STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K140	A. BUILDING 00 B. WING	04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN HEART HEALTH SERVICES LLC	7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268

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G 0000 Bldg. 00		G 0000		

This visit was for a recertification survey of a Medicaid home health agency. Three (3) complaints were investigated in conjunction with the recertification survey. This survey was partial extended on 4-17-19, and at 2:35 the administrator was so notified.

Complaint #s: IN 00291961; substantiated with findings.

IN 00264593; substantiated with findings

IN 00216370; substantiated with findings

Survey dates: 4-15, 4-16, 4-17, 4-18, 4-22, 4-23, and 4-24-2019

Facility #: 013772

Medicaid #: 15K140

Unduplicated skilled admissions prior 12 months: 1

Current census:

Skilled	8
Home Health Aide only	30
Total	38

Home visits with record review	3
Clinical record review only	7

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 0484 Bldg. 00	Total clinical records reviewed 10 Based on record review and interview, the agency failed to document the existence of 3 complaints, for 2017, 2018 and 2019, out of a total sample of 13 incident reports in 2017, 2018, and 2019, reviewed. The findings included: Review of a policy, "Client/Family Complaint/Grievance Policy," administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, "A complaint is defined as 'any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time by the staff present ... A grievance is any formal or informal or verbal expression of dissatisfaction with care or service that is expressed by the client/family that is not solved at the time by the staff present ... Any complaint that fits the grievance definition will require a written response to the person complaining ... Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file ... Grievances will be addressed ... within 7 calendar days of receipt ... a grievance is considered resolved when the the client is satisfied with the actions taken on their behalf ... " Review of the incident report/adverse event log, evidenced: An incident report, dated 4-19-17, a patient made an accusation their home health aide (HHA),	G 0484	G 484 1.The administrator has in-serviced the nursing staff on Client/family complaint/grievance policy. A complaint is defined as any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time by the staff present… A grievance is any formal or informal or verbal expression of dissatisfaction with care or service that is expressed by the client/family that is not solved at the time by the staff present… Any complaint that fits the grievance definition will require a written response to the person complaining… All client complaints will be documented on a client complaint form and filed with the complaint logbook. All grievances will be addressed within 7 calendar days of receipt of the complaint. The administrator has in-serviced the nursing staff on incident report policy. An incident report is an expression of dissatisfaction, a complaint form will be completed along with the incident report. Both incident and complaint forms will be completed and logged.	05/10/2019

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	former employee BB, was not following plan of care for the patient, asked for caregiver to sign visit note without providing all the time documented, and offered to pay one of the caregivers to give the patient a shower. The accusation was not found credible as HHA was having a surgical procedure on the alleged date of having offered caregiver money to shower patient, HHA visit notes evidenced the HHA did not always work the assigned hours, and modified work hours to meet school obligations. The daughters of the patient, one of whom filed the complaint, contradicted each others' statements. A credible HHA adamantly denied the accusation and presented supporting documentation of surgery date. This incident report represented an expression of dissatisfaction, and per agency policy, required documentation as a complaint in the complaint log, to include a resolution which satisfied the patient. An incident report, dated 3-15-18, a patient complained 2 pain medications (Norco) were missing from the bottle, and accused the HHA, former employee DD, of taking them. Document evidenced the patient requested the HHA not be assigned anymore. This incident report represented an expression of dissatisfaction, and per agency policy, required documentation as a complaint in the complaint log, to include a resolution which satisfied the patient. An incident report, dated 3-19-18, patient complained pain medication (Tramadol) was missing, and accused former employee DD, an HHA, of taking them. The patient later admitted having dropped the bottle of Tramadol, spilling pills out of the bottle, and instructed the HHA to put the 6-7 spilled on floor pills in the trash. This incident report represented an expression of		2.100% of all complaint/incident forms and logs will be reviewed quarterly for evidence that a written complaint form has been resolved within 7 days of receipt of the complaint. 3.The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	dissatisfaction, and per agency policy, required documentation as a complaint in the complaint log. On 4-23-19 at 10:54 AM, the above incident reports were reviewed with the administrator and the clinical manager. The administrator stated the incident reports had not been documented as complaints, as well as incident reports, and should have been. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
G 0572 Bldg. 00	Based on record review and interview, the agency failed to sure the services were provided according to the written physician's plan of care, as required by agency policy, for 2 (Patients #3 and 10) of 10 patients whose clinical record was reviewed. The findings included: 1. Review of a policy, "Plan of Care," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... to develop a plan of care individualized to meet specific identified needs ... To reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals ... The Plan of Care shall be completed in full to include: ... all pertinent diagnosis(es) ... type, frequency, and duration of all visits/services ... Medications,	G 0572	1.The director of nursing has in-serviced the nursing staff on the Plan of Care policy. Home care services are furnished under the supervision and direction of the client's physician. The purpose to develop a plan of care individualized to meet specific identified needs… To reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. The Plan of care shall be competed in full to include all pertinent diagnosis(es), type, frequency, and duration of all visits/services, medication treatments, and procedures. 2.10% of the clinical records will be reviewed for evidence that the plan of care is being followed and	05/10/2019

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	treatments, and procedures ... all of the above items must always be addressed on the Plan of Care ... " 2. Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 2-26 to 4-26-19, with orders for home health aide (HHA) services up to 8 hours, 7 days a week. Review of HHA visit notes evidenced the aide made 2 visits the week of 3-24 to 3-30-19 (5 missed visits); 6 visits the week of 3-31 to 4-6-19 (1 missed visit), and 5 visits the week of 4-7 to 4-13-19 (2 missed visits.) Review of a missed visit note dated 4-11-19, evidenced the reason for missed visit on 4-10-19, was "staffing issues." 3. Review of the clinical record of patient #10, evidenced a start of care date of 8-4-16, and contained a plan of care for the certification period of 10-3 to 12-1-16, with orders for home health aide (HHA) services 9 hours a day, 5 days a week, to assist with personal care, ADLs (Activities of Daily Living), light housekeeping as needed. Review of visit note 10-3-16, evidenced the HHA provided 4 hours of care; 10-4-16, the HHA provided 3 hours of care; 10-5-16, the HHA provided 4 hours of care; 10-6, 4 hours of care; 10-7, hours of care; 10-10, 5 hours of care; 10-11, 5 hours of care; 10-12, 5 hours of care; 10-13, 5 hours of care; 10-17, 5 hours of care; 10-18, 5 hours of care; 10-19; 5 hours of care; 10-20, 4 hours of care; 10-24, 4 hours of care; 10-25, 4 hours of care; 10-26, 4 hours of care; 10-27, 2 hours of care; 10-28, no care provided; 10-31, 5 hours of care; 11-1, 5 hours of care;11-2, 5 hours		the patient is receiving the hours of care ordered. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	of care; 11-3, 5 hours of care; 11-4, 4.75 hours of care; 11-7, 5 hours of care; 11-8, 2.5 hours of care; 11-9, 5 hours of care; 11-10, 5 hours of care; 11-11, 5 hours of care; 11-14, 2 hours of care; 11-17, 3.5 hours of care; 11-18, 4 hours of care; 11-21, 0 hours of care; 11-22, 4.5 hours of care; 11-23, 3 hours of care; 11-28, 2 hours of care; 11-29, 4 hours of care; 11-30, 5 hours of care; 12-1-16, 0 hours of care. Patient #10 did not receive the 9 hours of care ordered on the plan of care for any of the visits during the certification period. 4. On 4-23-19 at 3 PM, the administrator verified patients #3 and #10, had not received services as ordered in the plan of care. The administrator verified staffing issues was the cause of the failure to provide care as ordered. When queried for further explanation, information, or documentation, the administrator stated having nothing further to offer for review.			
G 0574 Bldg. 00	Based on record review and interview, the agency failed to ensure the plan of care did not include a frequency order of zero (0) for 5 (Patients #4, 5, 6, 7, and 9) of 10 patients, failed to ensure the duration of visits was ordered on the plan of care, as required by agency policy, for 3 (Patients #1, 3, and 10) of 10 patients; and failed to ensure the plan of care identified risks for emergency room visits and hospitalizations and interventions the agency would implement to reduce the risks for 1 (Patient #1) of 10 patients. The findings included: 1. Review of a policy, "Plan of Care,"	G 0574	G574 1.The Director of Nursing has in-serviced all nursing staff on the plan of care policy that it must include all the pertinent diagnoses, the patient's mental, psychosocial, and cognitive status, type of services, supplies, and equipment required, the frequency and duration of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury; a	05/13/2019

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	administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... to develop a plan of care individualized to meet specific identified needs ... The Plan of Care shall be completed in full to include: ... all pertinent diagnosis(es) ... type, frequency, and duration of all visits/services ... Medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care ... " 2. Review of the clinical record of patient #1, evidenced a start of care date of 6-12-18, and contained a plan of care for the certification period of 4-8 to 6-6-19, with order for home health aide services 8 hours a day, 5 days a week, and 6 hours a day, 1 day a week. The order failed to evidence the duration of the home health aide visits. Diagnoses included multiple sclerosis, dementia, osteoporosis, chronic kidney disease stage 3, depression. The plan of care failed to evidence underlying factors and interventions the agency would implement to reduce the risk of emergency room visits or hospitalization. 3. Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 2-26 to 4-26-19, with orders for home health aide (HHA) services up to 8 hours, 7 days a week. The order frequency included an order for zero (0) visits, because "up to" 8 hours included zero (0) visits. The order also failed to evidence a duration for the ordered visits. 4. Review of the clinical record of patient #4, evidenced a start of care date of 10-18-17, and contained a plan of care for the certification period of 2-10 to 4-10-19, with orders for skilled nursing		description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors etc. The Director for Nursing has in-serviced all nursing staff on documentation of the plan of care frequency, duration of visits, to identify risk for emergency room visits and hospitalization and interventions the agency would implement to reduce the risk of emergency room visits or hospitalization. The nursing staff will discontinue documenting "up to" the number of hours and ensure the duration of visits was ordered on the plan of care "0" hours cannot be documented. 2.Going forward, all charts will be audited until 100% of charts are compliant and then 10% will be audited quarterly for evidence that the plan of care includes duration for the ordered visits, frequency not to include zero (0) visits and the risk for emergency room visits and hospitalizations. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	and home health aide (HHA) services. HHA services were ordered up to 4 hours, 1 day a week, and up to 5 hours per day, 1 day a week. The order frequency included an order for zero (0) visits, because "up to" 4 hours, or "up to" 5 hours, included zero (0) visits. The order also failed to evidence a duration for the ordered visits. 5. Review of the clinical record for patient #5, evidenced a start of care date of 7-9-16, and contained a plan of care for the certification period of 3-6 to 5-4-19, with order for HHA up to 5 hours a day, 6 times a week. The order frequency included an order for zero (0) visits, because "up to" 5 hours, included the frequency of zero (0) visits. 6. Review of the clinical record for patient #6, evidenced a start of care date of 6-26-17, and contained a plan of care for the certification period of 2-16 to 4-16-19, with order for HHA up to 3 hours a day, 3 times a week, and up to 4 hours a day, 2 times a week. The order frequency included an order for zero (0) visits, because "up to" 3 hours, or "up to" 4 hours, included zero (0) visits as a frequency. 7. Review of the clinical record for patient #7 evidenced a start of care date of 7-9-16, and contained a plan of care for the certification period of 3-6 to 5-4-19, with order for HHA up to 3 hours a day, 3 times a week, and up to 4 hours a day, 2 times a week. The order frequency included an order for zero (0) visits, because "up to" 3 hours, or "up to" 4 hours, included zero (0) visits as a frequency. 8. Review of the clinical record for patient #9, evidenced a start of care date of 4-10-18, and contained a plan of care for the certification period			

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	of 3-10-19 to 5-8-19, with order for home health aide services "up to 4 hours a day, 6 times a week, for 9 weeks." The order included a frequency of zero (0), because up the order of up to 4 hours, included 0, 1, 2, 3, and 4 hours. 9. Review of the clinical record of patient #10, evidenced a start of care date of 8-4-16, and contained a plan of care for the certification period of 10-3 to 12-1-16, with orders for home health aide (HHA) services 9 hours a day, 5 days a week. The plan of care order failed to evidence the duration of the home health aide visits. 10. On 4-23-19 at 3 PM, the administrator verified the above findings. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
G 0580 Bldg. 00	Based on record review and interview, the agency failed to ensure a verbal order for disciplines, frequency of visits, duration of visits, and care orders was obtained prior to furnishing services for 7 (Patients #1, 2, 4, 5, 6, 8, and 10) of 10 patients who were retained on service more than 60 days. The findings included: Review of a policy, "Plan of Care," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... to develop a plan of care individualized to meet specific	G 0580	G580 1.The Director for Nursing has in-serviced all nursing staff on the Plan of Care policy that the home care services are furnished under the supervision and direction of the client's physician. The plan of care will be individualized to meet the specific identified needs and shall be completed in full to include all pertinent diagnosis(es), type, frequency, and duration for all visits/services, medication, treatment and procedures. The Director of Nursing has in-serviced all nursing staff on	05/13/2019

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	identified needs ... The Plan of Care shall be completed in full to include: ... all pertinent diagnosis(es) ... type, frequency, and duration of all visits/services ... Medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care ... " Review of a policy, "Physician Orders," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "All medications, treatments, and services provided to clients must be ordered by a physician ... When the nurse ... receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed with the full name and title of the person receiving the order, and be sent to the physician for signature ... " Review of the physicians orders in the clinical record of patient #1, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 4-7-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 4-8, 4-9, 4-10, 4-11, 4-12, and 4-13-19. The plan of care orders were signed by the physician on 4-15-19. Review of the physicians orders in the clinical record of patient #2, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 12-29-18. Review of home health aide		Physician Orders policy that all medication, treatment, and services provided to clients must be ordered by a physician. When the nurse receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order will verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature. On Recertification verbal orders for disciplines, frequency, duration of visits, and care orders must be completed. 2.10% of all clinical records will be audited quarterly for evidence that the plan of care includes all the pertinent diagnosis(es), type, frequency, and duration for all visits/services and includes a verbal order at the time of recertification. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	(HHA) visit notes, evidenced care visits were made on 1-4, 1-5, 1-6, 1-11, 1-12-19. The plan of care orders were signed by the physician on 1-16-19. Review of the physicians orders in the clinical record of patient #4, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 2-6-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 2-10, 2-11,and 2-13-19. The plan of care orders were signed by the physician on 2-14-19. Review of the physicians orders in the clinical record of patient #5, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 3-4-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 3-6, 3-7, and 3-8-19. The plan of care orders were signed by the physician on 3-11-19. Review of the physicians orders in the clinical record of patient #6, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 2-15-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 4-8, 4-9, 4-10, 4-11, 4-12, and 4-13-19. The plan of care orders were signed by the physician on 4-15-19. Review of the physicians orders in the clinical record of patient #8, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 12-1-16, and 2-1-17. Review of home health aide (HHA) visit notes, evidenced a care visits was made on 2-3-17. The plan of care orders were			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN HEART HEALTH SERVICES LLC	7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268

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	signed by the physician on 2-10-19. Review of the physicians orders in the clinical record of patient #10, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 9-29-16. Review of home health aide (HHA) visit notes, evidenced care visits were made on 10-3, 10-4, 10-5, 10-6, 10-7, 10-10, and 10-11-16. The plan of care orders were signed by the physician on 10-12-16. On 4-23-19, at 3 PM, the administrator verified the registered nurses had not received authorization and a verbal order with disciplines, frequency and duration of visits, and care orders, at the the time of recertification for the above patients. The administrator stated the HHAs had provided direct care of activities of daily living and instrumental activities of daily living for patients #1, 2, 4, 5, 6, 8, and 10. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
G 0706 Bldg. 00	Based on record review and interview, the registered nurse failed to ensure patient's needs were continually assessed and documented in the nurse visit in relation to reported fall for 1 (Patient #3) of 2 patients with reported fall during the certification period reviewed, of a total sample of 10 patients. The findings included: Review of the clinical record of patient #3,	G 0706	G706 1.The Director for Nursing has in-serviced all nursing staff on the ongoing interdisciplinary assessment of the patient and follow-up documentation of falls. Making sure that the patient's needs are continually assessed and documented on visit notes, communications notes, physician orders. Any injury must be assessed, and follow-up must be	05/14/2019

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	evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 4-27 to 6-25-18, with orders for with order for skilled nursing 1 time a week for medication set-up, and home health aide (HHA) 7 times a week to assist with activities of daily living. Review of a HHA visit note dated 5-20-18, evidenced patient #3 "fell, I called the nurse." Review of visit notes, communication notes, and physician orders, failed to evidence the registered nurse had assessed patient #3 for injury after the reported fall. On 4-23-19 at 3 PM, the administrator verified the above findings. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.		completed and documented. 2.10% of all clinical records will be audited quarterly for evidence that the nursing notes, communication notes, physician orders were properly documented, including assessments and follow-up visits. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
G 0768 Bldg. 00	Based on record review and interview, the agency failed to ensure the home health aide establishment of skills competency included the taking of temperature, pulse, and respiration, for 1 (employee R) of 1 home health aide whose establishment of skills competency was reviewed, of a total sample of 29 home health aides employed. The findings included: Review of the establishment of skills competency for employee R, a home health aide with date of hire of 8-9-16, date of first patient contact of 8-22-16, failed to evidence the establishment of	G 0768	G768 1.The Director of Nursing will in-service all nursing staff on competency evaluation to ensure the Home Health Aide skills competency includes the taking of Temperature, Pulse, and Respirations. Each skill must be documented. The Director of Nursing will ensure that all active Home Health Aides be competency evaluated/Skills competency on Temperature, Pulse, and respirations.	05/17/2019

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	competency to perform temperature, pulse, and respiration. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.		2.10% of all personnel records will be audited quarterly for evidence of proper documentation of the competency evaluation form. Each skill must be documented. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
G 0798 Bldg. 00	Based on record review and interview, the registered nurse failed to ensure the home health aide completed contained adequate code status information to honor the patient's rights (resuscitate/do not resuscitate) for 1 (Patient #3) of 10 patients whose clinical record was reviewed for 1 (Patient #3) of 10 patients. The findings included: Review of a policy, "Home Health Aide Care Plan," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... all home health aide staff will follow the identified plan ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... Prior to initiating care, the Home Health Aide shall be oriented by a Registered Nurse ... by phone or in person, to the client's care needs and shall be updated on the modifications	G 0798	G798 1.The Director of Nursing has in-service all nursing staff on the Home Health Aide Care Plan, Home Health aide assignments, duties and proper documentation of patient code status to honor the patient's rights regarding resuscitate/do not resuscitate. The home health aide is assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions including code status on the Home Health Aide Care plan which is prepared by that registered nurse. Prior to initiating care the Home Health Aide shall be oriented by a Registered Nurse via phone or in person, to the clients care needs. The Home Health Aide will report in modifications or changes in the	05/15/2019

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	or changes in the client's care ... " Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, with orders for skilled nursing visits and HHA visits 7 times a week for 9 weeks. Review of the home health aide care (HHA) plan, last reviewed 2-25-19; also reviewed 12-26-18, 10-24-18, and 8-27-18, failed to evidence the HHA had been provided the patient's code status in writing on the HHA care plan. Review of the clinical record of patient #3 evidenced patient was a full code. On 4-17-19 at 2:15 PM, the above findings were reviewed with the administrator, who verified the findings. The administrator stated HHAs are trained to use the HHA care plan for the delivery of services, and to confirm the patients' code status. The administrator stated the registered nurse should have completed the portion of the HHA care plan which identified patient #3's code status. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.		client's care. 2.10% of all clinical records will be audited quarterly for evidence of proper documentation of code status. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
G 0804 Bldg. 00	Based on record review and interview, the agency failed to implement its clinical documentation policy, and the interdisciplinary participation of a home health aide (employee to ensure the home health aide documented a change in the patient's condition, and failed to ensure the the nurse responsible for managing the client's care monitored the home health aide visit notes to	G 0804	G804 1.The Director of Nursing has in-serviced all nursing staff and Home Health Aides on clinical documentation. Home Health aides are members of interdisciplinary team and must report changes in the patient's condition to a registered nurse or	05/17/2019

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	ensure accurate and complete documentation of a patient's falls for 1 (Patient #3) of 10 patients. The findings included: Review of a policy, "Clinical Documentation," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Agency will document each direct contact with the client. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the client's care ... Purpose To ensure there is an accurate record of services provided, client response and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement." Review of a policy, "Home Health Aide Care Plan," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... all home health aide staff will follow the identified plan ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... Prior to initiating care, the Home Health Aide [HHA] shall be oriented by a Registered Nurse ... by phone or in person, to the client's care needs and shall be updated on the modifications or changes in the client's care ... " Review of HHA visit note dated 5-20-18, evidenced "she fell and I called the nurse" and 5-22-18, evidenced "she fell and I called the nurse," both entries were signed by former employee, HHA, employee UU. Review of nurse visit notes dated 5-24 and		other appropriate skilled professional and must complete appropriate clinical documentation. Each direct contact with the client will be documented. The documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the clients care. This will ensure there is an accurate record of services provided, client response and ongoing need for care. 2.10% of all clinical records will be audited quarterly for evidence of proper clinical documentation of the interdisciplinary team. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	5-29-18, failed to evidence the nurse had assessed patient #3 for injury after 2 reported falls. On 4-17-19 at 2:15 PM, the above findings were reviewed with the administrator, who verified the findings. The administrator stated HHAs were members of the interdisciplinary team, supervised by the registered nurse, and the HHA, former employee UU, failed to completely document the details of the 5-20 and 5-22-18 patient falls. The administrator stated the HHA and the registered nurse had not followed agency policy. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
G 0818 Bldg. 00	Based on record review and interview, the registered nurse failed to ensure the home health aide had complete information to honor the patient's rights in relation to code status (resuscitate/do not resuscitate) for 1 (Patient #3) of 10 patients whose clinical record was reviewed, and failed to identify the failure of the home health aide to provide care as ordered on the plan of care, due to missed visits, during supervisory visits for 1 (Patient #3) of 10 patients. The findings included: Review of a policy, "Home Health Aide Care Plan," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... all home health aide staff will follow the identified	G 0818	G818 1.The Director of Nursing has in-service all nursing staff on the Home Health Aide Supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to the following elements: following the Patient's plan of care for completion of tasks assigned, maintaining an open communication process with all parties, demonstrating competency with assigned task, complying with infection prevention, report changes in patients condition and honoring patient rights. Nursing staff will ensure the HHA has complete information to care for the patient, including code status	05/17/2019

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	plan ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... Prior to initiating care, the Home Health Aide shall be oriented by a Registered Nurse ... by phone or in person, to the client's care needs and shall be updated on the modifications or changes in the client's care ... " Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, with orders for skilled nursing visits and HHA visits 7 times a week for 9 weeks. Review of the home health aide care (HHA) plan, last reviewed 2-25-19; also reviewed 12-26-18, 10-24-18, and 8-27-18, failed to evidence the HHA had been provided the patient's code status in writing on the HHA care plan. Review of supervisory visit note dated 4-8-19, evidenced the nurse had marked the HHA was following the care plan, when during the certification period of 2-26 to 4-26-19, the HHA had missed visits on 2-26-19, 3-24, 3-25, 3-26, 3-27, 3-28, 4-6, and 4-7-19. Review of the clinical record of patient #3 evidenced patient was a full code. On 4-17-19 at 2:15 PM, the above findings were reviewed with the administrator, who verified the findings. The administrator stated HHAs were trained to use the HHA care plan for the delivery of services, and to confirm the patients' code status. The administrator stated the registered nurse should have completed the portion of the HHA care plan which identified patient #3's code status, and should have reviewed the HHA care plan at the time of supervisory visits to ensure code status was documented, and correctly identified the HHA had not followed the plan of		(resuscitate/do not resuscitate). Nursing staff will make sure code status is addressed on the HHA care plan. Supervisory visit notes will reflect proper documentation of questions, including HHA was following the care plan. 2.10% of all clinical records will be audited quarterly for evidence of proper documentation of code status on HHA care plan and supervisory visits notes 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	care due to missed care visits. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
G 0948 Bldg. 00	Based on record review and interview, the administrator failed to ensure 3 (Home Health Aide Medication Administration, Home Health Aide Care Plan, and Plan of Care,) of 19 policies reviewed were updated in compliance with federal and state requirements for a home health agency. The findings included: Review of the job description of the administrator, signed by the administrator on 7-5-16, evidenced, "Reports to Governing Body/Board of Directors ... Plans, organizes, and directs the Agency's ongoing functions ... Provides direction in formulating the programs and policies ... Assures compliance with federal/state regulations governing home health care services." Review of a policy, "Home Health Aide Medication Administration," the administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, " ... Purpose ... To assure that Home Health Aides are trained and deemed competent to assist in safe, accurate administration of regularly scheduled medications ... Procedure .. oral medications ... eye medications ... drop the prescribed number of drops into the middle of the client's lower lid ... ear drops ... rectal suppositories ... vaginal suppositories ... topical medications ... via gastrostomy tube ... " The policy failed to ensure	G 0948	G948 1.The Governing body in-serviced the Administrator on the day to day operations of the agency. The Administrator and Governing body have reviewed and revised the home health aide medication administration, home health aide care plan, and the plan of care to be in compliance with federal and state requirements. Home Health aide medication administration policy was revised to ensure only nurses could administer medication and HHA could assist patient to take medications. The Administrator and Governing has reviewed and revised the policy and procedures to remove Physical Therapy, since we do not offer this service at this time. The Director for Nursing has in-serviced all nursing staff on the Plan of Care policy that the plan of care must document all physicians' names and contact information, advance directive status, and risk of emergency room trips, or acute care hospital admission.	05/16/2019

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	only nurses could administer medications, and HHA could assist patient to take medications. Review of a policy, "Home Health Aide Care Plan," the administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, " ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... If the Home Health Aide is assigned to perform delegated nursing functions, such as administering medications, i.e. eye drops ... " The policy failed to ensure only nurses could administer eye drops and other medications, and HHA could assist patient to take medications. Review of a policy, "Plan of Care," the administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, "The Plan of Care shall be completed in full to include: a. all pertinent diagnosis(es), principle and secondary, including dates of onset b. Mental Status c. Type frequency, and duration of all visits services d. Specific procedures and modalities for therapy service e. Diagnostic tests, including laboratory and x-rays f. Surgical Procedures g. Prognosis h. Rehabilitation Potential i. Functional limitations and precautions j. Activities permitted or restrictions k. Specific dietary or nutritional requirements or restrictions l. Medications, treatments, and procedures m. Medical supplies and equipment needed n. Any safety measures to protect against injury o. Instructions to client/caregiver, as applicable p. Treatment goals q. Instructions for timely discharge r. Discharge plans s. Name and address of client's physician t. Other appropriate items u. All of the above items must always be addressed on the Plan of Care ... " The policy failed to include required items in the conditions of participation for home health agencies, effective 1-13-18, that required the plan		2.100% of all policy and procedures will be reviewed annually for evidence of any new, updates, revisions, changes in state/federal regulations that need to be made to the policy and procedures. 3.The Administrator and Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	of care document all physicians names and contact information, advance directive status, and risk of emergency room trips, or acute care hospital admission. During interview on 4-22-19 at 2:33 PM, the administrator stated the agency did not provide therapy services, stated home health aides' scope of practice did not include medication administration, and the plan of care must document the names of all patient physicians and contact information, advance directive status, and risk of emergency room trips, and risk acute care hospital admission. The administrator stated these policies had been in effect since 2015, and should have been revised. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
G 0966 Bldg. 00	Based on record review and interview, the clinical manager failed to ensure patient's needs were continually assessed in relation to reported fall for 1 (Patient #3) of 2 patients with reported fall during the certification period reviewed, of a total sample of 10 patients. The findings included: Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 4-27 to 6-25-18, with orders for with order for skilled nursing 1 time a week for medication set-up, and home health aide (HHA) 7 times a week to assist with activities of daily living.	G 0966	G966 1.The Director of Nursing has in-serviced all nursing staff on ensuring that patient needs are continually assessed related to any follow-up falls or injuries. The nursing staff will document all assessment information for follow-up on nursing notes, communication notes, HHA notes and physician orders. 1.10% of all clinical records will be audited quarterly for evidence that all documentation is completed, all follow-up documentation is completed on	05/16/2019

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	Review of a HHA visit note dated 5-20-18, evidenced patient #3 "fell, I called the nurse." Review of visit notes, communication notes, and physician orders, failed to evidence the registered nurse had assessed patient #3 for injury after the reported fall. On 4-23-19 at 3 PM, the administrator verified the above findings. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.		nursing notes, communication notes, HHA notes and physician orders. 1.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
G 0968 Bldg. 00	Based on record review and interview, the clinical manager failed to ensure the plan of care was implemented, as required by agency policy, for 2 (Patients #3 and 10) of 10 patients whose clinical record was reviewed. The findings included: 1. Review of a policy, "Plan of Care," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... to develop a plan of care individualized to meet specific identified needs ... To reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals ... The Plan of Care shall be completed in full to include: ... all pertinent diagnosis(es) ... type, frequency, and duration of all visits/services ... Medications,	G 0968	G968 1.The Director for Nursing has in-serviced all nursing staff on the Plan of Care policy that the home care services are furnished under the supervision and direction of the client's physician. The plan of care will be individualized to meet the specific identified needs and shall be completed in full to include all pertinent diagnosis(es), type, frequency, and duration for all visits/services, medication, treatment and procedures. The nursing staff will ensure that the plan of care is being implemented related to the HHA orders. 2.10% of all clinical records will be audited quarterly for evidence of Plan of Care being followed and the patient receiving the HHA	05/15/2019

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	treatments, and procedures ... all of the above items must always be addressed on the Plan of Care ... " 2. Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 2-26 to 4-26-19, with orders for home health aide (HHA) services up to 8 hours, 7 days a week. Review of HHA visit notes evidenced the aide made 2 visits the week of 3-24 to 3-30-19 (5 missed visits); 6 visits the week of 3-31 to 4-6-19 (1 missed visit), and 5 visits the week of 4-7 to 4-13-19 (2 missed visits.) Review of a missed visit note dated 4-11-19, evidenced the reason for missed visit on 4-10-19, was "staffing issues." 3. Review of the clinical record of patient #10, evidenced a start of care date of 8-4-16, and contained a plan of care for the certification period of 10-3 to 12-1-16, with orders for home health aide (HHA) services 9 hours a day, 5 days a week, to assist with personal care, ADLs (Activities of Daily Living), light housekeeping as needed. Review of visit note 10-3-16, evidenced the HHA provided 4 hours of care; 10-4-16, the HHA provided 3 hours of care; 10-5-16, the HHA provided 4 hours of care; 10-6, 4 hours of care; 10-7, hours of care; 10-10, 5 hours of care; 10-11, 5 hours of care; 10-12, 5 hours of care; 10-13, 5 hours of care; 10-17, 5 hours of care; 10-18, 5 hours of care; 10-19; 5 hours of care; 10-20, 4 hours of care; 10-24, 4 hours of care; 10-25, 4 hours of care; 10-26, 4 hours of care; 10-27, 2 hours of care; 10-28, no care provided; 10-31, 5 hours of care; 11-1, 5 hours of care; 11-2, 5 hours		hours are ordered by the physician. The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K140	A. BUILDING 00 B. WING	04/24/2019

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	of care; 11-3, 5 hours of care; 11-4, 4.75 hours of care; 11-7, 5 hours of care; 11-8, 2.5 hours of care; 11-9, 5 hours of care; 11-10, 5 hours of care; 11-11, 5 hours of care; 11-14, 2 hours of care; 11-17, 3.5 hours of care; 11-18, 4 hours of care; 11-21, 0 hours of care; 11-22, 4.5 hours of care; 11-23, 3 hours of care; 11-28, 2 hours of care; 11-29, 4 hours of care; 11-30, 5 hours of care; 12-1-16, 0 hours of care. Patient #10 did not receive the 9 hours of care ordered on the plan of care for any of the visits during the certification period. 4. On 4-23-19 at 3 PM, the administrator verified patients #3 and #10, had not received services as ordered in the plan of care. The administrator verified staffing issues were the cause of the failure to implement the plan of care as ordered. When queried for further explanation, information, or documentation, the administrator stated having nothing further to offer for review.			
N 0000 Bldg. 00	This visit was for a state re-licensure survey of a Medicaid home health agency. Three (3) complaints were investigated in conjunction with the state re-licensure survey. Complaint #s: IN 00291961; substantiated with findings. IN 00264593; substantiated with findings IN 00216370; substantiated with findings Survey dates: 4-15, 4-16, 4-17, 4-18, 4-22, 4-23, and 4-24-2019	N 0000		

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	Facility #: 013772 Medicaid #: 15K140 Unduplicated skilled admissions prior 12 months: 1 Current census: Skilled 8 Home Health Aide only 30 Total 38 Home visits with record review 3 Clinical record review only 7 Total clinical records reviewed 10			
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on record review and interview, the administrator failed to ensure 3 (Home Health Aide Medication Administration, Home Health Aide Care Plan, and Plan of Care,) of 19 policies	N 0444	N444 1.The Governing body in-serviced the Administrator on the Administrator job description that plans, organizes, and directs	04/26/2019

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	reviewed were updated in compliance with federal and state requirements for a home health agency, an ongoing function of the agency. The findings included: Review of the job description of the administrator, signed by the administrator on 7-5-16, evidenced, "Reports to Governing Body/Board of Directors ... Plans, organizes, and directs the Agency's ongoing functions ... Provides direction in formulating the programs and policies ... Assures compliance with federal/state regulations governing home health care services." Review of a policy, "Home Health Aide Medication Administration," the administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, " ... Purpose ... To assure that Home Health Aides are trained and deemed competent to assist in safe, accurate administration of regularly scheduled medications ... Procedure .. oral medications ... eye medications ... drop the prescribed number of drops into the middle of the client's lower lid ... ear drops ... rectal suppositories ... vaginal suppositories ... topical medications ... via gastrostomy tube ... " The policy failed to ensure only nurses could administer medications, and HHA could assist patient to take medications. Review of a policy, "Home Health Aide Care Plan," the administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, " ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... If the Home Health Aide is assigned to perform delegated nursing functions, such as administering medications, i.e. eye drops ... " The policy failed to ensure only nurses could		the agency's ongoing functions, provides direction in formulating the programs and policies, assures compliance with federal/state regulations governing home health care services. The Administrator and Governing body have reviewed and revised the home health aide medication administration policy, home health aide care plan policy, and the plan of care policy to be in compliance with federal and state requirements. Home Health aide medication administration and Home health Aide care plan policy was reviewed and revised to ensure only nurses could administer medication eye drops and other medications, and HHA could assist patient to take medications. The Director of Nursing has in-serviced all nursing staff on the plan of care to be completed in full, documenting all physicians' names and contact information, advance directive status, and risk of emergency room trips, or acute care hospital. 2.100% of all policy and procedures will be reviewed annually for evidence of any new, updates, revisions, changes in state/federal regulations that need to be made to the policy and procedures.	

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	administer eye drops and other medications, and HHA could assist patient to take medications. Review of a policy, "Plan of Care," the administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, "The Plan of Care shall be completed in full to include: a. all pertinent diagnosis(es), principle and secondary, including dates of onset b. Mental Status c. Type frequency, and duration of all visits services d. Specific procedures and modalities for therapy service e. Diagnostic tests, including laboratory and x-rays f. Surgical Procedures g. Prognosis h. Rehabilitation Potential i. Functional limitations and precautions j. Activities permitted or restrictions k. Specific dietary or nutritional requirements or restrictions l. Medications, treatments, and procedures m. Medical supplies and equipment needed n. Any safety measures to protect against injury o. Instructions to client/caregiver, as applicable p. Treatment goals q. Instructions for timely discharge r. Discharge plans s. Name and address of client's physician t. Other appropriate items u. All of the above items must always be addressed on the Plan of Care ... " The policy failed to include required items in the conditions of participation for home health agencies, effective 1-13-18, that required the plan of care document all physicians names and contact information, advance directive status, and risk of emergency room trips, or acute care hospital admission. During interview on 4-22-19 at 2:33 PM, the administrator stated the agency did not provide therapy services, stated home health aides' scope of practice did not include medication administration, and the plan of care must document the names of all patient physicians and contact information, advance directive status, and		3.The Administrator and Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	risk of emergency room trips, and risk acute care hospital admission. The administrator stated these policies had been in effect since 2015, and should have been revised. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
N 0456 Bldg. 00	410 IAC 17-12-1(e) Home health agency administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview, the administrator failed to maintain a quality assurance, performance improvement (QAPI) program for the 1st quarter of 2019, and failed to ensure the 2018 QAPI data tracked and analyzed adverse events and OASIS data, as required by policy, for 1 of 1 home health agency. The findings included: Review of a policy, "Performance Improvement," last reviewed/revised 8-24-2015, evidenced the policy stated, "Agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes ... The agency's performance improvement program consists of, but is not limited to the following: ... OASIS (Outcome and Assessment and Information Set)	N 0456	N456 1.The Governing Body has in-serviced the Administrator on maintaining a quality assurance, performance improvement (QAPI) program each quarter to track and analyze adverse events and OASIS data as required by policy. Administrator shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes across the spectrum of care. 2.QAPI will met quarterly to review its QAPI program and verify QAPI data. 3.The Administrator will be responsible for monitoring these	04/26/2019

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	review ... Adverse events ... " Review of the QAPI binder, on 4-23-19, failed to evidence documentation of data review and reporting for the 1st quarter of 2019. On 4-23-19 at 3:05 PM, the administrator stated the data from the 1st quarter of 2019 (January, February, and March) should have been tabulated and reviewed by now. The administrator stated the agency met quarterly to review its QAPI program, and verified the QAPI data from 2018 reviewed on 4-23-19 at 3:05 PM, failed to evidence tracking and analysis of adverse events and OASIS data, as required by agency policy.		corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the agency failed to maintain a quality assurance, performance improvement (QAPI) program for the 1st quarter of 2019, and failed to ensure the 2018 QAPI data tracked and analyzed adverse events and OASIS data, as required by policy, to ensure the QAPI program covered the entire spectrum of	N 0472	N472 1.The Governing Body has in-serviced the Administrator on maintaining a quality assurance, performance improvement (QAPI) program each quarter to track and analyze adverse events and OASIS data as required by policy.	04/26/2019

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	care, for 1 of 1 home health agency. The findings included: Review of a policy, "Performance Improvement," last reviewed/revised 8-24-2015, evidenced the policy stated, "Agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes ... The agency's performance improvement program consists of, but is not limited to the following: ... OASIS (Outcome and Assessment and Information Set) review ... Adverse events ... " Review of the QAPI binder, on 4-23-19, failed to evidence documentation of data review and reporting for the 1st quarter of 2019. On 4-23-19 at 3:05 PM, the administrator stated the data from the 1st quarter of 2019 (January, February, and March) should have been tabulated and reviewed by now. The administrator stated the agency met quarterly to review its QAPI program, and verified the QAPI data from 2018 reviewed on 4-23-19 at 3:05 PM, failed to evidence tracking and analysis of adverse events and OASIS data, as required by agency policy.		Administrator shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes across the spectrum of care. 2.QAPI will met quarterly to review its QAPI program and verify QAPI data. 3.The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
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.			

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	(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 the existence of 3 complaints, for 2017, 2018 and 2019, out of a total sample of 13 incident reports in 2017, 2018, and 2019, reviewed. The findings included: Review of a policy, "Client/Family Complaint/Grievance Policy," administrator stated last reviewed/revised 8-24-15, evidenced the policy stated, "A complaint is defined as 'any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time by the staff present ... A grievance is any formal or informal or verbal expression of dissatisfaction with care or service that is expressed by the client/family that is not solved at the time by the staff present ... Any complaint that fits the grievance definition will require a written response to the person complaining ... Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file ... Grievances will be addressed ... within 7 calendar days of receipt ... a grievance is considered resolved when the the client is satisfied with the actions taken on their behalf ... " Review of the incident report/adverse event log, evidenced: An incident report, dated 4-19-17, a patient made an accusation their home health aide (HHA), former employee BB, was not following plan of	N 0514	N514 1.The Director of Nursing has in-serviced all nursing staff on patient rights. Nursing must investigate all complaints made by a patient or the patient's family or legal representative for treatment or care that is furnished, lack of respect for the patient property by anyone furnishing services and must document both the existence of the complaint and the resolution. All complaints have to be completed and logged. The administrator has in-serviced the nursing staff on Client/family complaint/grievance policy. A complaint is defined as any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time by the staff present… A grievance is any formal or informal or verbal expression of dissatisfaction with care or service that is expressed by the client/family that is not solved at the time by the staff present… Any complaint that fits the grievance definition will require a written response to the person complaining… All client complaints will be documented on a client complaint form and filed	04/30/2019

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	care for the patient, asked for caregiver to sign visit note without providing all the time documented, and offered to pay one of the caregivers to give the patient a shower. The accusation was not found credible as HHA was having a surgical procedure on the alleged date of having offered caregiver money to shower patient, HHA visit notes evidenced the HHA did not always work the assigned hours, and modified work hours to meet school obligations. The daughters of the patient, one of whom filed the complaint, contradicted each others' statements. A credible HHA adamantly denied the accusation and presented supporting documentation of surgery date. This incident report represented an expression of dissatisfaction, and per agency policy, required documentation as a complaint in the complaint log, to include a resolution which satisfied the patient. An incident report, dated 3-15-18, a patient complained 2 pain medications (Norco) were missing from the bottle, and accused the HHA, former employee DD, of taking them. Document evidenced the patient requested the HHA not be assigned anymore. This incident report represented an expression of dissatisfaction, and per agency policy, required documentation as a complaint in the complaint log, to include a resolution which satisfied the patient. An incident report, dated 3-19-18, patient complained pain medication (Tramadol) was missing, and accused former employee DD, an HHA, of taking them. The patient later admitted having dropped the bottle of Tramadol, spilling pills out of the bottle, and instructed the HHA to put the 6-7 spilled on floor pills in the trash. This incident report represented an expression of dissatisfaction, and per agency policy, required		with the complaint logbook. All grievances will be addressed within 7 calendar days of receipt of the complaint. The administrator has in-serviced the nursing staff on incident report policy. An incident report is an expression of dissatisfaction, a complaint form will be completed along with the incident report. Both incident and complaint forms will be completed and logged. 2.100% of all complaint/incident forms and logs will be reviewed quarterly for evidence that a written complaint form has been resolved within 7 days of receipt of the complaint. 3.The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	documentation as a complaint in the complaint log. On 4-23-19 at 10:54 AM, the above incident reports were reviewed with the administrator and the clinical manager. The administrator stated the incident reports had not been documented as complaints, as well as incident reports, and should have been. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
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 sure patients needs were met according to the written physician's plan of care, as required by agency policy, for 2 (Patients #3 and 10) of 10 patients whose clinical record was reviewed. The findings included: 1. Review of a policy, "Plan of Care," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... to develop a plan of care individualized to meet specific identified needs ... To reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals ... The Plan of Care shall be completed in full to include: ... all	N 0520	N520 1.The Director of Nursing has in-serviced the nursing staff on the Plan of Care policy. Home care services are furnished under the supervision and direction of the client's physician. The purpose to develop a plan of care individualized to meet specific identified needs… To reflect client's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals. The Plan of care shall be competed in full to include all pertinent diagnosis(es), type, frequency, and duration of all visits/services, medication treatments, and procedures.	04/30/2019

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	pertinent diagnosis(es) ... type, frequency, and duration of all visits/services ... Medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care ... " 2. Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 2-26 to 4-26-19, with orders for home health aide (HHA) services up to 8 hours, 7 days a week. Review of HHA visit notes evidenced the aide made 2 visits the week of 3-24 to 3-30-19 (5 missed visits); 6 visits the week of 3-31 to 4-6-19 (1 missed visit), and 5 visits the week of 4-7 to 4-13-19 (2 missed visits.) Review of a missed visit note dated 4-11-19, evidenced the reason for missed visit on 4-10-19, was "staffing issues." 3. Review of the clinical record of patient #10, evidenced a start of care date of 8-4-16, and contained a plan of care for the certification period of 10-3 to 12-1-16, with orders for home health aide (HHA) services 9 hours a day, 5 days a week, to assist with personal care, ADLs (Activities of Daily Living), light housekeeping as needed. Review of visit note 10-3-16, evidenced the HHA provided 4 hours of care; 10-4-16, the HHA provided 3 hours of care; 10-5-16, the HHA provided 4 hours of care; 10-6, 4 hours of care; 10-7, hours of care; 10-10, 5 hours of care; 10-11, 5 hours of care; 10-12, 5 hours of care; 10-13, 5 hours of care; 10-17, 5 hours of care; 10-18, 5 hours of care; 10-19; 5 hours of care; 10-20, 4 hours of care; 10-24, 4 hours of care; 10-25, 4 hours of care; 10-26, 4 hours of care; 10-27, 2		2.10% of the clinical records will be reviewed for evidence that the plan of care is being followed and the patient is receiving the hours of care ordered. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K140	A. BUILDING 00 B. WING	04/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN HEART HEALTH SERVICES LLC	7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268

(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
	hours of care; 10-28, no care provided; 10-31, 5 hours of care; 11-1, 5 hours of care;11-2, 5 hours of care; 11-3, 5 hours of care; 11-4, 4.75 hours of care; 11-7, 5 hours of care; 11-8, 2.5 hours of care; 11-9, 5 hours of care; 11-10, 5 hours of care; 11-11, 5 hours of care; 11-14, 2 hours of care; 11-17, 3.5 hours of care; 11-18, 4 hours of care; 11-21, 0 hours of care; 11-22, 4.5 hours of care; 11-23, 3 hours of care; 11-28, 2 hours of care; 11-29, 4 hours of care; 11-30, 5 hours of care; 12-1-16, 0 hours of care. Patient #10 did not receive the 9 hours of care ordered on the plan of care for any of the visits during the certification period. 4. On 4-23-19 at 3 PM, the administrator verified patients #3 and #10, had not received services as ordered in the plan of care. The administrator verified staffing issues was the cause of the failure to provide care as ordered. When queried for further explanation, information, or documentation, the administrator stated having nothing further to offer for review.			
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: 1. Based on record review and interview, the agency failed to ensure a verbal order for disciplines, frequency of visits, duration of visits, and care orders was obtained prior to furnishing services for 7 (Patients #1, 2, 4, 5, 6, 8, and 10) of 10 patients who were retained on service more than 60 days. The findings included:	N 0522	N522 1.The Director of Nursing will in-service all nursing staff on verbal orders for disciplines, frequency of visits duration of visits and care orders are obtained prior to furnishing services. The Director for Nursing has in-serviced all nursing staff on the	04/30/2019

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	1. Review of a policy, "Plan of Care," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... to develop a plan of care individualized to meet specific identified needs ... The Plan of Care shall be completed in full to include: ... all pertinent diagnosis(es) ... type, frequency, and duration of all visits/services ... Medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care ... " 2. Review of a policy, "Physician Orders," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "All medications, treatments, and services provided to clients must be ordered by a physician ... When the nurse ... receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed with the full name and title of the person receiving the order, and be sent to the physician for signature ... " 3. Review of the physicians orders in the clinical record of patient #1, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 4-7-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 4-8, 4-9, 4-10, 4-11, 4-12, and 4-13-19. The plan of care orders were signed by the physician on		Plan of Care policy that the home care services are furnished under the supervision and direction of the client's physician. The plan of care will be individualized to meet the specific identified needs and shall be completed in full to include all pertinent diagnosis(es), type, frequency, and duration for all visits/services, medication, treatment and procedures. The Director of Nursing has in-serviced all nursing staff on Physician Orders policy that all medication, treatment, and services provided to clients must be ordered by a physician. When the nurse receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order will verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature. On Recertification verbal orders for disciplines, frequency, duration of visits, and care orders must be completed. 2.10% of all clinical records will	

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	4-15-19. 4. Review of the physicians orders in the clinical record of patient #2, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 12-29-18. Review of home health aide (HHA) visit notes, evidenced care visits were made on 1-4, 1-5, 1-6, 1-11, 1-12-19. The plan of care orders were signed by the physician on 1-16-19. 5. Review of the physicians orders in the clinical record of patient #4, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 2-6-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 2-10, 2-11,and 2-13-19. The plan of care orders were signed by the physician on 2-14-19. 6. Review of the physicians orders in the clinical record of patient #5, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 3-4-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 3-6, 3-7, and 3-8-19. The plan of care orders were signed by the physician on 3-11-19. 7. Review of the physicians orders in the clinical record of patient #6, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 2-15-19. Review of home health aide (HHA) visit notes, evidenced care visits were made on 4-8, 4-9, 4-10, 4-11, 4-12, and 4-13-19. The plan of care orders were signed by the physician on 4-15-19.		be audited quarterly for evidence that the plan of care includes all the pertinent diagnosis(es), type, frequency, and duration for all visits/services and includes a verbal order at the time of recertification. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	8. Review of the physicians orders in the clinical record of patient #8, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 12-1-16, and 2-1-17. Review of home health aide (HHA) visit notes, evidenced a care visits was made on 2-3-17. The plan of care orders were signed by the physician on 2-10-19. 9. Review of the physicians orders in the clinical record of patient #10, failed to evidence a verbal order for disciplines, frequency, duration of visits, and care orders at the time of recertification, on or about 9-29-16. Review of home health aide (HHA) visit notes, evidenced care visits were made on 10-3, 10-4, 10-5, 10-6, 10-7, 10-10, and 10-11-16. The plan of care orders were signed by the physician on 10-12-16. 10. On 4-23-19, at 3 PM, the administrator verified the registered nurses had not received authorization and a verbal order with disciplines, frequency and duration of visits, and care orders, at the the time of recertification for the above patients. The administrator stated the HHAs had provided direct care of activities of daily living and instrumental activities of daily living for patients #1, 2, 4, 5, 6, 8, and 10. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided.			

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	(B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure the plan of care did not include a frequency order of zero (0) for 5 (Patients #4, 5, 6, 7, and 9) of 10 patients, failed to ensure the duration of visits was ordered on the plan of care, as required by agency policy, for 3 (Patients #1, 3, and 10) of 10 patients; and failed to ensure the plan of care identified risks for emergency room visits and hospitalizations and interventions the agency would implement to reduce the risks for 1 (Patient #1) of 10 patients. The findings included: 1. Review of a policy, "Plan of Care," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... to develop a plan of care individualized to meet	N 0524	N524 1.The Director of Nursing has in-serviced all nursing staff on the plan of care policy that it must include all the pertinent diagnoses, the patient's mental, psychosocial, and cognitive status, type of services, supplies, and equipment required, the frequency and duration of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all medications and treatments, safety measures to protect against injury; 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	05/03/2019

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	specific identified needs ... The Plan of Care shall be completed in full to include: ... all pertinent diagnosis(es) ... type, frequency, and duration of all visits/services ... Medications, treatments, and procedures ... all of the above items must always be addressed on the Plan of Care ... " 2. Review of the clinical record of patient #1, evidenced a start of care date of 6-12-18, and contained a plan of care for the certification period of 4-8 to 6-6-19, with order for home health aide services 8 hours a day, 5 days a week, and 6 hours a day, 1 day a week. The order failed to evidence the duration of the home health aide visits. Diagnoses included multiple sclerosis, dementia, osteoporosis, chronic kidney disease stage 3, depression. The plan of care failed to evidence underlying factors and interventions the agency would implement to reduce the risk of emergency room visits or hospitalization. 3. Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 2-26 to 4-26-19, with orders for home health aide (HHA) services up to 8 hours, 7 days a week. The order frequency included an order for zero (0) visits, because "up to" 8 hours included zero (0) visits. The order also failed to evidence a duration for the ordered visits. 4. Review of the clinical record of patient #4, evidenced a start of care date of 10-18-17, and contained a plan of care for the certification period of 2-10 to 4-10-19, with orders for skilled nursing and home health aide (HHA) services. HHA services were ordered up to 4 hours, 1 day a week, and up to 5 hours per day, 1 day a week. The order frequency included an order for zero (0) visits, because "up to" 4 hours, or "up to" 5		etc. The Director for Nursing has in-serviced all nursing staff on documentation of the plan of care frequency, duration of visits, to identify risk for emergency room visits and hospitalization and interventions the agency would implement to reduce the risk of emergency room visits or hospitalization. The nursing staff will discontinue documenting “up to” the number of hours and ensure the duration of visits was ordered on the plan of care “0” hours cannot be documented. 2.10% of all clinical records will be audited quarterly for evidence that the plan of care includes duration for the ordered visits, frequency not to include zero (0) visits and the risk for emergency room visits and hospitalizations. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	hours, included zero (0) visits. The order also failed to evidence a duration for the ordered visits. 5. Review of the clinical record for patient #5, evidenced a start of care date of 7-9-16, and contained a plan of care for the certification period of 3-6 to 5-4-19, with order for HHA up to 5 hours a day, 6 times a week. The order frequency included an order for zero (0) visits, because "up to" 5 hours, included the frequency of zero (0) visits. 6. Review of the clinical record for patient #6, evidenced a start of care date of 6-26-17, and contained a plan of care for the certification period of 2-16 to 4-16-19, with order for HHA up to 3 hours a day, 3 times a week, and up to 4 hours a day, 2 times a week. The order frequency included an order for zero (0) visits, because "up to" 3 hours, or "up to" 4 hours, included zero (0) visits as a frequency. 7. Review of the clinical record for patient #7 evidenced a start of care date of 7-9-16, and contained a plan of care for the certification period of 3-6 to 5-4-19, with order for HHA up to 3 hours a day, 3 times a week, and up to 4 hours a day, 2 times a week. The order frequency included an order for zero (0) visits, because "up to" 3 hours, or "up to" 4 hours, included zero (0) visits as a frequency. 8. Review of the clinical record for patient #9, evidenced a start of care date of 4-10-18, and contained a plan of care for the certification period of 3-10-19 to 5-8-19, with order for home health aide services "up to 4 hours a day, 6 times a week, for 9 weeks." The order included a frequency of zero (0), because up the order of up to 4 hours, included 0, 1, 2, 3, and 4 hours.			

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	9. Review of the clinical record of patient #10, evidenced a start of care date of 8-4-16, and contained a plan of care for the certification period of 10-3 to 12-1-16, with orders for home health aide (HHA) services 9 hours a day, 5 days a week. The plan of care order failed to evidence the duration of the home health aide visits. 10. On 4-23-19 at 3 PM, the administrator verified the above findings. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.			

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	Based on record review and interview, the registered nurse failed to ensure the home health aide completed contained adequate code status information to honor the patient's rights (resuscitate/do not resuscitate) for 1 (Patient #3) of 10 patients whose clinical record was reviewed for 1 (Patient #3) of 10 patients. The findings included: Review of a policy, "Home Health Aide Care Plan," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... all home health aide staff will follow the identified plan ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... Prior to initiating care, the Home Health Aide shall be oriented by a Registered Nurse ... by phone or in person, to the client's care needs and shall be updated on the modifications or changes in the client's care ... " Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, with orders for skilled nursing visits and HHA visits 7 times a week for 9 weeks. Review of the home health aide care (HHA) plan, last reviewed 2-25-19; also reviewed 12-26-18, 10-24-18, and 8-27-18, failed to evidence the HHA had been provided the patient's code status in writing on the HHA care plan. Review of the clinical record of patient #3 evidenced patient was a full code. On 4-17-19 at 2:15 PM, the above findings were	N 0533	N533 1.The Director of Nursing has in-serviced the nursing staff that care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patient receiving only home health aide services in the absence of a skilled service. The nursing plan of care must contain the following: a plan of care and appropriate patient identifying information, the name of the patient's physician, services to be provided, the frequency and duration of visits, medication, diet, and activities, signed and dated clinical notes from all personnel providing services, supervisory visits, sixty (60) day summaries, the discharge note and signature of the registered nurse who developed the plan. Ensuring the HHA completed contained adequate code status information to honor the patient's rights (resuscitate/do not resuscitate. Ensuring that the HHA is oriented by a registered nurse via phone or in person, to the client's needs and the HHA will update on any modifications or changes in the client's care. Ensuring that the code status is clearly marked. 2.10% of all clinical records will be audited quarterly for evidence of proper documentation of code status.	05/08/2019

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	reviewed with the administrator, who verified the findings. The administrator stated HHAs are trained to use the HHA care plan for the delivery of services, and to confirm the patients' code status. The administrator stated the registered nurse should have completed the portion of the HHA care plan which identified patient #3's code status. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.		3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the registered nurse failed to ensure patient's needs were continually assessed and documented in the nurse visit in relation to reported fall for 1 (Patient #3) of 2 patients with reported fall during the certification period reviewed, of a total sample of 10 patients. The findings included: Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 4-27 to 6-25-18, with orders for with order for skilled nursing 1 time a week for medication set-up, and home health aide (HHA) 7 times a week to assist with activities of daily living.	N 0541	N541 1.The Director for Nursing has in-serviced all nursing staff on the ongoing interdisciplinary assessment of the patient and follow-up documentation of falls. Making sure that the patient's needs are continually assessed and documented on visit notes, communications notes, physician orders. Any injury must be assessed, and follow-up must be completed and documented. 2.10% of all clinical records will be audited quarterly for evidence that the nursing notes, communication notes, physician orders were properly documented,	05/08/2019

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	15K140	A. BUILDING 00 B. WING	04/24/2019

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GOLDEN HEART HEALTH SERVICES LLC	7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268

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	Review of a HHA visit note dated 5-20-18, evidenced patient #3 "fell, I called the nurse." Review of visit notes, communication notes, and physician orders, failed to evidence the registered nurse had assessed patient #3 for injury after the reported fall. On 4-23-19 at 3 PM, the administrator verified the above findings. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.		including assessments and follow-up visits. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0604 Bldg. 00	410 IAC 17-14-1(m) Scope of Services Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist. Based on record review and interview, the agency failed to implement its clinical documentation policy, and the interdisciplinary participation of a home health aide (employee to ensure the home health aide documented a change in the patient's condition, and failed to ensure the the nurse responsible for managing the client's care monitored the home health aide visit notes to ensure accurate and complete documentation of a patient's falls for 1 (Patient #3) of 10 patients. The findings included: Review of a policy, "Clinical Documentation," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Agency will document each direct contact with the client. This documentation will be completed by the direct caregivers and monitored by the skilled	N 0604	N604 1.The Director of Nursing has in-serviced all nursing staff and active Home Health Aides on clinical documentation and Home health aide care plan. Each direct contact with the client will be documented. The documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the clients care. This will ensure there is an accurate record of services provided, client response and ongoing need for care. To ensure document conformance with the plan of care, modifications to the plan, and interdisciplinary involvement. The home health aide care plan will	05/09/2019

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	professional responsible for managing the client's care ... Purpose To ensure there is an accurate record of services provided, client response and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement." Review of a policy, "Home Health Aide Care Plan," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... all home health aide staff will follow the identified plan ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... Prior to initiating care, the Home Health Aide [HHA] shall be oriented by a Registered Nurse ... by phone or in person, to the client's care needs and shall be updated on the modifications or changes in the client's care ... " Review of HHA visit note dated 5-20-18, evidenced "she fell and I called the nurse" and 5-22-18, evidenced "she fell and I called the nurse," both entries were signed by former employee, HHA, employee UU. Review of nurse visit notes dated 5-24 and 5-29-18, failed to evidence the nurse had assessed patient #3 for injury after 2 reported falls. On 4-17-19 at 2:15 PM, the above findings were reviewed with the administrator, who verified the findings. The administrator stated HHAs are members of the interdisciplinary team, supervised by the registered nurse, and the HHA, former employee UU, failed to completely document the details of the 5-20 and 5-22-18 patient falls. The administrator stated the HHA and the registered		identify duties to be performed by the home health aide, shall be developed by a Registered Nurse, all HHA's will follow the identified plan Prior to initiating care the Home Health Aide shall be oriented by a Registered Nurse via phone or in person, to the clients care needs. The Home Health Aide will report in modifications or changes in the client's care. All interdisciplinary team member will document appropriately and completely, and all follow-up assessments will be documented. 2.10% of all clinical records will be audited quarterly for evidence of proper clinical documentation of the interdisciplinary team and all follow-up documentation is completed. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	nurse had not followed agency policy. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review.			
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on record review and interview, the registered nurse failed to identify the failure of the home health aide to provide care as ordered on the plan of care, due to missed visits, during supervisory visits for 1 (Patient #3) of 10 patients; and failed to ensure supervisory visits of the home health aide were not at least each 30 days for 1 (Patient #7) of 10 patients. The findings included: 1. Review of a policy, "Home Health Aide Care Plan," administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... all home health aide staff will follow the identified plan ... Purpose ... To provide documentation that the client's care is individualized to his/her specific needs ... Prior to initiating care, the Home Health Aide shall be oriented by a Registered Nurse ... by phone or in person, to the client's care needs and shall be updated on the modifications	N 0606	N606 1.The Director of Nursing has in-serviced all nursing staff on the scope of services. The Registered nurse shall make the initial visit to the patients residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met and hours are being work according to the plan of care. Supervisory visit notes will reflect proper documentation of questions, including HHA was following the care plan. Nursing staff will ensure the HHA has complete information to care for the patient, including code status (resuscitate/do not resuscitate). 2.10% of all clinical records will be audited quarterly for evidence of	05/10/2019

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	or changes in the client's care ... " 2. Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, with orders for skilled nursing visits and HHA visits 7 times a week for 9 weeks. Review of supervisory visit note dated 4-8-19, evidenced the nurse had marked the HHA was following the care plan, when during the certification period of 2-26 to 4-26-19, the HHA had missed visits on 2-26-19, 3-24, 3-25, 3-26, 3-27, 3-28, 4-6, and 4-7-19. 3. Review of the plan of care for patient #7, evidenced a start of care date of 3-13-18, and contained a plan of care for the certification period of 3-8 to 5-6-19, with order for home health aide services to assist with ADLs (activities of daily living) and IADLs (instrumental activities of daily living.) Review of supervisory visits evidenced a supervisory visit was made on 3-1-19; the next supervisory visit in the clinical record was dated 4-5-19, greater than 30 days. 4. On 4-17-19 at 2:15 PM, the above findings were reviewed with the administrator, who verified the findings. The administrator stated HHAs are trained to use the HHA care plan for the delivery of services, and to confirm the patients' code status. The administrator stated the registered nurse should have completed the portion of the HHA care plan which identified patient #3's code status, and should have reviewed the HHA care plan at the time of supervisory visits to ensure code status was documented, and correctly identified the HHA had not followed the plan of care due to missed care visits. When queried for further explanation, information, or documentation, the administrator stated having		proper documentation of code status on HHA care plan and supervisory visits notes. 3.The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	nothing further to present for review.			
N 9999 Bldg. 00	Based on personnel file review and interview, the administrator failed to ensure the agency complied with the requirements of Indiana Code 16-27-2.5, in relation to evidence of completion of a negative 5 drug screen, upon hire and prior to first patient contact, for 3 (employees F, M, and TTT) of 3 active home health aides employed after 7-1-2017, who had provided direct patient care, of a total sample of 29 home health aide employed, and failed to ensure drug screening was completed with an unexpired drug test kit for 4 of 4 home health aides hired after 12-31-18, whose drug screening was reviewed, of a total sample of 29 home health aides employed. The findings included: 1. Review of agency records for home health aide F, evidenced a date of hire of 3-1-19, date of first patient contact of 3-4-19, and evidenced an urine drug screen result of negative, dated 3-1-19, not signed by the collector/tester. 2. Review of agency records for home health aide M, evidenced a date of hire of 10-30-17, date of first patient contact of 11-1-17, failed to evidence documentation of the completion of a urine drug screen upon hire and prior to patient contact. 3. Review of agency records for home health aide TTT, evidenced a date of hire of 3-28-19, date of first patient contact of 3-29-19, failed to evidence documentation of the completion of a urine drug screen upon hire and prior to patient contact.	N 9999	N9999 1.The Administrator has in-serviced the Director of nursing on Drug Testing Screening requirements of Indiana Code 16-27-2.5. Drug Testing using the 5-drug screen panel must be completed upon hire and prior to first patient contract. Check all expirations dates on the drug test prior to testing. Complete the drug testing form and sign, date, and file in the employees file. 2.All current CNA/HHA's employee files will be reviewed and those without a drug screen will immediately be drugged screened and proof of passing the drug screen will be placed in their employee medical file. Going forward, all CNA/HHA's will be drug tested upon hire and then 10% of all personnel records will be audited quarterly for evidence that the drug tests have been given and the drug testing form has been completed, signed, dated and filed. 3.The Administrator and Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	05/10/2019

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	4. Review of agency records for home health aide K, evidenced a date of hire of 3-28-19, date of first patient contact of 3-29-19, evidenced documentation of the completion of a urine drug screen upon hire with an expired test kit, i Cup, expiration date 12-31-18, Lot # DOA 7010465, by Alere Toxicology. 5. Review of agency records for home health aide L, evidenced a date of hire of 3-22-19, date of first patient contact of 3-31-19, evidenced documentation of the completion of a urine drug screen upon hire with an expired test kit, i Cup, expiration date 12-31-18, Lot # DOA 7010465, by Alere Toxicology. 6. Review of agency records for home health aide NNN, evidenced a date of hire of 4-8-19, date of first patient contact of 4-12-19, evidenced documentation of the completion of a urine drug screen upon hire with an expired test kit, i Cup, expiration date 12-31-18, Lot # DOA 7010465, by Alere Toxicology. 7. Review of agency records for home health aide RRR, evidenced a date of hire of 2-15-19, date of first patient contact of 2-23-19, evidenced documentation of the completion of a urine drug screen upon hire with an expired test kit, i Cup, expiration date 12-31-18, Lot # DOA 7010465, by Alere Toxicology. 8. During interview of the alternate administrator on 4-23-19 at 3:00 PM, the administrator stated the agency had not drug tested home health aides M and TTT, prior to patient assignment, and had provided direct patient care. The administrator stated for HHA, employee F, the documentation of a drug screen test was incomplete and therefore			

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	not reliable. For HHAs, employees K, L, NNN, and RRR, the administrator stated the drug screen was performed with expired kits, which were not reliable negative readings, and these HHAs had provided direct patient care. When queried for further information, explanation, or documentation, the administrator stated having nothing further to present for review.			