K failed to address which medications the patient was required to take daily, the routes, and how often. During an interview on 11/18/2020 at 3:00 p.m. patient 2's caregiver stated the agency had never provided her with a copy of the patient's written medical instructions. During an interview on 11/19/2020 at 1:59 p.m. patient 2's case manager stated patient 2's caregiver had called her frantic and upset. The case manager stated the patient was forced to leave the home immediately by property management taking all belongings, the patient had no portable oxygen and is dependant on 2 liters, the patient is often confused, and the patient requires maximum assistance. The case manager stated patient 2's caregiver could not figure out the patient's medications, the patient's blood sugars were out of control, and that patient 2's caregiver stated she had made multiple attempts for medication assistance to the agency with no			

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	response. The case manager stated the patient also had homemaker and attendant care services which were also abruptly stopped. The case manager stated on 11/12/2020 she had emailed the agency begging if they would at the very least would fill the medications tower. The case manager received an email on 11/13/2020 from the agency indicating they would go fill the medication tower. When informed the agency did not refill the medication tower the case manager stated the agency failed to inform her that it had not occurred. The case manager stated she connected patient 2's caregiver with the company responsible for the medication tower to get it set up. The case manger stated patient 2's caregiver works a full time job, is unable to figure out the medications the patient needs, didn't know how to set up the patient's medication tower, and struggling as the caregiver is not able to move the patient independently. During an interview on 11/19/2020 at 10:37 am the administrator stated the case manager for patient 2 was notified of services being placed on hold. When asked about follow up the administrator stated the case manager takes over the follow up after informed. The administrator stated she was not sure if the physician was notified and was unable to find documentation the patient's physician had been notified of the patient's services being placed on hold. At 11:24 a.m. the administrator provided documents, not included in the clinical record or properly authenticated from the office stating the clinical manager had made attempts to refill patient 2's medication tower.			
G 0700 Bldg. 00	484.75 Skilled professional services Condition of participation: Skilled professional			

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	services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. Based on record review and interview, the agency failed to maintain compliance with the Condition of Participation of Skilled Professional Services. The skilled professionals failed to provide services in the plan of care (See G0710); and failed to educate family/caregivers on patient care when services were suspended (See G0714); and failed to maintain ongoing communication with the patient's physician in regards to revisions of the plan of care or changes in the patients status (See G0718). The cumulative effect of these systemic problems resulted in the home health agency's to be found out of compliance with the provision of quality health care in a safe environment for the Condition of Participation of Skilled Professional Services, 42 CFR 484.75.	G 0700	100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes, the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up	01/29/2021

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			with and dr. and case manager notified weekly. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician and Case Manager (if the patient has one) Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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G 0710 Bldg. 00	484.75(b)(3) Provide services in the plan of care Providing services that are ordered by the physician as indicated in the plan of care; Based on record review and the interview, the agency failed to ensure skilled professionals provided care as ordered by the plan of care for 1 of 11 patients on hold reviewed. (Patient 2) Findings include: 1. A 2015 policy titled 2.8 Care Plan was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential ... Continuing evaluation and service modifications is provided as indicated as an integral part of ongoing provision of Agency services ... 3. The Plan of Care reflects the participation of the client to the extent possible. The agency communicates the plan of care to the client/caregiver in a comprehensive way that the client/caregivers understands ... 5. Patient/Client Involvement in Care Planning and Decision-Making In order to optimize patient/family participation in care planning and decisions affecting patient/client care, including planning for transfer, referral or discharge ... i. The clinical record will contain evidence of Agency staff communication with the patient/caregiver, and/or periodic case conference documentation will reflect patient/caregiver issues during planning ..." 2. A document titled Patient Bill of Rights was provided on 11/18/2020 at 10:30 a.m. by the	G 0710	Professional nursing staff will be re-educated on transfer/discharge policy and that the HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHAs capabilities. Education will be completed by 1/29/2021. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. 100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of	01/29/2021

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	Clinical Manager. The document indicated, but was not limited to, "The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the person are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law ... The Patient has the right: ... 7. To participate in, and be informed about ... a. Completion of all assessments ... c. Establishing and revising the plan of care ... Any factors that could impact treatment effectiveness ... any changes in the care to be furnished ...14. To receive and access services consistently, with continuity, and in a timely manner from the agency ... 24. To access necessary professional services 24 hours a day, 7 days a week ... 25. To be referred to another agency if ... the agency cannot meet the patient's needs ... 27. To education, instruction and a list of requirements for continuity of care when the services of the agency are terminated ... 31. To receive all services as ordered. 3. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, a diagnosis of amnesia and orders for for skilled nursing for 1 hour per week for medication set up. A document titled Missed Visit dated on 11/3/2020. The document indicated, but was not		charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. On hold patients (if any) will be discussed weekly. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. A patient with services on hold list excel was created and includes, the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up with and dr. and case manager notified weekly. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the	

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HOME HELPERS HOME HEALTH	630 NORTH GARDNER ST SCOTTSBURG, IN 47170

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	limited to, "Missed skilled nursing visit for medication set up in medication tower and skilled nursing assessment. Client services placed on hold due to bed bug infestation." A document titled Missed Visit dated on 11/3/2020. The document indicated, but was not limited to, "Missed skilled nursing visit for medication set up in medication tower and skilled nursing assessment. Client services placed on hold due to bed bug infestation." A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020. The document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13 would be missed related to the patient having bed bugs. 9 days that had not yet occurred. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. The skilled professional failed to provide services as ordered by the plan of care.		document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going to his home.	

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			Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified.	
G 0714 Bldg. 00	484.75(b)(5) Patient and caregiver education Patient and caregiver education; Based on record review and interview, the skilled professional failed to provide education to the patient's family/caregiver when services were placed on hold for bed bugs in 1 of 3 patient records reviewed. (Patient 2). Findings include: The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification	G 0714	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing	01/29/2021

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	period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, a diagnosis of amnesia and orders for home health aide services 3 hours per day 5 days per week for all personal care and orders for skilled nursing for 1 hour per week for medication set up. A document titled Communication Note dated 11/10/2020 signed by employee A, clinical manager, indicated the following: "12:42p Clients niece [sic] messaged that several of clients meds need refilled. She also inquired about resetting the medication tower. Writer explained process of medication refills and that med tower would have to be reset per agency nurse once re-entry allowed. Explained that if she planned to set up clients meds she could use medication cups in tower." A document titled Communication Note dated 11/13/2020 signed by employee A, indicated, but was not limited to, the following: (11-13-2020 at 441pm - (Caregiver) ... called again at this time. (Caregiver voiced concerns about this patient's Lantus Insulin. (Caregiver) voiced concerns that the patient is supposed to take 60ml of lantus twice a day. I let her know, no she isn't, she is to take 60 units, which is less than 1 mL due to Lantus insulin being 100 units per ml ... (Caregiver) seemed confused ... She voiced unhappiness with patients nurse at this time and patient not being able to take her insulin as directed ... " A document evidencing messages exchanged between patient 2's caregiver and employee K, RN, was provided by the patient's caregiver on 11/19/2020. The document evidenced patient 2's caregiver had asked for a phone call regarding patient 2's medications on 11/6/2020 at 1:00 p.m.		Department immediately and that the office will notify Physician and Case Manager. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager, and family if any are involved in the patients care. Also, to ensure that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur	

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	Patient 2's caregiver asked a second time at 8:17 p.m. for clarification on which medications to give to the patient. The document evidenced on 11/10/2020 at 12:41 p.m. patient 2's caregiver asked for assistance on refilling medications and setting up medication tower. Employee K first responded on 11/10/2020 at 2:56 p.m. Employee K informed patient 2 to call the pharmacy and enter the Rx (Prescription) numbers through the pharmacy's automated system and to get a pill planner as the medication tower was a process. Employee K failed to address or educate the caregiver on which medications the patient was required to take daily, the routes, and how often. During an interview on 11/18/2020 at 3:00 p.m. patient 2's caregiver stated the agency had never provided her with a copy of the patient's written medical instructions. During an interview on 11/19/2020 at 1:59 p.m. patient 2's case manager stated patient 2's caregiver had called and could not figure out the patient's medications, the patient's blood sugars were out of control, and that patient 2's caregiver stated she had made multiple attempts for medication assistance to the agency with no response. The case manager stated on 11/12/2020 she had emailed the agency begging if they would at the very least would fill the medications tower. The case manager received an email on 11/13/2020 from the agency indicating they would go fill the medication tower. When informed the agency did not refill the medication tower the case manager stated the agency failed to inform her that it had not occurred. The case manager stated she connected patient 2's caregiver with the company responsible for the medication tower to get it set up.			

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	Employee A, RN Clinical Manager, and Employee K, RN for patient 2, failed to provide education to caregiver on how to care for patient 2 while services were interrupted after a minimum of 7 requests for guidance from the caregiver.			
G 0718 Bldg. 00	484.75(b)(7) Communication with physicians Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview the skilled professional failed to communicate with all physicians involved in the plan of care for 10 of 11 patient's on hold reviewed potentially affecting all of the agencies 175 patients. (Patient 1, 2, 7, 8, 14, 15, 16, 17, 19, and 20) Findings include: 1. A 2015 policy titled 2.8 Care Plan was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential ... Continuing evaluation and service modifications is provided as indicated as an integral part of ongoing provision of Agency services ... 11. Revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient/client ... Evaluation of the Care Plan ... 2. A review of current patient/client status vs. services rendered." 2. A job description titled Registered Nurse was provided by employee B on 11/18/2020. The	G 0718	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including communication with Physician. Education on revised Missed Visits Policy was done with nursing staff and office staff on 12/1/2020 which included reporting missed visits to physician. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. An audit is used to check all client timesheets to make sure all missed visit forms are accounted for and have been sent to the doctor. Reporting to Supervisor education was done with all staff (including home health aides,	01/29/2021

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	document indicated but is not limited to, "Responsibilities ... Consult with the attending physician concerning alterations of Patient Care Plans ... Coordinate Patient Services ... Evaluate the patient, family member(s) and home situations to determine what health teaching will be required ... Observing signs and symptoms and reporting to the physician ... as well as changes in the patient's physical or emotional condition." 3. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee A. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment of take patient 2 to the ER (Emergency Room)." Employee A failed to notify the physician of the change in the patient's condition. Employee F failed to document if patient 2's family was advised to contact the MD or go the hospital per employee B's recommendation. The skilled professional failed to communicate the patients change in status to the physician.		nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician 10% of all clinical records will be audited quarterly for evidence that the physician ordered frequency is being followed and if a visit is missed that a missed visit note is faxed to the physician and that the Physician is notified of any changes as well as the Case Manager and that follow up is done The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	4. The complete clinical record for patient 19 was reviewed on 12/01/2020. Patient 19 had orders for home health aide services 2 hours per day 1 day per week to assist in activities of daily living, medication reminders, and fall precautions. The clinical record indicated, but was not limited to, the following: Documents titled "Missed Visit" dated for 04/29/2020 and for 5/27/2020. The documents indicated, but was not limited to, "Cancellation of Care ... services on hold at this time d/t (due to) coronavirus pandemic." The clinical record failed to evidence documentation of communication with patient 19's physician of services being placed on hold and how or if the plan of care should be revised. 5. The complete clinical record for patient 20 was reviewed on 12/01/2020. The patient had orders for home health aide services 7 hour per day for 3 days per week. The clinical record indicated, but was not limited to, the following: Documents titled "Missed Visit" dated for 04/29/2020 and for 5/28/2020. The documents indicated, but was not limited to, "Cancellation of Care ... services on hold at this time d/t coronavirus pandemic." A document titled 60 Day Summary/Case Conference signed by employee I, Registered Nurse, dated 5/28/2020. The document indicated, but was not limited to, "Client receives services of 7H/D. (7 hours per day) 3D/W (3 days per week)... He is satisfied with services at this time and wishes to continue them." The document was faxed to the physician on 06/04/2020. The patient			

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	had not received services since 04/2020. 6. The complete clinical record for patient 1 was reviewed on 11/19/2020 for the certification period 8/26/2020 to 10/24/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 8/28/20. The record indicated, but was not limited to, orders for a home health aide 2 hours per day, three days per week for all personal care. A document labeled Missed Visit Notes dated 8/13, 9/9, and 10/8. The documents indicated, but were not limited to, "Missed SUP visit d/t to no HHA available". A document labeled Missed or Changed Scheduled Visit dated 11/6/20. The document indicated, but was not limited to, "Client quarantined for covid". The visit was scheduled for 11/9/20. A document labeled Missed or Changed Scheduled Visit dated 11/11/20. The document indicated, but was not limited to, "Client quarantined for covid". The visit was scheduled for 11/12/20. The clinical record failed to evidence documentation of communication with patient 1's physician of services being placed on hold and how or if the plan of care should be revised. 7. The complete clinical record for patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and			

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	Plan of Care dated 10/18/20 for the certification period 10/18/20 to 11/19/20 was reviewed. The document indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received and all clear notification. The clinical record failed to evidence follow up and monitoring of patient during hold period, failed to document progress toward goals and how outcomes were to be met. 8. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days per week, for all personal care. A document titled 60 Day Summary/Case Conference dated 9/10/20. The document indicated, but was not limited to, "Pt has not had the HHA yet due to bed bugs in the home, that are being treated. Left a message with his case manager requesting an emergency button. Pt has had multiple falls and said he had to go to the ER last week and spent the night, due to a fall. " A document titled Communication Note with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "Pt AP (apical pulse) 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him			

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	the ER twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." A document titled Communication Note dated 11/10/20. The document indicated, but was not limited to, "A 60-day recertification was completed via phone due to bed bugs in the home (being treated) ...Pt wished to continue services through Home Helpers." The document failed to indicate services would be placed on hold, failed to evidence interventions for potential adverse outcomes, failed to reflect the patient would not be receiving services for an indefinite time period, and failed to identify how patient measurable goals and outcome would be measured and met. Missed visit notes for patient 8 indicated patient 8 failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 9. The limited clinical record for patient 14 was reviewed on 12/1/20 for the certification period 10/21/20 to 12/19/20. The record indicated, but was not limited to, the following:			

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	A document titled Home Health Certification and Plan of Care dated 10/20/20. The document indicated, but was not limited to, orders for a home health aide 2 hours per day, 3 days per week for all personal care. A document titled Missed Visit Notes dated 4/16, 5/8, 6/5, 7/3, 8/13, 9/10, 10/9 and 11/6. The documents indicated, but were not limited to, "Services are temporarily on hold per client's wishes due to Covid-19 pandemic." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 10. The limited clinical record for patient 15 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A record titled Home Health Certification and Plan of Care dated 9/21/20 for the certification period from 9/25/20 to 11/23/20 and 11/24/202 to 1/22/2021. The record indicated, but was not limited to, orders for a home health aide 2 hours per day, three days per week, for all personal care. A document showing home health aide visits was provided by the employee C. The document indicated, but was not limited to, the following: Visits on 11/10, 11/12, 11/13, 11/17, 11/19, 11/20 and 11/23 were missed with reason of "Out due to C-19". A document titled 60 Day Summary/ Case Conference dated 11/19/20. The document			

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	indicated, but was not limited to, the following: "Patient was seen in her home for a 60-day recertification ...patient is satisfied and thankful with care from Home Helpers and wished to continue with current services, but possibly put a hold on care, until the first of Dec. due to Covid." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 11. The limited clinical record for patient 16 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/2/20 for the certification period of 10/7/20 to 12/5/20. The document indicated, but was not limited to, the following: orders for a home health aide 4 hours per day, 5 days per week for all personal care. A document titled Missed Visit dated 11/23/20. The document indicated, but was not limited to, the following: "Missed supervisory visit of HHA by RN due to client putting services on hold temporarily." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met.			

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HOME HELPERS HOME HEALTH	630 NORTH GARDNER ST SCOTTSBURG, IN 47170

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	12. The limited clinical record for patient 17 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/2/20 for the certification period of 10/25/20 to 12/23/20. The document indicated, but was not limited to, the following: orders for a home health aide 4 hours per day, 4 days per week for all personal care. A document titled Missed Visit with the dates 9/21/20, 10/12/20 and 10/22/20 indicated, but were not limited to, the following: "Pt does not have a HHA at this time." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 13. During an interview on 11/20/2020 at 10:37 a.m. the administrator acknowledged the agency failed to notify the patient's physicians that services were placed on hold, continued to send out a plan of care for review to the physicians office which failed to accurately describe the services the patient would receive, and continued to send out 60 Day Summaries/Case Conferences indicating patients where receiving services which they were not receiving.			
G 1024 Bldg. 00	484.110(b) Authentication Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and			

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	timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure all documentation was properly authenticated and located in the patient's clinical record for 1 of 3 patients with services on hold related to bed bugs. (Patient 2) Findings include: Patient 2's clinical record included, but was not limited to, the following: A document titled Communication Note dated 10/28/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry. The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, employee O, of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/05/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry. The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, employee M, of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/05/2020 was provided by the administrator on 11/19/2020. The document included, but was not	G 1024	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including communication with Physician. Further education on Documentation will be completed by 1/29/2021 to include that all documentation is properly authenticated and include; signature, title, date, and time. 10% of all clinical records will be audited quarterly for evidence that all documentation is properly authenticated. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	01/29/2021

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	limited to, "(Communication) Sign and Date each entry." The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee N of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/06/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry." The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee O of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/09/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry." The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee O of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/09/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry." The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee P of the document and failed to include a time the entry was made. During an interview on 12/02/2020 at 3:30 p.m. the administrator stated that the staff would be educated on proper documentation guidelines.			

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N 0000 Bldg. 00		N 0000		
	This visit was for a complaint investigation survey of a Deemed Home Health Agency. Complaint #: IN00341660; substantiated with related and unrelated findings Survey Dates: 11/18, 11/19, 11/20, 11/23, 11/30, 12/1, and 12/2, of 2020 Facility ID: 013118 Provider #: 157663 Facility Census: 175 (Unduplicated last 12 months Parent and 2 Branches) Clinical Record Review: 11 hold records 2 closed records 7 active records Home Visits: 3			
N 0506 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on record review and interview, the agency failed to transfer or discharge 3 of 3 patients with services on hold according to agency policy when	N 0506	Professional nursing staff will be re-educated on transfer/discharge policy and that the HHA must arrange a safe and appropriate	01/29/2021

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	unable to meet the patients needs, with the potential to affect all patients. (Patient 2, 7, and 8) Findings include: 1. A 2015 policy titled 2.17 Discharge/Transfer Policy was provided by employee B on 11/18/2020 at 12:20 p.m. The policy indicated, but was not limited to, "Discharge of Patients in Unsafe Situations ... The safety of field staff is of primary importance. If in any way this safety would be compromised, the case (after all efforts to resolve the issues have been exhausted) will close ... If there are ongoing unsafe situations in the home or area, which field staff observes ... examples of unsafe situations include ... Environmental issues,, e.g., vermin, open flames near oxygen cylinders, animal dropping, etc ... Documentation will include a description of the situation, any discussions, and communications with the patient, caregiver, organizational staff, community resources, etc ... Interruption of Services When an interruption of services/transfer occurs during a patient/client's certification period, a form is to be completed and placed in the clinical record with previous progress notes to clarify why visits have not occurred. This will apply to instances in which the patient/client has been admitted to the hospital or to any other situation that creates the need for a brief, temporary hold on Agency services. It does not apply to a one-time missed visit occurrence. 1. When an interruption of services occurs the following procedure should be followed: a. Complete the 'Interruption of Services/Transfer' form which includes an explanation as to why services must be temporarily halted and anticipated length of hold, if known." 2. The complete clinical record for patient 2 was		transfer to other care entities when the needs of the patient exceed the HHAs capabilities education will be completed by 1/29/2021. The Interruption of Services Form will be used when there is any situation that creates the need for a brief, temporary hold on agency services. Education will be done with all nurses and office staff by 1/29/2020. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020 100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps	

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	reviewed on 11/19/2020 and indicated services had been placed on hold beginning 10/27/2020. The agency failed to follow their own policy by not discharging the patient if they were in an unsafe situation and/or by not completing an "Interruption of Services/Transfer" form. 3. The complete record of patient 7 was reviewed on 11/19/20 and indicated services had been placed on hold beginning 10/18/2020. The agency failed to follow their own policy by not discharging the patient if they were in an unsafe situation and/or by not completing an "Interruption of Services/Transfer" form. 4. The complete clinical record for patient 8 was reviewed on 11/19/20 and indicated services had been placed on hold beginning 7/16/2020 at the start of care. Patient was accepted on 07/16/2020 by the agency. The agency was aware the patient had bed bugs. The patient was first visited on 07/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 07/16/2020 to current and has only seen the patient 2 times for OASIS assessments. The agency failed to transfer or discharge patient's when unable to meet the patient's needs. The agency failed to follow their own policy by not discharging the patient if they were in an unsafe situation and/or by not completing an "Interruption of Services/Transfer" form. 5. During an interview with the administrator on 11/19/2020 at 10:37 a.m. when asked how long was a patient left on hold before being considered for		in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up with and dr. and case manager notified weekly. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to	

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	transfer/discharge if the agency was unable to meet their needs, the administrator stated it really depended on what the patient preferred.		Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going to his home. Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified. 10% of all clinical records will be audited quarterly, including a discharge and transfer chart, for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care	

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			and if the HHA is no longer able to meet the patient's needs that a discharge and/or transfer is completed. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	
N 0514 Bldg. 00	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the agency failed to document all complaints in the agency complaint log for 1 of 1 complaint log review. Findings include: A document titled 1.36 Patient/Client Grievance Procedure was provided on 11/18/2020 at 12:20 p.m. by employee B. The document indicated, but was not limited to, "3. When a grievance is received, whether written or verbal, it is to be documented in the patient/client's clinical record	N 0514	Professional nursing staff and office staff will be re-educated on the Complaint Policy, complaint log, and the proper procedure to follow for a complaint by 1/29/2020. Complaint log will be monitored and audited by the Administrator or a designee of the Administrator every two weeks for six months and then monthly to ensure that any complaints are handled per guidelines and documented with a documented	01/29/2021

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	by the Administrator or his/her designee. It is also to be noted in a log kept by the Administrator. 4. The resolution of the problem is also to be documented in the same manner ... 7. Each written or verbal grievance received is to be responded to in writing by the Administrator within (10) days ... A copy of the outcome is to be filed in the clinical record and noted in the Administrator's log." A document titled Patient Bill of Rights was provided on 11/18/2020 at 10:30 a.m. by the Clinical Manager. The document indicated, but was not limited to, "The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the person are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law ... The Patient has the right: ... 36. To voice grievances regarding treatment or care that is (or fails to be) furnish ... and the patient notified of the resolution within 30 days." The administrators/agency's complaint log was reviewed on 11/18/2020. The last complaint listed in the complaint log was dated 07/13/2020. A document titled Communication Note dated 11/13/2020 for Patient 2 signed by employee A, was provided by the administrator on 11/9/20. The document indicated, but was not limited to, "11-13-2020 at 441pm - (Caregiver) ... called again at this time ... She voiced unhappiness with patients nurse at this time and patient not being able to take her insulin as directed ... " The agency failed to log this complaint in the administrator's		resolution.	

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	complaint log, failed to document a resolution, and failed to respond to the complaint in writing within 10 days. A document titled Communication Note dated 11/05/2020 was provided by the administrator on 11/19/2020. The document indicated, but was not limited to, "We had a complaint on (employee F). Entity 2 does NOT want her back on their property. She will be banned from there. Non-employee GG from Entity 2 claims she is spreading rumors that is damaging to their company and she has yelled at staff as well as disregards company rules." The agency failed to log this complaint in the administrator's complaint log and failed to respond to the complaint in writing within 10 days. During an interview with the administrator on 11/19/2020 at 10:37 a.m. the administrator stated all complaints should be in the complaint log and clinical record if applicable. The administrator said she would have to look further into the situation. No other information was provided.			
N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on record review and interview, the agency failed to follow their own policy to prevent adverse outcomes for patients for 2 of 3 patients with services on hold related to a bed bug infestation and failed to coordinate care with the patient's family/caregiver while services where on hold (Patients 2 and 8).	N 0520	100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in	01/29/2021

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	Findings include: 1. An undated policy titled Bed Bug and Other Pest Control Policy was provided by the employee B, assistant clinical manager. The document indicated, but was not limited to, "Staff is typically temporarily pulled from a client's home with bed bugs until after the client has been cleared by a pest company. The agency will discuss this with the client's family to ensure that the client is getting the care they need while services are suspended. If the client is unable to go without services, the agency will provide staff with gowns, shoe covers, and hair covers ... If regular staff is unwilling to return to the clients home due to bed bugs, other staff will be asked if willing to go into the client's home." 2. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification periods 9/1/2020 to 10/30/2020 and 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per day 5 days per week for all personal care and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed Visit dated on 11/3/2020. The document indicated, but was not limited to, "Missed skilled nursing visit for medication set up in medication tower and skilled nursing assessment. Client services placed on hold due to bed bug infestation."		care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. Professional nursing staff will be re-educated on transfer/discharge policy and that the HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHAs capabilities education will be completed by 1/29/2021. An Interruption of Services Form will be used when there is any situation that creates the need for a brief, temporary hold on agency services. Education will be done with all nurses and office staff by 1/29/2020. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up with and dr. and case manager notified weekly.	

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	A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020. The document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13 would be missed related to the patient having bed bugs. 9 days that had not yet occurred. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020 was reviewed on 11/19/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. The agency failed to notify the physician patient 2's services were placed on hold 10/27/2020 and had remained on hold indefinitely until the agency received an all clear notification from a pest service agency. A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee B. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment of take patient 2 to the ER (Emergency Room)." Employee B failed to notify the physician of the change in the patient's condition. A document titled Skilled Nurse Visit Note for visit date 10/20/20 indicated, but was not limited to, "Appointment was not made last week (related to right lower extremity ulcer) due to client waiting		The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on	

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	on portable O2 (oxygen) tanks to be refilled to go to the MD (Medical Doctor). HHA to make appointment with podiatry for client to be seen in home. The document failed to evidence follow up on the patient's portable O2 tanks and the skilled nursing note for the subsequent visit on 10/27/2020 failed to document any information related to the empty 02 tanks. 3. Patient 2's caregiver indicated on 11/18/2020 that they had reached out to the agency on 11/6/2020 at 1:00 p.m. and 8:17 p.m. asking for assistance in identifying which medications the patient was supposed to take. On 11/10/2020 at 12:41 p.m. patient 2's caregiver sent pictures of the patient's medications and stated there were more medications in the home than the patient believes they are to take. Patient 2's caregiver also asked for assistance on refilling medications and setting up patient 2's medication tower. On 11/10/2020 at 2:56 p.m. the agency's nurse responded and told the caregiver to call the pharmacy and use the automated system for refills, stated to use a pill planner because the machine was quite a process. The nurse failed to identify which medications the patient was supposed to be receiving. 4. A document titled [Name of Hospital] Patient Visit information was provided by patient 2's caregiver on 11/19/2020. The document indicated patient 2 was hospitalized on 11/12/2020 and diagnosed with hyperglycemia and a urinary tract infection. The patient's blood sugar at the time of admittance was 513. 5. During a phone interview on 11/19/2020 patient 2's case manager stated that patient 2's caregiver had called her distraught not knowing which medications to give the patient and stated the agency would not assist her. The case manager		12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going to his home. Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues,	

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	stated patient 2 required maximum assistance and should have received 43 hours a month of personal care services along with the home health aide and skilled nursing services all of which had been abruptly suspended on 10/28/2020. She stated she had emailed the agency begging them to at the very least to refill the patient's medication dispenser. The agency responded to the case manager that they would send a nurse in on 11/13/2020 to refill the medications. 6. During an interview on 11/19/2020 at 10:37 am the administrator stated she would have to look into whether the physician was notified. She stated the case manager was notified. The administrator failed to find documentation indicating the physician had been notified the patient's services had been placed on hold, the patient's condition had changed, or the agency was unable to meet the goals set forth in the patient's plan of care. The administrator failed to find documentation evidencing other home health aides if they would be willing to assist patient 2 with proper PPE. 7. During an interview with patient 2's caregiver on 11/19/2020 the caregiver stated no one from the agency had reached out to her about offering alternative nurses or aides for the patient. The caregiver stated she had never been provided a written medication list from the agency or instructions related to patient 2's care. Patient 2's caregiver stated when she had found the patient, the patient was connected to an empty oxygen canister (patient is dependent on 2L of continuous oxygen), the patient had no Lantus (a long acting insulin) available, the patient was confused about her blood sugars, and the patient was in a soiled brief. 8. The complete clinical record for patient 8 was		etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	reviewed on 11/19/20 for the certification period 9/14/2020 to 11/12/2020. The record indicated, but was not limited to the following: A document titled Home Health Certification and Plan of Care dated 9/10/2020 for the certification period 9/14/20 to 11/12/20 was reviewed. The document indicated, but was not limited to, orders for home health aide serviced two hours per day, three days per week for all personal care as well as pre meal set-up, medication reminders and frequent skin inspections ... Orders to Notify physician if vitals fall out of parameters: pulse >120 or <60. Respirations >22 or <10. Systolic BP (Blood Pressure) >170 or < 90. Diastolic >90 or < 60. O2 sat (percent) <90. Fasting blood sugar >250 or <60. A document titled Communication Note with a date of 8/17/20 signed by employee E. The document indicated, but was not limited to, "Spoke with (Non-Employee DD) his new case manager. Made him aware of bed bug situation and possible eviction. He said he would look into it." A document titled Missed or Changed Scheduled Visit with a date of 8/7/20. The document indicated, but was not limited to, visit dates 8/3, 8/5, and 8/7 would be missed due to no HHA being available. A document tilted Communication Note with a date of 9/10/20 signed by employee E. The document indicated, but was not limited to, "Left a message for ... pt's cm, requesting ER button and informing him of broken brake on rollator." A document titled Oasis D1 Recertification with a date of 9/10/20 signed by employee E. The			

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	certification was completed via telephone. The document indicated, but was not limited to, "He (patient 8) does say his neck and shoulders hurt and has neuropathy that causes him to not be able to write. Fell about a week ago and went to ER and spent night in hospital. Has had multiple falls. Tailbone feels like someone took a hammer to it. Legs, feet and hands numb due to neuropathy." "Has a couple cuts on his left forearm where he fell." "Pt [patient] BS [blood sugar] 230 fasting this AM [morning]." "Pt expresses depression. Pt denies suicidal thoughts." A document titled 60 Day Summary/Case Conference signed by employee E. The document indicated, but was not limited to, "A 60 day recertification was completed via phone due to bed bugs in home (being treated). Left a message with his case manager requesting an emergency button." A document titled Missed or Changed Scheduled Visit with a date of 8/28/20. The document indicated, but was not limited to, visit dates 8/24, 8/26, 8/28 and 8/31 would be missed related to the patient having bed bugs. A document titled Communication Note with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "(Case Manager), I have been trying to reach you. Do you know anything about the bed bug situation? He says the exterminator is coming one more time." A document titled 60 Day Summary/Case Conference with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "A 60 day recertification was completed			

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	via phone due to bed bugs in the home (being treated)." A document titled Communication Note with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "Pt AP (apical pulse) 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him the ER twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." Missed visit notes for patient 8 indicated patient 8 failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs. Patient was accepted on 07/16/2020 by the agency. The agency was aware the patient had bed bugs. The patient was first visited on 07/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 07/16/2020 to current and had only seen the patient 2 times for OASIS assessments. The agency failed to discharge the patient when they were unable to meet the patient's needs; failed to notify the physician when the patient's pulse rate fell below ordered parameters; and failed to notify the physician of patient's unwitnessed falls, hospitalizations, and feeling faint. During an interview on 11/20/20 at 9:41 am with the administrator, when asked about follow up and if the physician had been notified the administrator stated that their follow-up procedure			

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	in the situation and on exterminator visits was reaching out to case management. The patient's case manager takes it from that point.			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to follow the plan of care for 3 of 11 patients with services on hold. (Patients 2, 7, and 8) Findings include: 1. An undated policy titled Policy on Missed Visits was provided by employee B on 11/18/2020 at 1:29 p.m. The policy indicated, but was not limited to, "When a missed visit is required due to staff being unable to complete shift with a client or due to client canceling, a missed visit form will be completed by office staff and turned into the agency. The missed visit form will then be faxed to the client's physician as well. Missed visits are monitored by the administrator. If there are a large amount of missed in a short amount of time, the administrator will follow up with office staff, the client, and the client's family to discuss a plan." 2. A 2015 policy titled 2.8 Care Plan was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential ... Continuing evaluation and service	N 0522	100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes, the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient	01/29/2021

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	modifications is provided as indicated as an integral part of ongoing provision of Agency services ... 2. A review of current patient/client status vs. services rendered. 3. The Plan of Care reflects the participation of the client to the extent possible. The agency communicates the plan of care to the client/caregiver in a comprehensive way that the client/caregivers understands ... 5. Patient/Client Involvement in Care Planning and Decision-Making In order to optimize patient/family participation in care planning and decisions affecting patient/client care, including planning for transfer, referral or discharge ... i. The clinical record will contain evidence of Agency staff communication with the patient/caregiver, and/or periodic case conference documentation will reflect patient/caregiver issues during planning ... 11. Revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient/client ... Evaluation of the Care Plan ..." 3. A job description titled Registered Nurse was provided by employee B on 11/18/2020. The document indicated but is not limited to, "Responsibilities ... Consult with the attending physician concerning alterations of Patient Care Plans ... Coordinate Patient Services ... Evaluate the patient, family member(s) and home situations to determine what health teaching will be required ... Observing signs and symptoms and reporting to the physician ... as well as changes in the patient's physical or emotional condition." 4. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification periods 9/1/2020 to 10/30/2020 and 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following:		has been followed up with and dr. and case manager notified weekly. The missed visits policy was reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. decided to not continue services at this time. DCS and Physician were notified. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020	

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	A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per day 5 days per week for all personal care including bathing, dressing, oral/hair/skin care, meal set-up, frequent skin assessments d/t (due to) incontinence and poor mobility, medication reminders, fall precautions, and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020 was reviewed on 11/19/2020. The document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13 would be missed related to the patient having bed bugs. 9 days that had not yet occurred. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020 was reviewed on 11/19/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. The clinical record failed to evidence an Interruption of Services/Transfer Form which includes an explanation as to why services must be temporarily halted and anticipated length of hold, if known per the agency's own policy. The agency failed to notify the physician and revise the plan of care to accurately reflect the services the patient was receiving. During an interview on 11/20/2020 at 10:37 a.m. the administrator stated employee K had discovered a		examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going to his home.	

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	bed bug while performing a recertification visit on 10/27/2020 and the decision was made to place patient 2's services on hold the same day the Case Conference/60 Day Summary was faxed to the physician indicating the patient was receiving services. The administrator stated the case manager for patient 2 was notified the same day. The administrator acknowledged the agency failed to notify the patient's physician that services were being placed on hold immediately and failed to revise the plan of care. 5. The complete clinical record for patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/18/20 for the certification period 10/18/20 to 12/16/20 was reviewed. The document indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received and all clear notification. The agency failed to make revisions to the plan of care to accurately reflect the care the patient was receiving. 6. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days		Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified.	

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	per week, for all personal care. A document titled 60 Day Summary/Case Conference dated 9/10/20. The document indicated, but was not limited to, "Pt has not had the HHA yet due to bed bugs in the home, that are being treated. Left a message with his case manager requesting an emergency button. Pt has had multiple falls and said he had to go to the ER last week and spent the night, due to a fall. " A document titled Communication Note dated 11/10/20. The document indicated, but was not limited to, "A 60 day recertification was completed via phone due to bed bugs in the home (being treated) ...Pt wished to continue services through Home Helpers." The document failed to indicate services would be placed on hold, failed to evidence interventions for potential adverse outcomes, failed to reflect the patient would not be receiving services for an indefinite time period, and failed to identify how patient measurable goals and outcome would be measured and met. Missed visit notes for patient 8 indicated patient 8 failed to receive services 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. Patient was accepted on 07/16/2020 by the agency. The agency was aware the patient had bed bugs. The patient was first visited on 07/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 07/16/2020 to current and had only seen the patient 2 times for OASIS assessments. The agency failed to			

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	157663	A. BUILDING 00 B. WING	12/02/2020

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	notify the physician of lack of services being received, failed to notify the physician of changes in patient's condition related to missed visits, failed to notify the physician of the patient reported adverse events that had occurred, and failed to modify the plan of care. During an interview on 11/20/2020 at 3:46 p.m. the administrator stated she was not aware missed visit notices were being sent in advance to the physician prior to the date of the scheduled visit. The administrator acknowledged the agency had no documentation to support the reasoning for sending missed visit notes dated in the future.			
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the agency failed to promptly alert the physician of changes in patient's condition and/or changes that would prevent the patient from meeting goals listed in the plan of care in 3 of 3 records reviewed for patients with bed bugs. (Patient 2, 7, and 8). Findings include: 1. An undated policy titled Policy on Missed Visits was provided by employee B on 11/18/2020 at 1:29 p.m. The policy indicated, but was not limited to, "When a missed visit is required due to staff being unable to complete shift with a client or due to client canceling, a missed visit form will be completed by office staff and turned into the	N 0527	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that	01/29/2021

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	agency. The missed visit form will then be faxed to the client's physician as well." 2. A job description titled Registered Nurse was provided by employee B on 11/18/2020. The document indicated but is not limited to, "Responsibilities ... Consult with the attending physician concerning alterations of Patient Care Plans ... as well as changes in the patient's physical or emotional condition." 3. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee A was reviewed on 11/19/2020. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment of take patient 2 to the ER (Emergency Room)." Employee A failed to notify the physician of the change in the patient's condition. Employee F failed to document if patient 2's family was advised to contact the MD or go the hospital per employee B's recommendation. The agency failed to notify the physician on 11/11/2020 patient 2's blood sugars were out range, the patient was not doing well, and the patient's family believed the patient may have a UTI which subsequently resulted in the patient being taken to the emergency room by the caregiver the following day.		the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	4. During an interview on 11/19/2020 at 10:37 a.m., the administrator failed to find documentation sent to the physician indicating the patient's services had been placed on hold, the patient's condition had changed, and the agency was unable to meet the goal's set forth in the patient's plan of care. The administrator was aware that patient had to be taken to the emergency room. 5. The complete record of patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record evidenced the following: A document titled Home Health Certification and Plan of Care dated 10/18/20 indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received an all clear notification. The agency failed to notify the patient's physician they would be unable to meet the patient's current goals and outcomes. 6. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for "home health aide services 2 hours per day, three days per week, for all personal care as well as pre meal set-up, medication reminders and frequent skin inspections ... Orders to Notify physician if vitals fall out of parameters: pulse >120 or <60. Respirations >22 or <10. Systolic BP (Blood			

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	Pressure) >170 or < 90. Diastolic >90 or < 60. O2 sat (percent) <90. Fasting blood sugar >250 or <60. A document titled Oasis D1 Recertification with a date of 9/10/20 signed by employee E. The certification was completed via telephone. The document indicated, but was not limited to, "He (patient 8) does say his neck and shoulders hurt and has neuropathy that causes him to not be able to write. Fell about a week ago and went to ER and spent night in hospital. Has had multiple falls. Tailbone feels like someone took a hammer to it. Legs, feet and hands numb due to neuropathy." "Has a couple cuts on his left forearm where he fell." "Pt BS 230 fasting this AM." "Pt expresses depression. Pt denies suicidal thoughts." Employee E failed to notify the physician of the patient's hospital visits and unwitnessed falls with injuries. A document titled Communication Note dated 11/10/20 was reviewed on 11/19/20. The document indicated, but was not limited to, "AP (apical pulse) pulse 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him up in the ER (emergency room) twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." Employee E failed to notify the physician of patient 8's apical pulse being out of physician prescribed parameters, failed to notify the physician of the patients deteriorating mental status, failed to notify the physician of the patient fainting, and failed to notify the physician of the patient's multiple unwitnessed falls. During an interview on 11/19/2020 at 10:37 a.m. the			

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	administrator failed to find documentation sent to the physician indicating the patient's services had been placed on hold, the patient's condition had changed, and the agency was unable to meet the goal's set forth in the patient's plan of care.			
N 0532 Bldg. 00	410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. Based on record review and interview, the agency failed to promptly alert the physician of changes in patient's condition and/or changes that would prevent the patient from meeting goals listed in the plan of care in 3 of 3 records reviewed for patients with bed bugs. (Patient 2, 7, and 8). Findings include: 1. An undated policy titled Policy on Missed Visits was provided by employee B on 11/18/2020 at 1:29 p.m. The policy indicated, but was not limited to, "When a missed visit is required due to staff being unable to complete shift with a client or due to client canceling, a missed visit form will be completed by office staff and turned into the agency. The missed visit form will then be faxed to the client's physician as well." 2. A job description titled Registered Nurse was provided by employee B on 11/18/2020. The document indicated but is not limited to,	N 0532	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow	01/29/2021

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	"Responsibilities ... Consult with the attending physician concerning alterations of Patient Care Plans ... as well as changes in the patient's physical or emotional condition." 3. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee A was reviewed on 11/19/2020. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment of take patient 2 to the ER (Emergency Room)." Employee A failed to notify the physician of the change in the patient's condition. Employee F failed to document if patient 2's family was advised to contact the MD or go the hospital per employee B's recommendation. The agency failed to notify the physician on 11/11/2020 patient 2's blood sugars were out range, the patient was not doing well, and the patient's family believed the patient may have a UTI which subsequently resulted in the patient being taken to the emergency room by the caregiver the following day. 4. During an interview on 11/19/2020 at 10:37 a.m., the administrator failed to find documentation sent to the physician indicating the patient's services had been placed on hold, the patient's condition had changed, and the agency was unable to meet the goal's set forth in the patient's		up is done. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	plan of care. The administrator was aware that patient had to be taken to the emergency room. 5. The complete record of patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record evidenced the following: A document titled Home Health Certification and Plan of Care dated 10/18/20 indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received an all clear notification. The agency failed to notify the patient's physician they would be unable to meet the patient's current goals and outcomes. 6. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for "home health aide services 2 hours per day, three days per week, for all personal care as well as pre meal set-up, medication reminders and frequent skin inspections ... Orders to Notify physician if vitals fall out of parameters: pulse >120 or <60. Respirations >22 or <10. Systolic BP (Blood Pressure) >170 or < 90. Diastolic >90 or < 60. O2 sat (percent) <90. Fasting blood sugar >250 or <60. A document titled Oasis D1 Recertification with a date of 9/10/20 signed by employee E. The			

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certification was completed via telephone. The document indicated, but was not limited to, "He (patient 8) does say his neck and shoulders hurt and has neuropathy that causes him to not be able to write. Fell about a week ago and went to ER and spent night in hospital. Has had multiple falls. Tailbone feels like someone took a hammer to it. Legs, feet and hands numb due to neuropathy." "Has a couple cuts on his left forearm where he fell." "Pt BS 230 fasting this AM." "Pt expresses depression. Pt denies suicidal thoughts." Employee E failed to notify the physician of the patient's hospital visits and unwitnessed falls with injuries.

A document titled Communication Note dated 11/10/20 was reviewed on 11/19/20. The document indicated, but was not limited to, "AP (apical pulse) pulse 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him up in the ER (emergency room) twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." Employee E failed to notify the physician of patient 8's apical pulse being out of physician prescribed parameters, failed to notify the physician of the patients deteriorating mental status, failed to notify the physician of the patient fainting, and failed to notify the physician of the patient's multiple unwitnessed falls.

During an interview on 11/19/2020 at 10:37 a.m. the administrator failed to find documentation sent to the physician indicating the patient's services had been placed on hold, the patient's condition had changed, and the agency was unable to meet the goal's set forth in the patient's plan of care.

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N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview the skilled professional failed to communicate with all physicians involved in the plan of care for 10 of 11 patient's on hold reviewed potentially affecting all of the agencies 175 patients. (Patient 1, 2, 7, 8, 14, 15, 16, 17, 19, and 20) Findings include: 1. A 2015 policy titled 2.8 Care Plan was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed, a care plan is essential ... Continuing evaluation and service modifications is provided as indicated as an integral part of ongoing provision of Agency services ... 11. Revision of the plan of care as frequently as necessary to reflect the changing care needs of the patient/client ... Evaluation of the Care Plan ... 2. A review of current patient/client status vs. services rendered."	N 0546	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including communication with Physician. Education on revised Missed Visits Policy was done with nursing staff and office staff on 12/1/2020 which included reporting missed visits to physician. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. An audit is used to check all client timesheets to make sure all missed visit forms are accounted for and have been sent to the doctor. Reporting to Supervisor	01/29/2021

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	2. A job description titled Registered Nurse was provided by employee B on 11/18/2020. The document indicated but is not limited to, "Responsibilities ... Consult with the attending physician concerning alterations of Patient Care Plans ... Coordinate Patient Services ... Evaluate the patient, family member(s) and home situations to determine what health teaching will be required ... Observing signs and symptoms and reporting to the physician ... as well as changes in the patient's physical or emotional condition." 3. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. A document titled Communication Note for patient 2 dated 11/11/2020 signed by employee A. The document indicated, but was not limited to, "Patient 2's caregiver told employee F that the client wasn't doing good and isn't taking med's, her sugars are sky high and possibly has a UTI (Urinary Tract Infection). I (employee B) advised for them to call the MD (Medical Doctor) to get an appointment of take patient 2 to the ER (Emergency Room)." Employee A failed to notify the physician of the change in the patient's condition. Employee F failed to document if patient 2's family was advised to contact the MD or go the hospital per employee B's recommendation. The skilled professional failed to		education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing Department immediately and that the office will notify Physician 10% of all clinical records will be audited quarterly for evidence that the physician ordered frequency is being followed and if a visit is missed that a missed visit note is faxed to the physician and that the Physician is notified of any changes as well as the Case Manager and that follow up is done The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur	

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	communicate the patients change in status to the physician. 4. The complete clinical record for patient 19 was reviewed on 12/01/2020. Patient 19 had orders for home health aide services 2 hours per day 1 day per week to assist in activities of daily living, medication reminders, and fall precautions. The clinical record indicated, but was not limited to, the following: Documents titled "Missed Visit" dated for 04/29/2020 and for 5/27/2020. The documents indicated, but was not limited to, "Cancellation of Care ... services on hold at this time d/t (due to) coronavirus pandemic." The clinical record failed to evidence documentation of communication with patient 19's physician of services being placed on hold and how or if the plan of care should be revised. 5. The complete clinical record for patient 20 was reviewed on 12/01/2020. The patient had orders for home health aide services 7 hour per day for 3 days per week. The clinical record indicated, but was not limited to, the following: Documents titled "Missed Visit" dated for 04/29/2020 and for 5/28/2020. The documents indicated, but was not limited to, "Cancellation of Care ... services on hold at this time d/t coronavirus pandemic." A document titled 60 Day Summary/Case Conference signed by employee I, Registered Nurse, dated 5/28/2020. The document indicated, but was not limited to, "Client receives services of 7H/D. (7 hours per day) 3D/W (3 days per week)... He is satisfied with services at this time and			

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	wishes to continue them." The document was faxed to the physician on 06/04/2020. The patient had not received services since 04/2020. 6. The complete clinical record for patient 1 was reviewed on 11/19/2020 for the certification period 8/26/2020 to 10/24/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 8/28/20. The record indicated, but was not limited to, orders for a home health aide 2 hours per day, three days per week for all personal care. A document labeled Missed Visit Notes dated 8/13, 9/9, and 10/8. The documents indicated, but were not limited to, "Missed SUP visit d/t to no HHA available". A document labeled Missed or Changed Scheduled Visit dated 11/6/20. The document indicated, but was not limited to, "Client quarantined for covid". The visit was scheduled for 11/9/20. A document labeled Missed or Changed Scheduled Visit dated 11/11/20. The document indicated, but was not limited to, "Client quarantined for covid". The visit was scheduled for 11/12/20. The clinical record failed to evidence documentation of communication with patient 1's physician of services being placed on hold and how or if the plan of care should be revised. 7. The complete clinical record for patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record indicated, but was not limited to, the following:			

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	A document titled Home Health Certification and Plan of Care dated 10/18/20 for the certification period 10/18/20 to 11/19/20 was reviewed. The document indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received and all clear notification. The clinical record failed to evidence follow up and monitoring of patient during hold period, failed to document progress toward goals and how outcomes were to be met. 8. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days per week, for all personal care. A document titled 60 Day Summary/Case Conference dated 9/10/20. The document indicated, but was not limited to, "Pt has not had the HHA yet due to bed bugs in the home, that are being treated. Left a message with his case manager requesting an emergency button. Pt has had multiple falls and said he had to go to the ER last week and spent the night, due to a fall. " A document titled Communication Note with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "Pt			

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	AP (apical pulse) 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him the ER twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." A document titled Communication Note dated 11/10/20. The document indicated, but was not limited to, "A 60-day recertification was completed via phone due to bed bugs in the home (being treated) ...Pt wished to continue services through Home Helpers." The document failed to indicate services would be placed on hold, failed to evidence interventions for potential adverse outcomes, failed to reflect the patient would not be receiving services for an indefinite time period, and failed to identify how patient measurable goals and outcome would be measured and met. Missed visit notes for patient 8 indicated patient 8 failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 9. The limited clinical record for patient 14 was reviewed on 12/1/20 for the certification period 10/21/20 to 12/19/20. The record indicated, but			

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	was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/20/20. The document indicated, but was not limited to, orders for a home health aide 2 hours per day, 3 days per week for all personal care. A document titled Missed Visit Notes dated 4/16, 5/8, 6/5, 7/3, 8/13, 9/10, 10/9 and 11/6. The documents indicated, but were not limited to, "Services are temporarily on hold per client's wishes due to Covid-19 pandemic." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 10. The limited clinical record for patient 15 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A record titled Home Health Certification and Plan of Care dated 9/21/20 for the certification period from 9/25/20 to 11/23/20 and 11/24/202 to 1/22/2021. The record indicated, but was not limited to, orders for a home health aide 2 hours per day, three days per week, for all personal care. A document showing home health aide visits was provided by the employee C. The document indicated, but was not limited to, the following: Visits on 11/10, 11/12, 11/13, 11/17, 11/19, 11/20 and 11/23 were missed with reason of "Out due to C-19".			

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	A document titled 60 Day Summary/ Case Conference dated 11/19/20. The document indicated, but was not limited to, the following: "Patient was seen in her home for a 60-day recertification ...patient is satisfied and thankful with care from Home Helpers and wished to continue with current services, but possibly put a hold on care, until the first of Dec. due to Covid." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 11. The limited clinical record for patient 16 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/2/20 for the certification period of 10/7/20 to 12/5/20. The document indicated, but was not limited to, the following: orders for a home health aide 4 hours per day, 5 days per week for all personal care. A document titled Missed Visit dated 11/23/20. The document indicated, but was not limited to, the following: "Missed supervisory visit of HHA by RN due to client putting services on hold temporarily." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to			

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	be met. 12. The limited clinical record for patient 17 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/2/20 for the certification period of 10/25/20 to 12/23/20. The document indicated, but was not limited to, the following: orders for a home health aide 4 hours per day, 4 days per week for all personal care. A document titled Missed Visit with the dates 9/21/20, 10/12/20 and 10/22/20 indicated, but were not limited to, the following: "Pt does not have a HHA at this time." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 13. During an interview on 11/20/2020 at 10:37 a.m. the administrator acknowledged the agency failed to notify the patient's physicians that services were placed on hold, continued to send out a plan of care for review to the physicians office which failed to accurately describe the services the patient would receive, and continued to send out 60 Day Summaries/Case Conferences indicating patients where receiving services which they were not receiving.			
N 0547 Bldg. 00	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where			

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	services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written). Based on record review and interview, the agency failed to provide services as ordered by the physician resulting in an adverse outcome in 2 of 3 patient records reviewed with services on hold related to bed bugs. (Patient 2 and 8) Findings include: 1. A document titled Patient Bill of Rights was provided on 11/18/2020 at 10:30 a.m. by the Clinical Manager. The document indicated, but was not limited to, "The patient or his/her designated representative has the right to exercise these rights. In the case of a patient adjudged incompetent, the rights of the person are exercised by the person appointed by law to act on the patient's behalf. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law ... The Patient has the right: ... 31. To receive all services as ordered." 2. The complete clinical record of patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record evidenced the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per	N 0547	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including communication with Physician. Education on revised Missed Visits Policy was done with nursing staff and office staff on 12/1/2020 which included reporting missed visits to physician. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. An audit is used to check all client timesheets to make sure all missed visit forms are accounted for and have been sent to the doctor. 10% of all clinical records will be audited quarterly for evidence that the physician ordered frequency is being followed and if a visit is missed that a missed visit note is faxed to the physician. The Administrator	01/29/2021

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	day 5 days per week for all personal care including bathing, dressing, oral/hair/skin care, meal set-up, frequent skin assessments d/t (due to) incontinence and poor mobility, medication reminders, fall precautions, and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020 was reviewed on 11/19/2020. The document indicated patient 2 failed to receive ordered services visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13. A written prescription order from patient 2's physician dated 11/12/20 was provided on 11/19/20 by the administrator. The prescription included orders for the patient to be monitored related to their insulin, preferably a home health aide the patient was familiar with. The agency failed to follow the 11/12/20 order and failed to notify the physician they could not meet the patient's need in regards to this prescription. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020 was reviewed on 11/19/2020. The document indicated patient 2 failed to receive ordered services for scheduled visit dates 11/16, 11/17, 11/18, 11/19, and 11/20. 3. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days		or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

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	per week, for all personal care. Missed visit notes for patient 8 indicated patient 8 failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. During an interview on 11/20/20 at 9:41 am with the administrator, when asked about follow-up and if the physician had been notified the administrator stated that their follow-up procedure in the situation and on exterminator visits was reaching out to case management. The patient's case manager takes it from that point. Patient 8 was first visited on 7/16/2020 for the initial assessment then visited on the last recertification on 11/19/2020. The agency had patient 8 on services from 7/16/2020 to current and has only seen the patient 2 times for OASIS assessments.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel.			

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	Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency's skilled professionals failed to ensure all patient documentation was included in the patient's clinical record for 10 of 11 patient's on hold reviewed. (Patient 1, 2, 7, 8, 14, 15, 16, 17, 19, and 20) Findings Include: 1. A 2015 policy titled 2.8 Care Plan was provided by employee B on 11/28/2020 at 12:20 p.m. The policy indicated but was not limited to, "In order to ensure that a patient/client's needs are being met adequately and appropriately, and services are adapted and adjusted within an individual patient/client situation as needed ... i. The clinical record will contain evidence of Agency staff communication with the patient/caregiver, and/or periodic case conference documentation will reflect patient/caregiver issues during planning ..." 2. The complete clinical record for patient 2 was reviewed on 11/19/2020 for the certification period 10/31/2020 to 12/29/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/27/2020 for the certification period 10/31/2020 to 12/29/2020 was reviewed. The document indicated, but was not limited to, orders for home health aide services 3 hours per	N 0608	100% of chart and schedules were reviewed by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care by 12/2/2020. 100% of charts and schedules were again reviewed by the Administrator, and HR Director to ensure no gaps in care by 1/29/2021. Going forward all patients needing a brief hold in services will be monitored by the Administrator, Assistant Operations Manager, and HR Director to ensure no gaps in care. On hold patients (if any) will be discussed weekly. A patient with services on hold list excel was created and includes, the patient's name, the date, reason, and when the case manager was notified (if has a CM) and when dr. was notified to ensure that there is coordination of care. This list will be reviewed weekly by Administrator, Operations Manager, Assistant Operations Manager, and HR director to review the reason, that the patient has been followed up with and dr. and case manager notified weekly. The missed visits policy was	01/29/2021

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	day 5 days per week for all personal care including bathing, dressing, oral/hair/skin care, meal set-up, frequent skin assessments d/t (due to) incontinence and poor mobility, medication reminders, fall precautions, and orders for skilled nursing for 1 hour per week for medication set up. A document titled Missed Visit dated on 11/3/2020. The document indicated, but was not limited to, "Missed skilled nursing visit for medication set up in medication tower and skilled nursing assessment. Client services placed on hold due to bed bug infestation." A document titled Missed Visit dated on 11/3/2020. The document indicated, but was not limited to, "Missed skilled nursing visit for medication set up in medication tower and skilled nursing assessment. Client services placed on hold due to bed bug infestation." A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020. The document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/19, 11/10, 11/11, 11/12, and 11/13 would be missed related to the patient having bed bugs. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/2/2020. The document indicated, but was not limited to, visit dates 11/2, 11/3, 11/4, 11/5, 11/6, 11/9, 11/10, 11/11, 11/12, and 11/13 would be		reviewed and revised 12/1/2020. All nursing and office staff were educated on revised policy as of12/1/2020. Per the revised Missed Visit Policy missed visits will be monitored by the Administrator. If there are a large amount of missed visits in a short amount of time the Administrator will follow up with Office Staff, the Patient, the Patient's family, Case Manager, and Physician to discuss a plan going forward. The COVID-19: Services on hold policy was reviewed and revised 12/1/2020. The Bed Bug Policy was reviewed and revised 12/1/2020 with all staff (including home health aides, nursing, and all office staff) educated on the revised policy 12/1/2020. Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including reporting to Nursing Department and communication with Physician. decided to not continue services at this time. DCS and Physician were notified. Reporting to Supervisor education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 examples were given in the document and that any changes in patient, issues, etc. must be reported to the Nursing	

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	missed related to the patient having bed bugs. 9 days that had not yet occurred. A document titled Missed or Changed Scheduled Visit signed by employee G with a date of 11/17/2020. The document indicated, but was not limited to, visit dates 11/16, 11/17, 11/18, 11/19, and 11/20 would be missed related to the patient having bed bugs. 3 days that had not yet occurred. A document titled Case Conference/60 Day Summary dated 10/27/2020 signed by employee K indicated, but was not limited to, "Dr. [Patient's Doctor] ... Patient receives home health aide services 3 hours a day 5 days a week and skilled nursing 1 hour weekly for medication set up and assessment. Patient is satisfied with home health services and wishes them to continue ..." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. During an interview with the administrator on 11/19/2020 concerning the missing information in the clinical record for patient 2 the administrator stated she would have to look into. On 11/20/2020 at 11:24 a.m. the administrator provided a stack of documents that were not in the clinical record including notification to the case manager of patient 2 having bed bugs, communication notes including 6 that were not properly authenticated, and 5 handwritten communication notes that had not been included in the clinical record.		Department immediately and that the office will notify Physician and Case Manager. 10% of all clinical records will be audited quarterly for evidence that the Physician is notified of any changes as well as the Case Manager and that follow up is done and that services are provided as in the Plan of Care. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur. Services for Patient # 2 were evaluated and it was found that the HHA could not provide the care the patient needed at this time. The CM was notified, the POA was notified and was notified of other agency options. 15-day discharge letter was sent 12/1/2020. Physician was notified by phone and the communication note from where the HHA spoke with the POA was faxed to Physician. Services for Patient #8 were evaluated. Patient's home was resprayed for bed bugs on 12/3/2020. A home health aide started back in the patient's home 12/4/2020. The CM and Physician were notified. The patient has a permanent home health aide going to his home. Services for Patient # 7 resumed 11/27/2020, CM and Physician were notified. On 12/15/2020 the patient's nurse spoke to patient's	

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	157663	A. BUILDING 00 B. WING	12/02/2020

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	3. The complete clinical record for patient 19 was reviewed on 12/01/2020. Patient 19 had orders for home health aide services 2 hours per day 1 day per week to assist in activities of daily living, medication reminders, and fall precautions. The clinical record indicated, but was not limited to, the following: A document titled Missed Visit dated on 04/29/2020. The document indicated, but was not limited to, "Cancellation of Care ... services on hold at this time d/t (due to) coronavirus pandemic." A document titled Missed Visit dated on 05/27/2020. The document indicated, but was not limited to, "Cancellation of Care ... services on hold at this time d/t (due to) coronavirus pandemic." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 4. The complete clinical record for patient 20 was reviewed on 12/01/2020. The patient had orders for home health aide services 7 hour per day for 3 days per week. The clinical record indicated, but was not limited to, the following: A document titled Missed Visit dated on 04/29/2020. The document indicated, but was not limited to, "Cancellation of Care ... services on hold at this time d/t coronavirus pandemic." A document titled Missed Visit dated on		mom about coming to do recertification, mom was hesitant with having someone come into her house that had been to other patient's houses with Covid-19 on the rise again. The nurse explained that we have the proper PPE and take infection control measures. Patient's mother stated she would talk it over with the patient's father. Patient's nurse called 12/16/2020 and the patient's mother stated they have decided to not continue services at this time. DCS and Physician were notified.	

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	05/28/2020. The document indicated, but was not limited to, "Cancellation of Care ... care on hold at this time d/t COVID-19 pandemic." A document titled 60 Day Summary/Case Conference signed by employee I, Registered Nurse, dated 5/28/2020. The document indicated, but was not limited to, "Client receives services of 7H/D. (7 hours per day) 3D/W (3 days per week)... He is satisfied with services at this time and wishes to continue them." The document was faxed to the physician on 06/04/2020. The patient had not received services since 04/2020.. The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 5. The complete clinical record for patient 1 was reviewed on 11/19/2020 for the certification period 8/26/2020 to 10/24/2020. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 8/28/20. The record indicated, but was not limited to, orders for a home health aide 2 hours per day, three days per week for all personal care. Documents labeled Missed Visit dated 8/13, 9/9, and 10/8. The documents indicated, but were not limited to, "Missed SUP (supervised) visit d/t (due to) no HHA available". A document labeled Missed or Changed Scheduled Visit dated 11/6/20. The document indicated, but was not limited to, "Client			

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	quarantined for covid". The visit was scheduled for 11/9/20. A document labeled Missed or Changed Scheduled Visit dated 11/11/20. The document indicated, but was not limited to, "Client quarantined for covid". The visit was scheduled for 11/12/20. The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 6. The complete clinical record for patient 7 was reviewed on 11/19/20 for the certification period 10/18/20 to 12/16/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/18/20 for the certification period 10/18/20 to 11/19/20 was reviewed. The document indicated, but was not limited to, orders for home health aide services eight hours per day, five days per week for all personal care. A document titled Initial Summary of Care dated 10/18/20. The document indicated but was not limited to, "Client's mother reports that they currently have bed bugs and humpback flies. She states she tries to spray for these pests with sprays she buys at the store. Writer has not seen any bed bugs or humpback flies at this time ...The office will contact client's case manager to have an exterminator come to client's house to spray for bed bugs and humpback flies."			

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	A document titled Communication Note dated 10/19/20. The document indicated, but was not limited to, "I (employee K) was contacted by employee F upon client's admission on 10/18/20 that the client's home has a bed bug infestation. Entity 1 was contacted and was made aware of the situation. After speaking to her immediate supervisor, they are going to be treating the home for the infestation immediately so we will be able to start serviced upon...approval." A document titled Communication Note dated 10/19/20. The document indicated, but was not limited to, "I contacted non-employee BB from entity 1 concerning this client having bed bugs. A that time entity 1 was informed that we will be unable to send anyone into the home until the situation is taken care of. Entity 1 would pay for them to come and spray ...as soon as possible." A document titled Communication Note dated 11/13/20. The document indicated, but was not limited to, "Non-employee BB from entity 1 contacted me ...and gave me the trip ID# for transportation on the client ...It is scheduled for November 18th at 2:30 pm." A document titled Communication Note dated 11/17/20. The document indicated, but was not limited to, "Non-employee BB entity 1 contacted me late this afternoon to inform us that transportation service FF has refused to pick up the client because it is not considered a medical necessity. Non-employee BB from entity 1 has been made aware that we can no start services with the client until the home has been treated for bed bugs." A document titled Communication Note dated 11/17/20. The document indicated, but was not			

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	limited to, "Non-employee BB from entity 1 contacted me around 9:30 pm to inform that they were able to make arrangements for the client to be transported by transportation service GG. Client is to be transported to a local church where he will stay for at least two hours or more so the home can be treated for bed bugs." A document titled Communication Note dated 11/19/20. The document indicated, but was not limited to, "Client's mother called me today saying that she talked to the man who came to spray for bed bugs Wednesday the 18th and he informed her that the back interior room was infested the worst and it would need to be sprayed again." The agency failed to notify the physician patient 7's services were placed on hold 10/18/20 and would not be started until the agency received and all clear notification. The clinical record failed to evidence follow up and monitoring of patient during hold period, failed to document progress toward goals and how outcomes were to be met. 7. The complete clinical record for patient 8 was reviewed on 11/19/20 for the certification period 9/14/20 to 11/12/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 9/10/20 for the certification period 9/14/20 to 11/12/20. The document indicated, but was not limited to, orders for home health aide services 2 hours per day, three days per week, for all personal care. A document titled Initial Summary of Care dated 7/16/20. The document indicated, but was not limited to, "He (patient) says he has no family and no friends. He says he has been homeless and			

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	was kicked out of homeless shelter. His apartment is infested with bed bugs and he says the apartment manager has accused him of bringing them into the apartment building and may be evicting him." A document titled Communication Note dated 7/17/20. The document indicated, but was not limited to, "Yesterday pt told me that the apartment manager had told him they were going to give him an eviction notice accusing him of being the one that brought the bed bugs into the apartment building. He said they are also charging him $400 for spraying for bed bugs ...I also tried to call non-employee CC to make her aware of the potential eviction and to see if she could help him with this and paying the $400 and emergency button and to try and get some other info." A document titled Communication Note dated 8/17/20. The document indicated, but was not limited to, "Spoke with non-employee DD his new CM. Made him aware of bed bug situation and possible eviction. He said he would look into it." A document titled Communication Note dated 9/8/20. The document indicated, but was not limited to, "Unable to get a hold of pt. Call to non-employee DD ...He said pt had not seen a bed bug in 3 weeks, but that the exterminator was supposed to come back at least one more time." A document titled Communication Note dated 9/10/20. The document indicated, but was not limited to, "Left a message for non-employee DD...requesting ER button and informing him of broken brake on rollator." A document titled 60 Day Summary/Case			

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	Conference dated 9/10/20. The document indicated, but was not limited to, "Pt has not had the HHA yet due to bed bugs in the home, that are being treated. Left a message with his case manager requesting an emergency button. Pt has had multiple falls and said he had to go to the ER last week and spent the night, due to a fall. " A document titled Communication Note with a date of 11/10/20 signed by employee E. The document indicated, but was not limited to, "Pt AP (apical pulse) 55 faint and irregular. Pt says he has multiple falls in the last 2 months, winding him the ER twice. Pt says he faints, resulting in falls. He is very unsteady." "Pt appears depressed. When asked about suicide, states no I don't want to do anything to myself, but I'm exhausted and I don't care anymore." A document titled Communication Note dated 11/10/20. The document indicated, but was not limited to, "Pt says he has not seen any bed bugs, but he hasn't gotten the clear from the exterminator yet and they are supposed to come one more time." A document titled Communication Note dated 11/10/20. The document indicated, but was not limited to, "A 60-day recertification was completed via phone due to bed bugs in the home (being treated) ...Pt wished to continue services through Home Helpers." The document failed to indicate services would be placed on hold, failed to evidence interventions for potential adverse outcomes, failed to reflect the patient would not be receiving services for an indefinite time period, and failed to identify how patient measurable goals and outcome would be measured and met. Missed visit notes for patient 8 indicated patient 8			

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	failed to receive service 8/3, 8/5, 8/7, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/7, 9/9, 9/11, 9/14, 9/16, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2, 10/5, 10/7, 10/9, 10/12, 10/14, 10/16, 10/19, 10/30, 11/4, and 11/6 related to services being on hold for bed bugs, 14 days of which had not yet occurred. The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 8. The complete clinical record for patient 14 was reviewed on 12/1/20 for the certification period 10/21/20 to 12/19/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/20/20. The document indicated, but was not limited to, orders for a home health aide 2 hours per day, 3 days per week for all personal care. Documents titled Missed Visit dated 4/16, 5/8, 6/5, 7/3, 8/13, 9/10, 10/9, and 11/6. The documents indicated, but were not limited to, "HHA services currently on hold per client's request due to Covid-19 pandemic." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met.			

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	9. The complete clinical record for patient 15 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A record titled Home Health Certification and Plan of Care dated 9/21/20 for the certification period from 9/25/20 to 11/23/20. The record indicated, but was not limited to, orders for a home health aide 2 hours per day, three days per week, for all personal care. A document showing home health aide visits was provided by the employee C and reviewed on 12/1/20. The document indicated, but was not limited to, the following: Visits on 11/10, 11/12, 11/13, 11/17, 11/19, 11/20 and 11/23 were missed with reason of "Out due to C-19". A document titled 60 Day Summary/ Case Conference dated 11/19/20. The document indicated, but was not limited to, the following: "Patient was seen in her home for a 60-day recertification ...patient is satisfied and thankful with care from Home Helpers and wished to continue with current services, but possibly put a hold on care, until the first of Dec. due to Covid." A document titled Home Health Certification and Plan of Care dated 11/19/20 with the certification period of 11/24/20 to 1/22/21. The document indicated, but was not limited to, the following: orders for a home heath aide 2 hours per day, three days per week for all personal care. The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to			

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	be met. 10. The complete clinical record for patient 16 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/2/20 for the certification period of 10/7/20 to 12/5/20. The document indicated, but was not limited to, the following: orders for a home health aide 4 hours per day, 5 days per week for all personal care. A document titled Missed Visit dated 11/23/20. The document indicated, but was not limited to, the following: "Missed supervisory visit of HHA by RN due to client putting services on hold temporarily." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 11. The limited clinical record for patient 17 was reviewed on 12/1/20. The record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care dated 10/2/20 for the certification period of 10/25/20 to 12/23/20. The document indicated, but was not limited to, the following: orders for a home health aide 4 hours per day, 4 days per week for all personal care. A document titled Missed Visit with the dates 9/21/20, 10/12/20 and 10/22/20 indicated, but were			

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	not limited to, the following: "Pt does not have a HHA at this time." The clinical record failed to evidence the date services were placed on hold, failed to evidence physician notification of services placed on hold, failed to evidence follow up and monitoring of patient during hold period, failed document progress toward goals and how outcomes were to be met. 12. During an interview on 12/02/2020 at 3:30 p.m. the administrator was notified the clinical records failed to identify when services were stopped, failed evidence communication with the physician, failed to evidence patient follow up while on hold, failed to evidence communication on education and options while services were placed on hold, failed to evidence follow up on adverse outcomes reported on patients, and failed to evidence a clear picture of the patients treatment and outcomes. The administrator stated all documentation including communication notes should have been included in the clinical record and that the staff would be educated.			
N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the agency failed to ensure all documentation was properly authenticated and located in the patient's clinical record for 1 of 3 patients with services on hold related to bed bugs. (Patient 2)	N 0610	Documentation/Communication education was done with all staff (including home health aides, nursing, and all office staff) on 12/1/2020 with the education including communication with Physician. Further education on	01/29/2021

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	Findings include: Patient 2's clinical record included, but was not limited to, the following: A document titled Communication Note dated 10/28/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry. The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, employee O, of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/05/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry. The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, employee M, of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/05/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry." The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee N of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/06/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry." The document failed to have a signature		Documentation will be completed by 1/29/2021 to include that all documentation is properly authenticated and include; signature, title, date, and time. 10% of all clinical records will be audited quarterly for evidence that all documentation is properly authenticated. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not reoccur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157663	A. BUILDING 00 B. WING	12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOME HELPERS HOME HEALTH	630 NORTH GARDNER ST SCOTTSBURG, IN 47170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee O of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/09/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry." The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee O of the document and failed to include a time the entry was made. A document titled Communication Note dated 11/09/2020 was provided by the administrator on 11/19/2020. The document included, but was not limited to, "(Communication) Sign and Date each entry." The document failed to have a signature and a title (occupation), or a secured computer entry by a unique identifier, by the author, Employee P of the document and failed to include a time the entry was made. During an interview on 12/02/2020 at 3:30 p.m. the administrator stated that the staff would be educated on proper documentation guidelines.			