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	157609	A. BUILDING ______ B. WING ______	R 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE HOME HEALTH CARE LLC	**2056 45TH ST HIGHLAND, IN 46322**

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{G 000}	INITIAL COMMENTS	{G 000}		

{G 000} INITIAL COMMENTS

This visit was for a Federal Post Condition Revisit to a recertification and follow up to a State Licensure home health survey completed on July 26, 2019.

Facility #: 006656

Provider #: 157609

Survey dates: September 9, 10; 2019

Skilled Services: 10
Home Health Aide only: 0
Total Current Census: 7

Record reviews with home visit: 0
Record review without home visits: 3
Discharged record reviews: 0
Total clinical records reviewed: 3

These deficiencies reflects State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings.

During this survey, 1 Condition level deficiency and twelve (12) Standard level deficiencies were corrected.
One (1)condition- level deficiency (42 CFR 484.105) and eleven (11) standard-level deficiencies were recited.
One (1) condition (42 CFR 484. 100) and three (3) new standard-level deficiencies were cited.

Active Home Health Care, LLC remains out of compliance with Conditions of Participation 42 CFR 484.100 Compliance with Federal, State, and Local Law and 42 CFR 484.105 Organization

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{G 000}	Continued From page 1 and Administrative Services. Active Home Health continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning July 26, 2019 to July 26, 2021. Quality Review Completed: 9/26/19	{G 000}		
G 434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse failed to ensure consents were complete with the type of services, discipline, and frequencies of visits prior to patient signature while in the home for 1 of 3 active charts reviewed (#3). Findings include:	G 434		

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G 434	Continued From page 2	G 434		

A document dated 8/14/19 titled, "Patient's Rights and Responsibilities" stated, "...1. Patients's Rights:..Be fully informed in advance about the care and treatment to be furnished, including the skilled staff that will furnish the care and the proposed number of visits they will make to your home...Participate in planning of care and treatment or changes in care or treatment including goals, risks, and benefits of treatment...Be fully informed orally and in writing and in advance of the care of the Agency on the following; 1. All visits and services furnished...."

The clinical record of patient #3 was reviewed on 9/10/19 and indicated a start of care date of 9/6/19. The surveyor requested the chart of patient #3 for review on 9/10/19 at 10:30 AM from employee D. The employee indicated at that time, the chart was not finished.

On 9/10/19 at 10:35 AM, observed employee D and employee E with a hard chart with patient #3's name on it and several papers, forms, and a manilla file folder with information written on the inner portion as well as several loose hand written notes. Written on the inner portion of the manilla file folder was the following: 140/70, 98% and 64 (Blood pressure, oxygen saturations, heart rate). Further, observed a blank comprehensive assessment, blank aide care plan and an agreement for services form signed by the patient on 9/6/19, with blank frequencies evidenced at the top of the form. During this observation, employee D began to write on the form signed by the patient, the SN (skilled nurse), HHA (home health aide), PT (physical therapy) and OT (occupational therapy) frequencies and durations.

During an interview at that time, when employee

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G 434	Continued From page 3 D was asked if it was standard practice to document on paperwork after the patient had signed it,employee D failed to answer. Further, when asked employee D if the newly admitted patient had collaborated with the nurse to develop the HHA care plan while in the home, she indicated she told the patient what the HHA was going to do for her at the visits; "give you a bath, and things like that; I tell her what the aide is supposed to do; we talk about it." During an interview at 10:45 AM on 9/10/19, employee D indicated there was a copy of the aide care plan in the home for the aide to follow. When asked the employee about the presence of the blank, carbon copied aide care plan in the patient's incomplete paperwork, employee D failed to answer. Further, employee D indicated she had spoken with employee L, HHA and instructed her to pick up a copy of the aide care plan. During an interview on 9/10/19 at 12:52 PM, employee L, HHA, she indicated she picks up an aide care plan for each patient for herself, but there is "supposed to be one in the patient's folder that matches."	G 434		
{G 530}	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This ELEMENT is not met as evidenced by: Based on record review and interview, the	{G 530}		

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{G 530}	Continued From page 4	{G 530}		

agency failed to ensure comprehensive assessments contained individual patient goals, strengths, and care preferences identified by the patient for 2 of 3 records reviewed (#1, 2).

Findings include:

1. An undated agency document titled, "QUALITY ASSURANCE AUDIT TOOL", stated, " To be completed by the DON (director of nursing) with every OASIS (outcome and assessment information set) SOC (start of care)/ ROC (resumption of care) / Recert (recertification) / Discharge assessment ... Patient Care / Coordination ...C. Other Care Considerations ... 2. Are the patient's goals measurable? ...."

2. An undated agency document titled, "QUALITY ASSURANCE AUDIT ACTION PLAN", stated, "... C2. 1. If the patient does not have measurable goals: . Some goals may not have measurable metrics. Many goals can be measurable, but not all. Goals should be made in a measurable way whenever possible. 2. If you can create measurable goals, do so. This allows you to check progress towards the patient's goals, and determine more easily when the patient has met his / her goals. 3. Ensure that the measurable goals that you have created are discussed with the patient and that the patient agrees with them. The process of creating the goals must be collaborative, with the patient help set those goals. 4. Inform the MD (medical doctor) of the new goals. Update the POC (plan of care). 5. Educate the field staff on the importance of measurable goals ...."

3. The clinical record of patient #1 was reviewed on 9/9/19 and indicated a start of care date of

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{G 530}	Continued From page 5	{G 530}		

1/22/19. The record contained a plan of care for the certification period of 7/21/19 - 9/18/19. The recertification assessment completed on 7/18/19 failed to evidence specific patient goals and preferences they had made for themselves, and care preferences.

An agency document dated 9/5/19 titled "PATIENT'S GOAL SETTING", completed by employee E, RN, stated, "... 3. PATIENT will understand health condition better and be able to manage well and be healthy." The document failed to identify patient stated goals for care at time of recertification.

4. The clinical record of patient #2 was reviewed on 9/10/19 and indicated a start of care date of 5/5/18. The record contained an unsigned plan of care for the certification period of 8/28/19 - 10/26/19. The recertification completed on 8/26/19 failed to evidence specific patient goals, strengths and preferences the patient had identified for themselves. Further, the recertification, comprehensive assessment indicated the skilled nurse offered physical therapy and patient refused.

An agency document dated 8/21/19 titled "PATIENT'S GOALS SETTING", completed by employee E, RN stated, " ... 3. What are the patient's / caregivers goals? These goals should be measurable whenever possible: Patient wants to be able to get stronger again and be able to get enough rest @ (at) night so she can do more therapy..." The document failed to evidence the patient signature identifying the document was prepared in collaboration with the patient on 8/21/19.

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{G 530}	Continued From page 6 5. During an interview on 9/9/19 at 2:44 PM, with employee B, indicated employee C completed audits on every patient chart to identify areas that were lacking. 6. During an interview on 9/10/19 at 1:30 PM, with employee B, administrator, indicated the chart audits completed by employee C were kept in the patient's chart.	{G 530}		
{G 532}	Continuing need for home care CFR(s): 484.55(c)(3) The patient's continuing need for home care; This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the patient's comprehensive assessment reflected the continuining need for home care services warrented for 2 of 3 records reviewed (#1, 2, 3). Findings include: 1. The clinical record of patient #1 was reviewed on 9/9/19 and indicated a start of care date of 1/22/19. The record contained a plan of care for the certification period of 7/21/19 - 9/18/19. The recertification comprehensive assessment completed on 7/18/19 failed to evidence patients continued need for home care services. An agency document dated 7/18/19, signed by employee K stated, "... Justification for Recertification (of all disciplines) SN (skilled nurse) Frequency: 1 x 9 (1 time weekly for 9 weeks); vital signs, teach on disease process, educate on medications and compliance ...." During an interview on 9/10/19 at 3:30 PM with	{G 532}		

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{G 532}	Continued From page 7 employee B and employee C, when asked what specific skilled need the patient had for services, employee C indicated they did not know. 2. The clinical record of patient #2 was reviewed on 9/10/19 and indicated a start of care date of 5/5/18. The record contained an unsigned plan of care for the certification period of 8/28/19 - 10/26/19. The recertification comprehensive assessment completed on 8/26/19 failed to evidence patients continued need for home care services. An agency document dated 8/26/19, signed by employee G stated, "... Justification for Recertification (of all disciplines) SN (skilled nurse) Frequency: 1 x 9 (1 time weekly for 9 weeks); obtain vitals, assess all body systems, report to MD (medical doctor), educate pt (patient) on her disease process...." During an interview on 9/10/19 at 3:30 PM with employee B and employee C, when asked what specific skilled need the patient had for services, employee C indicated they did not know. 3. The clinical record of patient #3 was reviewed on 9/10/19 and indicated a start of care date of 9/6/19. The record failed to evidence a completed comprehensive assessment, aide care plan or plan of care. The record failed to evidence orders for initiation of home care services and failed to evidence any documentation regarding skilled need of services. On 9/10/19 at 10:30 AM, employees D and E was observed with a blank comprehesive assessment, aide care plan, and medication sheet with patient #3's name at the top. When	{G 532}		

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{G 532} Continued From page 8 {G 532}

asked if patient #3's comprehensive assessment was available for review, employee D indicated it was "not done."

During an interview on 9/10/19, at 10:45 AM, employee D indicated patient #3 had been admitted for education, teaching and therapy.

{G 536} A review of all current medications {G 536}
CFR(s): 484.55(c)(5)

A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
This ELEMENT is not met as evidenced by:
Based on record review and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained a complete review of medications with drug to drug interaction checks performed for 3 of 3 records reviewed (#1, 2, 3).

Findings include:

1. An undated agency document titled "Inservice List" identified as presented to the staff at an Agency Inservice on 8/14/19 stated, "... 5. Medications must be checked for duplications, potentially harmful interactions, and noncompliance. These checks should be done at least every time an OASIS (outcome and assessment information set) assessment is done. It should also be done anytime there is a medication change. For any concerns that are found the doctor MUST be notified immediately. You MUST speak to the doctor or a nurse, and

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{G 536}	Continued From page 9 get directions, even if it is for no changes, and DOCUMENT THE CONVERSATION in the form of an order...." 2. An agency document dated 8/15/19 titled, "QUALITY ASSURANCE AUDIT TOOL" stated, "... 4. Was a medication check performed? Yes / No. a. Were drug interactions or duplications found? Yes / No. b. If yes to part a, was the MD notified? Yes / No...." 3. An undated agency policy titled "Medication Administration Policy," stated "...A Registered Nurse from [agency] shall check all medicines a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medications and shall promptly report any problem to the patient's physician ...." 4. The clinical record of patient #1 was reviewed on 9/9/19 and indicated a start of care date of 1/22/19. The record contained a plan of care for the certification period of 7/21/19 - 9/18/19. The record contained a drug to drug interaction report from Drugs.com. The record failed to evidence the drug interaction report was provided to the physician. The report evidenced Major interactions between: fluoxetine and tramadol, alprazolam and tramadol. Moderate interactions were reported between: losartan and insulin, metformin and insulin, fluoxetine and polyethylene glycol, fluoxetine and insulin, metoprolol and alprazolam, fluoxetine and amlodipine, alprazolam and losartan, alprazolam and fluoxetine, metoprolol and insulin, metoprolol and amlodipine, metoprolol and fluoxetine, tramadol and polyethylene glycol.	{G 536}		

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The Drugs.com Major interaction definition stated, "Highly clinically significant. Avoid combinations; the risk of he interaction outweighs the benefit. Moderate interaction definition stated, "Moderately clinically significant. Usually avoid combination; use it only under special circumstances."

5. The clinical record of patient #2 was reviewed on 9/10/19 and indicated a start of care date of 5/5/18. The record contained an unsigned plan of care for the certification period of 8/28/19 - 10/26/19.

The plan of care identified the patient was receiving aspirin. The recertification comprehensive assessment completed on 8/26/19 failed to identify the patient was receiving aspirin. The record failed to evidence a drug to drug interaction check was performed and sent to the physician that included all medications the patient was receiving.

All medications from the agency plan of care were checked on Drugs.com for interactions. Moderate interactions were found to be present for aspirin and clopidogrel. The record failed to evidence a complete drug interaction check was completed and sent to the physician.

6. The clinical record of patient #3 was reviewed on 9/10/19 and indicated a start of care date of 9/6/19. The record failed to evidence a completed plan of care.

The record contained an "Addendum to Comprehensive assessment; Medication Profile" that evidenced in the document the following

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{G 536}	Continued From page 11 medications: Xarelto, Alendronate, Tylenol and Vit (vitamin) D. The document stated, "... Drug Regimen Review; Date 9/6/19 ... A. The patient reports experiencing 1 or more significant side effects to current drug regimen. Yes [blank] No [blank] ... E. Have potential adverse effects, significant drug interactions, duplicate / ineffective drug therapy and potential contraindications been identified? Yes [blank] No [blank]...." The record failed to evidence a drug to drug interaction check had been performed by the RN (registered nurse). 7. During an interview on 9/9/19 at 2:40 PM, with employee B, she indicated all the chart audit tools for compliance were completed and in the chart. Further she indicated all charts had been audited by either herself, employee C or employee D.	{G 536}		
{G 574}	410 IAC 17-14-1(a)(1)(B) Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments;	{G 574}		

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(xi) Safety measures to protect against injury;
(xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.
(xiii) Patient and caregiver education and training to facilitate timely discharge;
(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
(xv) Information related to any advanced directives; and
(xvi) Any additional items the HHA or physician may choose to include.
This ELEMENT is not met as evidenced by:
Based on observation, record review and interview, the agency failed to ensure the plan of care (POC) included all goals and safety measures, and was supported by the comprehensive assessment in 2 of 3 records reviewed. (#1, 2).

Findings include:

1. An undated agency policy titled, "Plan Of Care" provided on 9/10/19 at 2:00 PM by the administrator, stated, "1. A plan of care is developed for each patient admitted to the home health program in consultation with the referring physician...2. The plan of care ... includes the following information: g. Functional limitations and activities permitted as well as safety measures...Goals, rehabilitation potential and discharge plans...p. Reason homebound, unusual home / social facts...4....The supervising physician must be notified of any deviation, addition, or change from the care plan not previously ordered through a written physician's order...." The agency policy failed to include

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 574}	Continued From page 13 patient-specific interventions and education; measurable outcomes and goals identified by the patient. 2. An agency document titled "PATIENT GOALS" dated 8/13/19 stated, "The setting of patient goals, whether it be nursing goals or therapy goals, is to be a collaborative effort between the patient / caregiver and the agency field staff...Identifying patient selected goals is not only a requirement, but it is also the right thing to do...The patient's goals should also be measurable...." 3. The clinical record of patient #1 was reviewed on 9/9/19, start of care date of 1/22/19, evidenced an unsigned plan of care for the certification period of 7/21/19 - 9/18/19, with the following goals including, but not limited to, "Patient will have stable peripheral status and cardiac status. Patient will demonstrate activity to manage symptom, patient/ caregiver will be knowledgeable regarding cardiac limitations. Patient/ caregiver will be knowledgeable in S/S (signs and symptoms) of exacerbation Patient/ pcg (patient care giver) will verbalize factors that precipitate angina and identify measures to relieve chest pain or require calling MD (medical doctor) if pain persists. Patient will remain free of S/S of impending CVA (cerebrovascular accident)...." The plan of care evidenced safety measures, not limited to the following: " Use of 911 emergency procedures...transfer precaution, clear pathways, secure loose cords, bathroom safety, use of assistive devices during ambulation, avoid respiratory irritants." . An agency document dated 9/5/19, titled "Patient's Goal Setting", completed by employee	{G 574}		

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{G 574}	Continued From page 14 E, stated, "... This form is to be completed through an interview process with the patient / caregiver and documented below... 3. What are the patient's/ caregiver's goals? These should be measurable whenever possible: Patient will understand health condition better and be able to manage well and be healthy...." The document failed to evidence patient-specific, measurable goals. A Recertification/ Follow-up Assessment dated 7/18/19 completed by employee G indicated the patient had, not limited to the following diagnoses: Essential hypertension, type 2 diabetes and long term use of insulin. The assessment indicated the patient obtained her blood sugar daily. The comprehensive assessment evidenced the patient communicated following care preferences/ Patient's personal goals: "...... List all goal(s) and indicate if this is a N-New M-Modified existing goal; D-Discontinuation of existing goal; C-Completed/ met goal [blank]...." The plan of care failed to be supported by the comprehensive assessment for the assessment failed to evidence specific patient identified goals. Also, this plan of care for the same certification period failed to include safety measures in regards to hyper/ hypoglycemic precautions due to diabetes. 4. The clinical record of patient #2 was reviewed on 9/10/19, start of care date of 5/5/18, with an unsigned plan of care for the certification period of 8/28/19 - 10/26/19, with the following diagnoses: Chronic obstructive pulmonary disease, generalized anxiety and arthritis further, patient goals including, but not limited to: "...Patient will have stable respiratory status/	{G 574}		

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{G 574}	Continued From page 15 pulmonary status. Patient/ caregiver will be knowledgeable of respiratory limitations. Patient/ caregiver will be knowledgeable in emergency care measures. Patient will remain free of respiratory/ pulmonary infection. Patient will return to a stable breathing pattern and airway clearance...." The plan of care failed to identify patient-specific, measurable goals with interventions and outcomes identified by the patient. An agency document dated 8/21/19, titled "Patient's Goal Setting" completed by employee E, stated, "... This form is to be completed through an interview process with the patient/ caregiver and documented below... 3. What are the patient's/ caregiver's goals? These should be measurable whenever possible: Patient wants to be ale to get stronger again and be able to get enough rest @ (at) night so she can do more therapy. Signature of Patient or caregiver [blank]...." The document failed to evidence patient-specific, measurable goals and that the document was completed with the patient as evidenced by lack of patient signature on the form. A Recertification/ Follow-up Assessment dated 8/26/19 completed by employee G indicated the patient "...already have a goal(s) they are working on at this time... List all goal(s) and indicate if this is a N-New M-Modified existing goal; D-Discontinuation of existing goal; C-Completed/ met goal [blank]... Refused Cares PT (physical therapy) was recommended. Patient refuses PT at this time .... " The plan of care failed to be supported by the comprehensive assessment for the assessment failed to evidence specific patient identified goals.	{G 574}		

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{G 574}	Continued From page 16	{G 574}		

3. During an interview on 9/9/19 at 2:00 PM with employee B, administrator, she indicated patients with diabetes should have diabetic precautions present on safety measures and that patient goals and preferences should be patient specific and measurable. Further, she indicated she reviewed components required on the plan of care during the 8/14/19 agency-wide inservice.

410 IAC 17-13-1(a)(1)(D)(x)(xii)

G 684 — Infection control — G 684

CFR(s): 484.70(b)(1)(2)

Standard: Control.
The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include:

(1) A method for identifying infectious and communicable disease problems; and

(2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.
This STANDARD is not met as evidenced by:
Based on record review, and interview the agency failed to ensure that an agency-wide infection control program was maintained for the surveillance, identification, prevention, control of staff and patient infections for 1 of 1 agency.

Findings include:

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G 684	Continued From page 17	G 684		

An agency policy dated 8/14/19 titled, "Infection Control and Prevention" provided by employee A, office / business manager on 9/9/19 at 4:05 PM stated, "...Infection control and prevention standards are precautionary measures essential to protect in office staff, patients / clients and caregivers... from acquiring communicable diseases or infection and to prevent transmission or cross infection ...."

The agency infection control plan failed to include staff infections, communicable infections not requiring antibiotics, documentation when these infections occurred, and root cause analysis and tracking of the situation to ensure sick or exposed staff did not spread infections to patients as evidenced by:

An agency document titled, "...Survey Attachment List for Medicare Recertification and State Licensure Survey; July 24-26, 2019" provided at 4:05 PM, on 9/9/19 by employee A, evidenced the following attachments: "...U. Infection Control and Prevention V. Stop Germs! Stay Healthy! Wash Your Hands! W. Vaccines: What You Need to Know X. 3 Important Reasons for Adults to Get Vaccinated...."

An agency document dated, "2019" titled " [name of agency] Infection Control Log" stated, " No Infections occurred thru 7/15/19...." The document evidenced the following: " Patient Name; Date of Incident; Employee Name; Physician Name; MD (medical doctor) Notified; Intervention; Resolution; Comments."

An agency document dated, "2018" titled " [name of agency] Infection Control Log" stated, " No

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G 684	Continued From page 18 Infections occurred thru 7/15/19...." The document evidenced the following: " Patient Name: [patient #2]; Date of Incident: 10/10/18; Employee Name: [Employee G]; Physician Name: [name of physician]; MD (medical doctor) Notified: [check mark]; Intervention: Pt (patient) developed UTI (urinary tract infection) post death of her [family member]; Resolution: Started on Cipro (antibiotic); Comments: 10/15- symptoms resolving." The document failed to evidence additional reported infections. During an interview on 9/09/19 at 3:00 PM, the Administrator indicated she did not analyze infection data to identify trending of information. Lastly, employee B, administrator indicated the attachments provided in the plan of correction was the Infection control program and was provided to all staff on 8/14/19 as such.	G 684		
{G 710}	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on record review and interview, the Skilled nurse (SN) and Physical Therapist (PT) failed to provide care and services as ordered by the physician for 1 of 3 active records (#1). Findings include: An undated, agency policy provided by the administrator on 9/9/19, titled, "Plan of Care" stated "... 4. All disciplines caring for the patient are expected to follow the developed plan of care ...."	{G 710}		

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{G 710}	Continued From page 19 The clinical record of patient #1 was reviewed on 9/9/19 and indicated a start of care date of 1/22/19. The record contained a plan of care (POC) for the certification period of 7/21/19 - 9/18/19 that evidenced an order for "SN: 1 visit per week for 9 weeks and PT: 1 visit per week for 1 week...." An agency document dated, 7/18/19 titled "Physical Therapy Evaluation" completed by employee F, Physical Therapist and signed by the physician on 7/22/19, evidenced the following PT orders: "Frequency/ Duration of PT Visits: 1 W 1, 2 W 8. (1 time weekly for one week and 2 times weekly for 8 weeks)." The record failed to evidence that SN completed visits as ordered per the plan of care during week two and week four of the certification period. The record failed to evidence that PT completed visits as ordered per the plan of care by providing an additional visit during week 2 and week 3. Also, the record failed to evidence that PT provided two visits during week 4 of the certification period. During an interview on 9/10/19 at 3:15 PM, the administrator indicated the Skilled nurse and the Therapist should follow the plan of care. 410 IAC 17-14-1(a)(1)(H) 410 IAC 17-14-1(b)(4)	{G 710}		
{G 798}	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties.	{G 798}		

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{G 798}	Continued From page 20 Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This STANDARD is not met as evidenced by: Based on observation, record review and interview, the Registered Nurse failed to ensure the HHA (home health aide) care plan was created in collabortion with the patient while in the home for 1 of 3 active charts reviewed (#3). Findings include: A document dated 8/14/19 titled, "Patient's Rights and Responsibilities" stated, "...1. Patients's Rights:..Be fully informed in advance about the care and treatment to be furnished, including the skilled staff that will furnish the care and the proposed number of visits they will make to your home...Participate in planning of care and treatment or changes in care or treatment including goals, risks, and benefits of treatment...Be fully informed orally and in writing and in advance of the care of the Agency on the following; 1. All visits and services furnished...." On 9/10/19 at 10:35 AM, observed employee D and employee E with a hard chart with patient #3's name on it and several papers, forms and a manilla file folder with information written on the inner portion as well as several loose hand written notes. Further, observed a blank aide care plan and an agreement for services form signed by the patient on 9/6/19, with blank frequencies evidenced at the top of the form. During this	{G 798}		

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{G 798}	Continued From page 21 observation, employee D began to write on the form signed by the patient, the HHA (home health aide) frequencies and durations. During an interview at that time, when employee D was asked if it was standard practice to document on paperwork after the patient had signed it, in which employee D remained silent. Further, when asked if employee D had collaborated with the newly admitted patient to develop the HHA care plan while in the home, she indicated she "told" the patient what the HHA was going to do for her at the visits and stated "give you a bath, and things like that; I tell her what the aide is supposed to do. We talk about it." During an interview at 10:45 AM on 9/10/19, employee D indicated there was a copy of the aide care plan in the home for the aide to follow. When asked the employee about the presence of the blank, carbon copied aide care plan in the patient's incomplete paperwork, employee D remained silent. Further, employee D indicated she had spoken with employee L, HHA and instructed her to pick up a copy of the aide care plan. During an interview on 9/10/19 at 12:52 PM, employee L, HHA, indicated she would pick up an aide care plan for each patient for herself, but there was "supposed to be one in the patient's folder that matches." 410 IAC 17-13-2(a)	{G 798}		
G 848	Compliance with Federal, State, Local Law CFR(s): 484.100 Condition of participation: Compliance with	G 848		

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G 848	Continued From page 22	G 848		

Federal, State, and local laws and regulations related to the health and safety of patients.

The HHA and its staff must operate and furnish services in compliance with all applicable federal, state, and local laws and regulations related to the health and safety of patients. If state or local law provides licensing of HHAs, the HHA must be licensed.
This CONDITION is not met as evidenced by:
Based on document review and interview, the agency failed to ensure it was operating with a current Indiana Home Health Agency license (See Tag G848); failed to ensure the Indiana State Department of Health was notified of a change of alternate administrator, clinical supervisor, alternate clinical supervisor; and was informed of a change management/ownership (G852); failed to disclose to the Indiana State Department of Health (ISDH) and CMS (Centers for Medicare and Medicaid) the names and addresses of all persons with an ownership or controlling interest in the agency (G854); and failed to ensure it was operating with a current Indiana Home Health Agency license. (G860)

The cumulative effect of this systemic problem resulted in the agency is out of compliance with the Condition of Participation 42 CFR 484.100 Compliance with Federal/ State/ Local Laws and regulations relation to the health and safety of patients.

Findings include:

1. The Indiana statute for licensure of home health agencies was reviewed and indicated, "IC [Indiana Code] 16-27-1-8 Licensing Sec. [section] 8. (a) To operate a home health agency, a person

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G 848	Continued From page 23	G 848		

must first obtain a license from the state health commissioner."

2. A letter from Indiana State Department of Health dated 5/21/19, stated "Dear [administrator's name]: Our records indicate that your agency's license to operate a home health agency in the State of Indiana will expire 8/31/19. Enclosed is a renewal application for you to complete and submit with requested documentation and $250 license fee to: ... Please ensure your application is complete and arrives in advance of your facility's license expiration 8/31/19."

3. The Indiana State Department of Health received the renewal application on 8/27/19, in the mailroom, the cashier's office received on 9/3/19, and program received the application on 9/9/19.

4. On 9/9/19 at 4:45 p.m., Employee A and Employee D were interviewed with ISDH Home Health Director on the phone. Employee A and Employee D indicated the agency had 7 active patients. Both indicated a CHOW had occurred when Employee D's sister (listed owner of Active Home Health) had passed away in the Philippines October 15, 2018. Employee D indicated they did not receive the death paperwork from the American Embassy in the Philippines until 3/1/19. Employee A indicated there was a "Consent to Action without Meeting" between the deceased owner and employee D, that they would become owner in the event of the late owner's death. No action had been taken to notify the ISDH or CMS of the CHOW. Employee A indicated first contacting an attorney to assist with transaction on 9/5/19. Employee A indicated awareness the

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G 848	Continued From page 24 agency submitted the renewal application on 8/26/19, not providing ISDH opportunity to review and process renewal prior to expiration of license.	G 848		
{G 940}	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure the agency's organization and administrative control was clearly identified and failed to ensure that administrative duties were not delegated to another entity in 1 of 1 agency (See Tag G940); the Governing Body failed to ensure responsibility for the agency's operational plans by being aware of all contracted services and not delegating administrative duties to an outside entity (See Tag G942); the administrator failed to ensure they were to verbalize her availability to the agency during normal business working hours and continue to fail to provide adequate oversight for the day to day operations (See Tag G948); the Governing Body and Administrator failed to ensure they	{G 940}		

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{G 940}	Continued From page 25	{G 940}		

adhered to their plan of correction and met as often as needed to ensure they fulfilled their duties, such as the appointment of management to their positions (See Tag G954); and the Clinical Supervisor failed to ensure complete individualized plans of care were developed and implemented (See Tag G968).

The cumulative effect of this systemic problem resulted in the agency is out of compliance with the Condition of Participation 42 CFR 484.105 Organization and administration of services.

Findings include in relation to G940:

In regards to Administrative Control

1. Review of the ASPEN database indicated the Indiana State Department of Health (ISDH) had previously been informed on 7/24/19, Employee C was the alternate clinical supervisor. The database indicated the owner/ president was Individual M.

2. On 9/9/19 the ISDH home health program received the agency's home health license renewal application. The application indicated Employee C was the Alternate Administrator and Clinical Supervisor and Employee D was the new President/ Alternate Clinical Supervisor. The renewal application did not indicate effective dates for these roles. The renewal application identified in Section V "Ownership Information" B. "Ownership information", the agency had changed individuals with direct or indirect ownership to individual D. Section "D" indicated individual D was the president.

3. The Indiana State Department of Health had

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{G 940}	Continued From page 26	{G 940}		

not been notified of these changes in administration/management or of a Change of Ownership (CHOW) in advance of the license renewal application.

4. On 9/9/19 at 4:45 p.m., Employee A, Business Office Manager, and Employee D, President/ Alternate Clinical Supervisor, were interviewed with ISDH Home Health Director on the phone. Employee A and Employee D indicated the agency had 7 active patients. Both indicated a CHOW had occurred when Employee D's sister (listed as the owner of Active Home Health) had passed away in the Philippines October 15, 2018. Employee D indicated they did not receive the death paperwork from the American Embassy in the Philippines until 3/1/19. Employee A indicated there was a "Consent to Action without Meeting" between the deceased owner and employee D, that they would become owner in the event of the late owner's death. No action had been taken to notify the ISDH or CMS of the CHOW. Employee A indicated first contacting an attorney to assist with transaction on 9/5/19.

In regards to delegating administrative duties to another entity

A contract between Entity #1 and the home health agency was reported by and owned by employee D. The contracted provider had billed 2,500.00 monthly for services to the agency for the years: 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018 and 2019. The contract stated, "...1. Services to be performed; The Agency shall arrange for services needed to provide quality care to its clients and ensure the smooth and continuous operation of the Agency. This Agreement does not guarantee or purport to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE HOME HEALTH CARE LLC	2056 45TH ST HIGHLAND, IN 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 940}	Continued From page 27 guarantee a minimum number of service hours to Provider. The services to be furnished by Provider to Agency are as follows: A) Quality Assurance audits of Patient Medical Charts, both active patients and discharges 1. Call Physician for any orders not complete 2. Obtain any laboratory results not in the chart 3. Obtain patient satisfaction surveys as needed 4. Ensure each medical chart is complete and accurate...13. The provider agrees to comply with all Agency Policies and Procedures, including those related to: Agency requirements for personnel records and medical requirements for employment. Agency Policies and Procedures for HIPPA (Health insurance protection and portability act) and confidentiality...." The agency failed to ensure they did not delegate administrative duties to an outside entity. The agency also failed to identify the use of the contracted agency during the recertification process in July of 2019. 410 IAC 17-12-1(a) 410 IAC 17-12-1(b)	{G 940}		
G 942	Governing body CFR(s): 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on record review and interview, the	G 942		

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G 942	Continued From page 28 Governing Body failed to ensure responsibility for the ageny's operational plans by being aware of all contracted services and not delegating administrative duties to an outside entity for 1 of 1 agency. Findings include: 1. A contract between Entity #1 and the home health agency was reported by and owned by employee D. The contracted provider had billed 2,500.00 monthly for services to the agency for the years: 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018 and 2019. The contract stated, "...1. Services to be performed; The Agency shall arrange for services needed to provide quality care to its clients and ensure the smooth and continuous operation of the Agency. This Agreement does not guarantee or purport to guarantee a minimum number of service hours to Provider. The services to be furnished by Provider to Agency are as follows: A) Quality Assurance audits of Patient Medical Charts, both active patients and discharges 1. Call Physician for any orders not complete 2. Obtain any laboratory results not in the chart 3. Obtain patient satisfaction surveys as needed 4. Ensure each medical chart is complete and accurate...13. The provider agrees to comply with all Agency Policies and Procedures, including those related to: Agency requirements for personnel records and medical requirements for employment. Agency Policies and Procedures for HIPPA (Health insurance protection and portability act) and confidentiality...." The agency failed to identify the use of the contracted agency during the recertification process in July of 2019. 2. A contract between the agency and the	G 942		

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G 942	Continued From page 29 physical therapy entity, "Employee F, DPT (doctor of physical therapy)...Reliable Potential Physical Therapy ... was observed to be invalid as of 5/13/19. The contract agreement stated as of 5/13/16: "... This agreement...is effective as of May 13, 2016. This Agreement is valid for three (3) years and will expire on May 13, 2019...." The agency failed to monitor contracts and services provided by the therapy company. 3. During an interview on 9/10/19 at 3:47 PM, employee A failed to provide an answer as to why the contract by Conric, LLC was not disclosed during the recertification survey in July of 2019. 4. During an interview on 9/10/19 at 4:45 PM, employee A indicated he was unaware the contract with the therapy agency was no longer valid. 410 IAC 17-12-1 410 IAC 17-12-1(b)	G 942		
{G 948}	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the administrator failed to provide adequate oversight for the day to day operations for 1 of 1 agency. Findings include: 1. An agency policy titled, "Job Description - Title: Administrator" dated 2015, stated, " ... Principal Function: Has the authority for the management	{G 948}		

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{G 948}	Continued From page 30 of the business affairs and the overall agency operation. Directs the operation of the Agency which includes planning, budgeting, marketing, sales, service, and product development and program evaluation ...." 2. In regards to availability, notification to ISDH, and lines of authority ISDH Presurvey documentation was reviewed prior to entrance to the agency on 9/9/19 indicated the agency's hours of operation were Monday through Friday 9:00 AM to 5:00 PM and indicated the Alternate Nursing Supervisor was employee C. On 9/9/19 at 12:20 PM, a bright orange sign was observed on the front door of the agency that stated, "Office will be closed this Friday Aug. 2, 2019; Sept. 13, 2019 every other Friday." ISDH failed to be notified of the change in office hours. The document titled, "Division of Acute Care; Indiana State Department of Health; Home Health Agencies Report" completed by Employee A on 9/9/19, indicated the agency office hours of Monday through Thursday 9:00 AM to 5:00 PM and every other Friday 9:00 AM to 5:00 PM. On 9/9/19 at 12:25 PM, Employee A, Business/ Office Manager of the Agency arrived and was asked about the arrival of the Administrator, in which he stated the Administrator would be here in 15 minutes or so. The entrance conference was conducted at 1:00 with Employee A and Employee B, the Administrator. On 9/9/19 at 1:10 PM, asked employee B what her office hours were. Employee B failed to give	{G 948}		

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{G 948}	Continued From page 31 a specific answer, only stated "I am here more; whenever they need me." On 9/9/19 at 1:34 PM, Employee D, who was the family member of the deceased owner of the agency and family member of Employee A, indicated she was now the Alternate Clinical Supervisor and the agency's President. Employee D stated she sent out paperwork to ISDH two weeks ago to become the Alternate Clinical Supervisor and President. Review of an employee list indicated employee D date of hire was 8/6/19. 3. In regards to contracts and delegating administrative duties to another entity A contract between Entity #1 and the home health agency was reported by and owned by employee D. The contracted provider had billed 2,500.00 monthly for services to the agency for the years: 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018 and 2019. The contract stated, "...1. Services to be performed; The Agency shall arrange for services needed to provide quality care to its clients and ensure the smooth and continuous operation of the Agency. This Agreement does not guarantee or purport to guarantee a minimum number of service hours to Provider. The services to be furnished by Provider to Agency are as follows: A) Quality Assurance audits of Patient Medical Charts, both active patients and discharges 1. Call Physician for any orders not complete 2. Obtain any laboratory results not in the chart 3. Obtain patient satisfaction surveys as needed 4. Ensure each medical chart is complete and accurate...13. The provider agrees to comply with all Agency Policies and Procedures, including those related	{G 948}		

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{G 948} Continued From page 32 {G 948}

to: Agency requirements for personnel records and medical requirements for employment. Agency Policies and Procedures for HIPPA (Health insurance protection and portability act) and confidentiality...." The agency failed to identify the use of the contracted agency during the recertification process in July of 2019.

A contract between the agency and the physical therapy entity, "Employee F, DPT (doctor of physical therapy)...Reliable Potential Physical Therapy ... was observed to be invalid as of 5/13/19. The contract agreement stated as of 5/13/16: "... This agreement...is effective as of May 13, 2016. This Agreement is valid for three (3) years and will expire on May 13, 2019...." The agency failed to monitor contracts and services provided by the therapy company.

During an interview on 9/10/19 at 3:47 PM, employee A failed to provide an answer as to why the contract by Conric, LLC was not disclosed during the recertification survey in July of 2019.

During an interview on 9/10/19 at 4:45 PM, employee A indicated he was unaware the contract with the therapy agency was no longer valid.

410 IAC 17-12-1(c)(1)

{G 954} Ensures qualified pre-designated person {G 954}
CFR(s): 484.105(b)(2)

When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the

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{G 954}	Continued From page 33 administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. This ELEMENT is not met as evidenced by: Based on record review and interview, the Governing Body and Administrator failed to ensure they adhered to their plan of correction and met as often as needed to ensure they fulfilled their duties, such as the appointment of management to their positions for 1 of 1 agency. Findings include: An undated, agency document titled, "Employees" failed to evidence a start date or that Employee C was an active employee. On 7/25/19, ISDH received letter from the agency indicating Employee C was the new Alternate Clinical Supervisor. On 8/23/19, ISDH accepted the agency's Review of the agency's plan of correction for the 7/26/19 survey, which indicated "The agency staff was educated in an inservice (see Attachments C and D) on the importance of the Board of Directors meeting regularly, and performing all assigned duties. These duties include, but are not limited to, appointment of management positions, such as Administrator/ Alternate Admin., Director of Nursing/ Alternate DON. In addition, it was emphasized that the Board of Directors must meet more frequently, and it was decided that the Board of Directors would meet at least twice a year, and more often as needed to fulfill its duties." The date of completion was 8/16/19. On 9/9/19 the ISDH home health program received the agency's home health license	{G 954}		

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{G 954} Continued From page 34 {G 954}

renewal application. The application indicated Employee C was the alternate administrator and clinical supervisor and individual B was the new president/ alternate clinical supervisor. The renewal application did not indicate effective dates for these roles.

On 9/9/19 at 1:49 PM, the governing body binder was reviewed. The binder failed to evidence a governing body meeting since November 7, 2018. The binder evidenced a loose, blank form with the agency logo and the date "2019." The governing body minutes failed to evidence appointment of Employee C by the Governing body to the position of Clinical Supervisor and Alternate Administrator.

During an interview on 9/9/19 at 1:00 PM, employee A indicated he had been in contact with ISDH regarding the appointments of the director of nursing, alternate director of nursing and assistant director of nursing.

During an interview on 9/9/19 at 1:38 PM, Employee B indicated the governing body had not met since November of 2018. Employee B stated the next governing body meeting was to be on September 17th, 2019 at 2:00 PM. She stated all the plan of correction information would be presented at that time. Further, she indicated the governing body members were "together all the time and knew what we were doing; but, never wrote it down." Employee B was asked if any of the plan of correction initiatives or the staff appointments were approved by the governing body, she indicated they had not been, as the governing body had not met yet.During an interview on 9/9/19 at 1:00 PM, employee A indicated he had been in contact with ISDH

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{G 954}	Continued From page 35 regarding the appointments of the director of nursing, alternate director of nursing and assistant director of nursing. 410 IAC 17-12-1(d)(8)	{G 954}		
{G 968}	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the Clinical Supervisor failed to ensure the plan of care (POC) included all goals and safety measures, and was supported by the comprehensive assessment in 2 of 3 records reviewed. (#1, 2). Findings include: 1. An undated agency policy titled, "Plan Of Care" provided on 9/10/19 at 2:00 PM by the administrator, stated, "1. A plan of care is developed for each patient admitted to the home health program in consultation with the referring physician...2. The plan of care ... includes the following information: g. Functional limitations and activities permitted as well as safety measures...Goals, rehabilitation potential and discharge plans...p. Reason homebound, unusual home / social facts...4....The supervising physician must be notified of any deviation, addition, or change from the care plan not previously ordered through a written physician's order...." The agency policy failed to include patient-specific interventions and education; measurable outcomes and goals identified by the patient.	{G 968}		

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{G 968}	Continued From page 36 2. An agency document titled "PATIENT GOALS" dated 8/13/19 stated, "The setting of patient goals, whether it be nursing goals or therapy goals, is to be a collaborative effort between the patient / caregiver and the agency field staff...Identifying patient selected goals is not only a requirement, but it is also the right thing to do...The patient's goals should also be measurable...." 3. The clinical record of patient #1 was reviewed on 9/9/19, start of care date of 1/22/19, evidenced an unsigned plan of care for the certification period of 7/21/19 - 9/18/19, with the following goals including, but not limited to, "Patient will have stable peripheral status and cardiac status. Patient will demonstrate activity to manage symptom, patient/ caregiver will be knowledgeable regarding cardiac limitations. Patient/ caregiver will be knowledgeable in S/S (signs and symptoms) of exacerbation Patient/ pcg (patient care giver) will verbalize factors that precipitate angina and identify measures to relieve chest pain or require calling MD (medical doctor) if pain persists. Patient will remain free of S/S of impending CVA (cerebrovascular accident)...." The plan of care evidenced safety measures, not limited to the following: " Use of 911 emergency procedures...transfer precaution, clear pathways, secure loose cords, bathroom safety, use of assistive devices during ambulation, avoid respiratory irritants." . An agency document dated 9/5/19, titled "Patient's Goal Setting", completed by employee E, stated, "... This form is to be completed through an interview process with the patient / caregiver and documented below... 3. What are	{G 968}		

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{G 968}	Continued From page 37	{G 968}		

the patient's/ caregiver's goals? These should be measurable whenever possible: Patient will understand health condition better and be able to manage well and be healthy...." The document failed to evidence patient-specific, measurable goals.

A Recertification/ Follow-up Assessment dated 7/18/19 completed by employee G indicated the patient had, not limited to the following diagnoses: Essential hypertension, type 2 diabetes and long term use of insulin. The assessment indicated the patient obtained her blood sugar daily. The comprehensive assessment evidenced the patient communicated following care preferences/ Patient's personal goals: "...... List all goal(s) and indicate if this is a N-New M-Modified existing goal; D-Discontinuation of existing goal; C-Completed/ met goal [blank]...." The plan of care failed to be supported by the comprehensive assessment for the assessment failed to evidence specific patient identified goals.

Also, this plan of care for the same certification period failed to include safety measures in regards to hyper/ hypoglycemic precautions due to diabetes.

4. The clinical record of patient #2 was reviewed on 9/10/19, start of care date of 5/5/18, with an unsigned plan of care for the certification period of 8/28/19 - 10/26/19, with the following diagnoses: Chronic obstructive pulmonary disease, generalized anxiety and arthritis further, patient goals including, but not limited to: "...Patient will have stable respiratory status/ pulmonary status. Patient/ caregiver will be knowledgeable of respiratory limitations. Patient/ caregiver will be knowledgeable in emergency

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{G 968}	Continued From page 38 care measures. Patient will remain free of respiratory/ pulmonary infection. Patient will return to a stable breathing pattern and airway clearance...." The plan of care failed to identify patient-specific, measurable goals with interventions and outcomes identified by the patient. An agency document dated 8/21/19, titled "Patient's Goal Setting" completed by employee E, stated, "... This form is to be completed through an interview process with the patient/ caregiver and documented below... 3. What are the patient's/ caregiver's goals? These should be measurable whenever possible: Patient wants to be ale to get stronger again and be able to get enough rest @ (at) night so she can do more therapy. Signature of Patient or caregiver [blank]...." The document failed to evidence patient-specific, measurable goals and that the document was completed with the patient as evidenced by lack of patient signature on the form. A Recertification/ Follow-up Assessment dated 8/26/19 completed by employee G indicated the patient "...already have a goal(s) they are working on at this time... List all goal(s) and indicate if this is a N-New M-Modified existing goal; D-Discontinuation of existing goal; C-Completed/ met goal [blank]... Refused Cares PT (physical therapy) was recommended. Patient refuses PT at this time .... " The plan of care failed to be supported by the comprehensive assessment for the assessment failed to evidence specific patient identified goals. 3. During an interview on 9/9/19 at 2:00 PM with employee B, administrator, she indicated patients	{G 968}		

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{G 968}	Continued From page 39 with diabetes should have diabetic precautions present on safety measures and that patient goals and preferences should be patient specific and measurable. Further, she indicated she reviewed components required on the plan of care during the 8/14/19 agency-wide inservice.	{G 968}		
G1028	Protection of records CFR(s): 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the Registered Nurse (RN) failed to protect patient information from loss (#3). Findings include: A document dated 8/14/19 titled, "Patient's Rights and Responsibilities" stated, "...Confidentiality of clinical records in accordance with Federal and State laws...Patient's clinical records will be protected from unauthorized disclosure or use...." The clinical record of patient #3 was reviewed on 9/10/19 and indicated a start of care date of 9/6/19. The record failed to evidence a completed plan of care. On 9/10/19 at 10:35 AM, observed employee D and employee E with a hard chart with patient #3's name on it and several papers, forms and a manilla file folder with information written on the	G1028		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE HOME HEALTH CARE LLC	**2056 45TH ST HIGHLAND, IN 46322**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G1028	Continued From page 40 inner portion as well as several loose hand written notes. Written on the inner portion of the manilla file folder was the following: 140/70, 98% and 64. Further, was observed a blank comprehensive assessment, blank aide care plan and an agreement for services form signed by the patient on 9/6/19, with blank frequencies evidenced at the top of the form. During this observation, employee D began to write on the form previously signed by the patient, the SN (skilled nurse), HHA (home health aide), PT (physical therapy) and OT (occupational therapy) frequencies and durations. During an interview at that time, when employee D was asked if it was standard practice to document on paperwork after the patient had signed it,employee D failed to answer. During an interview on 9/10/19 at 10:43 AM, employee E indicated she had lost her hand written notes from the manilla file folder that contained the comprehensive / physical assessment performed on 9/6/19 for patient #3. She indicated she had looked in her car and in the loose paperwork on her desk and was unable to find the assessment. When asked what was her process for completing the physical assessment if she is unable to locate her original information. Employee E stated, "I would go out and do it again." 410 IAC 17-15-1(c)	G1028		
{E 000}	Initial Comments	{E 000}		