STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	300031340	A. BUILDING B. WING	04/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments POC accepted on 6-5-2022 by email and on 8-4-2022 in the Gateway Deborah Franco, RN This visit was for a revisit survey for State Re-licensure of a Medicaid Home Health Agency. Survey Dates: 4/12/22, 4/13/22, 4/14/22, 4/18/22, 4/19/22, and extended off-site to 4/21/22, for receipt of additional data. Census: 34 At this state re-licensure revisit survey 3 deficiencies were corrected (N 458, N 468, and N 9999), no state deficiencies were re-cited, and no new state deficiencies were identified. QR by Area 3 completed on 5-13-2022	N0000	G000 Golden Heart Health Services is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Golden Heart HealthServices that the findings and allegations contained herein are accurate andtrue representations of the quality of care and services provided to patientsof the Agency. Golden Heart Health Services desires this Plan of Correction tobe considered our Allegation of Compliance."	2022-06-25

			Golden Heart Health Services continues to utilize theservices of a nurse consultant.	
G0000	INITIAL COMMENTS This visit was for a Post-Condition Revisit (PCR) survey for Federal Recertification and State Re-licensure of a Medicaid Home Health Agency. On 4/14/22 at 4:10 PM, the administrator and the clinical manager were informed the survey was fully extended. On 4/21/22, the administrator was notified via phone that CMS form 1572 was inadvertently omitted during the entrance interview. The form was emailed to the administrator on 4/21/22 at 10:14 AM and returned completed at 3:50 PM. The administrator was informed the survey completion date was extended to 4/21/22 to allow for the completion of CMS form 1572. Survey Dates: 4/12/22, 4/13/22, 4/14/22, 4/18/22, 4/19/22, and 4/21/22. Golden Heart Health Services continued to be out of compliance with Conditions of Participation 42 CFR 484.55, Comprehensive Assessment of Patients and 42 CFR 484.105, Organization and Administration of Services. Condition-level deficiencies were identified during the November 19, 2021 survey, in which your agency was subject to a fully extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act. Condition-level deficiencies were also cited during your fully extended PCR survey on 4/12/22. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating or being the site of a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning November 19, 2021, and continuing through November 18, 2023. These deficiencies reflect State Findings cited	G0000	G000 Golden Heart Health Services is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Golden Heart HealthServices that the findings and allegations contained herein are accurate andtrue representations of the quality of care and services provided to patientsof the Agency. Golden Heart Health Services desires this Plan of Correction tobe considered our Allegation of Compliance.” Golden Heart Health Services continues to utilize theservices of a nurse consultant.	2022-06-25

	Form for State only deficiencies. QR by Area 3 completed on 5-13-2022			
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure patients received all services ordered on the plan of care for 5 (Patient 2, 1, 4, 12, and 14) of 12 patients whose clinical record was reviewed. The findings included: 1. A review of an undated agency policy C-140, titled "Admission Policy," indicated clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Agency in the client's place of residence, and Agency services must be appropriate and available to meet the specific needs and requests of the client and caregiver. 2. A review of the plan of care for Patient #2, for the certification period of 2/17/22 - 4/17/22, indicated orders for an RN (Registered Nurse) for supervision of the home health aide (hha) at least every 30 days and home health aide services 6 hours/day x 7 x/week x 9 weeks to assist with bathing, meal preparation, and light housekeeping. A review of the certification period for 2/17/22 - 4/17/22 evidenced Patient 2 received services for 2 days/week during week 1 and 5	G0436	G0436 Agency is unable to correct the issue of patients notreceiving ordered frequencies as the dates have already passed. Director of Nursing/Administrator/designe e will reviewpatient schedules every Monday to ensure visit frequency on schedule matchesdiscipline frequency on 485. This will be done for one month (Completion date 6/25/22).After one month 10% of schedules will be compared to ordered frequencies weeklyto ensure compliance is maintained. (On-going) Director of Nursing/Administrator/designe e will compare allvisit notes submitted weekly to the patient schedule to ensure orderedfrequency was followed. There needs to be a visit note or missed visit note.Once 100% compliance is achieved 10% will be audited quarterly to	2022-06-25

	to receive all the care visits ordered in the plan of care of 6 hours/day x 7x/week. 3. Review of the clinical record of Patient #1, indicated a start of care date of 3-24-21. The record contained a plan of care for the recertification period from 1-18-22 to 3-18-22. The plan of care orders included registered nurse (RN) for Supervisory visits of the home health aide (HHA) at least every 4 weeks for 9 weeks. HHA 6-12 hours a day, 5-7 times a week, for 9 weeks to assist with Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs) per the HHA care plan. A review of the HHA care plan, not updated since 11-05-21, evidenced the HHA had duties of ADLs and IADs, to include bathing, oral care, safety, and meal preparation. A review of HHA visit notes failed to evidence HHA services had been furnished on (3-21, 3-24, 3-27, 3-28, 3-30, 3-31, 4-4, 4-5, 4-7, and 4-11-22) of the certification period, as required by the plan of care orders. During an interview on 4-13-22, at 12:28 PM, the clinical manager, when queried about patient #1 s missed visits stated, "I did not know I needed to notify the physician (MD) about missed visits. We have been searching for a replacement HHA for the patient. During a home visit at Patient #1 s on 4-13-22, at 8:00 AM, a family member, Person A, confirmed Patient #1 cannot be left alone due to safety concerns related to right leg below the knee amputation. Person A confirmed they stay with Patient 1 Monday thru Friday and Employee E, a Certified Nursing Assistant, is assigned to stay there on the weekends.		ensurecompliance is maintained. (On-going) Director of Nursing/Administrator/designe e will audit aidecare plans for all current patients. Care plans will be reviewed atrecertification or supervisory visit (whichever comes first), revised as neededand signed/dated to indicate reviewed/revised. (Complete by 6/25/22) Once all current patient aide care plans are reviewed 10% ofaide care plans will be reviewed quarterly by Administrator/Director ofNursing/designee to ensure they are reviewed at least every 60 days (recertificationtime) and as needed and revised as needed. (On-going) Administrator will speak with Director of Nursing at theAssisted Living Facility, referenced in survey, weekly for 4 weeks to ensurethere are no concerns regarding services provided by Golden Heart. (CompletionDate 6/25/22). After the 4 weeks Administrator will speak with Director ofNursing at Assisted Living Facility	

	4. A review of the clinical record of Patient #4, indicated a start of care date of 1-24-21. The record contained a plan of care for the recertification period from 1-19-22 to 3-19-22. The plan of care indicated orders for a Skilled Nurse (SN) visit at least every 4 weeks for 9 weeks to supervise the HHA. HHA visits were ordered1 hour a day, 5 times a week, for 9 weeks to assist with ADLs/IADLs per the HHA care plan. A review of HHA visit notes failed to evidence HHA services had been furnished on (2-18, 3-4, 3-8, 3-11, and 3-17-22) of the certification period, as required by the plan of care orders. The clinical record contained a plan of care for the recertification period from 3-20-22 to 5-18-22. HHA visits were ordered 1 hour a day, 5 times a week, for 9 weeks to assist with personal care, light housekeeping, and meal prep. A review of the HHA care plan, not updated since 9-20-21, evidenced the HHA had duties of temperature each visit, assistance each visit with hair care, shampoo per patient request, skin care, mouth/denture care, foot care may file only, nail care may file only, dressing, light laundry, bed linen change, make the bed, light housekeeping, dust, sweep, vacuum, take the trash out, prepare a meal, personal care per patient request, shower per patient request, sponge bath up in chair per patient request, and assist with ambulation walker and scooter. A review of HHA visit notes failed to evidence HHA services had been furnished on (3-21, 3-22, 3-23 3-25, 3-28, 3-29, 3-31, 4-4, 4-6, 4-7, 4-11) of the certification period, as required by the plan of care orders. During an interview with Patient #4 on 4-13-22, at 2:16 PM, Patient #4 indicated not having HHA care visits as ordered and their assigned HHA had been sick and did not go to the one day of training in Indianapolis, and the aide was terminated. Patient #4 indicated not being able to bathe without assistance, not having help with safe transfers, being too weak to prepare their meals, and needing HHA care visits to help them. During an interview on 4-13-22, at 3:15 PM,		concerns. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

services, the administrator indicated knowing the agency was supposed to furnish ordered care visits or find another agency who can.

5. A review of the clinical record of Patient #12, indicated a start of care date of 2-5-21. The record contained a plan of care for the recertification period from 1-31-22 to 3-31-22. HHA visits were ordered 1 hour a day, 5 times a week, for 9 weeks to assist with bathing, meal prep, and light housekeeping.

A review of the HHA care plan, not updated since 12-2-21, evidenced the HHA had duties of temperature each visit, assistance each visit with hair care, shampoo weekly, skin care, mouth/denture care, foot care, nail care, dressing, light laundry weekly, bed linen change weekly, make the bed, light housekeeping, dust, sweep, vacuum, take the trash out weekly, prepare a meal encourage fluids, personal care per patient request, shower per patient request, and sponge bath up in chair per patient request.

A review of HHA visit notes failed to evidence HHA services had been furnished on (2-22, 3-4, 3-8, 3-11, 3-14, 3-17, 3-21, 3-23, 3-24, 3-25, 3-28, 3-29-22) of the certification period, as required by the plan of care orders.

During an interview on 4-18-22 at 2:18 PM, the director of nursing, Person D, at Entity C, an assisted living facility (ALF), confirmed Patient #12 had mental health concerns and needed a bath every day due to hygiene concerns and would never refuse care visits. Person D further confirmed there have been concerns about Golden Heart Health Services not having provided care visits as ordered for patients who live in the ALF.

6. A review of the clinical record of Patient #14, indicated a start of care date of 4-27-21. The record contained a plan of care for the recertification period from 2-21-22 to 4-21-22. HHA visits were ordered 3 hours a day, 3 times a week, for 9 weeks to assist with bathing, meal prep, and light housekeeping.

A review of HHA visit notes failed to evidence HHA services had been furnished on (2-28, 3-9, 3-11, 3-14, 3-23-22) of the certification period, as required by the plan of care orders.

During an interview on 4-19-22 at 10:30 AM, a

	family member, Person Y, confirmed Patient #14 needed bathing, dressing, and personal care assistance because the home health aide visits allowed Person Y to complete chores around the house and obtain groceries as Patient 14 was unable to be left alone due to forgetfulness and risk for falls.			
G0440	Payment from federally funded programs 484.50(c)(7)(i, ii, iii, iv) Be advised, orally and in writing, of- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f). Based on record review and interview, the agency failed to advise the patient and/or patient representative orally and in writing in advance of starting services of the extent to which planned services would be covered by Medicaid or any other federally funded program; the charges for services not covered by Medicaid, or any other federally funded program; and any expected charges that must be paid prior to	G0440	G440 Administrator/Director of Nursing will instruct nurses theAdmission Service Agreement must be completed to include the extent to whichplanned services would be covered by Medicaid or any other Federally fundedprogram and the patient's out-of-pocket costs and services to be provided. Thiswas done on 04-26-2022. Director of Nursing/designee will audit all admissions doneweekly to ensure the Admission Service Agreement is completed correctly. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) Director of Nursing will instruct nurses they must leave theadmission packet with completed paperwork with patient and document folder wasleft in home. Nurse will	2022-06-22

	the initiation of care for 5 of 8 active patients reviewed (Patients #1, 2, 4, 12, and 13) and 4 of 4 patients reviewed whose services were on hold. (Patients #3, 8, 9, 10.) Findings Include: 1. A review of undated agency policy C-160, titled Service Agreement, evidenced A Service Agreement shall be developed with all clients upon admission before care is provided. The service agreement will identify the services to be provided, disciplines providing care, charges, and expected sources of reimbursement for services. The client will be informed of their liability for payment." 2. A review of the clinical record for Patient #2, start of care 2/22/21, evidenced a service agreement signed by the patient in the section for POA (Power of Attorney)/Representative. The document failed to evidence the extent to which services would be covered by Medicaid, any charges not covered by Medicaid, and liability, if any, for payment prior to the initiation of care. During a home visit for Patient #2, on 4/13/22 at 1:30 PM, the agency folder and admission information were reviewed and indicated an unsigned, 2-page document titled "Home Health Service Agreement." The service agreement failed to evidence the extent to which services would be covered by Medicaid, any charges not covered by Medicaid, and/or any liability for payment prior to the initiation of care. The clinical manager (Employee B), who was present during the home visit, was interviewed as to whether the document was completed, and confirmed it was blank. 3. A review of the clinical record for Patient #3, start of care 4/8/22, failed to evidence a service agreement or other documentation which indicated the extent to which services		document patient was verbally informed of what was inthe packet including which planned services would be covered by Medicaid or anyother Federally funded program and the patient's out-of-pocket costs andservices to be provided. This was done on 04-26-2022. Director of Nursing/designee will audit all admissions doneweekly to ensure there is documentation admission packet was let in home andpatient was verbally informed of which planned services would be covered byMedicaid or any other Federally funded program and the patient's out-of-pocketcosts and services to be provided. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Administrator/Director of Nursing will ensure all currentpatients receive an updated home folder that contains a completed ServiceAgreement which includes the extent to which planned services would be coveredby Medicaid or any other Federally funded program	

	would be covered by Medicaid, any charges not covered by Medicaid, and/or any liability for payment prior to the initiation of care. 4. A review of the clinical record for Patient #8, start of care 1/5/21, failed to evidence a service agreement or other documentation which indicated the extent to which services would be covered by Medicaid, any charges not covered by Medicaid, and/or any liability for payment prior to the initiation of care. 5. A review of the clinical record for Patient #9, start of care 12/22/20, failed to evidence a service agreement or other documentation which indicated the extent to which services would be covered by Medicaid, any charges not covered by Medicaid, and/or any liability for payment prior to the initiation of care. 6. During a home visit at Patient #1 s home on 4-13-22 at 8:00 AM, the patient's agency folder contained the agency service agreement and the cost of services was blank and not signed by the clinician or patient. The clinical manager, Employee C, also confirmed the patient s admission packet contained an agency document titled, Home Health Admission Service Agreement that was not completed and/or signed by the clinician or patient. A review of the clinical record of Patient #1, with the start of care date of 3-24-21, failed to evidence a service agreement and failed to evidence the patient was advised in writing of the extent to which planned services would be covered by Medicaid or any other federally funded program, and the patient's out of pocket costs. During an interview on 4-13-22 at 10:57 AM, when queried about Patient #1 s service agreement for admission on 3-24-21, the administrator, Employee B, provided a blank agency document titled, Home Health Admission Service Agreement that was not completed and/or signed by the clinician or patient. The administrated stated, This is part of the survey I don t like. I don t want to give		and the patient'sout-of-pocket costs and services to be provided. This will be done by June 22,2022. Administrator/Director of Nursing will audit all currentpatient charts weekly to ensure there is an accurately completed AdmissionService Agreement and documentation form was reviewed with patient and copyplaced in home folder. This will continue until 100% of current patients havecompleted form and documentation in chart. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

these to you.

7. A review of the clinical record of Patient #4, with a start of care date of 1-24-21, failed to evidence a service agreement and failed to evidence the patient was advised in writing of the extent to which planned services would be covered by Medicaid or any other federally funded program, and the patient's out of pocket costs.

During an interview on 4-18-22 at 11:26 AM, when queried about Patient #4 s service agreement for admission on 1-24-21, the administrator, Employee B, provided a blank agency document titled, Home Health Admission Service Agreement that was not completed and/or signed by the clinician or patient. The administrated stated, This one is blank too. I am sorry. I wish I had more.

8. A review of the clinical record of Patient #10, with a start of care date of 2-7-19, failed to evidence a service agreement and failed to evidence the patient was advised in writing of the extent to which planned services would be covered by Medicaid or any other federally funded program, and the patient's out of pocket costs.

During an interview on 4-18-22 at 9:58 AM, when queried about Patient #10 s service agreement for admission on 2-7-19, the administrator, Employee B, provided an agency document dated 1-14-22, titled, Home Health Admission Service Agreement. The Home Health Admission Service Agreement contained the patient s signature only and was not completed. The administrated stated, This one is not completed either.

9. A review of the clinical record of Patient #12, with a start of care date of 2-5-21, failed to evidence a service agreement and failed to evidence the patient was advised in writing of the extent to which planned services would be covered by Medicaid or any other federally funded program, and the patient's out of pocket costs.

During an interview on 4-18-22 at 9:58 AM,

	agreement for admission on 2-5-21, the administrator, Employee B, provided an agency document dated 1-12-22, titled, Home Health Admission Service Agreement. The Home Health Admission Service Agreement contained the patient s signature only and was not completed. The administrated stated, This one is not completed either. 10. A review of the clinical record of Patient #13, with a start of care date of 8-5-20, failed to evidence a service agreement and failed to evidence the patient was advised in writing of the extent to which planned services would be covered by Medicaid or any other federally funded program, and the patient's out of pocket costs. During an interview on 4-18-22 at 11:26 AM, when queried about Patient #13 s service agreement for admission on 8-5-20, the administrator, Employee B, provided a blank agency document titled, Home Health Admission Service Agreement that was not completed and/or signed by the clinician or patient. The administrated stated, This one is blank too. I am sorry. I wish I had more.			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on record review and interview, the agency failed to ensure all patients received an in-person complete and accurate comprehensive assessment which	G0510	G510 See G528, G530, G534, G536, G546, G548, G550 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-06-17

	included the patients current health status, past/current medical history, and accurate psychosocial			

	status, functional capacity, and cognitive status (See G 528;) failed to ensure all patients received an			

	in-person complete and accurate comprehensive assessment which included the patients strengths,			

	care preferences, and evidence of patient-specific goals or progress toward previous goals (See G 530;)			

	failed to ensure a complete and accurate assessment of the patient s medical, nursing, rehabilitative,			

	social, and discharge planning needs was completed (See G 534;) failed to evidence a registered			

	nurse reconciled all medications with the patient, health care representative, outside agencies,			

	and ordering physicians (See G 536;) failed to ensure a recertification comprehensive			

	assessment was conducted during the last 5 days of every 60 days (See G 546;) failed to ensure all			

	patients received a complete and accurate comprehensive assessment within 48 hours of			

	returning home after hospital admission (See G 548;) and failed to ensure discharged patients			

	received an updated comprehensive assessment that included a summary of the patient's			

	progress in meeting the care plan goals (See G 550.) These deficient practices have the potential to affect all patients who are currently receiving home health services from this provider. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality health care, thus being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment. 1. The agency failed to ensure that all patients			

	comprehensive assessment which would include the patients' current health status, past/ current medical history, accurate psychosocial status, functional capacity, and accurate cognitive status. (See G528) 2. The agency failed to ensure a complete and accurate assessment of the patient's strengths, goals, and care preferences. (See G530) 3. The agency failed to ensure a complete and accurate assessment of the patient's medical, nursing, rehabilitative, social, and discharge planning needs. (See G534) 4. The agency failed to ensure a registered nurse reconciled all medications, including prescription and over-the-counter medications. (G536) 5. The agency failed to ensure the comprehensive assessment was completed within the last 5 days of the certification period, including day 60. (See G546) 6. The agency failed to ensure an assessment was completed within 48hours of the patient's return from a hospital admission. (See G548) 7. The agency failed to ensure an assessment was completed at discharge. (See G550)			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to	G0528	G528 Agency is unable to correct assessments cited in survey as thoseassessments occurred several months ago. Administrator/Director of	2022-04-22

	ensure that all patients received an in-person complete and accurate comprehensive assessment which included the patients current health status, past/current medical history, and accurate psychosocial status, functional capacity, and cognitive status in 3 of 8 active records reviewed (Patients #4, 11, 12) and 3 of 4 records reviewed for patients on hold.(Patients #8, 9, 10) Findings Include: 1. A review of an undated agency policy C-145, titled "Comprehensive Client Assessment," indicated the comprehensive assessment must accurately reflect the client's current health, psychosocial, functional, and cognitive status. 2. On 4/18/22 at 3:11 PM, the surveyor attempted to view the current comprehensive assessment for Patient #8 via the EMR (Electronic Medical Record) and was unable to locate the document. Further review of the electronic medical record indicated the most recent comprehensive assessment was dated 12/29/22. The record failed to evidence the patient received a comprehensive recertification assessment every 60 days that reflected the patient's current health, psychosocial, functional, and cognitive status. On 4/18/22 at 3:30 PM, the clinical manager was asked to print the patient's comprehensive assessment for the current certification period of 3/1/22 - 4/29/22. On 4/19/22 at 3 PM, the clinical manager provided a skilled nursing visit note, dated 2/24/22, which indicated the visit type was "supervisory." The clinical manager had no further information for Patient #8. 3. A review of the clinical record for Patient #9, start of care 12/20/20, evidenced missed visits due to hospitalization on 2/4/22 and 2/5/22, but failed to evidence a comprehensive assessment was completed that reflected the		Nursing will instruct nurses thatcomprehensive re-assessments must be done in person. This was done on April 22,2022 Director of Nursing will instruct nurses the comprehensiveassessment must include patient's complete current and past health,psychosocial, functional, and mental status and be head to toe. This includesupdating diagnosis dates, caregiver status, etc. This was done on April 22,2022 Director of Nursing/designee will audit all comprehensiveassessments done weekly to ensure they are complete and include complete headto toe, current and past health, psychosocial, functional, and mental status.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) Director of Nursing/Administrator will review scheduleweekly for previous week to ensure if patient was due for recertification thereis a	

	functional, and cognitive information after the patient's hospitalization. On 4/18/22 at 3:16 PM, Person HH, the representative for Patient #9, was interviewed and confirmed the patient was hospitalized in April but declined to discuss the details. 4. A review of the clinical record of Patient #1, the start of care date of 3-24-21, for the recertification period from 3-19-22 to 5-17-22. The clinical record contained an agency document dated 3/16/22, that was titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Family Support the patient had a granddaughter who worked full time for support. The section failed to list the primary son who stays there throughout the week. The section titled, Diagnosis indicated the diagnoses of; Acquired absence of right leg above the knee, Essential hypertension, Dysphagia following cerebral infarction, Chronic obstructive pulmonary disease with an acute respiratory infection, and Urge incontinence with onset dates all listed as 10-21-2000. The comprehensive assessment indicated under respiratory status the patient was a smoker for 60 years and their lung sounds were clear. The record failed to evidence the patient s complete current and past health not updating diagnosis dates of onset, psychosocial reflecting depression and wife just passing, functional, and mental status. During an interview on 4-13-22 at 8:00 AM, with family members, Person A, and Employee H confirmed Patient #1 s wife passed away in February and they were worried about Patient #1 now. 5. A review of the clinical record of Patient #4, the start of care date of 1-24-21, for the recertification period from 1-19-22 to 3-19-22. The clinical record contained an agency document dated 1/14/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated, under the section titled, Elimination Status the visit was via a telehealth visit. The record failed to evidence the patient s complete current and		completed comprehensive assessment. (On-going) Director of Nursing will instruct nurses that when apatient, who has been on hold due to hospitalization, is released from hospitala comprehensive assessment must be done that reflects the patient's updatedhealth, psychosocial, functional, and cognitive information after thehospitalization. This was done on April 22, 2022. Director of Nursing will audit all resumptions of care doneweekly to ensure there is comprehensive assessment done and it accuratelyreflects the patient’s updated health, psychosocial, functional, and cognitiveinformation. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

past health, psychosocial, functional, and mental status.

6. A review of the clinical record of Patient #10, the start of care date of 2-7-19, for the recertification period from 1-22-22 to 3-22-22. The clinical record contained an agency document dated 1/17/22, that was titled, Skilled Nursing Visit Note. The skilled nursing visit note indicated the type of visit was a telehealth visit.

Review of an agency document dated 1/17/22, titled, Assessment Details, indicated recertification (follow up) reassessment via telehealth. The record failed to evidence the patient s complete current and past health, psychosocial, functional, and mental status.

7. A review of the clinical record of Patient #11, the start of care date of 12-29-20, for the recertification period from 2-22-22 to 4-22-22. The clinical record contained an agency document dated 3/15/22, that was titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Elimination Status the visit was a telehealth visit. The record failed to evidence the patient s complete current and past health, psychosocial, functional, and mental status.

8. A review of the clinical record of Patient #12, the start of care date of 2-5-21, for the recertification period from 1-31-22 to 3-31-22. The clinical record contained an agency document dated 2/27/22, that was titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Vision visit was completed via telehealth. The record failed to evidence the patient s complete current and past health, psychosocial, functional, and mental status.

During an interview on 4-13-22, at 3:36 PM, the administrator confirmed telehealth visits had been prohibited at the agency since November 2021, and the nurses had been instructed only in-person visits were to occur.

410 IAC 17-14-1(a)(1)(B)

G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure all patients received an in-person complete and accurate comprehensive assessment which included the patients strengths, care preferences, and evidence of patient-specific goals or progress toward previous goals in 4 of 8 active records reviewed (Patient #2, 4, 11, 12) and 4 of 4 records reviewed for patients on hold. (Patients #3, 8, 9, 10) Findings Include: 1. A review of undated agency policy, titled "Comprehensive Client Assessment," indicated "The Comprehensive Assessment must accurately reflect the client's status, and must include at a minimum ... The client's strengths, goals, and care preferences, including information that may be used to demonstrate the client's progress toward achievement of the goals identified by the client and the measurable outcomes identified by the agency. [The] Intent is to engage the client to take an active role in their home care." The policy indicated that the depth and frequency of ongoing assessments would be done at least once every sixty-day period. 2. A review of undated agency policy C-155, titled "Client Reassessment/Update of	G0530	G530 Agency unable to correct issues cited in survey as thosevisits as those assessments occurred several months ago. Director of Nursing will instruct nurses the comprehensiveassessment must include patient strengths, patient-specific care preferences,and goals that are patient-specific and measurable. Must document if there isprogress towards goals. April22, 2022 Director of Nursing will audit all comprehensive assessmentsdone weekly to ensure they include patient strengths, patient-specific carepreferences, and goals that are patient-specific and measurable and is theredocumentation regarding progress towards goals. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Administrator/Director of Nursing will instruct nurses thatcomprehensive	2022-04-22

	reassessments must be done every second calendar month beginning with the start of care (within the last five days of the episode), and within forty-eight hours of, or knowledge of, the client's return home from a hospital admission of more than 24 hours. 3. A review of the comprehensive assessment for Patient #2, dated 2/12/22, evidenced goals of: "Patient Patient will remain safe at home during plan of care; Patient/caregiver will be knowledgeable of s/sx (signs and symptoms) of angina and initiation of appropriate interventions within cert (certification) period; Patient/caregiver will verbalize understanding of measures to alleviate pain and factors that increase pain within cert period; Patient's integumentary status will improve as evidenced by no new wound formation during plan of care; Patient will be well hydrated within cert period; Patient/caregiver will be knowledgeable about signs and symptoms of UTI (Urinary Tract Infection) and appropriate actions to take within cert period; Patient/caregiver will be knowledgeable of nutritional and fluid regimen within cert period; Patient/caregiver will verbalize understanding about signs and symptoms of hypo/hyperglycemia and appropriate actions to take; Patient/caregiver will verbalize and demonstrate safe ambulation and transfer technique within cert period; Patient will be safe in their home setting with personal care assistance as evidenced by no injuries/fall during plan of care; Patient's personal hygiene needs will be met with the assistance of the home health aide during plan of care; and Patient/caregiver will verbalize understanding of safety and emergency interventions within cert period. The patient's goal was to be more independent with ADLs (Activities of Daily Living). The patient's strength was "to become more involved in care." The assessment indicated the patient lived alone, had no caregiver, and would benefit from the assistance of an hha (home health aide) up to 2-6 hours, 2 - 7 days/week x 9 weeks to help with meal preparation, bathing, dressing, and light housekeeping duties. The		re-assessments must be done in person. This was done byApril 22, 2022 Director of Nursing will instruct nurses that when apatient, who has been on hold due to hospitalization, is released from hospitala comprehensive assessment must be done that reflects the patient's updatedstrengths, patient-specific care preferences, and goals that arepatient-specific and measurable. Thiswas done on April 22, 2022 Director of Nursing will audit all resumptions of care doneweekly to ensure there is comprehensive assessment done and it accuratelyreflects the patient’s updated patient strengths, patient-specific carepreferences, and goals that are patient-specific and measurable. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is	

	were ordered to provide education for the patient and/or caregiver on measures needed for safety, skin, UTI symptoms and interventions, emergency interventions, nutrition and hydration regimen, measures to alleviate pain, hypo/hyperglycemia and appropriate actions to take for each, and observation of the patient and/or caregiver's demonstration of safe ambulation and transfer; failed to evidence how the goals of a home health aide 2-6 hours, 2-7 days/week would keep the patient safe and free of falls 24h/d x 7d/wk; failed to evidence the use of a caregiver in the patient's goals for a patient with no caregiver; and failed to evidence the time frame for "cert period" and for "during plan of care." The assessment failed to evidence documentation that the patient was asked about specific care preferences, failed to evidence documentation of the patient's strengths, failed to evidence documentation of progress made toward previous goals, and failed to evidence patient-specific and measurable goals pertinent to the patient's needs and ordered care. 4. A review of the comprehensive assessment for Patient #3, dated 4/8/22, evidenced goals of: "Patient will remain safe at home during plan of care; Patient/caregiver will be knowledgeable of s/sx (signs and symptoms) of angina and initiation of appropriate interventions within cert (certification) period; Patient/caregiver will verbalize understanding of measures to alleviate pain and factors that increase pain within cert period; Patient's integumentary status will improve as evidenced by no new wound formation during plan of care; Patient will be well hydrated within cert period; Patient/caregiver will be knowledgeable about signs and symptoms of UTI and appropriate actions to take within cert period; Patient/caregiver will be knowledgeable of nutritional and fluid regimen within cert period; Patient/caregiver will verbalize understanding about signs and symptoms of hypo/hyperglycemia and appropriate actions to take; Patient/caregiver will verbalize and demonstrate safe ambulation and transfer technique within cert period; Patient/caregiver will verbalize		corrected and will notrecur.	

compliance with safety needs within cert period; Patient's personal hygiene needs will be met with the assistance of the home health aide during plan of care; Patient/caregiver will verbalize understanding of safety and emergency interventions within cert period.

The comprehensive assessment indicated the patient would benefit from hha services for 1 hour/day x 5 days/week to help with bathing and light housekeeping. The assessment failed to evidence skilled services were ordered to provide education for the patient and/or caregiver on measures needed to achieve the goals for safety, skin, emergency interventions, nutrition and hydration regimen, measures to alleviate pain, UTI, hypo/hyperglycemia, and appropriate actions to take, and observation of the patient and/or caregiver's demonstration of safe ambulation and transfer; failed to evidence how the presence of the home health aide for 1 hour/day x 5 days/week would keep the patient safe and free of falls 24 hours/day x 7 days/week; failed to evidence the measurable time frame for "cert period" and for "during plan of care." The assessment failed to evidence documentation that the patient was asked about specific care preferences, failed to evidence documentation of the patient's strengths, failed to evidence documentation of progress toward previous goals, and failed to evidence patient-specific and measurable goals pertinent to the patient's needs and ordered care.

5. A review of the clinical record for Patient #8 evidenced the most recent comprehensive assessment was dated 12/29/21. The record failed to evidence the patient received a comprehensive recertification assessment that included the patient's strengths, goals, care preferences, and progress toward previous goals for the current certification period of 3/1/22 - 4/29/22.

On 4/18/22 at 3:30 PM, the clinical manager was asked to print the patient's comprehensive assessment for the current certification period of 3/1/22 - 4/29/22. On 4/19/22 at 3 PM, the clinical manager provided a skilled nursing visit

type was "supervisory." The clinical manager had no further information for Patient #8.

6. A review of the clinical record for Patient #9, start of care 12/20/20, evidenced the patient was hospitalized on 2/4/22 and 2/5/22, but failed to evidence an updated comprehensive assessment was completed post-hospitalization that included strengths, goals, care preferences, and progress toward previous goals.

On 4/18/22 at 3:16 PM, Person HH, the representative for Patient #9, was interviewed and confirmed the patient was hospitalized in April but declined to discuss the details.

7. A review of the clinical record of Patient #4, the start of care date of 1-24-21, for the recertification period from 1-19-22 to 3-19-22. The clinical record contained an agency document dated 1/14/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated, that under the section titled, Elimination Status, the visit was via a telehealth visit. The record failed to evidence documentation of the patient s strengths, care preferences, and documentation of evidence of patient-specific goals or progress toward previous goals.

A review of the clinical record of Patient #10, the start of care date of 2-7-19, for the recertification period from 1-22-22 to 3-22-22. The clinical record contained an agency document dated 1/17/22, that was titled, Skilled Nursing Visit Note. The skilled nursing visit note indicated the type of visit was a telehealth visit.

Review of an agency document dated 1/17/22, titled, Assessment Details, indicated recertification (follow up) reassessment via telehealth. The record failed to evidence documentation of the patient s strengths, care preferences, and documentation of of patient-specific goals or progress toward previous goals.

8. A review of the clinical record of Patient #11, the start of care date of 12-29-20, for the

	recertification period from 2-22-22 to 4-22-22. The clinical record contained an agency document dated 3/15/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Elimination Status, the visit was a telehealth visit. The record failed to evidence documentation of the patient s strengths, care preferences, and documentation of patient-specific goals or progress toward previous goals. 9. A review of the clinical record of Patient #12, the start of care date of 2-5-21, for the recertification period from 1-31-22 to 3-31-22. The clinical record contained an agency document dated 2/27/22, that was titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Vision visit was completed via telehealth. The record failed to evidence documentation of the patient s strengths, care preferences, and documentation of patient-specific goals or progress toward previous goals. During an interview on 4-13-22, at 3:36 PM, the administrator, confirmed the nursing staff had been instructed there were to be no more telehealth visits effective November 2021, and the agency nurses were instructed the agency only permitted in-person visits and in-person visits and assessments.			
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the agency failed to ensure a complete and accurate assessment which documented the patient s medical, nursing, rehabilitative, social, and discharge	G0534	G534 Agency unable to correct issues cited in survey as thosevisits as those assessments occurred several months ago. Director of Nursing will instruct nurses the comprehensiveassessment must include patient -centered goals, needs and how needs are	2022-04-22

planning needs was completed for 3 of 8 active records reviewed (Patients #2, 11, 12) and 3 of 4 records reviewed for patients on hold. (Patients #3, 8, and 9)

Findings Include:

1. A review of undated agency policy C-145, titled Client Comprehensive Assessment," indicated the comprehensive assessment must accurately reflect the client's status and must include the client's medical, nursing, rehabilitative, and discharge planning needs.

2. A review of the comprehensive assessment for Patient #2, dated 2/12/22, indicated the patient lived alone, was dependent upon supportive devices, used a walker and wheelchair, was at high risk for hospitalization, was unsafe to leave home unassisted, had shortness of breath on exertion, and was a smoker. The assessment indicated the patient would benefit from home health aide services 2-6 hours/day x 2-7 days /week x 9 weeks to help with meal preparation, bathing, dressing, and light housekeeping. Discharge plans indicated "When patient-centered goals are met." The comprehensive assessment failed to evidence documentation of patient-centered goals, failed to evidence the patient's needs, including but not limited to, medication management, smoking cessation and safety, fall prevention, socialization, disease management, and hospitalization prevention, and failed to indicate how the patient's needs such as hygiene, dressing, meals, medication, and socialization, were met during the hours the aide was not present.

3. A review of the comprehensive assessment for Patient #3, dated 4/8/22, evidenced the patient reported frequent falls, used a walker and wheelchair, had chronic pain, had poor endurance with shortness of breath (SOB), and

metwhen agency staff not present. Must document if there is progress towardsgoals. This was done on April 22, 2022.

Director of Nursing will audit all comprehensive assessmentsdone weekly to ensure they include patient -centered goals, needs and how needsare met when agency staff not present. Once 100% compliance is achieved 10%will be audited quarterly to ensure compliance is maintained. (On-going)

Administrator/Director of Nursing will instruct nurses thatcomprehensive re-assessments must be done in person. This was done on April 22,2022.

Director of Nursing will instruct nurses that when apatient, who has been on hold due to hospitalization, is released from hospitala comprehensive assessment must be done that reflects the patient's updatedstrengths, patient-specific care preferences, and goals that arepatient-specific and measurable. This was done on April 22, 2022.

	indicated "When patient-centered goals are met," but failed to evidence documentation of patient-centered goals or the patient's needs, including but not limited to, medication management, fall prevention, meals, socialization, finances, and pain management. The summary indicated the patient would benefit from home health aide services for 1 hour/day x 5 days per week for bathing and light housekeeping but failed to indicate how the patient's needs were met during the hours the aide was not present. 4. A review of the clinical record for Patient #8 indicated a comprehensive assessment dated 12/29/22. The record failed to evidence the patient received an updated comprehensive recertification assessment for the certification period of 3/1/22 - 4/29/22. On 4/18/22 at 3:30 PM, the clinical manager was asked to print the Patient 8's comprehensive assessment for the current certification period of 3/1/22 - 4/29/22. On 4/19/22 at 3 PM, the clinical manager provided a skilled nurse visit note dated 2/24/22, and indicated there was no further information for Patient #8. 4. A review of the clinical record for Patient #9, start of care 12/20/20, evidenced the patient was hospitalized on 2/4/22 and 2/5/22, and services resumed on 2/28/22. The record failed to evidence an updated comprehensive assessment was completed post-hospitalization. On 4/18/22 at 3:16 PM, Person HH, the representative for Patient #9, was interviewed and confirmed Patient 9 was hospitalized in April. 6. A review of the clinical record of Patient #11, the start of care date of 12-29-20, for the recertification period from 2-22-22 to 4-22-22.		Director of Nursing will audit all resumptions of care doneweekly to ensure there is comprehensive assessment done and it accuratelyreflects the patient’s updated patient strengths, patient-specific carepreferences, and goals that are patient-specific and measurable. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	document dated 3/15/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Elimination Status the visit was a telehealth visit. The record failed to evidence the patient received an in-person recertification assessment that included the patient s medical, nursing, rehabilitative, social, and discharge planning needs. During an interview on 4-19-22 at 10:07 AM, Patient #11 indicated the nurse comes every once in a while, but could not give the date of the last visit. 7. A review of the clinical record of Patient #12, the start of care date of 2-5-21, for the recertification period from 1-31-22 to 3-31-22. The clinical record contained an agency document dated 2/27/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Vision visit was completed via telehealth. The record failed to evidence the patient received an in-person recertification assessment that included the patient s medical, nursing, rehabilitative, social, and discharge planning needs. During an interview on 4-13-22 at 3:36 PM, the administrator confirmed there were to be no more telehealth visits effective November 2021 and that the nurses were instructed on only in-person visits were to occur. 410 IAC 17-14-1(a)(1)(B)			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.	G0536	G536 Director of Nursing/Administrator will instruct nurses that allvisits must be done in person. This was done on April22, 2022. Director of Nursing will in-service nurses on need	2022-06-22

	Based on record review and interview, the agency failed to evidence a registered nurse reconciled all medications with the patient, health care representative, outside agencies, and ordering physicians in 7 of 8 active records reviewed (Patient #2, 4, 11, 12, 13, 14, 15) and 4 of 4 records reviewed for patients on hold. (Patients #3, 8, 9, and 10) Findings Include: 1. A review of undated agency policy C-145, titled "Comprehensive Client Assessment," indicated the assessment must include "A review of all medications the client is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and noncompliciance with drug therapy... " 2. A review of an undated agency policy C-709, titled "Medication Reconciliation," indicated "At the time of admission to the home care agency, the admitting professional will document a complete list of medications taken by the client prior to admission. This will include all over-the-counter [sic], prescribed, and PRN (as needed) medications ... The admission professional will review this medication list with the physician/allowed non-physician practitioner (NNP) and confirm those medications that are to be continued or discontinued. The doses will be confirmed with the physician ... and changes will be noted in the record and on the Plan of Care ... If the client continues to receive home care after the first 60 days, the clinician doing the reassessment will again review all medications." 3. A review of the comprehensive assessment for Patient #2, dated 2/12/22, failed to evidence documentation the patient's medications were reconciled and reviewed as		todocument at admission, resumption, recertification and anytime there is achange in medication that medications were reviewed and reconciliation wasdone. This is to be documented. This was done on April 22, 2022. Director of Nursing will audit all assessments (admission,recertification, resumption) submitted weekly to ensure there is documentationmedications were reviewed and reconciled. All visit notes submitted weekly willbe audited to ensure if there is mention of a medication change there isdocumentation a review was done and medications were reconciled. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) Director of Nursing/designee will audit all medicationprofiles of current patients to ensure they have been updated and signed/datedby an RN. This will be done by June 22, 2022. Director of Nursing/designee will ensure all currentpatients are given an updated	

	part of the comprehensive assessment. During a home visit on 4/14/22 at 9:30 AM, Patient 2 indicated all active medications were located in a basket on a table in the living room. A review of the medications in the basket vs the medication profile on the agency plan of care revealed Patient 2 had medications in the home not listed on the medication profile. 4. A review of the comprehensive assessment for Patient #3, dated 4/8/22, indicated the patient had 35 active medications but failed to evidence documentation the medications had been reviewed and reconciled as a part of the comprehensive assessment. 5. A review of the clinical record for Patient #8 indicated the most recent comprehensive assessment was dated 12/29/22. The record failed to evidence the patient received an updated comprehensive recertification assessment that included a review and reconciliation of all active medications prior to the current certification period of 3/1/22 - 4/29/22. On 4/18/22 at 3:30 PM, the clinical manager was asked to print Patient 8's comprehensive assessment for the current certification period of 3/1/22 - 4/29/22. On 4/19/22 at 3 PM, the clinical manager provided a skilled nurse visit note dated 2/24/22, and stated there was no further information for Patient 8. 6. A review of the clinical record for Patient #9, start of care date of 12/22/20, evidenced the patient was hospitalized on 2/24/22 and 2/25/22, and services resumed on 2/28/22.The record failed to evidence an updated comprehensive assessment was completed. 7. On 4/18/22 at 2:04 PM, the clinical manager was queried as to the agency's process for		medication profile.Nurses will document in patient chart that an updated signed/dated copy ofmedication profile was placed in home folder. This will be done by June 22,2022. Director of Nursing/Administrator will review alladmissions, recertifications, resumptions done weekly to ensure the medicationprofile has been signed/dated by the RN. (On-going) Director of Nursing will instruct nurses that when apatient, who has been on hold due to hospitalization, is released from hospitala comprehensive assessment must be done. This was done on April 22, 2022. Director of Nursing will ensure patients who have beenhospitalized have a comprehensive assessment done when returning to agency. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	medication review and reconciliation. The clinical manager indicated the clinician reviewed the medications during the assessment and then faxed the list to the patient's physician. The clinical manager indicated there was no fax confirmation or documentation of receipt because the medication list was faxed through the electronic medical record. The clinical manager indicated If a signed medication list was not eventually obtained, it was resent. 8. A review of the clinical record of Patient #4, with a recertification period of 1-19-22 to 3-19-22. The clinical record contained an agency document dated 1/14/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated, under the section titled, Elimination Status the visit was via a telehealth visit. The RN, former employee FF, failed to document all medications were reconciled with the patient, health care representative, outside agencies, and ordering physicians. On 4-18-22 at 2:00 PM, an agency document titled, Medication Profile was provided by the clinical manager, when requested evidence the RN reconciled all medications with the patient, health care representative, and outside agencies, of Patient #4 s medications. The medication profile contained a section titled, Reviewed by: Name and Signature that was left blank, and the date was left blank (former RN employee FF.) During an interview on 4-14-22, at 8:55 AM, the director of nursing of Entity C, Person D, stated, Employee E, was the clinical manager at Golden Heart and my contact. Employee E was the scheduler for Golden Heart, and indicated RN, former employee FF, for Patient 4 failed to document evidence Patient #4 s medications had been reconciled with the assisted living, Entity C. 9. A review of the clinical record of Patient #10, with the recertification period of 1-22-22 to 3-22-22. The clinical record contained an agency document dated 1/17/22, titled, Skilled Nursing Visit Note. The skilled nursing visit note indicated the type of visit was a telehealth visit.			

Review of an agency document dated 1/17/22, titled, Assessment Details, indicated recertification (follow up) reassessment via telehealth and failed to document medications were reconciled with the patient, health care representative, outside agencies, and ordering physicians.

On 4-18-22 at 12:00 PM, an agency document titled, Medication Profile was provided by the clinical manager, when requested evidence the RN reconciled all medications with the patient, health care representative, and outside agencies, of patient #10 s medications. The medication profile contained a section titled, Reviewed by: Name and Signature that was left blank, and the date was left blank (former RN employee FF.)

During phone interviews on 4-18-22 at 10:42 AM, 4-19-22 at 8:57 AM, and 4-19-22 at 10:15 AM, with the medical assistant, Person G, confirmed Patient #10 s physician, Person H, was treating Patient #10. Person G, indicated would fax a medication list, hospital records from the patient s hospital stay, and last visit note. The documentation was not received prior to the survey exit.

10. A review of the clinical record of Patient #11, for the recertification period of 2-22-22 to 4-22-22, evidenced the clinical record contained an agency document dated 3/15/22, titled, Skilled Nursing Visit Note. The skilled nursing visit note indicated the type of visit was a telehealth visit.

On 4-18-22 at 12:00 PM, an agency document titled, Medication Profile was provided by the clinical manager, when queried what documentation evidenced reconciliation of all medications with the patient, health care representative, and outside agencies, for Patient #11 s medications, the administrator indicated having nothing more to provide. The medication profile provided evidenced for medications, Reviewed by: Name and Signature that was left blank, and the date was left blank (former RN employee FF.)

11. A review of the clinical record of Patient #12, for the recertification period from 1-31-22 to 3-31-22, revealed the clinical record contained an agency document dated 2/27/22, titled, Assessment Details, which indicated

	recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Vision visit was completed via telehealth. Former RN, employee FF, failed to document all medications were reconciled with the patient, health care representative, outside agencies, and ordering physicians. A review of the recertification period from 4-1-22 to 5-30-22 contained a recertification assessment dated 4-4-22. The RN(former RN employee FF) failed to document all medications were reconciled with the patient, health care representative, outside agencies, and ordering physicians. On 4-18-22 at 12:00 PM, an agency document titled, Medication Profile, was provided by the clinical manager, upon request. The document evidenced the medication profile contained a section titled, Reviewed by: Name and Signature that was left blank, and the date was left blank (former RN employee FF.) 12. A review of the clinical record of Patient #13, for the recertification period from 3-28-22 to 5-26-22, contained a document dated 2/27/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The assessment (former RN employee FF) failed to document all medications were reconciled with the patient, health care representative, outside agencies, and ordering physicians. On 4-18-22 at 2:04 PM, an agency document titled, Medication Profile, was provided by the clinical manager, upon request. The medication profile contained a section titled, Reviewed by: Name and Signature that was left blank, and the date was left blank (former RN employee FF.) During an interview on 4-14-22, at 8:55 AM, the director of nursing of Entity M, Person D, stated, Employee E, is the clinical manager at Golden Heart and my contact. Employee E is the scheduler for Golden Heart. Former RN, employee FF, failed to document Patient #13 s medications had been reconciled with the assisted living, Entity C. 13. A review of the clinical record of Patient #14, for the recertification period from 2-21-22 to 4-21-22. The clinical record contained an			

agency document dated 3/17/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The assessment failed to document all medications were reconciled with the patient, health care representative, outside agencies, and ordering physicians (former RN employee FF.)

On 4-18-22 at 2:04 PM, an agency document titled, Medication Profile was provided by the clinical manager, upon request. The document failed to evidence the RN reconciled all medications with the patient, health care representative, and outside agencies, of the Patient #14 s medications. The medication profile contained a section titled, Reviewed by: Name and Signature that was left blank, and the date was left blank (former RN employee FF.)

During an interview on 4-19-22 at 10:47 AM, the clinical manager, Person X, of the hospice agency, Entity W, confirmed Patient #14 was under their care. Person X, further indicated there was no documentation in the communication of coordination of care of Golden Heart Health Services communicating since November, 2021, the date when Golden Heart Health Services referred Patient #14 to their services. Former RN, employee FF, failed to document Patient #14 s medications had been reconciled with the assisted living, Entity W.

14. A review of the clinical record of Patient #15, for the recertification period from 2-13-22 to 4-13-22. The clinical record contained an agency document dated 2/24/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. Former RN, employee FF, failed to document all medications were reconciled with the patient, health care representative, outside agencies, and ordering physicians and failed to sign and date the document.

During an interview on 4-18-22, at 2:04 PM, the clinical manager, when queried about requests made for the documents which showed the medication reconciliation had been completed, and the agency instead provided medication profiles, stated, It is on the plan of care we send to the physician. The Electronic Medical Record system does that. We do not see it, review it, or control

	how/when it is sent. 410 IAC 17-14-1(a)(1)(B)			
G0546	Last 5 days of every 60 days unless: 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. Based on record review, and interview the agency failed to ensure a recertification comprehensive assessment was conducted during the last 5 days of every 60 days, in 6 of 8 active records reviewed (Patients #4, 11, 12, 13, 14, 15) and 3 of 4 records reviewed for patients placed on hold. (Patients #8, 9, and 10) Findings Include: 1. A review of an undated agency policy C-1 titled "Client Reassessment/Update of Comprehensive Assessment," indicated "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants ...Reassessments must be done at least: Every second calendar month beginning with start of care ... Within forty-eight hours of ... client return home from hospital admission of more than twenty-four hours ..." 2. On 4/18/22 at 3:11 PM, when attempted to view the current comprehensive assessment for Patient #8 via the EMR (Electronic Medical	G0546	G546 Agency unable to correct issues cited in survey as thosevisits as those assessments occurred several months ago. Director of Nursing/Administrator will instruct nurses thatall visits must be done in person. This was done on April 22, 2022. Director of Nursing will instruct nurses that comprehensivere-assessments must be done between days 56-60 of cert period. This wascompleted on April 22, 2022. Director of Nursing will audit all recerts done weekly toensure they are done between days 56-60 of cert period. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) Director of Nursing/designee will review the recertificationlist at start of each month to ensure recerts due that month are	2022-04-22

	Further review of the clinical record revealed the most recent comprehensive assessment was dated 12/29/22. The clinical record failed to evidence Patient 8 received a comprehensive recertification assessment the last 5 days prior to the current certification period of 3/1/22 - 4/29/22. On 4/18/22 at 3:30 PM, the clinical manager, Employee B, was asked to print the patient's comprehensive assessment for the current certification period of 3/1/22 - 4/29/22. On 4/19/22 at 3 PM, the clinical manager provided a skilled nurse visit note dated 2/24/22, and stated no further documentation of comprehensive assessment was available for the patient. 3. A review of the clinical record of Patient #4, with a recertification period of 1-19-22 to 3-19-22, evidenced it contained an agency document dated 1/14/22, that was titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated, that under the section titled, Elimination Status the visit was via a telehealth visit. The agency failed to ensure an in-person recertification was completed within the 5-day window of days 56-60. A review of the clinical record of Patient #4 contained a recertification comprehensive assessment dated 3-21-22, for the recertification period of 3-20-22 to 5-18-22. The agency failed to ensure a recertification comprehensive assessment was completed within the 5-day window of days 56-60. 4. A review of the clinical record of Patient #10, with the recertification period of 1-22-22 to 3-22-22, evidenced it contained an agency document dated 1/17/22, titled, Assessment Details, that indicated recertification (follow up) reassessment via telehealth. The agency failed to ensure a recertification comprehensive assessment was completed in-person within the 5-day window of days 56-60. A review of the recertification period from 3-23-22 to 5-21-22, contained a recertification assessment dated 4-8-22. The agency failed to		scheduledappropriately. Nurses will be instructed to notify Director of Nursing/designeeif patient refuses to have recert done during required time frame. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	ensure a recertification comprehensive assessment was completed within the 5-day window of days 56-60. 5. A review of the clinical record of Patient #11, with the recertification period of 2-22-22 to 4-22-22, evidenced it contained an agency document dated 3/15/22, titled, Assessment Details, that indicated recertification (follow up) reassessment via telehealth. The agency failed to ensure a recertification comprehensive assessment was completed within the 5-day window of days 56-60. 6. A review of the clinical record of Patient #12, for the recertification period from 1-31-22 to 3-31-22, evidenced it contained an agency document dated 2/27/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Vision visit, the comprehensive assessment was completed via telehealth. The agency failed to ensure the recertification comprehensive assessment was completed in-person and within the 5-day window of days 56-60. A review of the recertification period from 4-1-22 to 5-30-22, contained a recertification assessment dated 4-4-22. The agency failed to ensure the recertification comprehensive assessment was completed within the 5-day window of days 56-60. 7. A review of the clinical record of Patient #13, for the recertification period from 3-28-22 to 5-26-22, evidenced it contained an agency document dated 2/27/22, titled, Assessment Details which indicated recertification (follow up) reassessment. The agency failed to ensure the recertification comprehensive assessment was completed within the 5-day window of days 56-60. 8. A review of the clinical record of Patient #14, for the recertification period from 2-21-22 to 4-21-22, evidenced it contained an agency document dated 3/17/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. The agency failed to ensure the recertification comprehensive assessment was completed within the 5-day window of days 56-60.			

	9. A review of the clinical record of Patient #15, for the recertification period from 2-13-22 to 4-13-22, evidenced it contained an agency document dated 2/24/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. The agency failed to ensure the recertification comprehensive assessment was completed within the 5-day window of days 56-60. During an interview on 4-13-22, at 3:36 PM, the administrator confirmed there were to be no more telehealth visits effective November 2021, and the nurses were instructed only in-person visits and physical assessments were to occur. During an interview on 4-18-22, at 11:40 AM, when queried regarding the timeline for comprehensive assessments, the clinical manager confirmed every 60 days the last five days of the certification period. 410 IAC 17-14-1(a)(1)(B)			
G0548	Within 48 hours of the patient's return 484.55(d)(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner - ordered resumption date; Based on record review and interview, the agency failed to ensure all patients received a complete and accurate comprehensive assessment within 48 hours of returning home after hospital admission for 1 of 1 patient records reviewed for patients who were hospitalized. (Patient 9) Findings include: 1. A review of an undated agency policy C-155, titled "Client Reassessment/Update of Comprehensive Assessment," indicated reassessments must be done "Within	G0548	G548 Agency unable to correct issues cited in survey as thosevisits as those assessments occurred several months ago. Director of Nursing will instruct nurses that when apatient, who has been on hold due to hospitalization, is released from hospitala comprehensive assessment must be done. This was done on 04-22-2022 DON will audit all resumptions of care done weekly to ensurethere is a comprehensive assessment in the file. Once	2022-04-22

	forty-eight (48) hours of (or knowledge of) client return home from hospital admission of more than twenty-four (24) hours ..." A review of the clinical record for Patient #9, start of care date of 12/22/20, evidenced missed visits for 2/24/22 and 2/25/22, due to hospitalization. The record indicated home health aide services were resumed on 2/28/22. The clinical record failed to evidence Patient 9 received a resumption of care updated comprehensive assessment within 48 hours post-hospitalization. 2. On 4/18/22 at 3:16 PM, Person HH, the representative for Patient #9, was interviewed and confirmed Patient 9 was hospitalized in April but declined to discuss the details.		10% will beaudited quarterly to ensure compliance is maintained. Director of Nursing will ensure patients who have beenhospitalized have a comprehensive assessment done when returning to agency.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the agency failed to ensure discharged patients received an updated comprehensive assessment at the time of discharge and included a summary of the patient's progress in meeting the care plan goals for 3 of 3 closed records reviewed. (Patients #5, 6, 7) Findings include: 1. A review of an undated agency policy C-155, titled "Client Reassessment/Update of Comprehensive Assessment," indicated "Reassessments must be done ... within forty-eight (48) hours of (or knowledge of) discharge or transfer."	G0550	G550 Agency unable to correct issues cited in survey as theyoccurred several months ago. Director of Nursing will in-service nurses that when apatient is discharged there must be a comprehensive assessment completed. Ifpatient refuses, then assessment will be done using data from last nursingvisit and indicating date of that visit. Assessment must indicate patient'sprogress towards their goals, RN signature must be present. There must bedocumentation MD was notified of discharge	2022-06-17

	2. A review of the "Patient Communication Log," for Patient #5 evidenced during a phone call with the physician's office on 2/10/22, the receptionist indicated the patient had chosen another agency and no further information could be shared with Golden Heart Health Services. Further review of the clinical record failed to evidence a comprehensive assessment, including Patient #5's goals and progress was completed at the time after discharge. During a phone interview on 4/14/22 at 12:55 PM, Patient #5 indicated having left (discharged) from this agency around 2/10/22, due to a decrease in approved hours and due to both of the patient's aides having told Patient #5 they had been terminated. 3. Review of the inactive clinical record for Patient #6, indicated a discharge date of 1-17-22, and failed to evidence the discharge summary was complete. The discharge summary revealed a signed date of 12-13-2021 at 5:30 PM, the Clinician s Signature line was blank. The document failed to include whether the physician was notified of Patient 6's discharge and failed to evidence documentation verifying the discharge information/summary was sent to Patient 6's physician. On 4-14-22 at 12:24 AM, requested discharge (dc) assessment, discharge physician notification, and any communication notes regarding discharge and/or discharge education. Received on 4-14-22 at 12:57 PM, from the clinical manager, an incomplete discharge summary, no communication notes regarding discharge, discharge planning or discharge education, and no discharge physician notification. During an interview on 4-14-22 at 12:11 PM, the family member and former home health aide (HHA), Person V, indicated they were sick with the flu when Golden Heart Health Services required person V to come in for mandatory 1-day training or lose their job. When queried about assistance with a replacement caregiver or assistance in finding another agency, Person		and that MD was sent a dischargesummary. There must be documentation agency offered to assist patient with findinganother agency to provide care if patient is discharged for inability to staff.This will be done by 06-17-2022. Director of Nursing/designee will audit all discharges doneweekly to ensure there is a comprehensive assessment that is complete and includesprogress towards goals, it is signed, documentation that MD was notified ofdischarge, there is a completed discharge summary, proof summary was sent toMD. If patient was discharged for inability to staff there must bedocumentation patient was provided list of other agencies to contract and nurseoffered to assist patient with finding an agency to provide care to patient.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is	

	V confirmed Golden Heart Health Services did not assist with discharge planning or offer another HHA to replace them. During an interview on 4-14-22 at 12:57 PM, the clinical manager confirmed there were no communication notes or documentation of discharge education or planning. 4. A review of the inactive clinical record for Patient #7 indicated a discharge date of 2-9-22, and evidenced an incomplete discharge summary which failed to evidence the signature of the writer, administrative assistant, Employee H, and was dated 3-7-22. A review of agency documents titled, Patient Communication Log, revealed dates of the following; 1-29, 1-30, 2-1, 2-3, and 2-7-22, indicating Golden Heart Health Services staffing coordinator, Employee N, was unable to staff the care visit needs (HHA) for Patient #7. During an interview on 4-14-22 at 1:41 PM, a family member, Person Z, confirmed the agency was unable to provide adequate staff for all ordered visits for Patient 7 after the HHA who cared for Patient #7 was sick with COVID-19. This HHA was terminated from the agency due to missing a day of mandatory training. When queried about assistance with finding another agency, Person Z stated, They sent me 40 pages of agencies but did not help me find one.		corrected and will notrecur.	
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.	G0564	G564 Agency unable to correct issues cited in survey as theyoccurred several months ago. Director of Nursing will in-services nurses that when apatient is discharged there must be a comprehensive assessment completed. Ifpatient refuses then assessment will be	2022-04-22

Based on record review and interview, the agency failed to ensure a discharge or transfer summary that included the necessary medical information pertaining to the current course of illness and treatment, post-discharge goals of care, and treatment preferences were sent to the receiving facility or health care practitioner in 3 of 3 discharged patients reviewed. (Patients #5, 6, 7)

Findings Include:

1. A review of an undated agency policy C-155, titled "Client Reassessment/Update of Comprehensive Assessment," indicated "Reassessments must be done ... within forty-eight (48) hours of (or knowledge of) discharge or transfer."

2. A review of the "Patient Communication Log," for Patient #5 evidenced during a phone call with the physician's office on 2/10/22, the receptionist indicated the patient had chosen another agency and no further information could be shared with Golden Heart Health Services. The clinical record failed to evidence a comprehensive assessment was completed after notification of the patient's discharge.

During a phone interview on 4/14/22 at 12:55 PM, Patient #5 confirmed discharging from the agency around 2/10/22 due to being left with no services after the patient's hours were decreased and both of the patient's scheduled aides were notified they were being terminated.

On 4/18/22 at:30 PM, the clinical manager was interviewed as to the discharge of patient #5 and indicated the physician's office notified them the patient transferred, but would not share the name of the new agency, so they were unable to send a discharge summary

done using data from last nursing visitand indicating date of that visit. Assessment must indicate patient's progresstowards their goals, RN signature must be present. There must be documentationMD was notified of discharge and that MD was sent a discharge summary. Theremust be documentation agency offered to assist patient with finding anotheragency to provide care if patient is discharged for inability to staff. This was doneon April 22, 2022.

Director of Nursing/designee will audit all discharges doneweekly to ensure there is a comprehensive assessment that is complete and includesprogress towards goals, it is signed, documentation that MD was notified ofdischarge, there is a completed discharge summary, proof summary was sent toMD. If patient was discharged for inability to staff there must bedocumentation patient was provided list of other agencies to contract and nurseoffered to assist patient with finding an agency to provide care to patient.Once 100% compliance is achieved 10% will be audited quarterly to

	as to whether the discharge summary was sent to the patient's health care practitioner, the clinical manager indicated no information was sent. 3. A review of the inactive clinical record for Patient #6, indicated a discharge date of 1-17-22, and contained an incomplete discharge summary. The discharge summary indicated a signed date of 12-13-2021 at 5:30 PM. The clinician s signature line was blank. The document failed to document physician notification and failed to document discharge information/summary was sent to Patient 6's physician. On 4-14-22 at 12:24 AM, requested discharge (dc) assessment, dc order, and communication notes regarding the discharge. Received on 4-14-22 at 12:57 PM, from the clinical manager, an incomplete discharge summary, no documentation of communication notes regarding discharge, and no documentation of discharge planning or discharge education for Patient 6. During an interview on 4-14-22 at 12:11 PM, the family member and former home health aide (HHA), Person V, indicated they were sick with the flu when Golden Heart Health Services required person V to come in for mandatory 1-day training or lose their job. When queried about assistance with a replacement caregiver or assistance in finding another agency confirmed that Golden Heart Health Services did not assist with discharge planning or offer another HHA to replace them. The record failed to evidence documentation of coordination of care and discharge planning. During an interview on 4-14-22 at 12:57 PM, the clinical manager confirmed there were no communication notes regarding Patient 6's discharge. 4. A review of the inactive clinical record for Patient #7 indicated a discharge date of 2-9-22, and contained an incomplete discharge summary which had been signed by the administrative assistant, Employee H, and dated 3-7-22.		ensurecompliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	A review of agency documents titled, Patient Communication Log, revealed the dates: 1-29, 1-30, 2-1, 2-3, and 2-7-22, indicating Golden Heart Health Services staffing coordinator, Employee N, was unable to staff the needs of Patient #7. The record failed to evidence documentation of coordination of care and discharge planning. During an interview on 4-14-22 at 1:41 PM, the family member, Person Z, confirmed the agency was unable to provide HHA staff after the HHA who cared for Patient #7 was sick with COVID-19 and was terminated from the agency due to missing a mandatory training. When queried about assistance in finding another agency, Person Z stated, They sent me 40 pages of agencies but did not help me find one.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure all patients received an individualized plan of care that was established and reviewed by the physician every 60 days, and included patient-specific interventions and measurable goals	G0572	G572 Agency unable to correct issues cited in survey as theyoccurred several months ago. Director of Nursing/Administrator will instruct nurses thatall visits must be done in person. This was done on April 22, 2022 Patients cited in survey were aide only cases. Regulationsrequire all known diagnoses be listed but since this was not a skilled casethere are no measurable goals or outcomes for the diagnoses as there is noorder for skilled care. Goals are individualized to reflect aide services.	2022-04-22

	and outcomes in 5 of 8 active records reviewed (Patients #1, 2, 4, 11, 12) and 4 of 4 records reviewed of patients on hold. (Patients #3, 8, 9, 10) Findings include: 1. A review of the unsigned plan of care for Patient #2, for the certification period of 2/17/22 - 4/17/22, indicated a goal of "Personal care needs will be met with assist of aide" and "Will remain free from falls ..." The plan of care failed to include patient-specific, measurable, and pertinent goals and interventions based on the patient's current needs. Further review of the clinical record failed to evidence the plan of care was established by the physician and reviewed every 60-days because the plan of care had not yet been signed. On 4/18/22 at 3:30 PM, the clinical manager was asked for a copy of the patient's physician-signed plan of care. The clinical manager indicated there was no signed copy. 2. A review of the plan of care for Patient #3, for the certification period of 4/8/22 - 6/6/22, evidenced goals of "Pt (patient) will remain safe at home AEB (as evidenced by) no falls/injuries for the length of the home health episode" and "Personal care needs will be met with assist of aide." The plan of care failed to include patient-specific, individualized, and pertinent goals and interventions that were realistic/attainable and measurable. 3. A review of the clinical record for Patient #8 failed to evidence a plan of care or comprehensive assessment for the current certification period of 3/1/22 - 4/29/22. On 4/18/22 at 3:30 PM, the clinical manager		Director of Nursing will in-service nurses on requirementfor plans of care to be individualized, reviewed by the physician every 60 daysand include patient-specific interventions and goals that arerealistic/attainable and measurable and based on patient preference. This was doneon April 22, 2022. Director of Nursing will audit all plans of care submittedweekly to ensure they are individualized and include patient-specificinterventions and goals that are realistic/attainable and measurable and basedon patient preference. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) Director of Nursing will instruct nurses that when apatient, who has been on hold due to hospitalization, is released from hospitala comprehensive assessment must be done that reflects the patient's updatedstrengths, patient-specific care preferences, and goals that arepatient-specific and	

	the current certification period of 3/1/22 - 4/29/22. On 4/19/22 at 3 PM, the clinical manager was asked to print the patient's current plan of care and accompanying comprehensive assessment. The clinical manager provided a skilled nurse visit note dated 2/24/22, and indicated no further information was available for Patient #8. 4. A review of the clinical record for Patient #9, start of care 12/20/20, evidenced Patient 9 was hospitalized on 2/4/22 and 2/5/22. The clinical record failed to evidence an updated resumption of care comprehensive assessment was completed post-hospitalization that included strengths, goals, care preferences, and progress toward previous goals. 5. The clinical record of Patient #1 was reviewed on 4/13/22 and indicated a start of care date of 3/24/21. The record contained a comprehensive recertification assessment completed on 3/16/22, with diagnoses of Acquired absence of right leg above the knee, Essential hypertension, Dysphagia following cerebral infarction, Chronic obstructive pulmonary disease with an acute respiratory infection, and Urge incontinence with onset dates all documented as 10-21-2000. The comprehensive assessment failed to evidence patient-specific measurable goals for integumentary integrity due to incontinence, and failed to evidence patient-specific measurable goals for depression with the recent loss of their wife. A review of a plan of care for the recertification period of 3/19/22 to 5/17/22, revealed orders included HHA care visits 16 hours a day, 7 times a week, for 9 weeks to assist with personal care, light housekeeping, and meal prep. The agency failed to ensure an individualized plan of care that identified patient-specific measurable outcomes and goals, failed to have specific interventions for depression, and incontinence, and failed to		measurable. This was done on April 22, 2022. Director of Nursing will audit all resumptions of care doneweekly to ensure there is comprehensive assessment done and it accurately reflectsthe patient's updated patient strengths, patient-specific care preferences, andgoals that are patient-specific and measurable. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

parameters not generalized.

A review of a Missed Visit Note dated 2-23-22, indicated the patient was on a leave of absence with family for a funeral which was the reason for the missed visit.

During a home visit on 4/13/22 at 8:00 AM observed a hospital bed in the middle of the living room behind Patient #1 s recliner chair. The patient s family member, Person A, confirmed the bed was Patient #1 s spouse's bed, who had passed away 2 months ago.

During an interview on 4-13-22 at 12:28 PM, the clinical manager confirmed Patient #1's plan of care was not individualized with patient-specific measurable outcomes and goals, failed to have specific interventions for depression, and incontinence.

6. The clinical record of Patient #4 was reviewed on 4/13/22, and indicated a start of care date of 1-24-21. The record contained an agency document dated 1/14/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated the diagnoses of Atherosclerosis Heart Disease, Type 2 Diabetes with diabetic neuropathy, Type 2 Diabetes with diabetic kidney disease, Morbid Obesity, Cellulitis of the left lower limb, Spondylosis without myelopathy or the lumbar region, Essential hypertension, and Long term use of steroids without dates of onset. The comprehensive reassessment failed to evidence individualized patient-specific measurable outcomes and goals for the above diagnoses.

A review of a plan of care for the recertification period of 1-19-22 to 3-19-22, indicated orders for a Skilled Nurse (SN) at least every 4 weeks for 9 weeks to supervise the home health aide (HHA). The plan of care further indicated an as-needed (PRN) visit to capture the re-certification window and included order for HHA 1 hour a day, 5 times a week, for 9 weeks to assist with Activities of Daily Living

	(IADLs) per the HHA care plan. The plan of care failed to evidence individualized and measurable outcomes and goals pertinent to the patient s diagnosis and care needs. 7. The clinical record of Patient #10 was reviewed on 4/14/22, and indicated a start of care date of 2-7-19. The record contained an agency document dated 1/17/22, titled, Assessment Details, with diagnoses of Hemiplegia, unspecified affecting right non-dominant side, Mild intermittent asthma, Chronic obstructive pulmonary disease, Major depressive disorder, Schizophrenia, Cerebral infarction, Epilepsy, and Malignant neoplasm of upper lobe bronchus or lung. A review of a plan of care for the recertification period of 1-22-22 to 3-22-22, indicated orders for a Skilled Nurse (SN) at least every 4 weeks for 9 weeks to supervise the home health aide (HHA). The plan of care further indicated an as-needed (PRN) visit to capture the re-certification window and HHA 3 hours a day, 4 times a week, for 9 weeks to assist with Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs) per the HHA care plan. The Goals/Rehabilitation Potential/Discharge Plans indicated Fair to meet stated goals. HHA Goals: Patient (Pt) will remain safe at home as evidenced by (AEB) no fall injuries for the length of the home health episode. No plans to discharge as long as the patient s living conditions remain the same. The agency failed to ensure the patient s plan of care was individualized and identified patient-specific measurable outcomes and goals based on a comprehensive assessment that included Patient 10's care preferences. 8. The clinical record of Patient #11 was reviewed on 4/14/22, and indicated a start of care date of 2-7-19. The record contained an agency document dated 1/17/22, titled, Assessment Details which indicated recertification (follow up) reassessment via telehealth and failed to document vital signs, a current assessment of skin and lung sounds, abnormal smells coming from the patient, etc. The agency failed to develop a plan of care with individualized and identified patient-specific measurable outcomes and goals which would have been derived from an in-person assessment.			

	A review of the clinical record of Patient #11, the start of care date of 12-29-20, for the recertification period from 2-22-22 to 4-22-22, with diagnoses of hypertensive heart disease and GERD (gastroesophageal reflux disease) evidenced it contained an agency document dated 3/15/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated the visit was a telehealth visit. The patient care preferences were blank, and the patient s goals, and strengths, were blank. The agency failed to develop a plan of care with individualized and identified patient-specific measurable outcomes and goals which would have been derived from an in-person assessment. 9. A review of the clinical record of Patient #12, the start of care date of 2-5-21, for the recertification period from 1-31-22 to 3-31-22, evidenced an agency document dated 2/27/22, titled, Assessment Details, which indicated recertification (follow up) reassessment. The comprehensive reassessment indicated under the section titled, Vision the visit was completed via telehealth. The agency failed to develop a plan of care with individualized and identified patient-specific measurable outcomes and goals which would have been derived from an in-person assessment. During an interview on 4-13-22, at 3:36 PM, the administrator confirmed there were to be no more telehealth visits effective November 2021 and that the nurses were instructed only in-person visits were to occur. The administrator further confirmed the comprehensive assessment was to be audited for completion and sent back to the nurse for any corrections needed. The administrator verified telehealth assessments could not replace in-person comprehensive assessments because of missed opportunities for observation, ausculation, palpation, smell, and observation of the home environment for changes. 410 AC 17-13-1 (a)			

G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review, observation, and interview, the agency failed to ensure the plan of care was individualized and	G0574	G0574 Agency unable to correct issues cited in survey as theyoccurred several months ago. Director of Nursing will instructnurses on all the required elements for an individualized plan of care whichinclude: Tiswill be completed by June 22, 2022. (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications andtreatments; (xi) Safety measures to	2022-06-22

	with their date of onset/exacerbation, all supplies, and equipment necessary to meet the patients' needs in their home, failed to ensure documentation of patients' specific needs, nutritional requirements, accurate medications and treatments, all safety measures, services being provided by outside agencies/facilities, all necessary interventions, specific education and training provided, measurable outcomes and goals identified by the home health agency and the patient, and orders may be received/accepted by outside physicians for 8 of 8 active patient records reviewed (Patient #1, 2, 4, 11, 12, 13, 14, 15), and 4 of 4 records reviewed for patients on hold. (Patient #3, 8, 9, 10) Findings Include: 1. A review of the plan of care for Patient #2, for the certification period of 2/17/22 - 4/17/22, failed to evidence all equipment, including Patient 2's walker and wheelchair; failed to include all medications, including the patient's injectable insulin; failed to include all diabetic supplies, including syringes and sharps container; failed to include all safety measures, including diabetic and smoking precautions; failed to include the frequency ordered for patient-obtained blood sugars; failed to include the risk for falls and rehospitalization; failed to document the patient received medication management services via another home health agency; and failed to include interventions necessary to meet goals. 2. A review of the plan of care for Patient #3, for the certification period of 4/8/22 - 6/6/22, failed to include all diabetic supplies, including sharps container; failed to include the frequency of patient obtained blood sugars; failed to include all pertinent diagnoses, including wounds; failed to include all		protectagainst injury; (xii) A description of thepatient's risk for emergency department visits and hospital re-admission, andall necessary interventions to address the underlying risk factors. (xiii) Patient and caregivereducation and training to facilitate timely discharge; (xiv) Patient-specificinterventions and education; measurable outcomes and goals identified by theHHA and the patient (xv) Information related to anyadvanced directives; and (xvi) Any additional items the HHAor physician or allowed practitioner may choose to include. Infection control precautions Services being provided by outsideagencies/ facilities Orders could be received/ acceptedby outside physicians Care coordination with otherentities providing care	

	interventions, including wound treatment and interventions related to abnormal gait, dyspnea with minimal exertion, paralysis, vision impairment, and risk for falls; failed to include the risk for falls and hospitalization. 3. A review of the clinical record for Patient #8 failed to evidence an active plan of care for the current certification period of 3/1/22 - 4/29/22. On 4/18/22 at 3:30 PM, the clinical manager was asked to print the patient's plan of care for the current certification period of 3/1/22 - 4/29/22. On 4/19/22 at 3 PM, the clinical manager provided a skilled nursing visit note, dated 2/24/22. The clinical manager had no further documentation for Patient #8 in relation to durable medical equipment needed, nutritional requirements, medications and treatments, safety measures, etc. 4. A review of the clinical record for Patient #9, for the certification period of 2/15/22 - 4/15/22, evidenced the patient was hospitalized on 2/4/22 and 2/5/22 but failed to evidence an updated plan of care upon resumption of care to document changes in mobility, nutrition, medications, assistive devices, safety precautions, and updated measurable and objective goals. 5. A review clinical record of patient #1, indicated a start of care date of 3/24/21. Review of the comprehensive recertification assessment completed on 3/16/22 that indicated diagnoses, Acquired absence of right leg above the knee, Essential hypertension, Dysphagia following cerebral infarction, Chronic obstructive pulmonary disease with an acute respiratory infection, and Urge incontinence with onset dates all listed as 10-21-2000. The comprehensive reassessment indicated the patient used a Continuous Positive Airflow Pressure (CPAP) machine at night. The 60-day summary indicated the		Director of Nursing/designee willaudit all plans of care done each week to ensure they are individualized forthat patient and contain all the required elements. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) Director of Nursing will instruct nurses on coordinatingcare with other entities providing care. Nurse must document name of entity, who they spoke with, services that entityis providing with the frequency and what services/frequency Golden Heart isproviding, changes discussed and/or development of the plan of care. Thisis to be done at admission, recert, resumption and anytime there is a change inservices being provided by Golden Heart. This will be completed by June 22, 2022 Director of Nursing/designee willaudit all admissions, recerts and resumptions submitted weekly to ensure thereis documentation of care coordination including name of entity, who they spokewith,	

	patient had sleep apnea and was a smoker.		services that entity is providing with the frequency and whatservices/frequency Golden Heart is providing, changes discussed and/or developmentof the plan of care as appropriate. Once 100% compliance is achieved 10% willbe audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur.	

	A review of a physician signed plan of care for the recertification period of 3/19/22 to 5/17/22, indicated the following diagnoses: Acquired absence of right leg above the knee, Essential hypertension, Dysphagia following cerebral infarction, and Chronic obstructive pulmonary disease with an acute respiratory infection, and Urge incontinence with onset dates listed as 10-21-2000, but failed to list diagnoses consistent with the drug use of Protonix (a medication used to treat acid reflux/heartburn), Atorvastatin Calcium (a medication used to treat high cholesterol), Tamsulosin HCl (a medication used to treat enlarged prostate gland), Quetiapine Fumarate (a medication used to treat mental/mood conditions loss of interest in life and manic depressive disorder), Fluoxetine HCl (a medication used to treat depression), and failed to list a diagnosis of sleep apnea consistent for use of CPAP machine. The plan of care further indicated orders for RN to assess vital signs and notify physician: Blood pressure >180/100 or <90/50; Respirations >20 or < 12; Temperature >100 or < 96; Pulse Rate >100 or < 60; O2sat <90% that failed to be individualized for the patient. The plan of care failed to evidence the inclusion of the CPAP machine in the section Durable Medical Equipment (DME) and Supplies and incorrectly evidenced the patient had a urinary ostomy. The agency failed to ensure an individualized plan of care that identifies patient-specific measurable outcomes and goals, failed to provide HHA services per the plan of care, failed to have specific interventions for depression, and incontinence, and failed to obtain specific physician call orders for parameters not generalized. The plan of care evidenced "Care Coordination: Patient sees [Entity II, (a human services non-profit organization)] " but failed to evidence what care coordination occurred with the organization, Entity II. Further review of the clinical record failed to evidence documentation of case coordination including what services, needs, or changes were discussed and/or development of the plan of care, or what services were received from the physician of patient #1. 6. A review of the clinical record of patient #4, indicated a start of care date of 1/24/21. Review of an untimely comprehensive			

recertification assessment completed on 3/21/22 that indicated diagnoses, Atherosclerosis heart disease of the native coronary artery, Type 2 diabetes with diabetic neuropathy, Type 2 diabetes with diabetic chronic kidney disease, Morbid obesity, Spondylosis without myelopathy or radiculopathy lumbar region, Hypoxemia, Cellulitis of left lower limb, Essential hypertension, Long term use of inhaled steroids onset dates listed all 5-1-2014. The 60-day summary indicated the patient is on continuous oxygen at 2 liters per nasal cannula, but the patient takes it off while they smoke, the patient indicated they were on a regular diet, and blood sugars remain in the 90-100s, and the weekly injection help maintain their blood sugar.

A review of a physician signed plan of care for the recertification period of 3-20-22 to 5-18-22, indicated the following diagnoses: Atherosclerosis heart disease of the native coronary artery, Type 2 diabetes with diabetic neuropathy, Type 2 diabetes with diabetic chronic kidney disease, Morbid obesity, Spondylosis without myelopathy or radiculopathy lumbar region, Hypoxemia, Cellulitis of left lower limb, Essential hypertension, Long term use of inhaled steroids onset dates listed all 5-1-2014, but failed to list diagnoses consistent with the drug use of Effexor XR (a medication used for depression), Lipitor (a medication used to lower cholesterol), Pantoprazole Sodium (a medication used to treat acid reflux/heartburn), Xanax (a medication used to treat anxiety), and Fenofibrate (a medication used to treat high cholesterol). The plan of care further indicated orders for RN to assess vital signs and notify the physician: Blood pressure >180/100 or <90/50; Respirations >20 or < 12; Temperature >100 or < 96; Pulse Rate >100 or < 60; O2sat <90% that failed to address blood sugar parameters, and to be individualized for the patient. The plan of care further failed to evidence the oxygen amount, route, and frequency that patient #4 was administering. The plan of care failed to evidence the inclusion of the insulin pen needles, and nasal cannulas in the section Durable Medical Equipment (DME) and Supplies. The plan of care evidenced "Care Coordination: Patient sees [Name of Person JJ,

	(a physician)] and [Name of Entity C (the assisted living facility patient resides)]" but failed to evidence what care coordination occurred with the patient's physician, and failed to evidence the care discussed or with whom it was discussed at entity C. Further review of the clinical record failed to evidence documentation of case coordination including what services, needs, or changes were discussed and/or development of the plan of care, or what services were received via entity C. During an interview on 4-13-22 at 2:16 PM, patient #4 stated the nurses at the assisted living facility, Entity C, check their blood sugar and give them their insulin injections. Patient #4 further confirmed they are on oxygen 2 liters per nasal cannula at all times and they do not like to be bothered until afternoon by anyone 7. A review of the clinical record of patient #10, indicated a start of care date of 2-7-19. The record contained an agency document dated 4/8/22, titled, Assessment Details which indicated recertification (follow up) reassessment. The untimely comprehensive reassessment indicated the diagnoses of Hemiplegia, unspecified affecting right non-dominant side, Mild intermittent asthma, Chronic obstructive pulmonary disease, Major depressive disorder, Schizophrenia, Cerebral infarction, Epilepsy, and Malignant neoplasm of upper lobe bronchus or lung. A review of a plan of care for the recertification period of 3-23-22 to 5-21-22, indicated the following diagnoses: Hemiplegia, unspecified affecting right non-dominant side, Mild intermittent asthma, Chronic obstructive pulmonary disease, Major depressive disorder, Schizophrenia, Cerebral infarction, Epilepsy, and Malignant neoplasm of upper lobe bronchus or lung, Chronic obstructive pulmonary disease with acute exacerbation all dated with the onset dates of 2-7-2019, listing chronic obstructive pulmonary disease twice. The plan of care further indicated orders for RN to assess vital signs and notify physician: Blood pressure >180/100 or <90/50; Respirations >20 or < 12; Temperature >100 or < 96; Pulse Rate >100 or < 60; O2sat <90% that failed be individualized for the patient.			

	The plan of care failed to evidence the inclusion of the oxygen concentrator, nasal cannulas, nebulizer, and nebulizer aerosol kits, in the section DME and Supplies, and incorrectly evidenced the patient had a urinary ostomy. The plan of care indicated, Discharge Plans: When centered goals are met. Discussed discharge plans with patient/caregiver: No. The plan of care evidenced "Care Coordination: For coordination of care patient is receiving services from [Entity B (a personal care agency)], [Entity P (a social service agency)], and [Person G (a physician)], but failed to evidence what care coordination occurred with the patient's physician, and failed to evidence the care discussed or with whom it was discussed at entity P and entity B. Further review of the clinical record failed to evidence documentation of case coordination including what services, needs, or changes were discussed and/or development of the plan of care, or what services were received via entity P and entity B. Phone calls were placed to person G, the patient s physician, on 4-18-22 at 10:42 AM and 4-19-22 at 8:57 AM for requested documentation of patient #10 s office visits, history, and last hospitalization on 4-10-22. Records were to be faxed and the physician s office was aware did not receive the requested documentation. A phone call was placed to patient #10 on 4-18-22 at 10:35 AM, a message was left for a return call. No calls returned. 8. A review of the clinical record of patient #11, indicated a start of care date of 12-29-20. The clinical record contained an agency document dated 3/15/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The untimely comprehensive reassessment indicated under the section titled, Elimination Status the visit was a telehealth visit. The untimely comprehensive reassessment indicated the diagnoses of Hypertensive heart disease without heart failure, Major depressive disorder, Diabetes Mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma, and Essential hypertension. In the section titled, Family Support evidenced, No.			

Caregiver able/willing to provide care. No. Caregiver able /willing to assist with activities of daily living (ADLs) and needed care. No. The caregiver was able to Safely Care for the Patient. NO. The 60-day summary indicated the patient lives with her daughter. The summary further indicated the patient s blood sugar ranges from 200 to 250, and the patient is on a regular diet.

A review of an agency document titled, Admissions Profile evidenced patient was referred by entity P, a social service agency.

A review of the plan of care for the recertification period of 2-22-22 to 4-22-22, indicated the following diagnoses: Hypertensive heart disease without heart failure, Major depressive disorder, Diabetes Mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma, Essential hypertension, Gastro-esophageal reflux disease. The plan of care further indicated orders for RN to assess vital signs and notify the physician: Blood pressure >180/100 or <90/50; Respirations >20 or < 12; Temperature >100 or < 96; Pulse Rate >100 or < 60; O2sat <90% that failed to address blood sugar parameters, and to be individualized for the patient. The plan of care in the section DME and Supplies, and incorrectly evidenced the patient had a urinary ostomy. The section titled, 60 Day Clinical Summary indicated the patient lives with her son. The section titled; Coordination of Care was blank. Further review of the clinical record failed to evidence documentation of case coordination including what services, needs, or changes were discussed and/or development of the plan of care, or what services were received from Entity B, (the personal care agency), from Entity P (the social service agency), and failed to evidence what care coordination occurred with the patient's physician.

During a phone interview on 4-19-22 at 10:07 AM, when queried regarding who gives the patient their insulin, patient #11 stated, My husband does. Further, the patient confirmed her son, employee J, is the aide who cares for them Monday thru Friday 8:00 AM to 4:00 PM, and their son, employee J, does their waiver hours in the evening Monday, Wednesday, and

	Friday from 4:00 PM to 10:00 PM. 9. A review of the clinical record of patient #12, the start of care date of 2-5-21, for the recertification period from 1-31-22 to 3-31-22. The clinical record contained an agency document dated 2/27/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The untimely comprehensive reassessment indicated under the section titled, Vision visit was completed via telehealth. The untimely comprehensive reassessment indicated the diagnoses of Chronic obstructive pulmonary disease with acute exacerbation, Gastro-esophageal reflux disease without esophagitis, Undifferentiated schizophrenia, Major depressive disorder, and recurrent severe without psych features. In the section titled Respiratory Status the assessment was blank, oxygen at 2 liters minute box was checked, and comments indicated the patient wears oxygen at 4.5 liters/minute per nasal cannula during sleep, and that the patient is a smoker. The section Skilled Nursing Instructions indicated the skilled was to evaluate, implement and instruct on: signs and symptoms of respiratory status and compromise and when to take action, oxygen safety and equipment care, inhalation treatment via nebulizer or meter dose inhaler, administration of oxygen at 2 liters/minute via nasal cannula, continuously/at rest/or as needed, signs and symptoms of hypo/hyperglycemia and patient s goal to verbalize understanding of hypo/hyperglycemia. The patient s record failed to evidence any history or diagnosis of hyperglycemia/hypoglycemia. The section titled, 60 Day Clinical Summary evidenced the patient lived at Entity C, an assisted living facility, smokes E-cigarettes, wears oxygen at 3 liters/minute continuously, and uses nebulizer treatments. A review of the plan of care for the recertification period of 1-31-22 to 3-31-22, indicated the following diagnoses: Chronic obstructive pulmonary disease with acute exacerbation, Gastro-esophageal reflux disease without esophagitis, Undifferentiated schizophrenia, Major depressive disorder, and recurrent severe without psych features, Iron			

	diagnoses consistent with the drug use of Senna (a medication used for constipation), Meclizine (a medication used for dizziness) and Omeprazole HCl (a medication used for nausea). The plan of care further indicated orders for RN to assess vital signs and notify physician: Blood pressure >180/100 or <90/50; Respirations >20 or < 12; Temperature >100 or < 96; Pulse Rate >100 or < 60; O2sat <90% that failed to be individualized for the patient. The plan of care in the section DME and Supplies, failed to evidence nasal cannulas, oxygen tubing, nebulizer tubing, aerosol kits and walker. The section titled, 60 Day Clinical Summary indicated the patient ambulates with a walker. Smoking cessation education was provided, and the patient lives at Entity C, an assisted living facility. The plan of care evidenced "Care Coordination: For coordination of care patient is receiving services from [Entity C (an assisted living facility where the patient resides)], but failed to evidence what care coordination occurred with the patient Entity C, and failed to evidence the care discussed or with whom it was discussed at entity C and failed to evidence what care coordination occurred with the patient's physician. Further review of the clinical record failed to evidence documentation of case coordination including what services, needs, or changes were discussed and/or development of the plan of care, or what services were received with Entity C. During an interview on 4-18-22 at 2:18 PM, the director of nursing, Person D, of the assisted living, Entity C, indicated the patient does not have a nebulizer and has mentally challenging issues with hygiene due to digging in ashtrays, trash, and has a disheveled appearance. During an interview on 4-19-22 at 3:30 PM, received a return call from the family member of patient #12, Person KK. Person KK stated, [Mom (patient #12)] has had special needs. Six years ago when Dad passed away, [Mom (the patient)] completed broke down mentally with her diagnosis of Schizophrenia. The nurses at Entity C, are giving. I have not met or talked to any nurses from Golden Heart Health Services in the 2 years she has been there. 10. A review of the clinical record of patient #13, indicated a start of care date of 8-5-20.			

	The clinical record contained an agency document dated 2/27/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The untimely comprehensive reassessment indicated the diagnoses of Parkinson s disease, Vascular dementia without behavior disturbances, Hypertensive heart disease with heart failure, Presence of cardiac pacemaker, Bipolar disorder, Acute pain, Auditory hallucinations, and Visual hallucinations. The comprehensive assessment indicated the patient lived in an assisted living facility, Entity M and had family support. The section titled, Cardiovascular Status/vital signs was blank. The section titled, 60 Day Clinical Summary evidenced the patient lived at Entity M, an assisted living facility, and the patient has complaints of chronic constipation. A review of the plan of care for the recertification period from 3-28-22 to 5-26-22, indicated the following diagnoses: Parkinson s disease, Vascular dementia without behavior disturbances, Hypertensive heart disease with heart failure, Presence of cardiac pacemaker, Bipolar disorder, Acute pain, Auditory hallucinations, Visual hallucinations, and Chronic pain due to trauma, but failed to list diagnoses consistent with the drug use Flonase (a medication that treats seasonal allergies), Levothyroxine (a medication that treats hypothyroidism), Melatonin (a medication that helps with sleep disturbances), MiraLAX (a medication that treats constipation), Myrbetriq (a medication that treats overactive bladder), Pantoprazole Sodium (a medication that treats acid reflux/heartburn), Bismuth (a medication that treats acid reflux/heartburn), and Divaloproex (a medication that treats seizures). The plan of care indicated a skilled nurse goal that the patient would verbalize signs/symptoms of hypo/hyperglycemia and appropriate actions. The plan of care further indicated the patient stated they had started physical therapy and occupational therapy at the assisted living, The plan of care failed to list a diagnosis of diabetes or hypo/hyperglycemia. The plan of care failed to evidence care coordination occurred with the patient's physician, Further review of the clinical record failed to evidence documentation of case coordination including what services, needs, or changes were			

discussed and/or development of the plan of care, or what services were received with Entity M, the assisted living facility.

11. A review of the clinical record of patient #15, indicated a start of care date of 7-14-16. The clinical record contained an agency document dated 2/24/22, that was titled, Assessment Details which indicated recertification (follow up) reassessment. The untimely comprehensive reassessment indicated the diagnoses of Aneurysm of the carotid artery, Cerebral infarction, Essential Hypertension, Type 2 diabetes mellitus, and Malignant neoplasm of unspecified site of the unspecified female breast with no onset dates. The section titled, 60 Day Clinical Summary evidenced the patient was on a low sodium diet, is at risk for skin breakdown related to incontinence, wears liner pads, as needed (PRN) accuchecks, reported to have a swollen knee on 10-18-21, and went to the hospital for treatment and came home.

A review of the plan of care for the recertification period 2-13-22 to 4-13-22, indicated the following diagnoses: Aneurysm of the carotid artery, Cerebral infarction, Essential Hypertension, Type 2 diabetes mellitus, and Malignant neoplasm of unspecified site of the unspecified female breast, Cerebral infarction, Personal history of malignant neoplasm of breast, and Hypokalemia, with the onset listed dates 2-15-2000. The plan of care further indicated orders for RN to assess vital signs and notify the physician: Blood pressure >180/100 or <90/50; Respirations >20 or < 12; Temperature >100 or < 96; Pulse Rate >100 or < 60; O2sat <90% that failed evidence blood sugar parameters, and to be individualized for the patient. The plan of care in the section DME and Supplies, failed to evidence glucometer, glucometer strips, and lancets, and incorrectly evidenced the patient had a urinary ostomy. The plan of care evidenced "Care Coordination: [Entity B (a personal care agency)], 5p-10p Monday through Friday. The plan of care failed to evidence care coordination with Entity P, (a social services agency), Person U, the case manager with Entity P, who assists patient #15 with personal care assistance under waiver services, failed to

	the patient Entity B, failed to evidence the care discussed or with whom it was discussed at entity B, and failed to evidence what care coordination occurred with the patient's physician. Further review of the clinical record failed to evidence documentation of case coordination including what services, needs, or changes were discussed and/or development of the plan of care, or what services were received with Entity B, Entity P, and Person U. During a phone interview on 4-19-22 at 11:32 AM, the case manager, Person U, with Entity P, a social service agency, confirmed patient #12 was receiving services from Entity B, personal care and he spoke to Employee N, scheduler related to patient #12 s hours. During an interview on 4-19-22 at 4:36, the administrator confirmed tools were given to the nurses and case conference notes and the tools were not used. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(i,ii,iii,v,vi,vii,viii,ix,x,xi,xiii)			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview the agency failed to ensure care was coordinated to meet the patient's needs and included all health care practitioners, home health and hospice agencies, assisted living facilities, and personal care agencies active in the patient's care for 8 of 8 active records reviewed	G0608	G608 Agency unable to correct issues cited in survey as theyoccurred several months ago. Director of Nursing will in-service nurses on requirementfor care coordination. Care coordination is to be done with all health careentities involved with patient. This includes other home health agencies, personalservices agencies, physicians, assisted living	2022-06-22

	(Patients #1, 2, 4, 11, 12, 13, 14, and 15), and for 4 of 4 records reviewed for patients on hold. (Patients #3, 8, 9, 10) Findings include: 1. A review of the plan of care for patient #2, for certification period 2/17/22 - 4/17/22, indicated care coordination with the patient's waiver case management company, but failed to evidence what care was coordinated and discussed. The plan of care also failed to evidence coordination of care with the skilled home health agency who managed the patient's medication, the personal services agency that provided waiver services, and the patient's physician. A review of the comprehensive assessment, dated 2/12/22, indicated care was coordinated with the physician and the aide but failed to indicate the specific individuals with whom care was coordinated or the content of the care coordination. The assessment also failed to evidence care coordination with the patient's waiver and skilled home health agencies. On 4/13/22 at 9:30 AM, the patient indicated receiving waiver services through another agency. When queried concerning medication management, the patient stated a nurse came out to set up the medications, but the patient was unable to remember the name of the agency. 2. A review of the plan of care for patient #3, for the certification period of 4/8/22 - 6/6/22, indicated "Coordination of care with [Entity M] RN/LPN oversees Medication and insulin administration, [Entity K] oversees wound care to BLE." (bilateral lower extremity.) The record		facilities, hospital. Things tobe discussed include disciplines provided, tasks provided, medicationreconciliation, progress of care, changes in plan of care, concerns. Documentationmut include date/time of coordination and who nurse spoke with at other entity.This is to be done at admission, recertification, resumption and anytime thereis a change in patient condition. Thiswill be done by June 22, 2022. Director of Nursing/designee will audit all admissions,recertifications, resumptions of care done weekly to ensure there isdocumentation of care coordination as appropriate and it contains requiredinformation. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing/designee will audit all visit notessubmitted weekly to ensure there is documentation of care coordination asappropriate and it contains required information. Once 100% compliance isachieved	

	coordinated with both entities, whether medications were reconciled, what wound treatments were provided, and the progress of care. A review of the comprehensive assessment, dated 4/8/22, indicated "Coordination of care with [Entity M] RN/LPN oversees Medication and insulin administration, [Entity K] oversees wound care to BLE." (bilateral lower extremity.) The record failed to indicate what care information was coordinated with both entities, whether medications were reconciled, what wound treatments were provided, the progress of care, and care coordination with the physician. 3. A review of the clinical record for patient #8 failed to evidence a current comprehensive assessment and plan of care for the current certification period of 3/1/22 - 4/29/22, and failed to evidence documentation of care coordination with the patient's physician. 4. A review of the clinical record for Patient #9, for the certification period of 2/15/22 - 4/15/22, indicated the patient was hospitalized on 2/24/22 and 2/25/22 and services resumed on 2/28/22. The record failed to evidence case coordination with the hospital, physician, patient, case manager, and home health aide related to the hospitalization, updated orders and medications, an updated plan of care, updated diagnoses, or increased needs post-hospitalization. 6. The clinical record of Patient #4, with a start of care date of 1-24-21, contained a plan of care for the recertification period of 3-20-22 to 5-18-22. The plan of care indicated Patient #4 lives at Entity C, an assisted living facility. The plan of care failed to evidence coordination of care with Entity C. A review of the recertification comprehensive assessment dated 3-21-22, failed to evidence was services and coordination of care Patient #4 was receiving from Entity C. A review of Patient Communication Log notes		10% will be audited quarterly to ensure compliance is maintained.(On-going) Director of Nursing will contact the Director of Nursing atthe assisted living facility listed in survey at least monthly to discusspatients receiving care from Golden Heart and any concerns. This will bedocumented in patient chart. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur.	

dated 2-3-22 to 4-6-22 failed to evidence case conferences completed or coordination of care with Entity C.

During an interview on 4-14-22 at 8:55 AM, the director of nursing of Entity C, Person D when queried about Golden Heart Health Services coordinating care confirmed they were not coordinating care. Person D, stated, Employee E, was the clinical manager, when queried who the clinical manager was of Golden Heart Health Services. Employee E is the scheduler, of the branch location of Golden Heart Health Services.

7. A review of the clinical record of Patient #10, with a start of care date of 2-7-19, contained a plan of care for the recertification period of 1-22-22 to 3-22-22. The plan of care failed to evidence the services and coordination of care patient #10 was receiving from Entity B, an attendant care company, and Entity BB, a behavioral health center.

A review of the recertification comprehensive assessment dated 3-21-22, failed to evidence was services and coordination of care patient #4 was receiving from Entity B, an attendant care agency, and Entity BB, a behavioral health center.

A review of a Patient Communication Log note dated 4-11-22, entered by the registered nurse (RN), Employee F, indicated the RN received a hold order for services from the patient s physician, Person G. The RN reported Patient #10 had fallen and sustained a fracture and partially collapsed lung and was at Entity CC, a hospital, in the intensive care unit. The RN failed to evidence and coordinate care delivery with Entity CC, the hospital.

A review of a Patient Communication Log Note dated 4-13-22, entered by the RN, Person F, indicated contact with Patient #10 s family member, who reported that Patient #10 was in the rehab and there is a large mix up with the medication Patient #10 is to take. The RN failed to evidence and coordinate care delivery with Entity DD, the rehabilitation section of the hospital.

A review of a Patient Communication Log note dated 4-15-22, entered by the scheduler,

aide clocked in on 4-14-22. Employee N, then contacted Employee O, the home health aide for Patient #10, who confirmed Patient #10 was home on 4-14-22 around 1:00 PM. The agency failed to coordinate care with Entity CC, the hospital, Entity DD, the rehabilitation unit, and Entity B, the attendant care agency.

During a phone interview on 4-18-22 at 10:42 AM, and 4-19-22 at 8:47 AM the medical assistant, Person H, for the patient s physician, Person G confirmed patient #10 was in the hospital and was to send the documentation requested.

8. A review of the clinical record of Patient #11, with a start of care date of 12-29-20, contained a plan of care for the recertification period of 2-22-22 to 4-22-22. The plan of care failed to evidence the services and coordination of care Patient #11 was receiving from Entity B, an attendant care company.

A review of the recertification comprehensive assessment dated 3-15-22, failed to evidence was services and coordination of care Patient #11 was receiving from Entity B, an attendant care agency.

A review of the Patient Communication Log Notes, dated 2-22-22 to 4-18-22, failed to evidence coordinating care or case conferences.

During an interview on 4-19-22, at 10:07 AM, Patient #11 confirmed receiving services through a waiver service, every Monday, Wednesday, and Friday evening from 4:00 PM to 10:00 PM and prior authorization (PA) Monday through Friday 8:00 AM to 4:00 PM provided by her son, who is employed by Entity B, and Golden Heart Health Services provides, Employee J.

9. A review of the clinical record of Patient #12, with a start of care date of 2-5-21, contained a plan of care for the recertification period of 1-31-22 to 3-31-22. The plan of care failed to evidence the services and coordination of care Patient #12 was receiving from Entity B, an attendant care company, and Entity C, an assisted living facility.

A review of the recertification comprehensive assessment dated 2-27-22, failed to evidence

	#12 was receiving from Entity B and Entity C. A review of the Patient Communication Log Notes, dated 2-22-22 to 4-18-22, failed to evidence coordinating care or case conferences with Entity B and Entity C. During an interview on 4-18-22 at 2:18 PM, the director of nursing, for Entity C, Person D, confirmed she was unaware that Golden Heart Health Services was now providing care five days a week until now. 10. A review of the clinical record of Patient #13, with a start of care date of 8-5-20, contained a plan of care for the recertification period of 3-28-22 to 5-26-22. The plan of care indicated that patient #13 made the RN aware they were receiving physical therapy and occupational therapy from Entity M. The plan of care failed to evidence the coordination of care patient #11 was receiving from Entity M, the assisted living facility. A review of the recertification comprehensive assessment dated 3-15-22, failed to evidence was services and coordination of care patient #13 was receiving from Entity M. A review of the Patient Communication Log Notes, dated 3-28-22 to 4-18-22, failed to evidence coordinating care or case conferences. During an interview on 4-14-22 at 9:03 AM, the director of nursing of Entity M, Person EE confirmed Patient #13 was a patient of Entity M and receiving physical therapy and occupational therapy at the facility. 11. A review of the clinical record of Patient #14, with a start of care date of 4-27-21, contained a plan of care for the recertification period of 2-21-22 to 4-21-22. The plan of failed to indicate Patient #14 was receiving services from Entity W, a hospice agency. A review of the recertification comprehensive assessment dated 3-17-22, failed to evidence was services and coordination of care Patient #14 was receiving from Entity W.			

	A review of the Patient Communication Log Notes, dated 2-21-22 to 4-18-22, failed to evidence coordinating care or case conferences. During an interview on 4-19-22 at 10:30 AM, the son of Patient #14, Person Y, confirmed since February, that the only nurse that comes to visit the patient is the one from Entity W. The nurse from Entity W, comes to check her blood levels. During an interview on 4-19-22 at 11:07 AM, the clinical manager of Entity W, Person X confirmed Patient #14 was a patient of Entity W. Person X verified patient's start of service date was 2-1-22. Person X further confirmed there were no communication notes in the patient s record since Golden Heart referred Patient #14 to them in November. 12. A review of the clinical record of Patient #15, with a start of care date of 4-19-16, contained a plan of care for the recertification period of 2-13-22 to 4-13-22. The plan of care failed to indicate Patient #15 was receiving services from Entity B an attendant care agency, and Entity P, a community resource agency. A review of the recertification comprehensive assessment dated 2-24-22, failed to evidence was services and coordination of care Patient #15 was receiving from Entity B and Entity P. A review of the Patient Communication Log Notes, dated 2-13-22 to 4-18-22, failed to evidence coordinating care or case conferences. During an interview on 4-19-22 at 11:32 AM, the case manager at Entity P, Person U, confirmed they were the case manager of Patient #15 for arranging hours for waiver care with Entity P and was aware of the hours under PA with Golden Heart Health Services. 13. During the entrance conference on 4-12-22 at 1:15 PM. when queried on how the agency coordinates with other agencies, the administrator confirmed that he and the clinical manager, and the nurses are to make communication logs in the patients charts along with case conference notes.			

	410 IAC 17-12-2(g)			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on interview and record review, the agency failed to ensure a written aide care plan was developed by a registered nurse for 1 of 15 patients with home health aide services (Patient 1) and failed to ensure the aide care plan included an acceptable minimum number of hygiene tasks for 2 of 9 active patient records reviewed. (Patient #1 and 12) Findings Include: 1. A review of an agency document for Patient #1, titled, Aide Plan of Care, last updated dated 11-8-21, evidenced an electronic signature of a certified nursing assistant (CNA), employee E, as the writer of the aide care plan. The aide care plan failed to be completed by a registered nurse (RN.) 2. During a home visit at Patient #1 s home on 4-13-22 at 8:00 AM, the patient was observed sitting in a recliner in the living area. When asked about bathing, Patient #1 confirmed they need to take a shower 2-3 times a week.	G0798	G798 Agency unable to correct issues cited in survey as theyoccurred several months ago. Director of Nursing will ensure all current patients have acurrent correct aide plan of care in home folder. This will be completed by June 22,2022 Director of Nursing/designee will audit all current patientaide care plans to ensure they have been completed by RN as evidenced by RNsignature. This will be completed byJune 22, 2022. Director of Nursing/designee will in-service nurses onrequirement for aide care plan to be individualized to meet patient's needs toinclude minimum number of showers/sponge baths per week to ensure basic hygiene,appropriate frequency/duration as indicated by current MD order and needs to besigned by nurse. This will be completedby June 22, 2022 Director of Nursing/designee	2022-06-22

	A review of the patient folder during the home visit on 4-13-22 at 8:00 AM, a review of the aide care plan indicated the HHA was to provide Patient 1 a shower weekly. The aide care plan failed to be individualized to establish an acceptable amount of hygiene tasks per week (3 time per week would be a minimum number of showers for basic hygiene.) A review of an untitled, undated document provided by the clinical manager, on 4-13-22, at 8:15 AM, indicated prepare meals, encourage fluids, assist with set up, personal care, shower, toileting/hygiene, and wheelchair. The document had the patient s pharmacy name and phone number, physician s name and phone number, and had 5.5 hours times 3 days and 12 hours times 2 days with a line through it with 6 hours times 5 days and 12 hours times 2 days written. A review of the plan of care for the recertification period of 3-19-22 to 5-17-22, indicated home health aide services were to be provided 16 hours a day, 7 days a week for 9 weeks to assist with personal care, light housekeeping, and meal prep. During an interview on 4-13-22 at 8:30 AM, the CNA, employee G for Patient #1, confirmed they document on their phone electronic application where they can view the aide care plan and mark off tasks completed. On 4-18-22 at 11:40 AM, the clinical manager stated she could not provide the updated home health aide care plan for Patient #1, nor could the clinical manager explain different HHA hours assigned within the same certification period in the absence of a physician order to adjust the visit schedule. The clinical manager indicated the HHA notes were not from the electronic record, they just did the paper one.		will audit aide care plans atadmission, recertification and resumption submitted weekly to ensure it hasbeen completed by RN as evidenced by RN signature, has appropriatefrequency/duration as indicated by current MD order, is individualized to meetpatient's needs to include minimum number of showers/sponge baths per week toensure basic hygiene. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur.	

3. The clinical record for Patient #12 was reviewed and included a plan of care for the recertification period of 4-1-22 to 5-30-22, the order for discipline and treatment indicated, HHA 1hour/day, 5 days/week x 9 weeks & Home health aide/CNA to assist with bathing, meal prep, and light housekeeping.

A review of an agency document titled, Aide Plan of Care, last updated 12-2-21, indicated the patient had Schizophrenia, COPD, Gastric Esophageal Reflux Disorder (GERD), and Major Depressive Disorder, regular diet, needs assistance for major adls, SOB on exertion, history of falls, up as tolerated, and no teeth. The aide plan of care indicated the following tasks; diabetic do not cut nails, diet regular, short of breath (SOB) on exertion, history of falls, up as tolerated, has dentures lower/upper, left-sided weakness due to history of cerebral vascular attacks (CVA s), major depressive disorder, fatigue, hypoxemia, angina, COPD, HTN, and morbid obesity. The aide plan of care indicated the following HHA tasks to be completed included but were not limited to personal care each visit per pt request, shower each visit per pt request, and sponge bath each visit per pt request. The aide care plan failed to be individualized to the patient s specific needs and ensure a minimum number of showers or sponge baths per week for basic hygiene.

During an interview on 4-18-22 at 2:18 PM, the director of nursing of the assisted living facility, person D, confirmed Patient #12 had mental behaviors. Person D indicated the patient demonstrated behavior causing poor hygiene such as; digging in the trash cans, the ashtrays outside, and dirt outside, which required the patient to have a shower every day.

During an interview on 4-13-22 at 3:40 PM, the administrator confirmed the aide's plan of care and plan of care must match. The administrator further indicated the nurses are

	the patient's needs. The administrator indicated a minimum frequency for bathing/hygiene should be documented in the aide care plan. IAC 410 17-14-1(m)			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and interview, the agency failed to ensure safe and effective delivery of all home health aide services; failed to ensure all aides followed a patient-specific care plan with tasks assigned by a registered nurse; failed to maintain open communication with the patient and representative (if any); failed to provide supervision and oversight of competency with	G0818	G818 Agency unable to correct issues cited in survey as theyoccurred several months ago. Director of Nursing/designee will in-service nurses onrequirement that aide care plans must be individualized to each patient toinclude appropriate precautions, specific tasks to be performed at each visit. This was done on April 22, 2022. Director of Nursing/designee will in-service nurses they areto complete the “aide supervisory note” when doing aide sup visit as itcontains the required items that must be addressed at a sup visit which includeis the aide competent, provided safe and effective personal care, followed thehome health aide plan of care, furnished care safely and effectively, demonstratedopen communication with the patient, representative, caregivers, or familymembers;	2022-06-10

assigned tasks, including reporting problems; and failed to ensure patient rights were honored in 8 of 8 active records reviewed (Patients #1, 2, 4, 11, 12, 13, 14, 15), and 4 of 4 records reviewed for patients on hold. (Patients #3, 8, 9, 10)

Findings Include:

1. A review of undated agency policy C-220, titled "Home Health Aide Services." indicated"Home Health Aide services will be provided to appropriate clients ... under the direct supervision of an agency Registered Nurse ..." Further review indicated "A specific care plan is developed documenting the Aide services to be provided.

2. A review of undated agency policy C-800, titled "Home Health Aide: Documentation," indicated "Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan ... The Home Health Aide shall be responsible for reporting any changes in the client's condition or other pertinent observations to the Supervising Nurse.

3. A review of undated agency policy C-340, titled "Home Health Aide Supervision," indicated "Agency shall provide Home Health Aide services under the direction and supervison of a Registered Professional Nurse ... When ... services are being furnished to a client who does not require the skilled service of a nurse ... A registered Nurse must make a supervisory visit to the client's residence at least once every thirty (30) days. At least every sixty (60) days the Registered Nurse must make supervisory visit [sic] when aide is present providing personal care." Further review indicated home health aide supervision must ensure that aides furnish care in a safe and effective manner, including but not limited to following the client's plan of care for completion of tasks assigned to a home health

followed infection control practices; reported changes in patientcondition; honors patient rights. This was done on April 22, 2022.

Director of Nursing/designee will audit all supervisoryvisits done weekly to ensure the proper sup visit form is used and properlycompleted. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going)

Director of Nursing/designee will audit all current patientsto ensure they have a current aide plan of care as appropriate. This wil bedone by June 10, 2022.

Director of Nursing/designee will audit all admissions,recerts, resumptions done weekly to ensure there is an accurately completedaide plan of care that is individualized to the patient. Once 100% complianceis achieved 10% will be audited quarterly to ensure compliance is maintained.(On-going)

Director of Nursing/designee will in-service nurses onrequirement for aide supervisory visits to be done at

	aide by the registered nurse, maintaining an open communication process with the client, representative (if any), caregivers, and family, demonstrating competency with assigned tasks, complying with infection prevention and control, reporting changes in the client's condition, and honoring patient rights. 4. A review of the clinical record for patient #2 evidenced a document titled "Aide Plan of Care" with an effective date of 10/15/21, but failed to evidence the plan of care had been reviewed and updated since October 2021. The patient's medical history and related information failed to include diabetic precautions/when to notify the nurse and smoking precautions. All assigned tasks indicated "per patient request," and failed to include patient-specific and individualized tasks to be completed at each visit. A review of the clinical record evidenced a skilled nursing visit note, dated 3/14/22, with a visit type of "supervisory." A section titled "HHA (home health aide) Supervisory Visit" failed to evidence the aide was competent, provided safe and effective personal care, followed the home health aide plan of care, and honored patient rights. Further review evidenced a skilled nursing visit note dated 2/22/22 and failed to evidence the competent, provided safe and effective personal care, followed the home health aide plan of care, and honored patient rights. 5. A review of the clinical record for patient #3 indicated a plan of care dated 4/8/22 - 6/6/22, with home health aide services 1 hour/day x 5 days/week x 9 weeks, but failed to evidence a home health aide plan of care. The clinical manager was interviewed concerning the patient's services, and stated the patient was placed on hold immediately		least every 30 days andat least every 60 days the aide must be present and RN is to observe personalcare. This is for aide only cases. This was done on April 22, 2022. Director of Nursing/designee will look at visit scheduleseach week to ensure if patient is due for a supervisory visit it is on scheduleand done at the appropriate 30 day intervals and if it is to be a shared visitit is scheduled during time aide will be present. (On-going) Director of Nursing/designee will ensure when an aide isassigned to a patient an RN reviews the aide plan of care with the aide. Thisis to be documented in patient chart. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur.	

assessment was completed, while the agency applied for insurance authorization for services, so no aide services had been provided since the start of care on 4/8/22.

6. A review of the clinical record for patient #8, start of care date 1/5/21, failed to evidence an active plan of care, based on an appropriate recertification assessment, for the current certification period of 3/1/22 - 4/29/22.

Further review of the clinical record evidenced an aide plan of care with an effective date of 9/2/21. The aide plan of care indicated diagnoses of Asthma, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease, and indicated the patient had shortness of breath with minimal exertion and failed to include an asthma action plan or instructions for the home health aide related to the patient's respiratory and fluid status, such as signs/symptoms of respiratory distress, signs/symptoms of fluid imbalance/edema, and when to notify a supervisor, All assigned tasks indicated "per patient request" and failed to include individualized and patient-specific tasks to be provided. The record also failed to evidence the home health aide plan of care was updated by a registered nurse at least every 60 days, was based on the patient's needs as identified in a current and accurate comprehensive assessment, and failed to evidence a supervisory visit was performed every 30 days, with the aide present every 60 days.

7. A review of the clinical record for patient #9 indicated the patient was hospitalized on 2/24/22 and 2/25/22, and services were resumed on 2/28/22. The record failed to evidence an updated and accurate comprehensive assessment was performed to determine the patient's current home health aide needs post-hospitalization.

Further clinical record review evidenced a home health aide plan of care with an effective date of 10/13/21, and indicated the patient

	was diabetic, had a low sodium diet, and needed assistance for major adls (activities of daily living). The home health aide plan of care failed to evidence diet instructions related to the patient's diabetes, including the low concentrated sweets diet on the current medical plan of care; failed to include diabetic precautions or signs/symptoms of when to notify the supervisor related to hypo/hyperglycemia (low/high blood sugar). All assigned tasks indicated "per patient request" and failed to be patient-specific and individualized. The record also failed to evidence the home health aide plan of care was updated by a registered nurse at least every 60 days, was based on the patient's needs as identified in a current and accurate comprehensive assessment, and failed to evidence a supervisory visit was performed every 30 days, with the aide present every 60 days. On 4/18/22 at 2:04 PM, the clinical manager was interviewed concerning supervisory visits and indicated the registered nurse should do a supervisory visit every 30 days, with the aide present every 60 days for non-skilled patients. The clinical manager indicated the agency was not compliant with the timing or content related to supervision and did not include all elements, such as whether the aide was competent, provided safe and effective personal care, followed the home health aide plan of care, and honored patient rights. When queried as to whether the home health aides were assigned to patients by a registered nurse, the clinical manager indicated the schedulers assign the aides to each patient. 8. The clinical record for Patient #1 was reviewed and included a Skilled Nursing Visit Note visit dated 1-13-22. The Skilled Nursing Visit Note indicated the type of visit was supervisory and the aide was not present, and the care plan/care coordination with the physician, HHA, reviewed/revised with the patient, and the next nurse visits every 30 days. The supervisory visit note failed to include the following in regards to the HHA furnished care safely and effectively; following the client s care plan; demonstrating open communication			

	with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. 9. The clinical record for Patient #4 was reviewed and included a Skilled Nursing Visit Note visit dated 1-14-22. The Skilled Nursing Visit Note indicated the type of visit was supervisory and the aide was not present, and the care plan/care coordination with the physician, HHA, reviewed/revised with the patient, and the next nurse visit every 30 days. The supervisory visit note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. 10. The clinical record for Patient #10 was reviewed and included a Skilled Nursing Visit Note visit dated 1-17-22. The Skilled Nursing Visit Note indicated the type of visit was supervisory-telehealth and the aide was not present, and the care plan/care coordination with the physician, HHA, reviewed/revised with the patient, and the next nurse visit every 30 days. The supervisory visit note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. A review of a Skilled Nursing Visit Note dated 2-17-22 indicated the type of visit was supervisory- telehealth and the aide was present, and the care plan/care coordination with the physician, HHA, reviewed/revised with the patient, and the next nurse visit every 30 days. The supervisory visit note failed to include the following in regards to the HHA			

	furnishing care safely and effectively; following the client s care plan; demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. A review of a Skilled Nursing Visit Note dated 3-29-22 indicated the type of visit was supervisory- telehealth and the aide was not present, and the care plan/care coordination with physician, HHA, reviewed/revised with the patient, and the next nurse visit every 30 days. The supervisory visit note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights 11. The clinical record for Patient #11 was reviewed and included a Comprehensive reassessment recertification visit note dated 3-15-22. The comprehensive reassessment indicated the document was recertification and supervisory completed. The supervisory note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; if the aide was present, demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. 12. The clinical record for Patient #12 was reviewed and included a Skilled Nursing Visit Note visit dated 2-25-22. The Skilled Nursing Visit Note indicated the type of visit was supervisory and the aide was not present, and the care plan/care coordination with the physician, HHA, reviewed/revised with the patient, and the next nurse visit every 30 days. The supervisory visit note failed to include the following in regards to the HHA furnishing			

	care safely and effectively; following the client s care plan; demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. 13. The clinical record for Patient #13 was reviewed and included a Comprehensive reassessment recertification visit note dated 1-22-22. The comprehensive reassessment indicated the document was recertification and supervisory completed. The supervisory note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; if the aide was present, demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. A review of the Comprehensive reassessment recertification visit note dated 2-27-22. The comprehensive reassessment indicated the document was recertification and supervisory completed. The supervisory note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; if the aide was present, demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. 14. The clinical record for Patient #14 was reviewed and included a Skilled Nursing Visit Note visit dated 3-17-22. The Skilled Nursing Visit Note indicated the type of visit was supervisory and the aide was not present nor not present left blank. The supervisory visit note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices;			

	reporting changes in patient condition; honoring patient rights. 15. The clinical record for Patient #15 was reviewed and included a Comprehensive reassessment recertification visit note dated 2-24-22. The comprehensive reassessment indicated the document was recertification and supervisory completed. The supervisory note failed to include the following in regards to the HHA furnishing care safely and effectively; following the client s care plan; if the aide was present, demonstrating open communication with the patient, representative, caregivers, or family members; following infection control practices; reporting changes in patient condition; honoring patient rights. During an interview on 4-14-22 at 4:04 PM, the administrator, and clinical manager, when queried about the home health aide supervisory visit process, confirmed the aide supervisory visits are to be done every 30 days and 60 days with the aide present. The case manager is to complete the supervisory visit on the agency document titled, Supervisory Visit Note not the skilled nurse visit note or comprehensive assessment documents.			
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored	G0940	G940 A new contract was signed between the agency and the RNnurse consultant that covers all aspects of her current contractualobligations. This was done by April 22,2022. See G942 The Administrator will be responsible for monitoring these correctiveactions to	2022-04-22

	and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the Governing Body failed to organize, manage, and administer its resources to attain the highest functional capacity and the provision of optimal care for 1 of 1 home health agency (See below,) and the governing body failed to update a policy to ensure it required the minimum regulatory elements for the contents of a plan of care, for 1 of 1 governing body (See G 942.) The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality health care, thus being out of compliance with Condition of Participation 42 CFR 484.105 Organization and Administration of Services. Findings incude: On 4/18/22 at 3:30 PM, the Administrator was interviewed concerning the agency's operation and management. The Administrator indicated the agency retained the services of Person O, for registered nurse and home health consulting, and for whom the Administrator was employed prior to accepting the Administrator position at Golden Heart. The Administrator indicated having accepted a full-time position as the Administrator with Golden Heart Health Services to assist the agency in achieving compliance with Federal regulations and State rules after their last full survey in November 2021. The Administrator indicated working "day and night" and "continuously" with Person O and indicated		ensure this deficiency is corrected and will not recur.	

more time was needed to achieve total compliance. The Administrator indicated the agency had focused heavily on home health aide competency and retraining but had difficulty retaining a registered nurse or company that could satisfy the requirements for home health aide training and competency. The Administrator indicated no audit information was available as part of the agency's QAPI program, the Administrator indicated the QAPI was robust and each time a new problem was identified, the Administrator added it to the QAPI book. The administrator indicated follow-up data/information, audits, or reviews had not been conducted, including but not limited to, the ability to meet ordered visit frequencies for patients, supervisory visit compliance, the start of care and recertification within the regulatory requirements, the content of the comprehensive assessment, authentication of hours worked, aide plans of care, and employee competency, the Administrator indicated he was not a clinically trained professional, the clinical manager was new, and they were working directly with Person O, the consultant. The Administrator indicated the primary focus had been home health aide competency and training, but many aides had resigned or were terminated, and a new clinical manager, alternate clinical manager, and administrator were also added. As a result, the agency needed more time to achieve compliance with the citations. The administrator indicated the current contract with Person O, which evidenced Person O was retained for the sole purpose of training the clinical manager, the Administrator indicated having failed to initiate a new contract for consulting with Person O.

A review of the personnel records for, Employee W, a home health aide, evidenced Employee W was hired on 3/22/22 and had no patient contact as of 4/18/22. A review of a document titled "Home Health Hospice Aide Written Competency Assessment Exam Scoring Sheet," dated 3/29/22, indicated the written test was divided into 14 individually graded sections. Each section had a number required for passing. A review of the scoring for Employee W indicated the HHA had failed sections 1, 5, 8, 10, and 14, but had an overall

	composite score of 119/160, which was considered a passing score. A review of a document titled "Home Health Aide/Hospice Aide Competency checklist," dated 3/29/22, failed to evidence Employee W had demonstrated all required skills on a patient, or pseudo-patient if applicable. When queried as to the rules for the home health aide competency testing, including the number of sections on the written test that could be failed and what items must be physically demonstrated on a patient, or pseudo-patient, the Administrator indicated Employee T, a Registered Nurse, provided the off-site aide competency training and he had nothing to do with verifying competency had been correctly established and documented. A review of the contract with employee T indicated the agency was not involved in any part of the training listed and Employee T reported directly to Person O. When queried as to whether the Administrator was responsible to ensure all employees were appropriately evaluated for competency, regardless of whether the agency performed the competency, the Administrator stated he was not clinical, and the consultant and Employee T addressed the aide competency. When queried as to whether the Administrator was responsible for all day-to-day activities, including ensuring all employees were competent, the Administrator indicated yes.			
G0942	Governing body 484.105(a)	G0942	G942 Policy C580, cited in policy, has been revised to include	2022-04-22

	Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the governing body failed to update a policy to ensure it required the minimum regulatory elements for the contents of a plan of care, for 1 of 1 governing body. Findings include: 1. A review of an undated agency policy C-580, titled "Plan of Care," indicated the plan of care will be consistently reviewed at least every 60 days and will include treatment goals. The policy failed to indicate the plan of care must include patient-specific and measurable treatment goals and interventions; failed to evidence the plan of care must be established and reviewed by the physician; failed to indicate the time frame required for obtaining the physician's signature, all elements which were required by the conditions of participation. 2. During an interview with the administrator on 4/19/22 at 12 noon, the administrator verified the plan of care policy reviewed failed to include the requirements the plan of care because the policy failed to require patient-specific and measurable treatment goals and interventions; failed to include the requirement the plan of care must be established and reviewed by the physician; and failed to include a discrete and identifiable time period for the return of a physician-reviewed and signed plan of care had been established.		missingitems. See attachment A. The Administrator will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur. **PLAN OF CARE** **C580** **POLICY** Home careservices are furnished under the supervision and direction of the client'sphysician/allowed non-physician practitioner (NPP). The Plan of Care is basedon a comprehensive assessment and information provided by the client/family andhealth team members. Planning for care is a dynamic process that addresses thecare, treatment and services to be provided. The plan will be consistentlyreviewed to ensure that client needs are met, and will be updated as necessary,but at least every sixty (60) days. In cases whereclient care is provided in a clinical setting with rotating staff	

			non-physician practitioner (NPP), orders shall be processedin accordance with Agency policy and the agency shall accept the signature anddate of the physician/allowed non-physician practitioner (NPP) assigned to theclinic at the time orders are presented for signature as the attendingphysician/allowed non-physician practitioner (NPP) for the client. **PURPOSE** Toprovide guidelines for agency staff to develop a plan of care individualized tomeet specific identified needs. Toreflect client's ability to make choices and actively participate inestablishing and following the plan designated to attain personal health goals. Toassure that the plan meets state/federal guidelines, and all applicable lawsand regulations. **SPECIAL INSTRUCTIONS** 1. An individualized Plan of Care signedby a physician/allowed	

			(NPP) shall be required foreach client receiving home health and personal care services. 2. The Plan of Care shall be completed infull to include: a. Allpertinent diagnosis(es), principle and secondary, including dates of onset. b. Mentalstatus. c. Type,frequency, and duration of all visits/services. d. Specificprocedures and modalities for therapy services. e. Needfor/presence of home medical equipment and assistive devices. f. Diagnostictests, including laboratory and x-rays. g. Surgicalprocedure(s). h. Prognosis. i. Rehabilitationpotential. j. Functionallimitations and precautions. k. Activitiespermitted or restrictions.	

			l. Specificdietary or nutritional requirements or restrictions. m. Medications, treatments, andprocedures. n. Medicalsupplies and equipment required. o. Anysafety measures to protect against injury. p. Instructionsto client/caregiver, as applicable. q. Treatmentgoals. r. Instructionsfor timely discharge or referral. s. Dischargeplans. t. Patient-specific and measurable treatment goals and interventions u. Nameand address of client's physician/allowed non-physician practitioner (NPP). v. Otherappropriate items. w. *Allof the above items must always be addressed on the Plan of Care.* 3. If a physician/allowed non-physicianpractitioner (NPP) refers a client under a Plan of	

			Care that cannot becompleted until after an assessment visit, the physician shall be consulted toapprove additions or modifications to the original plan. The plan of care mustbe established and reviewed by the physician/non-physician practitioner. The skilled assessment visit order will bedocumented on a Doctor's/allowed non-physician practitioner's (NPP) Order Formand mailed/faxed to the physician for signature. 4. Orders for therapy services shallinclude the specific procedures and modalities to be used and the amount,frequency, and duration. 5. The Plan of Care/485 will be developedfollowing the initial assessment and the original will be mailed or faxed tothe physician for signature. The plan of care is developed within five (5)working days or asrequired by agency/state guidelines. The written Plan of Care mustbe signed by the physician/allowed non-physician practitioner (NPP) andreturned to the agency. A copy of the Plan of	

withinthe client's clinical record until the original Plan of Care is returned.

6. Signed physicians'/allowednon-physician practitioners' (NPP) orders will be obtained as quickly aspossible butwithin thirty (30) days and no claimswill be sent prior to receiving signed orders when required by payer.

7. The client, Therapist,and other agency personnel shall participate in developing the Plan of Care.The client shall be informed of any changes in the Plan of Care.

8. The total Plan of Care shall bereviewed by the attending physician/allowed non-physician practitioner (NPP)and agency personnel as often as the severity of the client's conditionrequires, but at least one time every sixty (60) days.

9. At the time of certification andrecertification, a written summary of the client's current status and theservices being provided are submitted with the plan of care for review. Thesummary shall include but is

			clients physical orpsychosocial condition, client response to care/services and outcome of careand services. 10. Professional staff shall promptlyalert the physician/allowed non-physician practitioner (NPP) to any changesthat suggest a need to alter the Plan of Care. 11. Verbal/telephone orders shall beobtained from the client's physician/allowed non-physician practitioner (NPP)for changes in the Plan of Care *(refer tothe Physician Orders policy)*. 12. The PRN orders will be accompanied bya description of the client's needs that could warrant a visit. Physician/allowed non-physicianpractitioner (NPP) orders must be signed and dated by the physician. No rubber stamp for signature will beaccepted. Electronic signatures will be accepted by the agency.	

G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure the clinicians documented the date and time with each entry authentication for 9 of 9 active records reviewed. (Patient #1, 2, 4, 12, 11, 12, 13, 14, 15) Findings Include: 1. A review of the clinical record for Patient #1, which contained a plan of care for the recertification period of 1-18-22 to 3-18-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the registered nurse (RN), former employee FF. Former employee FF failed to evidence the date and time of the entry. A review of the comprehensive reassessment dated 1-13-22, evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the time of the entry. A review of a plan of care for the recertification period of 3-19-22 to 5-17-22, indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, employee C. Employee C failed to evidence the date and time of the entry.	G1024	G1024 Unable to correct issues cited for employee FF in survey asemployee is no longer employed by agency. Director of Nursing/designee will in-service all staff onneed to sign/date all documentation. This was done on April 22, 2022. Director of Nursing/designee will audit all documentationsubmitted weekly to ensure it is signed/dated by employee. Once 100% complianceis achieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur.	2022-04-22

A review of the comprehensive reassessment dated 3-16-22, evidenced an electronic signature of the RN, employee C. Employee C failed to evidence the time of the entry.

2. A review of the clinical record for Patient #4, which contained a plan of care for the recertification period of 1-19-22 to 3-19-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the date and time of the entry.

A review of the comprehensive reassessment/supervisory visit dated 1-14-22, evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the time of the entry.

A review of a plan of care for the recertification period of 3-20-22 to 5-18-22, indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, employee C. Employee C failed to evidence the date and time of the entry.

A review of the comprehensive reassessment dated 3-21-22, evidenced an electronic signature of the RN, employee C. Employee C failed to evidence the time of the entry.

A review of a supervisory visit note dated 3-21-22, evidenced an electronic signature of the RN, employee C. Employee C failed to evidence the time of the entry.

3. A review of the clinical record for Patient #10, which contained a plan of care for the recertification period of 1-22-22 to 3-22-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the date and time of the entry.

A review of the comprehensive reassessment dated 1-17-22, evidenced an electronic signature of the RN, Former employee FF. Former employee FF failed to evidence the time of the entry.

A review of a plan of care for the recertification

period of 3-23-22 to 5-21-22, indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, Employee F. Employee F failed to evidence the date and time of the entry.

A review of the late comprehensive reassessment dated 4-8-22, evidenced an electronic signature of the RN, employee F. Employee F failed to evidence the RN s electronic signature at the time of the entry.

4. A review of the clinical record for Patient #11, which contained a plan of care for the recertification period of 2-22-22 to 4-22-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the date and time of the entry.

A review of the comprehensive reassessment dated 3-15-22, evidenced an electronic signature of the RN, former Employee FF. Former Employee FF failed to evidence the time of the entry.

5. A review of the clinical record for Patient #12, which contained a plan of care for the recertification period of 1-31-22 to 3-31-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the date and time of the entry.

A review of the late comprehensive reassessment dated 2-27-22, evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the time of the entry.

A review of a plan of care for the recertification period of 4-1-22 to 5-30-22, indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, employee C. Employee C failed to evidence the date and time of the entry.

A review of the comprehensive reassessment dated 4-4-22, evidenced an electronic signature of the RN, employee C. Employee C

failed to evidence the time of the entry.

6. A review of the clinical record for Patient #13, which contained a plan of care for the recertification period of 1-27-22 to 3-27-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the date and time of the entry.

A review of the late comprehensive reassessment dated 1-22-22, evidenced an electronic signature of the RN, former Employee FF. Former Employee FF failed to evidence the time of the entry.

A review of a plan of care for the recertification period of 3-28-22 to 5-27-22, indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the date and time of the entry.

A review of the early comprehensive reassessment dated 2-27-22, evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the RN s electronic signature at the time of the entry.

7. A review of the clinical record for Patient #14, which contained a plan of care for the recertification period of 2-21-22 to 4-21-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the date and time of the entry.

A review of the late comprehensive reassessment dated 3-17-22, evidenced an electronic signature of the RN, former Employee FF. Former Employee FF failed to evidence the time of the entry.

8. A review of the clinical record for Patient #15, which contained a plan of care for the recertification period of 2-13-22 to 4-13-22. The plan of care indicated in the section titled, Nurse s Signature and Date of Verbal SOC when Applicable evidenced an electronic signature of the RN, former Employee FF.

	Former Employee FF failed to evidence the date and time of the entry. A review of the late comprehensive reassessment dated 2-24-22, evidenced an electronic signature of the RN, former employee FF. Former employee FF failed to evidence the time of the entry. During an interview on 4-19-22 at 12:00 PM, the administrator confirmed the clinical manager and nurses were to complete the audit tool sheet on all comprehensive assessments. When audits were requested, the administrator indicated not being able to provide any. The administrator confirmed the audit tools for compliance were not done. 410 IAC 17-15-1(a)(7)			

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

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