DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 300031340	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/23/2022

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

POC accepted in Gateway 8-22-2022

(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
G0000	INITIAL COMMENTS This visit was for a Second Post-Condition Revisit (PCR) survey for Federal Recertification and State Re-licensure of a Medicaid Home Health Agency. Survey Dates: 06-21, 06-22, and 06-23-2022 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 second PCR survey on 06-22-22. 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 in accordance with 410 IAC 17. See the State	G0000	G0000 Deborah Franco, RN GOLDEN HEART HEALTH SERVICES issubmitting the following Plan of Correction in response to the 2567 issued byISDH and/or CMS as it is required to do by applicable state and federalregulations. The submission of this Plan of Correction is not intended as anadmission, does not constitute an admission by and should not be construed asan admission by GOLDEN HEART HEALTH SERVICES that the findings and allegationscontained herein are accurate and true representations of the quality of careand services provided to patients of the Agency. GOLDEN HEART HEALTH SERVICESdesires this Plan of Correction to be considered our Allegation of Compliance.”	2022-08-26

	Form for State only deficiencies. QR by Area 3 completed on 8-12-2022 in iQIES		The Administrator will beresponsible for monitoring these corrective actions to ensure that this deficiencyis corrected and will not recur.	
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure all patients participated in and were informed about the care and services to be provided, including, but not limited to, disciplines and frequency of visits expected in 5 of 8 active records reviewed (Patients #3, 4, 7, 9, 11)	G0434	G0434 Director of Nursing (DON)in-serviced nurses on patients right to participate in, be informed about, andconsent or refuse care in advance of and during treatment, where appropriate,with respect to-- (i) Completion of allassessments; (ii) The care to be furnished,based on the comprehensive assessment; (iii) Establishing and revisingthe plan of care; (iv) The disciplines that willfurnish the care; (v) The frequency of visits; (vi) Expected outcomes of care,including patient-identified goals, and anticipated risks and benefits;	2022-08-24

patients on hold. (Patients #8, 10, 12) of a total sample of 13 patients.

Findings Include:

6. A review of the clinical record for Patient #3 indicated a service agreement/consent for care. The consent indicated home health aide services but failed to indicate the disciplines and frequency of the home health aide services, the date the agreement was signed, or the date services began. The record also failed to evidence the patient was informed about and consented to the care and services provided including, but not limited to, the disciplines and frequencies expected.

7. A review of the clinical record for Patient #4 indicated a service agreement/consent for care. The consent failed to indicate the disciplines provided, the frequency of services, the date the agreement was signed, or the date services began. The record also failed to evidence the patient was informed about and consented to the care and services provided including, but not limited to, the disciplines and frequencies expected.

8. A review of the clinical record for Patient #9 indicated a service agreement/consent for care which failed to indicate the disciplines provided, the frequency of services, the date the agreement was signed, or the date services began. The record also failed to evidence the patient was informed about and consented to the care and services provided including, but not limited to, the disciplines and frequencies expected.

9. A review of the clinical record for Patient #11 indicated a service agreement/consent for care, signed by the patient. The consent failed to indicate the disciplines provided, the frequency of services, the date the agreement was signed, or the date services began. The record also failed to evidence the patient was informed about and consented to the care and services provided including, but not limited to, the disciplines and frequencies expected.

(vii) Any factors that couldimpact treatment effectiveness; and

(viii) Any changes in the care tobe furnished

Date completed was 07-15-2022

Administrator/DON will ensure allactive patients receive a new consent form that indicates disciplines provided,frequency of services, date agreement was signed, and the date services began. Datecompleted 08-24-2022.

DON has instructed nurses theyare to document in patient chart that patient was provided new home folder witha current consent form. DON will audit charts weekly and keep a list ofpatients who have received the new consent form until all active patientsreceived new consent form and documentation is present in their chart. Datecompleted, 08-24-2022.

DON/designee will audit alladmissions done weekly to ensure consent form is completed with requiredinformation. Once

410 IAC 17-12-3 (b)(2)(D)(i)(AA)&(BB)

410 IAC 17-12-3 (b)(2)(D)(ii)(AA)&(BB)

1. A review of an undated agency policy C-660, titled "Care Plans," evidenced that "Each client will have a care plan on file...This plan is developed with the client and family, as indicated..."

2. A review of the clinical record for Patient #7 contained an agency document titled, Home Health Admission Agreement/Consent for Care Service. The consent failed to indicate the disciplines provided, the frequency of services, the date agreement was signed, and the date services began. The record also failed to evidence the patient was informed about and consented to the care and services provided, including, but not limited to, the disciplines and frequencies expected.

3. A review of the clinical record for Patient #8 contained an agency document titled, Home Health Admission Agreement/Consent for Care Service. The consent failed to indicate the disciplines provided, the frequency of services, the date the agreement was signed, and the date services began. The record also failed to evidence the patient was informed about and consented to the care and services provided, including, but not limited to, the disciplines and frequencies expected.

4. A review of the clinical record for Patient #10 contained an agency document titled, Home Health Admission Agreement/Consent for Care Service. The consent failed to indicate the disciplines provided, the frequency of services, the date agreement was signed, and/or the date services began. The record also failed to evidence the patient was informed about and consented to the care and services to be provided including, but not limited to, the disciplines and frequencies expected.

5. A review of the clinical record for Patient #12 contained an agency document titled, Home Health Admission Agreement/Consent for Care Service. The consent failed to indicate

100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going)

Director of Nursing in-servicednurses on informing patients about the care and services to be provided,including, but not limited to, the disciplines and frequencies expected. Nursesare to document in patient chart they informed patient about these and ifpatient consented to them. Date completed, 08-24-2022.

Director of Nursing will ensureorientation of newly hired nurses includes training on consent form foradmissions must indicate disciplines to be provided, frequency of services,date agreement was signed, and the date services to begin. (On-going)

The Administrator will be responsiblefor monitoring these corrective actions to ensure that this deficiency iscorrected and will not recur.

	services, the date agreement was signed, and/or the date services began. The record also failed to evidence the patient was informed about and consented to the care and services to be provided including, but not limited to, the disciplines and frequencies expected.			
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 the services ordered in the plan of care for 3 of 8 active records reviewed. (Patients #5, 6, and 7) of a total of 13 patients in the sample. Findings Include: 1. A review of an undated agency policy titled Client Admission Process, policy number C-140, indicated, Services will be initiated within 48 hours after the assessment unless documentation supports alternative plan based on client needs and wishes and physician orders &. 2. A review of an undated agency policy titled Care Plans, policy number C-660, indicated Policy: Each client will have a care plan on file that addresses their identified needs and the agency s plan to respond to those needs. This plan is developed with the client...and is based on services needed &. 3. A review of the clinical record for Patient #5, the start of care date of 07-08-20, indicated a document titled Assessment Details, dated 05-17-2022. The assessment indicated the patient required an HHA (Home Health Aide) 1 hour a day 5 times a week for bathing, dressing, light housekeeping, and transfers. A review of an agency document titled Home	G0436	G0436 Director of Nursing in-servicedclinicians on requirement for patients receive all services ordered by MD inthe plan of care. Director of Nursing/designeeaudited all current active patient charts to ensure patients were receiving theservices ordered by MD in the plan of care. Visit notes were compared to planof care to ensure frequency and tasks were provided as ordered on plan of care.This was completed by 07-15-2022. Director of Nursing/designee willaudit all visit notes submitted weekly and compare notes to plan of care toensure frequency and tasks provided follow the plan of care. If frequency isnot provided as ordered Director of Nursing/designee will ensure there is amissed visit report that was sent to MD and	2022-07-15

	initial certification period of 04-29-2022 to 06-27-2022 indicated the patient was to receive a home health aide (HHA) 1 hour a day 5 times a week for 9 weeks for assistance with bathing, and light housekeeping. A review of an unsigned agency document titled Verbal Order, dated 05-17-22, indicated Verbal order resumption of care assessment &HHA frequency 1 hour x 3 days/week x 4 weeks for bathing, housekeeping, and light meal prep &. A review of an agency document titled Case Conference Form, dated 05-01-22 and signed by the Clinical Manager, indicated a section titled Date/Times/Hours and Care Provided. The form indicated 5/1-5/30 HHA T W Thurs &. A review of an agency document titled Case Conference Form, dated 06-01-22 and signed by the Clinical Manager, indicated a section titled Date/Times/Hours and Care Provided. The form indicated 6/1-6/30 HHA T W Thurs &. A review of an agency document titled Aide Plan of Care, dated 05-26-22, indicated the patient received a HHA 1 hour a day 5 times a week. The home health agency failed to ensure all visits were completed as ordered on the plan of care, as evidenced by: A. A review of the agency documents titled, Aide Visit Note-Daily evidenced Patient #5 received 2 home health aide visits dated 05-03-22, 05-05-22, and a missed visit note for 05-04-22 the week of 05-01-22 to 05-07-22. The record failed to evidence the patient received the ordered visits of 1h/d x 5d/wk. B. Record review evidenced 3 home health aide visits dated 05-17-22, 05-18-22, and 05-19-22, the week of 05-15-22 to 05-21-22. The record failed to evidence the patient received the ordered visits of 5 times per week. C. Record review evidenced 3 home health aide visits dated 05-24-22, 05-25-22, and 05-26-22, the week of 05-22-22 to 05-28-22. The record failed to evidence the patient received the ordered visits of 5 times per week. . D. Record review evidenced 3 home health		documentation in chart indicatingthis. If a task is not marked as provided on visit note Director ofNursing/designee will ensure there is documentation indicating why task wasn'tdone (i.e. – patient refused). Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Director of Nursing/designee willreview visit schedule weekly to ensure each patient is scheduled for frequencyordered on the plan of care. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Director of Nursing in-servicedschedulers on scheduling aide visits according to the frequency ordered on theplan of care. This was completed by 07-15-2022. Director of Nursing/designee willreview nursing schedule weekly to ensure visits are scheduled as per orderedfrequency on the plan of care. (On-going) Director of Nursing will	

	aide visits dated 05-31-22, 06-01-22, and 06-02-22, the week of 05-29-22 to 06-04-22. The record failed to evidence the patient received the ordered visits of 5 times per week. . E. Record review evidenced 3 home health aide visits dated 06-05-22, 06-07-22, and 06-08-22, the week of 06-05-22 to 06-11-22. The record failed to evidence the patient received the ordered visits of 5 times per week. . F. Record review evidenced 2 home health aide visits dated 06-14-22, and 06-15-22, the week of 06-12-22 to 06-18-22. The record failed to evidence the patient received the ordered visits of 5 times per week. During an interview on 06-21-2022, at 1:20 PM, the administrator confirmed there were no other missed visits or documentation to provide for Patient #5 s clinical record. 4. A review of the clinical record for Patient #6, the start of care date of 05-20-2022, indicated a document titled Assessment Details, dated 05-20-2022. The initial comprehensive assessment indicated that Patient #6 could use the assistance of an HHA for 1 hour a day 5 times a week for bathing and light housekeeping. A review of an agency document titled Home Health Certification and Plan of Care, for the initial certification period of 05-20-2022 to 07-18-2022, indicated the patient received a home health aide for 1 hour a day 5 times a week for 9 weeks for assistance with bathing, light housekeeping, and meal prep per the HHA care plan. The clinical record failed to evidence a hold order for services pending payor approval. A review of an agency document titled Aide Plan of Care indicated the patient received a home health aide visit 1 hour a day 5 times a week. The record failed to evidence the patient received any home health aide visits between 5/20/22 6/11/22. During an interview on 06-21-2022, at 3:55 PM, the Clinical Manager confirmed that they did not document any communication notes, coordination of care notes, notifying the physician care visits had not begun or to		ensureorientation of newly hired staff (schedulers/nurses/aides) includes training onproviding frequencies as ordered on plan of care. Nurses/aides will be orientedon what process is/documentation required when tasks on plan of care are notfollowed. (On-going) The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

obtain a physician order to place services for Patient #6 on hold until prior authorization was received.

5. A review of the clinical record for Patient #7, the start of care date of 03-24-21, evidenced a recertification assessment document titled Assessment Details, dated 05-20-2022. The comprehensive recertification assessment indicated the patient could use the assistance of an HHA 1 hour a day 5 times a week for bathing, dressing, and light housekeeping.

A review of an agency document titled Home Health Certification and Plan of Care, for the initial certification period of 05-18-2022 to 07-16-2022, indicated orders for a home health aide (HHA) for 1 hour a day 5 times a week for 9 weeks for assistance with bathing, light housekeeping, and meal prep per the HHA care plan.

A review of an agency document titled Aide Plan of Care indicated the patient received an HHA for 1 hour a day 5 times a week. The home health agency failed to ensure all visits were completed as ordered on the plan of care, as evidenced by:

A. A review of the agency documents titled Aide Visit Note-Daily evidenced Patient #7 received 4 home health aide visits dated 05-03-22, 05-04-22, 05-05-22, and 05-06-22 the week of 05-01-22 to 05-07-22, rather than the 5 ordered visits.

B. A review of the agency documents titled Aide Plan of Care indicated the patient received 4 home health aide services dated 06-13-22, 06-14-22, 06-15-22, and 06-16-22 the week of 06-12-22 to 06-18-22, rather than the 5 ordered visits.

C. A review of the agency documents titled Aide Plan of Care evidenced 2 home health aide visits dated 06-21-22 and 06-22-22, for the week of 06-19-22 to 06-23-22. No other documentation/missed visit note/communication note was in the clinical record or provided upon request for the home health aide s 3 missed visits.

During an interview on 06-22-22, at 11:50 AM,

	having to do without an aide. I fell and broke my back years ago, so I cannot bend down to wash my lower part.			
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 orally and in writing in advance of starting services of the extent to which 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 before the initiation of care for 3 or 8 patients records reviewed (Patients #5, 7, 12) of a total sample of 13 patients.	G0440	G0440 Administrator/Director of NursingAdministrator/DON ensured all active patients received a new consent form thatadvised patient in writing of the extent to which services would be covered byMedicaid or any other federally funded program; the charges for services notcovered by Medicaid, or any other federally funded program; and any expectedcharges that must be paid before the initiation of care. Date completed will be08-24-2022. Administrator/DON instructednurses they were to also notify patient verbally of which services will becovered by Medicaid or any other federally funded program; the charges forservices not covered by Medicaid, or any other federally funded program; andany expected charges that must be paid before the initiation of care. Date completedwill be 08-24-2022. DON has instructed nurses	2022-08-24

Findings Include:

1. A review of an undated agency policy titled Service Agreement, policy number C-160, indicated A Service Agreement shall be developed with all clients upon admission before care is provided. The service agreement will identify & 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 of Patient #5, with a start of care date of 03-21-21, contained a service agreement, undated and signed by Patient #5. The document failed to evidence the extent to which Medicaid would cover services, any charges not covered by Medicaid, and the patient's liability, if any, for payment.

During an interview on 06-21-2022, at 11:41 AM, the clinical manager confirmed Patient #5 s consents were not filled out and further indicated she could not do everything.

3. A review of the clinical record of Patient #7, with a start of care date of 07-08-20, indicated a service agreement, undated and signed by Patient #7. The document failed to evidence the extent to which Medicaid would cover services, any charges not covered by Medicaid, and the patient's liability, if any, for payment.

During a home visit for Patient #7 on 06-22-22 at 1:50 PM, the agency folder and admission information were reviewed and contained an unsigned agency 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 any liability for payment before the initiation of care. The clinical manager, who was present during the home visit, confirmed the admission agreement was blank.

4. A review of the clinical record of Patient #12, a newly admitted patient with a start of care date of 05-21-22, indicated a service agreement, undated and signed by Patient #12. The document failed to evidence the extent to which Medicaid would cover services, any charges not covered by Medicaid, and the patient's liability, if any, for payment.

The above findings were reviewed on

theyare to document in patient chart that patient was provided new home folder witha current consent form. They are to document information was given in writingand verbally. DON will audit charts weekly and keep a list of patients who havereceived the new consent form until all active patients received new consentform and documentation is present in their chart. Date completed will be08-24-2022.

DON/designee will audit alladmissions done weekly to ensure consent form is completed with requiredinformation and there is documentation in chart patient was provideddocumentation in writing and verbally. Once 100% compliance is achieved 10%will be audited quarterly to ensure compliance is maintained. (On-going)

Director of Nursing will ensureorientation of newly hired nurses includes training on consent form foradmissions must indicate patient was advised verbally and in writing of theextent to which services would be covered by Medicaid

	06-23-22, at 5:00 PM, with the Administrator, Clinical Manager, Owner, and Alternate Administrator; when reviewed, the patient's service agreements were without the date signed and incomplete, at which time they had nothing further to provide.		or any other federallyfunded program; the charges for services not covered by Medicaid, or any otherfederally funded program; and any expected charges that must be paid before theinitiation of care. (On-going) The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	
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 the comprehensive assessments were conducted in-person to achieve complete information and were completely filled out to accurately reflected the patient's past medical history and	G0510	G0510 See G528, G530, G536, G546. Director of Nursing in-servicesnurses on requirement for comprehensive assessments to be conducted in-personto achieve complete information and are to be completely filled out toaccurately reflected the patient's past medical history and current health,psychosocial, functional, and cognitive status, to include the patient'smedical, nursing, rehabilitative needs, to include the patient's strengths,goals, and care preferences; to reflect all of the	2022-07-15

	current health, psychosocial, functional, and cognitive status, to include the patient's medical, nursing, rehabilitative needs, to include the patient's strengths, goals, and care preferences; to reflect all of the patient's needs, included an appropriate review/reconciliation of all prescription and over the counter medications; and failed to ensure comprehensive assessments were completed within the last 5 days of the certification period, 8 of 8 active patient records reviewed (Patient #3, 4, 5, 6, 7, 9, 11,13), and 3 of 3 patients records on hold. (Patient #8, 10, and 12). These deficient practices have the potential to affect all 45 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 services which could result in the agency not providing quality health care, thus resulting in non-compliance with Condition of Participation 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, resulting in non-compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment.		patient's needs, included anappropriate review/reconciliation of all prescription and over the countermedications; and comprehensive assessments are to be completed within the last5 days of the certification period. Date completed was 07-15-2022. The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur	

	Findings include: 1. The agency failed to ensure that all patients received a complete and accurate comprehensive assessment which included 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 assessment of the patient's strengths, goals, and care preferences. (See G530) 3. The agency failed to ensure a registered nurse reconciled all medications including prescription and over-the-counter medications. (G536) 4. The agency failed to ensure the comprehensive assessment was completed within the last 5 days of the certification period, including day 60. (See G546)			
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 ensure all patients received a complete comprehensive assessment that included health, psychosocial, and cognitive assessments in 4 of 8 active records reviewed. (Patients #5, 6, 7, and 13) Findings Include: 1. A review of an undated agency policy titled	G0528	G0528 Director of Nursing in-servicednurses on requirement that all patients are to receive a complete comprehensiveassessment that includes health, psychosocial, and cognitive assessments. Thisincludes documenting effects of medication, interventions for diseaseprocesses, education on medications, depression screening, indicating whichlobes of lungs have diminished sounds if	2022-07-15

	Client Reassessment/Update of Comprehensive Assessment," policy number C-155, indicated, " Clients who are not receiving skilled services under the & Medicaid program will be assessed using the OASIS tool or an alternative form identified by the agency & The assessment will identify & any applicable physical, psychosocial, and or spiritual resources & 2. A review of the clinical record of Patient #5, with a start of care date of 03-21-21, indicated a resumption of care (ROC) comprehensive assessment dated 05-17-22. The ROC indicated diagnoses including chronic respiratory failure, chronic systolic congestive heart failure, chronic obstructive pulmonary disease (COPD), paroxysmal atrial fibrillation, and chronic kidney disease stage 5. The section titled Neuro/Emotional/Behavior indicated, that Patient #5 experienced anxiety, depression, difficulty coping with altered health status, normal difficulty coping with changes in body image, and unrealistic expectations but failed to evidence the effects of the medication Valium 2 mg(milligrams) 2 tablets three times a day for anxiety, failed to provide interventions for increased anxiety, and education of the medication side effects, and failed to complete a standardized depression screening. The respiratory section indicated, wheezes and diminished, but failed to indicate the locations of auscultation left, upper left, lower left, right, upper right, and lower right were blank. A review of a document received from Entity L, the medical group of Person N, dated 06-10-22, titled, Outpatient Progress Note evidenced diagnoses that included, but were not limited to, acute chronic heart failure, chronic respiratory failure, atrial fibrillation, benign essential hypertension, cardiomyopathy, chronic kidney disease stage 3, COPD, diabetes mellitus, type 2, and edema, generalized anxiety disorder (GAD), and degenerative disc disease. During an interview on 06-21-22 at 11:15 AM,		assessment indicates diminished lungsounds, if patient smokes, completing pain assessment, allergies, if patient ison oxygen, signs/symptoms to report, all diagnoses patient has, visionimpairments, etc. Date completed was 07-15-2022. Director of Nursing in-servicednurses that if patient lives in an assisted living they need to contact nurseat the assisted living to discuss patient condition to ensure agency has an accurateassessment of patient’s condition and needs. This discussion needs to bedocumented on assessment. Date completed was 07-15-2022. Agency is unable to correctpatient assessments cited in survey as the assessments are at least 2 monthsold. Director of Nursing/designee willaudit all comprehensive assessments done weekly to ensure they are complete andinclude health, psychosocial, and cognitive assessments and areaccurate/specific to each patient. Once 100% compliance	

	Person T, the family member of Patient #5, indicated that Patient #5 had been in and out of the hospital. Person T further confirmed the patient s anxiety, fears of being discharged from the facility due to reoccurring hospitalizations, support systems, and understanding of medications for anxiety and depression and their effects. A review of the agency s plan of correction after the survey dated 4/21/22 indicated the Clinical Manager would audit 100% of all comprehensive assessments for the patient s complete current and past health, psychosocial, functional, and mental status. Once 100% compliance was achieved the Clinical Manager would audit 10% of all comprehensive assessments quarterly to ensure compliance was maintained. During an interview on 06-21-22, at 11:41 AM, the Clinical Manager confirmed the comprehensive assessments had not been audited. 3. A review of the clinical record of Patient #6, with a start of care date of 05-20-22, indicated a recertification (follow-up) comprehensive reassessment dated 06-10-2022. The comprehensive reassessment indicated diagnoses including, but not limited to, chronic obstructive pulmonary disease, chronic pain syndrome, fracture of unspecified neck of the right femur, unilateral primary osteoarthritis of the right hip, primary osteoarthritis of the right shoulder, and disc disorders with radiculopathy of the thoracic region. The section titled "Respiratory Status" indicated the patient s lung sounds were diminished but was incomplete because it failed to evidence auscultation of the lung sounds location left, upper left lower left, right, upper right, and lower right were blank and failed to evidence the patient was an active smoker. The assessment indicated the patient denied pain but failed to reveal a pain assessment was completed that addressed the chronic pain syndrome, the arthritis pain, the fracture, and the disc injury. The section titled Allergies indicated Patient #6 had drug allergies to codeine and contrast dye and failed to list morphine.		is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Director of Nursing/designee willaudit all comprehensive assessments done weekly to ensure they include health,psychosocial, and cognitive assessments. If patient lives in an assisted livingthere needs to be documentation nurse spoke with nurse at assisted living todiscuss patient’s condition. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur	

A review of the Medication Review Report, dated 06-22-22, received from Entity B, the patient s assisted living facility, indicated that the patient had allergies to codeine, morphine, and contrast dye.

During a home visit with Patient #6, on 06-22-22, at 1:50 PM, at an assisted living facility, Entity B, Patient #6 confirmed they went down for supper and smoked a cigarette. CNA #2, who provided care for Patient #6, confirmed that Patient #6 smoked a cigarette when the patient went down for supper every evening. Patient #6 further confirmed they were always in pain due to their fracture and arthritis, used a wrist support on their left wrist, a heating pad while up in a recliner, and took multiple pain relievers to help. The Clinical Manager confirmed Patient #6 always used the heating pad for pain, regardless of the season.

4. A review of the clinical record for Patient #7, with a start of care date of 03-24-21, indicated a comprehensive recertification reassessment dated 05-20-22. The reassessment evidenced diagnoses including, but not limited to, chronic obstructive pulmonary disease with acute exacerbation, major depressive disorder, and pain. The comprehensive reassessment indicated, Smoker 1 pack/day, 35 years smoke, cough, non-productive, diminished lung sounds, wear a CPAP (Continuous Positive Air Pressure) at night, sob (short of breath) on exertion. The reassessment was incomplete because it failed to evidence the patient received a complete respiratory assessment including, but not limited to, lung fields were left blank, respiratory rate was blank, and quality need for continuous oxygen at 5 liters per nasal cannula, oxygen was blank, fatigue, oxygen saturation was blank, and effectiveness of the oxygen. The reassessment section titled Neuro/Emotional/Behavior Status indicated the patient had anxiety, agitation, depression, and used psychotropic drugs. However, it failed to evidence the effectiveness of the antidepressants and psychotropic drugs, the

failed to complete a depression screening, the patient s problem-solving and coping strategies, and signs and symptoms to report.

During a home visit on 06-22-22, at 11:25 AM, observed Patient #7 sitting in a recliner in the living room upon the director of nursing, Person F, of Entity D. At this assisted living facility, the patient resides. Person F indicated they needed to recheck Person #7 s blood pressure due to it was 172/100 earlier this am when the patient was upset regarding their breakfast encounter with the kitchen staff. Patient #7 was observed to have a nasal cannula attached to oxygen tubing leading to an oxygen concentrator by the tv on the other side of the living room. Patient #7 confirmed they were upset regarding kitchen staff this am.

5. A review of the clinical record for Patient #13, with a start of care date of 05-16-22, indicated an initial comprehensive reassessment dated 05-16-22. The assessment with diagnoses included, but were not limited to, vascular dementia without behavior disturbances, atherosclerotic heart disease, acute systolic congestive heart failure, Blindness right eye category 3, blindness left eye category 3, mood disorder due to known physical condition with depressive features, ischemic cardiomyopathy, and benign prostatic hyperplasia with lower urinary tract symptoms. The initial reassessment failed to evidence the patient s diagnosis of Alzheimer s dementia and atrial fibrillation. The assessment in the section titled Cardiovascular status/vital signs indicated chest pain, dull, and intermittent the assessment failed to evidence respirations blank, follow-up, and notification to the patient s physician failed to address the patient had an automatic cardioverter/defibrillator, atrial fibrillation, and a heart murmur on auscultation. The section titled Vision indicated glaucoma, both but failed to indicate the patient is blind in both left and right eyes, affecting the patient s ability to complete activities of daily living, including feeding themselves. The assessment in section Pain Assessment indicated the

	section Cardiovascular status indicated the patient had chest pain. The section titled Respiratory indicated Normal ; however, it failed to evidence respirations or lung sounds were assessed. The assessment section titled Bowel status indicated, last bm (bowel movement) 5/15/22, constipation, lax (laxative)/enema type: senexon, bowel sounds active, and abdomen soft but failed to evidence patient was incontinent and due to behaviors played in their stool. The section titled Neuro/Emotional/Behavior status indicated anxiety, depression, difficulty coping with altered health status, normal, weakness site generalized, hand grips equal, a psychotropic drug prescribed, and Comments Cymbalta 60mg but failed to evidence trazodone, memantine, and donepezil, failed to evidence the effectiveness of the antidepressants. Psychotropic drugs, compliance with medication therapy, failed to complete a depression screening, failed to address possible side effects, the importance of compliance with drug therapy, problem-solving and coping strategies, and signs and symptoms to report. The assessment section titled ADL (Activities of Daily Living)/IADLs (Independent Activities of Daily Living) indicated, Functional limitations: legally blind, bowel/bladder incontinence, dyspnea with minimal exertion, and ambulation. The section titled Patient /Caregiver Education indicated Independent with diet management, but the patient requires meals to be prepped and fed.			

	A review of a facility document received from Entity L, the physician s office, for Person M, dated 03-02-22, titled, Outpatient Primary Care Progress Note. The progress note section titled Chronic Problem List listed the following; automatic cardioverter/defibrillator, Alzheimer s dementia, abnormal nuclear stress test, actinic keratosis, ataxic gait, atrial fibrillation, basal skin carcinoma of skin trunk, behavior, adult, blindness, depressive disorder, falls frequently, nocturia, incomplete bladder emptying, benign prostatic hyperplasia, cerebral ischemia, cardiomyopathy, chest pain, and peripheral neuropathy. The assessment indicated cardiovascular auscultation patient has a soft systolic murmur. During an interview on 06-21-22, at 11:30 AM, the director of nursing, Person F, of the assisted living facility, Entity B, where Patient #13 resided, indicated Patient #13 was blind and required assistance with feeding, was incontinent and played in their feces. Person F confirmed that was why they referred Patient #13 to feed them at meals and to provide extra care Patient #13 requires with behaviors and incontinent episodes. 410 IAC 17-14-1(a)(1)(A)			
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 a complete assessment of the patient s strengths, goals, and care preferences in 8 of 8 active	G0530	G0530 Director of Nursing in-servicednurses on need to do complete assessment of the patient’s strengths, goals, andcare preferences, need to have goals that are patient-specific, measurable andpertinent to current diagnoses and reason for home health care. There must beorders for skilled care and	2022-07-15

	records reviewed (Patient #3, 4, 5, 6, 7, 9,11, and 13) and 2 of 3 patients on hold. (Patients #8, and 12) Findings Include: 8. A review of the recertification comprehensive assessment for Patient #9, dated 5/27/22, indicated a primary diagnosis of hemiplegia, mild intermittent asthma, COPD, major depressive disorder, schizophrenia, cerebral infarction, epilepsy, malignant neoplasm of upper lobe/ bronchus/lung, and multiple rib fractures. The assessment indicated patient/caregiver goals to remain safe at home, demonstrate safety measures and techniques, be knowledgeable about emergency information and the preparedness plan, cardiac status will return to and remain within normal limits without further progression of complications, to be knowledgeable of signs and symptoms of angina and appropriate interventions, to verbalize measures to alleviate pain, to verbalize understanding of the healing process and ways to promote healing and prevent complications, to understand universal precautions and infection control measures, to have improved respiratory status and oxygenation, to be knowledgeable of the care and use of respiratory equipment, to have resolved pulmonary infections, to be well hydrated, to have increased knowledge of pulmonary disease and care, to be free of urinary tract infections, to be knowledgeable about signs and symptoms of urinary tract infections, to be knowledgeable about the importance of good nutrition and hydration, to verbalize signs and symptoms of hypo/hyperglycemia, to reach maximum functional potential and have stable neurological status, to transfer/ambulate and use assistive device safely, and to have personal hygiene needs met with the assistance of a home health aide. The assessment failed to include goals that were patient-specific, measurable, and pertinent to the current diagnoses and reason for home health care as identified in the comprehensive assessment, for a patient receiving home health aide services only; failed to evidence orders for the skilled discipline and frequency needed to provide the clinical teaching and		frequency needed to provide clinical teaching andoversight necessary to meet stated goals. Statements must be complete andappropriate. Nurse must document these areas were discussed during theassessment. Date completed was 07-15-2022. Director of Nursing will reviewaide plan of care for patient #7, cited in survey, to ensure it reflected thepatient's preference of only taking a shower 3 times a week, aide to assistwith shaving and patient does own denture care. Date completed was 07-15-2022. Director of Nursing will obtaina verbal order for patient #11, cited in survey, to reflect patient isnon-verbal, medical condition will remain stabilized with cert period. Datecompleted was 07-15-2022. Director of Nursing/designeewill audit all comprehensive assessments done weekly to ensure they are complete,accurately reflect patient's condition and needs, patient's strengths, goalsand care preferences, measurable goals, reason for home health	

	oversight necessary to meet the stated goals; and failed to indicate care preferences were discussed with the patient. 9. A review of the start of care comprehensive assessment for Patient #11, dated 5/20/22, evidenced a primary diagnosis of other sequelae of cerebral infarction with secondary diagnoses of primary hypertension, diabetes due to underlying condition, and GERD. The clinical summary indicated multiple additional diagnoses including hyperlipidemia, history of previous strokes, angina, dementia, dysphagia, aphasia, and anxiety. The assessment indicated the patient had normal communication, however during a home visit on 6/22/22 at 2 PM, person K, a relative and caregiver, indicated patient #11 was completely non-verbal but was still able to fully understand language and conversation. The patient received all fluids, medications, and nutrition via a gastrostomy tube (G-tube), had lost more than ten pounds in the last 12 months, and was bedridden and completely dependent for all wants and needs. The comprehensive assessment indicated the patient needed a skilled nurse 5 hours/day x 6 days/week x 9 weeks and included skilled goal of Patient s medical condition will remain stabilized within &, however the statement was incomplete and failed to be patient-specific, measurable, reasonable, and pertinent to the patient s needs as indicated in the comprehensive assessment. The summary also indicated The patient could benefit from skilled nursing 5 days/6 hours per day and HHA 5 hours/2 days [sic per] week due to recent stroke & Goals included that the patient or patient/caregiver would receive assistance needed, remain compliant with medication safety, be knowledgeable about emergency information and the preparedness plan, verbalize understanding of ambulation safety and fall precautions, verbalize understanding of infection control and precautions, have improved skin, improved respiratory status and oxygenation, be free of urinary tract infection within the certification period, verbalize signs and symptoms of hyper/hypoglycemia and actions to take within (sentence not completed), demonstrate proper blood sugar monitoring and log within (sentence not completed), be free from aspirations within 60 days, verbalize		care and thereis documentation these areas were discussed during assessment. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) Agency unable to correct issuescited with patients #6, #8, #9, #11, #12, #13, cited is survey, as assessmentsare over a month old and/or clinician who did assessment is no longer employedby agency. The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

understanding of the neurological disease/disorder process and management within (sentence not completed), be safe at home with personal care assistance as evidenced by no injuries/fall during plan of care, be knowledgeable about disease process and mobility problems by (sentence not completed), verbalize understanding and demonstrate compliance with safety needs within (sentence not completed), have assistance with personal care and IADLs (Instrumental Activities of Daily Living) with the assistance of the home health aide during the plan of care, be free of exacerbation from [was blank] within 60 days, and medical condition will remain stabilized within (sentence no completed). The assessment failed to evidence discussion occurred with the patient and/or caregivers concerning how best to communicate with the patient, how the patient makes needs and wants known, interventions for comfort and pain management, pressure sore prevention, preferences for mouth care for a patient with a feeding tube, favorite TV shows or music, or routine daily schedule. The assessment also failed to evidence goals which were individualized, patient-specific, and measurable; failed to evidence the goals were realistic and pertinent to the patient s status; and failed to accurately reflect the patient s needs as identified in the comprehensive assessment.

1. A review of an undated agency policy titled "Client Reassessment/Update of Comprehensive Assessment" policy number C-155 indicated, Clients who are not receiving skilled services under the...Medicaid program will be assessed using the OASIS tool or an alternative form identified by the agency...The assessment will identify the problems, needs, and strengths of the client...assessments include consideration of the following: Specific individualized client needs pertinent to the care or service being provided..."

2. A review of the clinical record for Patient #5, for the recertification period of 04-29-22 to 06-27-22, evidenced a resumption of care comprehensive assessment dated 05-17-22. A review of the section titled, 60-day Summary

failed to indicate specific care preferences, or whether care preferences were discussed during the assessment.

3. A review of the clinical record for Patient #6, for the initial certification period 05-20-22 to 07-18-22, evidenced a recertification (follow-up) comprehensive assessment dated 6-10-22. The recertification (follow-up) comprehensive assessment indicated diagnoses including, but not limited to, chronic obstructive pulmonary disease, chronic pain syndrome, fracture of unspecified neck of the right femur, unilateral primary osteoarthritis of the right hip, primary osteoarthritis of the right shoulder, and disc disorders with radiculopathy of the thoracic region. failed evidence patient strengths, specific care preferences, or whether care preferences were discussed during the assessment.

During a home visit with Patient #6, on 06-22-22, at 1:50 PM, at Entity B, an assisted living facility, Patient #6 confirmed going downstairs for supper and smoked a cigarette. CNA #2, who provided care for Patient #6, confirmed Patient #6 smoked a cigarette when the patient went down for supper every evening. Patient #6 further confirmed they were always in pain due to their fracture and arthritis, used a wrist support on their left wrist, a heating pad while up in a recliner, and took multiple pain relievers to help. The clinical manager confirmed Patient #6 always used the heating pad for pain, regardless of the season.

4. A review of the clinical record for Patient #7, for the recertification period 05-18-22 to 07-16-22, evidenced a recertification comprehensive assessment dated 05-20-22. The reassessment evidenced diagnoses including, but not limited to chronic obstructive pulmonary disease with acute exacerbation, major depressive disorder, and pain. The reassessment indicated, Patient s strength is a willingness to participate in POC (Plan of Care). The reassessment failed to evidence the patient s specific care preferences or whether care preferences were discussed during the assessment.

During a home visit with Patient #7, on

06-22-22, at 11:25 AM, at an assisted living facility, Entity D, Patient #7 confirmed they only took showers three times a week. Patient #7 required the assistance of the CNA to shave them daily, due to their hand numbness and inability to grip items. Patient #7 further indicated they cared for their dentures and only wore them when they went out somewhere. The reassessment failed to evidence the patient s specific care preferences or whether care preferences were discussed during the assessment.

5. A review of the clinical record for Patient #8, for the initial certification period 05-17-22 to 07-15-22, evidenced a start of care comprehensive assessment dated 5-17-22. The initial assessment evidenced diagnoses including, but not limited to mild cognitive impairment, osteoporosis, alcoholic fatty liver, morbid obesity, and primary open-angle glaucoma. The initial comprehensive assessment failed evidence of patient strengths and care preferences or whether care preferences were discussed during the assessment.

6. A review of the clinical record for Patient #12, for the initial certification period 05-21-22 to 07-19-22, evidenced a start of care comprehensive assessment dated 5-21-22. The initial assessment evidenced diagnoses including, but not limited to shortness of breath, type 2 diabetes mellitus, essential hypertension major depressive disorder, and generalized anxiety disorder. The initial comprehensive assessment indicated, Patient s strength is a willingness to participate in POC (Plan of Care). The assessment failed to evidence the patient s care preferences or whether care preferences were discussed during the assessment.

7. A review of the clinical record for Patient #13, for the initial certification period 05-16-22 to 07-14-22, evidenced a start of care comprehensive assessment dated 05-16-22. The assessment with diagnoses included, but were not limited to, vascular dementia without behavior disturbances, atherosclerotic heart disease, acute systolic congestive heart failure, Blindness right eye category 3, blindness left eye category 3, mood disorder due to known

	ischemic cardiomyopathy, and benign prostatic hyperplasia with lower urinary tract symptoms. The assessment indicated, Patient s strength is a willingness to participate in POC (Plan of Care). The assessment failed to evidence the patient s care preferences or whether care preferences were discussed during the assessment.			
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. Based on observation, record review, and interview, the agency failed to complete a review of all medications the patient was currently using, including potential adverse effects, drug reactions, ineffective drug therapy, side effects, duplicate therapy, and noncompliance in 7 of 8 active records reviewed. (Patient #3, 4, 5, 6, 7, 9, and 13) Findings Include: 7. A review of the most recent comprehensive assessment for patient #3, dated 5/5/22, evidenced the assessment was a ROC after a hospitalization due to severe pain and severe swelling in the legs on 5/2/22 5/3/22. The patient s primary diagnosis was COPD, with secondary diagnoses that included fibromyalgia, osteoarthritis, site unspecified (loss of cartilage between bones/joints resulting in pain and inflammation), primary hypertension, low back pain, age-related bilateral nuclear cataract (cloudy area on the	G0536	G0536 Director of Nursing in-servicednurses on need to complete a review of all medications patient currently usingprescription/over the counter, including potential adverse effects, drugreactions, ineffective drug therapy, side effects, duplicate therapy, andnoncompliance. Nurse is to run interactions and fax those interactions to MD.Nurse is to do a complete medication reconciliation. Nurse is to documentreconciliation done, interactions run and faxed to MD if interactions found.Anytime patient is started on a new medication all the above is to be done anddocumented. Date completed was 07-15-2022. Director of Nursing in-servicednurses on need for assessment to accurately reflect patient allergies,education on medications and teaching on	2022-07-15

	hereditary deficiency of other clotting factors (a blood clotting disorder resulting in formation of blood clots). The patient experienced an average pain level in the lower extremities of 7/10, with a pain level of 10/10 at worst and indicated breakthrough medication was needed 2 or 3 times a day because pain medication was not effective. Further review evidenced a fall risk assessment which indicated poorly controlled pain along with medication that affected level of functioning. Review of the ROC medication list evidenced thirty-two separate oral, inhaled, topical, and injectable medications, including duplicate orders for albuterol sulfate inhalation nebulization solution, ProAir HFA inhalation solution, Symbicort inhalation aerosol, Symbicort inhaler, Lovenox, warfarin 10mg daily, Plavix, Lovenox injection, warfarin 10mg, warfarin 2mg, hydrochlorothiazide 25 mg, hydrochlorothiazide 25mg, losartan, losartan 25mg, protonix, and metformin. The ROC indicated the date the physician was notified of the plan of treatment was 5/9/22 at 12:00 AM. The name of the person contacted was blank. Further review of the EMR indicated an active medication list from 5 days back dated 5/31/22 and included sixteen of the 39 active medications listed in the ROC, including medications which were inconsistent with the diagnoses listed in the ROC. The ROC assessment failed to evidence the patient s current medications were reviewed and reconciled post-hospitalization for changes/additions, effectiveness, compliance/understanding, side effects, duplicates, or interactions related to pain management, respiratory management, management of GERD, management of blood pressure, and management of a life-threatening blood clotting disorder. 8. On 6/21/22 at 1:10 PM, the electronic medical record (EMR) for Patient #4 was reviewed and evidenced the patient was hospitalized for a left hip replacement from 6/3/22 6/4/22. A resumption of care comprehensive assessment indicated the patient was assessed post-hospitalization over 48 hours after the Administrator was notified the patient discharged to home. Review of the 24-page ROC, dated 6/8/22, indicated a primary diagnosis of spinal stenosis (narrowing of the spinal column that can cause pressure		medications. Date completed was07-15-2022. Director of Nursing/designee willreview all assessments done weekly to ensure there is documentation on patientallergies, education on medications and teaching on medications. The medicationprofile will be reviewed to ensure if allergies are listed on assessment they arealso listed on medication profile. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Director of Nursing/designee willaudit all admissions, resumptions and recerts to ensure there is documentationmedications were reviewed, teaching was done and interactions were run ifrequired. One 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing will auditall nursing documentation done weekly to ensure if there is a new medicationlisted nurse had documented medication	

on the spinal cord resulting in pain) with secondary diagnoses including sarcoidosis of the lung (a condition causing inflammation and scarring of the lungs), hemiplegia (mild or partial weakness or loss of strength on one side of the body) and hemiparesis (severe or complete loss of strength or paralysis on one side of the body). fibromyalgia (a condition which causes widespread pain, fatigue, problems sleeping, and often emotional and psychological problems), essential hypertension (high blood pressure that is not a result of a medical condition but is caused by lifestyle such as diet, smoking, and obesity), gastro-esophageal reflux (GERD, a condition where stomach contents and acids flow back into the esophagus causing heartburn), chronic obstructive pulmonary disease (COPD, a group of diseases that causes air-flow blockage and breathing related problems), and depression. The patient s vital signs indicated tachycardia (rapid heartbeat) of 110 beats/minute, an average pain level of 7/10 with the least pain being 5/10 and the worst pain being 9/10, for which pain medication was both effective and required breakthrough pain medication 2 3x/day , and an elevated blood pressure of 146/92. The assessment failed to evidence the patient s current medications were reviewed and reconciled post-hospitalization for changes/additions, effectiveness, compliance/understanding, side effects, or interactions related to pain management, respiratory management, weakness/paralysis, management of GERD, management of depression, and management of blood pressure.

On 6/21/22 at 1:42 PM, Patient #4 was interviewed via phone and indicated having a lot of pain due to a right hip replacement done on 6/3/22. When asked if the patient was taking pain medication, the patient indicated yes, but it did not help. The patient also indicated feeling frustrated and upset due to the inability to care for a spouse with dementia

On 6/21/22 at 3:46 PM, the surveyor requested a printed copy of the patient s comprehensive assessments dated 6/8/22. On 6/21/22 at 4 PM the Administrator provided printed documents

reconciliation was done, teaching doneon new medication and interactions run and if any were noted they were faxed toMD. Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going)

Director of Nursing/designee willreview nursing visit schedule weekly to ensure recertification visits arescheduled timely (day 56 to 60 of cert period). (On-going)

Director of Nursing in-servicednurses that if patient lives in an assist living nurse is to contact the nurseat the assisted living to discuss patient’s medications to ensure medicationlist agency has is accurate at admission, recertification and resumption ofcare. Date completed was 07-15-2022.

Director of Nursing in-servicednurses on requirement to document on assessment the name of person contacted atMD office regarding the plan of treatment. Date completed was 07-15-2022.

	for patient #4 and indicated all items requested were present. Further review of the printed documents indicated the assessment failed to include pages 11 24 of the 24-page document. On 6/22/22 at 10 AM, the surveyor made a second request to the Administrator for the 6/8/22 ROC. No further documents were provided for patient #4. 9. A review of the most recent recertification comprehensive assessment for patient #9, dated 5/27/22, indicated a primary diagnosis of right-sided hemiplegia and secondary diagnoses of mild/intermittent asthma, COPD, mild and recurrent major depressive disorder, schizophrenia, cerebral infarction, unspecified/not intractable epilepsy without status epilepticus, malignant neoplasm of upper lobe/bronchus/lung (side not specified), and multiple right-sided rib fractures. The assessment indicated the patient was receiving 17 oral, inhaled, intravenous, and injectable medications, including but not limited to, Albuterol Sulfate via nebulizer, Albuterol Sulfate via aerosol, Amuity Ellipta inhaled aerosol powder, Spiriva HandiHaler inhalation capsule for asthma/COPD, Vimpat oral solution twice daily for seizure treatment, trazadone once at night for insomnia, ibuprofen every 6 hours for pain, oxycodone every 6 hours as needed for pain, Divalproex Sodium Delayed-Release Sprinkle twice daily for migraines, and ondansetron every 8 hours for nausea and vomiting. The assessment indicated the Vimpat was a change. and all other medications were new. The assessment failed to evidence the patient s current medications were reviewed, reconciled, and updated every 56 60 days and as needed for changes/additions, effectiveness, compliance/understanding, side effects, duplicates, or interactions, including but not limited to, pain management, respiratory management, seizures, osteoporosis, and schizophrenia. 410 IAC 17-14-1(a)(1)(B) 1. A review of an undated agency policy titled, "Medication Profile" policy C-700 was received on 06-23-2022, from the administrator. The		The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

policy indicated, "The Nurse/Therapist shall record...all prescribed and over-the-counter (OTC) medications the client is currently taking." Further review indicated the medication profile should include allergies, the date the medication was ordered or care was initiated, the medication's full name (with no abbreviations), dosage (using only accepted abbreviations), route and frequency of administration, contraindications or special precautions, medication actions and side effects, discontinuation date, appropriate storage directions, and drug or food-drug interactions. All prescription medication taken by the client must be ordered by a physician. The nurse should review all medications with the client and/or caregiver to ensure he/she understands how the drugs are to be stored, administered, and was aware of side effects and interactions. The policy evidenced, "The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation and, at minimum, every sixty (60) day...Medication profiles created through electronic point of care documentation systems will have a copy in the client record and client's home if the agency is setting up or managing the medication administration.

2. A review of an undated agency policy titled, "Medication Reconciliation," policy number C-709, was received on 06-23-2022, from the administrator. The policy indicated, "Agency will reconcile all medications taken by the client prior to admission to home care...at 60-day reassessment visits, ..." The policy defined medications to include all over the counter, prescription, regularly taken PRN (as needed) medications, herbals, and nutraceuticals that the client takes in all places of residence ... after the first 60 days, the clinician doing the reassessment will again review all medications client is taking, update the records and the client plan of care."

3. A review of the clinical record for Patient #5, for the recertification period 04-29-22 to 06-27-22, indicated an agency document titled Assessment Details with a date of 05-17-22. The assessment indicated, Resumption of care

(after inpatient stay), in the section titled 60-Day Clinical Summary indicated, Medications reviewed with the patient, SB nurse, and doctor. The document failed to evidence whether the patient was compliant with all medications, and medication interactions, patient responses to medications, patient understanding of dose, route, side effects, frequency, purpose, compliance, and failed to evidence the patient received a complete medication reconciliation that included all prescription and OTC medications taken by the patient. The assessment also failed to evidence the patient received a full medication reconciliation/review.

A review of an agency document titled Verbal Order indicated, Symbicort Inhalation Aerosol 160-4.5 MCG (micrograms)/ACT-2 puffs-twice daily COPD (Chronic Obstructive Pulmonary Disease) -inhalation-Change & with a date of 05-17-22 and signed by the clinical manager. The record failed to evidence the patient received education on use, a full medication reconciliation/review that included compliance, understanding of dose/route/frequency/purpose, response, interactions, side effects, and response.

During an interview on 06-23-22, at 12:25 PM, the Clinical Manager confirmed they could not provide evidence that the medication reconciliation was sent to the physician. The Clinical Manager further confirmed they only document medication reviews in the clinical summary.

4. A review of the clinical record of Patient #6 for the certification period of 05-20-22 to 07-18-22 indicated an agency document titled Assessment Details. The recertification (follow-up) comprehensive reassessment dated 06-10-2022, under the section titled Allergies, listed codeine and contrast dye. The section titled Medications indicated but was not limited to, &Nicotine Step 2 Transdermal Patch 24 Hour 14 MG (milligrams)/24hr (hour)-1patch-every am, remove old patch-oral-New-Nicotine Withdraw... The record failed to list the patient as a current smoker, failed to evidence the patient received education regarding using the patches and smoking, and failed to indicate interactions, responses, side effects, and responses. The

assessment failed to list Morphine as an allergy.

A review of the agency document titled Medication Profile indicated but was not limited to &Nicotine Step 2 Transdermal Patch 24 hour patch 14mg/24 hr, 1 patch every am nicotine withdrawal &. The medication profile in the section titled Allergies indicated Codeine.

The medication profile dated 06-21-22 was signed and reviewed by the Clinical Manager but failed to evidence morphine and contrast dye.

A review of the facility document from Entity B, the assisted living facility where Patient #6 resides, was received on 06-22-22 from Person C, the facility s Director of Nursing. The document titled Medication Review Report indicated under a section titled Allergies that Patient #6 had allergies to codeine, morphine, and contrast dye.

During a home visit with Patient #6, on 06-22-22, at 1:50 PM, at an assisted living facility, Entity B, Patient #6 confirmed she goes down for supper and smokes a cigarette. CNA #2, who provided care for Patient #6, confirmed that Patient #6 smokes a cigarette when the patient goes down for supper every evening. The Clinical Manager stated, I never knew she ever smoked.

5. A review of the clinical record for Patient #7 for the certification period 05-18-22 to 07-16-22 indicated a document titled Assessment Details. The untimely recertification comprehensive assessment indicated a completion date of 05-20-22. The comprehensive reassessment under the section titled Respiratory indicated that the patient uses a CPAP (Continuous Positive Airway Pressure) at night. The comprehensive reassessment indicated that the physician was notified. The contact person reported in the office was Person R. The comprehensive assessment failed to indicate the patient is on continuous oxygen per nasal cannula and the amount of oxygen. The untimely recertification reassessment listed medications but failed to evidence whether the patient was compliant with all medications, any medication interactions, patient responses to medications,

patient understanding of dose, route, side effects, frequency, purpose, compliance, and failed to evidence the patient received a complete medication reconciliation that included all prescription and OTC medications taken by the patient. The assessment also failed to evidence the patient received a full medication reconciliation/review within the 5-day window.

A review of an agency document titled Medication Profile in the section titled Medications indicated, &Oxygen 2 liters NC (Nasal Cannula) at noc (night)for sleep apnea &. The medication profile failed to indicate the accurate amount of oxygen the patient was on and the frequency of the continuous oxygen.

A review of a facility document titled The [Entity D] Service Plan was received from Person F, the Director of Nursing for Entity D, an assisted living facility. The service plan indicated, under the section titled, Treatment Procedures, the patient used a CPAP at noc (night) and was on oxygen 3 liters per nasal. Entity P was the company supplying the oxygen and supplies.

During a home visit at Patient #7 s apartment on 06-22-22 at 11:50 AM, I observed patient #7 remove their oxygen tubing from their nares and ambulate to the bathroom for their shower. Upon completing the CNA assisting the patient with dressing, Patient #7 ambulated with a rollator walker to their recliner. The patient had become short of breath. Patient #7 confirmed that after applying the nasal cannula, they were always on 3 liters of oxygen via nasal cannula.

During an interview on 06-23-22, at 9:57 AM, Person J, the nurse for Person I, Patient #7 s physician, at Entity H, indicated Patient #7 has had a lot of no-show appointments, the patient doesn t come in much, noncompliance, the patient had checked themselves into rehab for a while, and was seen in March last. Person J further confirmed Person R has not been at that office in over 6 months.

6. A review of the clinical record for Patient #13, with an initial certification date of 05-16-22 to 07-14-22, indicated a document

comprehensive assessment under the section titled, Medications indicated, Aspirin 81mg-1-tab-once daily- oral-New-blood clot preventative, Lipitor 40 mg-1-tab-every bedtime-oral-New-hyperlipidemia, Bumex 1 mg-1-tab-twice daily-oral-New-HTN (Hypertension), Coreg 6.25 mg-1-tab-twice daily with food-oral-New HTN, Diltiazem CD 180 mg-1-cap-once daily-oral-New-HTN, Donepezil HCI 10mg-1-tab-every bedtime-oral-New-dementia, Dorzolamide HCI Ophthalmic solution 22.3-6.8mg/ml (milliliters)-1-drop-left eye twice daily-eye drop-New-glaucoma, Cymbalta 60 mg -1 cap-once daily-oral-New-depression, Isosorbide Mononitrate ER 30mg-1-tab-once daily-oral-New angina, Latanoprost Ophthalmic Solution 0.005%-1-drop-left eye daily at bedtime-eye drop-New-glaucoma, Memantine HCI 10 mg-1-tab-twice daily-oral-New-dementia, Potassium Chloride ER 20 MEQ (Milliequivalents)-1-tab-once daily-oral-New-hyperkalemia, Senexon-S 8.6-50mg-1-tab-twice daily-oral-New-constipation, Tamsulosin HCI 0.4 mg-1-cap-daily at bedtime-oral-New-BPH (Benign Prostatic Hyperplasia). The medication list failed to include the following; Trazadone 50 mg take 2 tabs =100 mg orally at bedtime, Xarelto 15mg 1 tablet orally every evening, Polyethylene glycol 3350 17 gm as needed for constipation, Cholecalciferol 5000 international units orally every am, and Duloxetine 60 mg oral daily. The initial comprehensive medication list failed to evidence whether the patient was compliant with all medications, any medication interactions, patient responses to medications, patient understanding of dose, route, side effects, frequency, purpose, and compliance, and failed to evidence the patient received a complete medication reconciliation that included all prescription and OTC medications taken by the patient. The assessment also failed to evidence the patient received a full medication reconciliation/review upon the initial start of care assessment.

A review of a facility document received from Person M s office Entity L, Patient #13 s physician s office, evidenced a document titled Medication List. The medications listed were not limited to, &Trazadone 50 mg take 2 tabs =100 mg orally at bedtime, Xarelto 15mg 1

	3350 17 gm as needed for constipation, Cholecalciferol 5000 international units orally every am, and Duloxetine 60 mg oral daily & During an interview on 06-23-22, at 12:25 PM, the Clinical Manager confirmed they could not provide evidence that the medication reconciliation was sent to the physician. The Clinical Manager further confirmed they only document medication reviews in the clinical summary.			
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 the comprehensive recertification assessment was conducted during the last 5 days of every 60 days, in 2 of 5 records reviewed (Patient #5 and 7) of patients who had continued care, in a sample of 8 active patient records reviewed. Findings Include: 1. A review of undated agency policy titled, "Client Reassessment/Update of Comprehensive Assessment" policy number C-155, was received on 06-23-2022, from the administrator. The policy indicated, "...Reassessments must be done at 1 &beginning with the start of care [within last five (5) days of the episode, including day sixty (60)] & 2. A review of the clinical record of Patient #5,	G0546	G0546 Director of Nursing in-servicednurses on requirement for comprehensive recertification assessment to beconducted day 56 to 60 of current certification period. Date completed was07-15-2022. Director of Nursing/designee willreview nursing visit schedule weekly to ensure patients needing recertifiedthat week are on the schedule timely. (On-going) Director of Nursing/designee willaudit all comprehensive assessments done weekly to ensure they are completed inthe required time frame. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will	2022-07-15

	for the recertification period from 04-29-22 to 06-27-22, evidenced it contained an agency document dated 04-29-22, 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 06-22-22, at 2:50 PM, the clinical manager confirmed they got behind due to being the only nurse for both territories. 3. A review of the clinical record of Patient #7, for the recertification period from 05-18-22 to 07-16-22, contained an agency document dated 05-20-22, 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 a daily conference on 06-21-22, at 4:00 PM, the findings were reviewed with the administrator and clinical manager who had nothing further to provide. 410 IAC 17-14-1(a)(1)(B)		beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur	
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. Based on record review and interview, the agency failed to ensure that all necessary information pertaining to the	G0564	G0564 Director of Nursing in-servicednurses on requirement when patient is transferred to the hospital/dischargedfrom agency the health care practitioner/MD and receiving agency must receiveall necessary information pertaining to the patient’s current services beingprovided, and treatment preferences. This is to include patient’s currenthealth, psychosocial	2022-07-15

	patient s current services being provided, and treatment preferences, were provided to the health care practitioner/physician and receiving agency in 1 of 2 patients transferred to the hospital, (Patient #5) and in 1 of 1 discharged patients discharged records reviewed. (Patient #1) Findings Include: 5. A review of the discharge summary for patient #1, discharge date 4/29/22, evidenced a clinical summary taken from the patient s plan of care. The summary indicated Patient stated [he/she] has O2 (oxygen). No equipment seen. MD office to clarify & Waiting for call back from MD office & Patient could benefit from the assistance of a HHA (also hha, home health aide) & to help with bathing, dressing, medication reminders, light housekeeping and meal prep duties & Patient verbalized understanding of services provided and agrees & Presented and educated on & Patient Bill of Rights & Home Safety & Golden Heart s phone number & provided information in booklet to review. The discharge summary failed to include a current and pertinent clinical summary that included the patient s current health, psychosocial status, and care preferences, including but not limited to the patient s refusal to receive services from anyone but the son due to high anxiety, progress toward goals for services already received, status of supplemental oxygen needs, medication compliance and management, available caregivers and family support, and other services used by the patient. On 6/22/22 at 12:45 PM, the administrator indicated the patient had significant anxiety and refused all caregivers except the son, who was employed as an hha by Golden Heart Health Services until being required to complete home health aide competency training and skills check off as part of the agency s compliance plan. When the patient s son was no longer qualified as a home health aide, the patient refused an alternate home health aide or CNA (certified nursing assistant) and refused assistance finding another		status, and care preferences, including but not limited tothe patient’s progress toward goals for services already received, medicationcompliance and management, available caregivers and family support, and otherservices used by the patient. Date completed was 07-15-2022. Director of Nursing in-servicednurses on need to notify Director when patient has been transferred or is to bedischarged so Director can ensure summary is completed and sent to appropriateentities. Date completed was 07-15-2022. Director of Nursing/designee willaudit all transfer/discharge summaries done weekly to ensure all the requiredinformation is present on the summary. Once 100% compliance is achieved 10%will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

company. The administrator indicated the patient also received waiver services via a personal services agency.

1. A review of an undated agency policy titled, "Client Transfer" policy number C-840 was received on 06-23-2022, from the administrator. The policy indicated, "...Purpose: To ensure continuity of care by providing pertinent information to another &facility &3. A Transfer Summary shall be completed by the Registered Nurse/Therapist. This summary will be based on data collected on the last visit and shall include documentation of services received the reason for transfer &the client s physical and psychosocial status, current medications, continuing symptom management needs, instruction, and referrals provided to the client. Summary of care, any existing advance directives, and any relevant changes in caregiver support or lab results &.

2. Review of an undated agency policy C-500, titled "Client Discharge Process," evidenced "Discharge Planning is initiated for every home care client at the time of the client's admission for home care."

3. Review of an undated agency policy C-380, titled "Statement of Rights," evidenced an attestation signature page which indicated, "I have been provided with a copy of the Home Care Bill of Rights. I have read the Bill of Rights or had it explained to me. I understand the Bill of Rights and have had a chance to have all of my questions answered."

4. A review of the clinical record of Patient #5 contained an agency document titled Verbal Order with a date of 05-10-22 and was signed and dated by the clinical manager on 05-17-22. The verbal order indicated, Verbal order for hold PA services d/t (due to) hospitalization DVT right lower extremity &. The agency failed to evidence a transfer summary was completed by the Registered Nurse providing a summary of care for continuity of the patient s care needs and preferences.

A review of a facility document titled ED

	06-23-22, from Entity H, the patient s physician s office. The progress note indicated Patient #5 was admitted to Entity S on 06-20-22. The agency failed to evidence a transfer summary was completed by the Registered Nurse providing a summary of care for continuity of the patient s care needs and preferences. During an interview on 06-23-22, at 12:39 PM, when queried about Patient #5 s transfer summaries and notification to the facility and health care provider stated, I didn t know we were to do those.			
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.	G0574	G0574 Directorof Nursing in-serviced nurses on what is required in a plan of care and theplan must be individualized: Date completed was07-15-2022. Theindividualized 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;	2022-07-15

	(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 and interview, the agency failed to implement its policy that required the plan of care to be individualized to include all pertinent diagnoses with their date of onset/exacerbation, all supplies, and equipment necessary to meet the patient's needs in their home and 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 for 7 of 8 active patient records reviewed. (Patient #4, 5, 6, 7, 9, 11, and 13) Findings Include: 6. A review of the clinical record for patient #4 indicated the patient was hospitalized from 6/3/22 6/4/22 and received a resumption of care comprehensive assessment dated 6/8/22. The record evidenced a verbal order dated 6/8/22 to conduct a resumption of care following a left hip replacement. A review of the plan of care for the certification period of 4/25/22 6/23/22 failed to evidence all pertinent diagnoses including left hip replacement and pain; all pertinent safety measures including safety related to total hip replacement; all functional limitations such as hemiplegia and hemiparesis, pain, and safe use of medications; all activities or limitations including mobility restrictions and post-operative exercises for total hip replacement; patient-specific, measurable, and		(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 andhospital re-admission, and all necessary interventions to address theunderlying risk factors. (xiii)Patient and caregiver education and training to facilitate timelydischarge; (xiv)Patient-specific interventions and education; measurable outcomes and goalsidentified 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 toinclude.	

	pertinent goals as determined during the ROC; all orders for skilled nursing and home health aide services including an accurate frequency and duration; all interventions necessary to meet the stated goals; availability of caregivers; care coordination with other providers; and discharge plans. 7. A review of the plan of care for Patient #11, for the certification period of 5/20/22 7/18/22, failed to include all pertinent diagnoses including the patient s gastrostomy status, dysphagia, dysphasia, dementia, angina, anxiety, and incontinence; all durable medical equipment and supplies, such as suction catheters, g-tube type/brand and balloon size, emergency g-tube supplies, g-tube syringes, bedrails, briefs; all functional limitations such as ambulation/bedfast status and speech; all safety measures such as diabetic precautions, aspiration precautions, skin precautions, and emergency g-tube dislodgement/replacement; mental status including dementia and anxiety; correct frequencies and durations for skilled nurse and home health aide services; complete and accurate orders and interventions including preparation of medications for g-tube delivery such as crushing and dissolving in liquid, skilled care such as bathing and hygiene, g-tube care and dressing type, routine and emergent care of the g-tube and surrounding skin, toileting, mobility exercises/range of motion, frequency of vital signs and daily assessments, and home health aide plan of care orders. The plan of care also failed to accurately reflect the patient s status as indicated in the comprehensive assessment, including the patient s ability to communicate and understand, ability to make needs known, and the patient s rehabilitation potential and discharge planning needs. The plan of care also failed to include patient-specific, measurable, and reasonable goals consistent with the patient s needs as indicated in the comprehensive assessment; and failed to include an accurate list of all medications and preparation for delivery via g-tube; and all treatments such as g-tube and medication flushes post-delivery; and care coordination with other care providers. On 6/22/22 at 3:45 PM the Administrator was interviewed concerning plans of care. The administrator indicated they had done a lot of		Directorof Nursing will audit all current patient plans of care and comprehensiveassessments to ensure they contain all required information and reflect needsbased on their comprehensive assessment. If required information is missing averbal order will be obtained for missing information. Date completed was07-15-2022. Directorof Nursing will audit all plans of care done weekly to ensure they contain allrequired components and are individualized for that patient. The assessmentdone will be compared to the plan of care to ensure the information matches andis accurate. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) TheAdministrator will be responsible for monitoring these corrective actions toensure that this deficiency is corrected and will not recur.	

work and thought plans of care were better. No further information was provided.

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)

1. A review of an undated agency policy titled, "Plan of Care" policy number C-580 was received on 06-23-2022, from the administrator. The policy indicated, "Policy: The Plan of Care is based on a comprehensive assessment &The plan will be consistently reviewed to ensure the client needs are met, and will be updated as necessary, but at least every (60) days &Purpose: to provide guidance for agency staff to develop a plan of care individualized &Special Instructions: 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis (es) &including dates of onset. b. mental status. c. Type, frequency, and duration of all visits &l. Specific dietary or nutritional requirements or restrictions. m. Medications, treatments, and procedures. n. Medical supplies and equipment are required. o. Any safety measure to protect against injury. p. Instructions to client/caregiver, as applicable. q. Treatment goals &s Discharge plans. t. Patient-specific and measurable treatment goals and interventions &6. Signed physicians /allowed non-physician practitioners (NPP) orders will be obtained as quickly as possible but within (30) days &.

2. A review of the clinical record for Patient #5, for the recertification period of 04-29-22 to 06-27-22, evidenced the patient was hospitalized on 05-09-22 and 06-16-22 but failed to evidence an updated plan of care upon resumption of care to document changes in mobility, nutrition, blood sugars, respiratory needs, medications, assistive devices, safety precautions, and updated measurable and objective goals. The plan of care failed to be individualized, to include the accurate frequency of services (ex. HHA 1 hour a day 3 days a week for 9 weeks), failed to evidence the inclusion of nasal cannulas,

(Continuous Positive Airway Pressure) machine, CPAP supplies and failed to have call parameters for blood sugars, and failed to evidence who coordination of care pertaining to who was provided oxygen and supplies.

A review of an agency document titled Case Conference Form dated 05-01-22, indicated the following: the patient has had frequent hospitalizations, the patient refuses to comply with diet and activity, restrictions/cigarettes, and 05-01-22 to 05-30-22 home health aide T (Tuesday) W (Wednesday) Thurs (Thursday).

A review of an agency document titled Case Conference Form dated 06-01-22, indicated the following: Patient is still non-compliant with diet, activity, and smoking, patient educated to quit smoking and resources to be compliant with diet and restrictions, and 06-01-22 to 06-30-22 home health aide T (Tuesday) W (Wednesday) Thurs (Thursday).

During an interview on 06-21-22, at 11:15 AM, the family member of Patient #5, Person T, confirmed the patient has issues with her blood sugars and respiratory system. Patient #5 wears continuous oxygen and has a CPAP.

3. A review of the clinical record of patient #6 indicated a start of care date of 05-20-22. The record contained a comprehensive recertification (follow-up) reassessment completed on 06-10-22, indicated diagnoses, Chronic obstructive pulmonary disease, Essential hypertension, chronic pain syndrome, radiculopathy, thoracic region, unilateral primary osteoarthritis, right hip, dorsalgia, primary osteoarthritis, right shoulder. The 60-day summary indicated the patient is incontinent and had suffered a fall and right femur head fracture on 03-23-22.

A review of a physician signed plan of care for the recertification period of 05-20-22 to 07-18-22, indicated the following diagnoses: Chronic obstructive pulmonary disease, Essential hypertension, pure hypercholesterolemia, chronic pain syndrome, fracture of unspecified part of neck of right femur, invert disc disorders with radiculopathy, thoracic region, unilateral primary osteoarthritis, right hip, dorsalgia, primary osteoarthritis, right shoulder onset dates listed all 10-20-2001, but failed to list diagnoses

consistent with the drug use of Colace (a medication used to constipation), Nicotine Step 2 Transdermal patch (a medication used to treat nicotine withdraw), diphenhydramine(a medication used to treat insomnia), Miralax (a medication used to treat constipation), Effexor (a medication used to treat depression), The plan of care listed allergies: codeine, and contrast dye, but failed to list allergy to morphine. 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 <92% that failed to be individualized for the patient. The plan of care in the section Durable Medical Equipment (DME) and Supplies 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, failed to have specific interventions for pain, incontinence, and failed to address patient interventions regarding smoking and using patches, and failed to obtain specific physician call orders for parameters not generalized.

4. A review of the clinical record of patient #7 indicated a start of care date of 03-24-21. The record contained a comprehensive recertification assessment completed on 05-20-22 that indicated diagnoses, Type 2 diabetes without complications, Chronic obstructive pulmonary disease, Essential hypertension, Major depressive disorder, Chronic atrial fibrillation, Allergic rhinitis, Nausea, Hypokalemia, and Pain Long term use of inhaled steroids onset dates listed all 10-21-2000. The 60-day summary indicated the patient is a smoker. The patient indicated their blood sugars ranged between 150-200s, with Accu-checks 4 times a day.

A review of a plan of care for the recertification period of 05-18-22 to 07-16-22, indicated the following diagnoses: Chronic obstructive pulmonary disease, Essential hypertension, Major depressive disorder, Atherosclerotic heart disease of the native coronary artery, Benign paroxysmal vertigo, Gastro-esophageal reflux disease, Mixed hyperlipidemia, Diabetes

due to underlying condition with diabetic neuropathy, and Obstructive sleep apnea, but failed to list diagnoses consistent with the drug use of Tramadol (a medication used for pain), Risperdal(a medication used to for schizophrenia), Chantix(a medication used to treat smoking cessation), Cyclobenzaprine (a medication used to treat muscle spasms), and Potassium Chloride (a medication used to treat low potassium). 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 <92% 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 #7 was administering. The plan of care failed to evidence the inclusion of the motorized power chair, CPAP, masks, tubing, oxygen tubing, and nasal cannulas in the section Durable Medical Equipment (DME) and Supplies. 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, failed to have specific interventions for pain, incontinence, and failed to address patient interventions regarding smoking and using patches, and failed to obtain specific physician call orders for parameters not generalized.

During an interview on 06-22-22 at 12:20 PM, patient #7 stated the nurses at the assisted living facility, Entity D, check their blood sugar and give them their insulin injections. Patient #7 further confirmed they are always on oxygen, 3 liters per nasal cannula. Patient #7 indicated they do not have a wheelchair, only a rollator walker and a motorized scooter.

5. A review of the clinical record of patient #13 indicated a start of care date of 05-16-22. The record contained an initial comprehensive assessment completed on 05-16-22 that indicated diagnoses, Vascular dementia without behavioral disturbance, Atherosclerotic heart disease of the native coronary artery with angina pectoralis with spasm, Acute systolic (congestive) heart failure, Blindness right eye category 3, blindness left

eye category 3, Mood disorder due to known physical condition with depressive features, Mixed hyperlipidemia, Essential hypertension, Benign prostatic hyperplasia with lower urinary tract symptoms, and Ischemic cardiomyopathy, onset dates listed all 10-20-2010. The 60-day summary indicated the patient was at risk for skin breakdown due to urinary incontinence. The patient required assistance to get up with a walker to a wheelchair for dressing, bathing, meal prep, and light housekeeping.

A review of a plan of care for the recertification period of 05-18-22 to 07-16-22, indicated the following diagnoses: Vascular dementia without behavioral disturbance, Atherosclerotic heart disease of the native coronary artery with angina pectoralis with spasm, Acute systolic (congestive) heart failure, Blindness right eye category 3, blindness left eye category 3, Mood disorder due to known physical condition with depressive features, Mixed hyperlipidemia, Essential hypertension, Benign prostatic hyperplasia with lower urinary tract symptoms, and Ischemic cardiomyopathy, onset dates listed all 10-20-2010, but failed to list diagnoses consistent with the drug use of Senexon (a medication used for constipation), and Potassium Chloride (a medication used to treat low potassium). 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 <92% that failed to be individualized for the patient. The plan of care in the section Durable Medical Equipment (DME) and Supplies incorrectly evidenced the patient had a urinary ostomy and failed to list a wheelchair and walker. 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 behaviors, failed to have specific interventions for pain, incontinence, and failed to address patient interventions regarding blindness, and failed to obtain specific physician call orders for parameters not generalized.

These findings were reviewed with the administrator, clinical manager, and alternate administrator on 06-23-22, from 5:00 PM to

	5:38 PM, which they had no further documentation was provided. The administrator confirmed they were aware of still having issues.			
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 clinical records included information about the services the patient received from other agencies and failed to ensure they coordinated care delivery to meet the patient s needs for 1 of 1 active patient records reviewed (Patient #6) receiving outside services. Findings Include: 3. A review of the clinical record for Patient #3 evidenced a plan of care for the certification period of 4/5/22 6/3/22 and included Coordination of Care: [Name of Entity A, a personal services agency] 5p to 9p Monday through Friday. [Name of Entity S, case management company] The plan of care failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services. A review of the comprehensive assessment dated 5/5/22 failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals	G0608	G0608 Director of Nursing in-servicednurses on requirement to include in comprehensive assessment and on plan ofcare the name of all agencies/health care entities patient is receivingservices from. Need to include name of agency/entity, type of service andfrequency. The nurse is to contact those agencies and document coordination ofcare was completed. Documentation is to include name of agency, date/time,person spoke with and what was discussed. Date completed was 07-15-2022. Director of Nursing will reviewall current patient assessments to ensure if there is documentation of anotherhealth care entity/agency providing care it is listed on the plan of care. Willensure all required information is documented regarding care coordination. Datecompleted was 07-15-2022.	2022-07-29

	and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services. A review of the clinical record failed to evidence communication notes, Interdisciplinary Group notes, case conference notes, or other documentation that indicated the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative for the certification period of 4/5/22 6/3/22 to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services. 4. A review of the clinical record for patient #4 evidenced a plan of care for the certification period of 4/25/22 6/23/22 and included Coordination of care: [Name of Entity S] [Name of Entity A] ATTC (attendant care) MThF 4 hours, 2p 6p. The plan of care failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services. A review of the comprehensive assessment dated 6/8/22 failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services. A review of the clinical record failed to evidence communication notes, Interdisciplinary Group notes, case conference notes, or other documentation that indicated the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative for the certification period of 4/5/22 6/3/22 to ensure accurate goals and progress, review		Administrator/Director ofNursing will ensure case conferences are done at least monthly and anytimethere is a change in patient condition with other agencies/health care entitiesinvolved in patient’s care and it is documented. Conferences will includeupdating information to ensure goals are accurate and whether there isprogress, review and update medications and orders, discuss patient needs,review services provided, and prevent duplication of services On-going07-29-2022. The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.

5. A review of the clinical record for Patient #9 evidenced a plan of care for the certification period of 5/22/22 7/20/22 and indicated Coordination of Care: [Name of Entity A, a personal services agency] T/Th/Sat 3 hours 1P 4P. The plan of care failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.

A review of the comprehensive assessment dated 5/27/22 failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.

A review of the clinical record failed to evidence communication notes, Interdisciplinary Group notes, case conference notes, or other documentation that indicated the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.

6. A review of the clinical record for Patient #11 evidenced a plan of care for the certification period of 5/20/22 7/18/22 and failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.

A review of the comprehensive assessment dated 5/20/22 failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.

A review of the clinical record failed to evidence communication notes, Interdisciplinary Group notes, case conference notes, or other documentation that indicated the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.

On 6/22/22 at 3:45PM, the Administrator indicated the agency does not have interdisciplinary group meetings because that is only a requirement in hospice regulations. When asked if the agency holds group discussion with the nurses, aides, Clinical Manager, and Administrator to discuss the patients ongoing needs, concerns, discharge plans, goals, and progress toward goals the administrator indicated those occur monthly, but they are not called interdisciplinary group meetings. The Administrator also indicated any documentation of the meetings would be on a care coordination form. When asked when the most recent care coordination meeting occurred and how the patient s needs are monitored if they are only discussed monthly, the Administrator had no further information.

410 IAC 17-12-2(g)

1. A review of an undated agency policy titled, "Coordination of Client Services" policy number C-360 was received on 06-23-2022, from the Administrator. The policy indicated, "Policy: The agency will integrate services &assure the identification of client needs and factors that could affect client safety and the effectiveness of treatment. The coordination of care is provided by all disciplines &and

	&Special Instructions &4. Agency will communicate with ALL physicians &5. Agency will integrate services, whether services are provided directly or under the arrangement, to assure the identification of client needs and factors that could affect client safety and treatment and the coordination of care providers &. 2. A review of the clinical record for Patient #9 evidenced a plan of care for the certification period of 5/22/22 7/20/22 and indicated Coordination of Care: [Name of Entity A, a personal services agency] T/Th/Sat 3 hours 1P 4P. The plan of care failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services. A review of the comprehensive assessment dated 5/27/22 failed to evidence the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services. A review of the clinical record failed to evidence communication notes, Interdisciplinary Group notes, case conference notes, or other documentation that indicated the agency coordinated care and updated information with the physician, case management company, personal services agency, caregiver, and/or representative to ensure accurate goals and progress, review and update medications and orders, discuss patient needs, review services provided, and prevent duplication of services.			
G0682	Infection Prevention	G0682	G0682	2022-07-15

	484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure the Certified Nursing Assistants (CNAs) implemented standard precautions, including proper hand hygiene and infection control practices while performing a shower and assisting the patients with activities of daily living (ADLs) in 2 of 2 home visits observed. (Patients #6, 7) Findings Include: 1. A review of an undated agency policy titled, "Infection Prevention/Control," policy number B-403, was received on 06-23-2022, from the administrator. The policy indicated, "Policy: Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC) &Purpose: To ensure employee and client safety &Special Instructions &2. Hands are washed &immediately after gloves are removed &3. Gloves are worn when touching blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items &Standard precautions will be used with all clients &. 2. A review of the Centers for Disease Control When to Perform Hand Hygiene, retrieved from cdc.gov/hand hygiene/providers/index.html and last updated January 2021, indicated "Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient. Before performing an aseptic task [e.g., placing an indwelling device] or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces. Immediately after		Director of Nursing willin-service all clinicians on proper standard precautions to include proper handhygiene, when to glove/change gloves and infection control practices. Datecompleted 07-15-2022. Director of Nursing willin-service nurses on observing aides for proper standard precautions when doinga supervisory visit if aide is present at time of visit. Date completed was07-15-2022. Director of Nursing willin-service aides on proper hand hygiene and gloving when providing personalcare. Date completed was 07-15-2022. Director of Nursing/designeewill in-service all clinical staff yearly on proper standard precautions andclinicians will be required to demonstrate proper hand hygiene yearly as partof that in-service. 9On-going) The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

glove removal. Wash with Soap and Water: When hands are visibly soiled...After known or suspected exposure to spores &When using alcohol-based hand sanitizer: Put product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds...The CDC Guideline for Hand Hygiene in Healthcare Settings recommends: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product...and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use towel to turn off the faucet...Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right time. ... When and How to Wear Gloves: Wear gloves...when...contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur...Change gloves and perform hand hygiene during patient care; if gloves become damaged, gloves become visibly soiled...moving from work on a soiled body site to a clean body site on the same patient or in another...."

3. During a home visit for Patient #7, at Entity D, an assisted living facility, on 06-22-2022, at 11:50 AM, CNA #1 was observed donning gloves to shave Patient #7. Upon completion, the CNA removed the gloves, discarded them into the kitchen trash container, and donned another pair of gloves without performing hand hygiene. During the patient s shower, the patient was observed washing their peri/rectal area with a washcloth, which they returned to the aide, who was observed using the same washcloth to wash the patient s lower extremities. While wearing the same gloves used to handle the dirty washcloth, the aide assisted the patient with drying and dressing, then removed the gloves and discarded them in their scrub shirt pocket. The CNA failed to change the washcloth after it was contaminated, failed to change gloves after they were contaminated, failed to discard dirty gloves in an appropriate receptacle, failed to

complete hand hygiene before and after changing gloves, failed to follow the CDC guidelines for infection control, and failed to follow its policy for infection control.

4. During a home visit for Patient #6, at Entity B, an assisted living facility, on 06-22-2022, at 2:00 PM, CNA #2 was observed performing hand hygiene, donning gloves, and taking Patient #6 s temperature. Upon completion, the CNA was observed to discard the gloves into the trash and donned another pair of gloves without performing hand hygiene. CNA #2 checked the patient s incontinence pad, discarded the gloves into the trash, and donned new gloves without performing hand hygiene. CNA #2 assisted the patient to the bathroom toilet, removed the patient s pull-up that was soiled with urine, discarded their gloves, and donned another pair of gloves without performing hand hygiene. The CNA assisted Patient #6 in undressing, placed the dirty clothes in the hamper, discarded their gloves in the trash, and donned another pair of gloves without performing hand hygiene. CNA #2 assisted the patient into the walk-in shower, handed the patient a soapy washcloth, then observed Patient #6 wash upper body and peri-area. The patient handed the dirty washcloth to the aide, who was observed washing Patient #6 s back, lower bilateral extremities, and feet with the dirty washcloth. The CNA failed to discard the dirty washcloth and obtain a clean washcloth to wash Patient #6, failed to complete hand hygiene before and after changing gloves, failed to follow the CDC guidelines for infection control, and failed to follow its policy for infection control.

During an interview on 06-22-2022, at 2:45 PM, the Clinical Manager confirmed hand hygiene is supposed to be performed after discarding gloves and between going dirty to clean.

During a review of the home visit observations, on 06-23-2022, at 5:00 PM, the Administrator and Clinical Manager confirmed that hand hygiene is supposed to be performed after

	gloves are removed and going from dirty to clean surfaces. The management team further confirmed the CNA s infection control issues with using the dirty washcloth to wash the patient s back after the patients had used the washcloths on their peri/rectal areas. 410 IAC 17-12-1(m)			
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 observation, record review, and interview, the Case Manager failed to ensure that the aide care plan was individualized and patient-specific for 3 of 8 active records reviewed. (Patient #5, 6, and 7) Findings Include: 1. A review of an undated agency policy titled, Home Health Aide Care Plan policy number C-751 was received on 06-23-2022, from the administrator. The policy indicated, Policy: A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse... All home health aide staff will follow the identified plan. The Care Plan will be available to all persons involved in client care including contract providers. Purpose: To provide a means of assigning	G0798	G0798 Director of Nursing in-servicednurses on requirement that aide care plan must be individualized and patientspecific. If patient lives in an assisted living nurse is to speak with nurseat assisted living about what patient's needs are to ensure patient receivesactual care needed. This conversation is to be documented in patient chart. Expecteddate of completion is 08-26-2022. Director of Nursing will auditall current aide care plans for patients receiving aide services to ensure planof care is specific to patient needs based on their comprehensive assessment.Any aide care plan that is not accurate or specific to patient will be revisedby having nurse obtain verbal order to revise the aide plan of care. If patientlives in an assisted living nurse will	2022-08-26

	to the Nurse, Home Health Aide, and to the client/caregiver being served. To provide documentation that the supervising Nurse oriented the assigned Aide to the client s care before initiating the care. To provide documentation that the client s care is individualized to his/her specific needs &. 2. The clinical record of Patient #5 was reviewed and contained a plan of care for the certification period of 04-28-22 to 06-27-22, with diagnoses that included, but were not limited to, chronic respiratory failure, type 2 diabetes mellitus without complications, chronic systolic congestive heart failure, chronic obstructive pulmonary disease, rhabdomyolysis, essential hypertension, gastro reflux diseases, paroxysmal atrial fibrillation, and chronic kidney disease stage 3. The plan of care indicated the patient was to receive a home health aide (HHA) 1 hour a day, 5 times a week, for 9 weeks for assistance with bathing and light housekeeping. A review of an aide care plan dated 05-26-22, indicated the patient was to receive aide services 1 hour/day, 5 days/week, diabetic, do not cut nails, their diet was NCS (No Concentrated Sweets), alone most of the time, needs assistance for major ADLs (Activities of Daily Living), SOB (Short of Breath) on exertion, confusion/forgetful, up as tolerated, poor vision, hearing deficit, has dentures upper and lower, and other dialysis. The aide care plan had parameters to notify the case manager of temperature > 100 and <96, temperature every visit, hair care every visit, shampoo weekly, skin care every visit, mouth/denture care every visit, foot care every visit, dressing every visit, light laundry every visit, bed linen change weekly, make the bed every visit, light housekeeping bedroom, bathroom, kitchen every visit, clean equipment weekly, dust weekly, sweep every visit, vacuum weekly, take out trash weekly, encourage fluids every visit, personal care every visit, shower every visit, sponge bath every visit, toileting/hygiene every visit, assist with walker every visit, and wheelchair every visit. The aide care plan failed to evidence that all services to be provided were specific to the patient's needs, in regards to Patient #5 was not on dialysis. During an interview on 06-23-22, at 3:06 PM,		speak with nurse at assisted living toensure patient’s actual needs are met. G0798. Expected date of completion is 08-26-2022. Director of Nursing in-servicednurses on requirement that aide care plan must be individualized and patientspecific. If patient lives in an assisted living nurse is to speak with nurseat assisted living about what patient’s needs are to ensure patient receivesactual care needed. This conversation is to be documented in patient chart. Expecteddate of completion is 08-26-2022.	

the clinical manager confirmed the care plan for Patient #5 was wrong, indicating the patient was on dialysis when they are not.

3. The clinical record for Patient #6 was reviewed and contained a plan of care for the certification period of 05-20-22 to 07-18-22, with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, chronic pain, fracture of unspecified part of neck of right femur, depression, hypertension, right shoulder osteoarthritis. The plan of care indicated the patient was to receive a home health aide (HHA) 1 hour a day, 5 times a week, for 9 weeks for assistance with bathing, light housekeeping, and meal prep per the HHA care plan.

A review of an aide care plan dated 06-21-22, indicated the patient was to receive aide services 1 hour/day, 5 days/week, their diet was REG (Regular), alone most of the time, needs assistance for major ADLs, SOB on exertion, confusion/forgetful, history of falls, up as tolerated, hearing deficit, and has dentures upper and lower. The aide care plan had parameters to notify the case manager of temperature > 100 and <96, temperature every visit, hair care every visit, shampoo weekly, skin care every visit, mouth/denture care every visit, foot care every visit, nail care every visit, dressing every visit, light laundry every visit, bed linen change weekly, make the bed every visit, light housekeeping bedroom, bathroom, kitchen every visit, clean equipment weekly, dust weekly, sweep every visit, vacuum weekly, take out trash weekly, encourage fluids every visit, personal care every visit peer patient request, shower every visit per patient request, sponge bath every visit per patient request, toileting/hygiene every visit, assist with walker every visit, and wheelchair every visit. The aide care plan failed to evidence that all services to be provided were specific to the patient's needs and not per patient request, failed to evidence Patient #6 cares for their dentures, failed to evidence the patient sleeps in a chair, not a bed, failed to evidence the patient only wears gowns and failed to evidence patient only takes showers.

During a home visit with Patient #6, on 06-22-22, at 1:50 PM, at an assisted living

Director of Nursing will auditall current aide care plans for patients receiving aide services to ensure planof care is specific to patient needs based on their comprehensive assessment.Any aide care plan that is not accurate or specific to patient will be revisedby having nurse obtain verbal order to revise the aide plan of care. If patientlives in an assisted living nurse will speak with nurse at assisted living toensure patient’s actual needs are met. Expected date of completion is08-26-2022.

Director of Nursing/designeewill audit all aide care plans done weekly to ensure they are accurate andpatient specific by comparing aide care plan to the comprehensive assessment.If patient lives in an assisted living there needs to be documentation nursespoke with nurse at assisted living regarding patient’s needs. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going)

The Administrator will beresponsible for monitoring these corrective actions to

	facility, Entity B, Patient #6 observed a studio apartment with a living area with a recliner and a bathroom and kitchen. Patient #6 was in the recliner in the living room. There is no bedroom or bed noted in Patient #6 s apartment. When queried, Patient #6 regarding their care confirmed that they only wear their dentures when going out of the apartment and always take care of them. Patient #6 further confirmed they only take showers. The clinical manager indicated that the patient always wears a gown and, no matter what season, has a heating pad in their recliner for pain. 4. The clinical record for Patient #7 was reviewed and contained a plan of care for the certification period of 05-18-22 to 07-16-22, with diagnoses that included, but were not limited to, type 2 diabetes mellitus, chronic pain, chronic obstructive pulmonary disease, essential hypertension, major depressive disorder, and gastroesophageal reflux disease. The plan of care indicated the patient was to receive a home health aide (HHA) 1 hour a day, 5 times a week, for 9 weeks for assistance with bathing, light housekeeping, and meal prep per the HHA care plan. A review of an aide care plan dated 05-20-22, indicated the patient was to receive aide services 1 hour/day, 3-5 days/week, diabetic, do not cut nails, their diet was regular, alone most of the time, needs assistance for major ADLs, SOB on exertion, history of falls, up as tolerated, and has dentures partial upper. The aide care plan had parameters to notify the case manager of temperature > 100 and <96, temperature every visit, hair care every visit, shampoo weekly, skin care every visit file only, mouth/denture care every visit, foot care every visit, dressing every visit, light laundry every visit, bed linen change weekly, make the bed every visit, light housekeeping bedroom, bathroom, kitchen every visit, clean equipment weekly, dust weekly, sweep weekly, vacuum weekly, take out trash weekly, encourage fluids every visit, personal care every visit per pt (patient) request, shower every visit per pt request, sponge bath every visit per pt request, and assist with walker every visit rollator. The aide care plan failed to evidence that all services to be provided were specific to the		ensure that thisdeficiency is corrected and will not recur. Director of Nursing/designeewill audit all aide care plans done weekly to ensure they are accurate andpatient specific by comparing aide care plan to the comprehensive assessment.If patient lives in an assisted living there needs to be documentation nursespoke with nurse at assisted living regarding patient’s needs. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

	failed to evidence Patient 7 only showers 3 times a week, and failed to evidence Patient #7 cared for their own dentures and only wore them when they go out, failed to evidence Patient 7 required a shave every visit, and failed to evidence Patient 7 required oxygen per nasal cannula continuously. During a home visit with Patient #7, on 06-22-22, at 11:25 AM, at an assisted living facility, Entity D, Patient #7 confirmed they only take showers three times a week and required the assistance of the CNA to shave them daily due to their hand numbness, and they cannot grip items. Patient #7 further indicated they care for their dentures and only wear them when they go out. During an interview on 06-22-22, at 2:50 PM, the Clinical Manager stated, I can t do everything. I am the only nurse for Indy and Terre Haute.			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and interview, the agency failed to ensure home health aides (HHA) provided services per the plan of care in 3 of 8 active records reviewed. (Patient #5, 6, and 7) Findings Include: 1. A review of an undated agency policy titled,	G0800	G0800 Director of Nursing willin-service aides on requirement to provide tasks as assigned on aide plan ofcare. If patient refuses an assigned task aide is to mark that task as "R" or"refused" and notify RN of the refusal. Expected date of completion is08-26-2022. Director of Nursing willin-service aides/schedulers on requirement to notify Director of anymissed/refused aide visits daily as soon as made aware a missed/refused visit. Expected date of completion is 08-26-2022.	2022-08-26

	number C-800 was received on 06-23-2022, from the administrator. The policy indicated, Policy: Home Health Aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan. Purpose: To provide documentation of the care performed &. 2. The clinical record for patient #5 was reviewed and contained an aide care plan dated 05-26-22, which indicated the patient was to receive aide services 1 hour/day, 5 days/week, diabetic, do not cut nails, their diet was NCS (No Concentrated Sweets), alone most of the time, needs assistance for major ADLs (Activities of Daily Living), SOB (Short of Breath) on exertion, confusion/forgetful, up as tolerated, poor vision, hearing deficit, has dentures upper and lower, and other dialysis. The aide care plan had parameters to notify the case manager of temperature > 100 and <96, temperature every visit, hair care every visit, shampoo weekly, skin care every visit, mouth/denture care every visit, foot care every visit, dressing every visit, light laundry every visit, bed linen change weekly, make the bed every visit, light housekeeping bedroom, bathroom, kitchen every visit, clean equipment weekly, dust weekly, sweep every visit, vacuum weekly, take out trash weekly, encourage fluids every visit, personal care every visit, shower every visit, sponge bath every visit, toileting/hygiene every visit, assist with walker every visit, and wheelchair every visit. A review of the plan of care for the certification period of 04-29-22 to 06-27-22, with diagnoses that included, but were not limited to, chronic respiratory failure, type 2 diabetes mellitus without complications, chronic systolic congestive heart failure, chronic obstructive pulmonary disease, rhabdomyolysis, essential hypertension, gastro reflux diseases, paroxysmal atrial fibrillation, and chronic kidney disease stage 3. The plan of care indicated the patient was to receive a home health aide (HHA) 1 hour a day, 5 times a week, for 9 weeks for assistance with bathing and light housekeeping. A review of agency documents titled, Aide Visit Note-Daily evidenced the following:		Director of Nursing/designeewill audit all aide visit notes submitted weekly to ensure tasks assigned onaide plan of care were completed or there is documentation indicating why atask wasn't provided. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) Director of Nursing/designeewill compare actual number of aide visits done per week to the orderedfrequency on plan of care to ensure ordered frequency was provided. If there isa visit missing there needs to be a missed visit note with reason for missedvisit, documentation RN was notified and missed visit report was sent to MD.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) Director of Nursing willin-service nurses on requirement to review aide care plan at supervisory visitsand revise as needed to reflect patient's needs and to ensure plan of care isindividualized.	

	A. During the week of 04-29-22, no home health aide visits were made B. During the week of 05-01-22, only 2 visits were made. 1. A review of a visit note dated 05-03-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, personal care, shower, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care. 2. A review of a visit note dated 05-05-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care. C. During the week of 05-08-22, 0 visits were made due to the patient being hospitalized. D. During the week of 05-15-22, only 3 visits were made. 1. A review of a visit note dated 05-17-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care. 2. A review of a visit note dated 05-18-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, personal care, shower, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care. 3. A review of a visit note dated 05-19-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, personal care, sponge bath, assistance with a walker,		Nurse is to document when aide care plan is reviewed andrevised. Expected date of completion is 08-26-2022. The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

E. During the week of 05-22-22, only 3 visits were made.

1. A review of a visit note dated 05-24-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 05-25-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 05-26-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

F. During the week of 05-29-22, only 3 visits were made.

1. A review of a visit note dated 05-31-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, personal care, sponge bath, wheelchair, encourage fluids, light laundry, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 06-01-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 06-02-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

G. During the week of 06-05-22, only 3 visits were made.

1. A review of a visit note dated 06-05-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 06-07-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 06-08-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, personal care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

H. During the week of 06-12-22, only 2 visits were made.

1. A review of a visit note dated 06-14-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care,

sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 06-15-22 from 1:00 PM to 2:00 PM failed to evidence the patient had mouth/denture care, foot care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, bed linen change, make the bed, light housekeeping, clean equipment, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

During an interview on 06-21-22, at 11:15 AM, the family member of Patient #5, Person T, confirmed the patient is not on dialysis.

During an interview on 06-23-22, at 3:06 PM, the clinical manager confirmed the care plan for Patient #5 was wrong, indicating the patient was on dialysis when they are not.

3. The clinical record for patient #6 was reviewed and contained an aide care plan dated 06-21-22, which indicated the patient was to receive aide services 1 hour/day, 5 days/week, their diet was REG (Regular), alone most of the time, needs assistance for major ADLs, SOB on exertion, confusion/forgetful, history of falls, up as tolerated, hearing deficit, and has dentures upper and lower. The aide care plan had parameters to notify the case manager of temperature > 100 and <96, temperature every visit, hair care every visit, shampoo weekly, skin care every visit, mouth/denture care every visit, foot care every visit, nail care every visit, dressing every visit, light laundry every visit, bed linen change weekly, make the bed every visit, light housekeeping bedroom, bathroom, kitchen every visit, clean equipment weekly, dust weekly, sweep every visit, vacuum weekly, take out trash weekly, encourage fluids every visit, personal care every visit peer patient request, shower every visit per patient request, sponge bath every visit per patient request, toileting/hygiene every visit, assist with walker every visit, and wheelchair every visit.

A review of the plan of care for the certification period of 05-20-22 to 07-18-22,

with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, chronic pain, fracture of unspecified part of neck of right femur, depression, hypertension, right shoulder osteoarthritis. The plan of care indicated the patient was to receive a home health aide (HHA) 1 hour a day, 5 times a week, for 9 weeks for assistance with bathing, light housekeeping, and meal prep per the HHA care plan.

A review of agency documents titled, Aide Visit Note-Daily evidenced the following:

A. During the week of 05-20-22, no home health aide visits were made.

B. During the week of 05-22-22, no home health aide visits were made.

C. During the week of 05-29-22, no home health aide visits were made.

D. During the week of 06-05-22, no home health aide visits were made.

E. During the week of 06-12-22, only 4 home health aide visits were made.

1. A review of a visit note dated 06-13-22 from 7:30 PM to 8:30 PM failed to evidence the patient had mouth/denture care, nail care, sponge bath, assistance with a wheelchair, light laundry, bed linen change, make the bed, light housekeeping, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 06-15-22 from 2:00 PM to 3:00 PM failed to evidence the patient had nail care, foot care, sponge bath, assistance with a walker, wheelchair, light laundry, bed linen change, take out the trash, make the bed, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 06-16-22 from 2:00 PM to 3:00 PM failed to evidence the patient had mouth/denture care, nail care, foot care, sponge bath, assistance with a walker, wheelchair, encourage fluids, light laundry, bed linen change, light housekeeping, make the bed, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

4. 1. A review of a visit note dated 06-17-22 from 7:30 PM to 8:30 PM failed to evidence the patient's sponge bath, light laundry, bed linen change, make the bed, light housekeeping, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

F. During the week of 06-19-22, only 2 home health aide visits were made

1. A review of a visit note dated 06-21-22 from 2:00 PM to 3:00 PM failed to evidence the patient had nail care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, and encourage fluids, light laundry, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 06-22-22 from 2:00 PM to 3:00 PM failed to evidence the patient had nail care, foot care, personal care, sponge bath, assistance with a walker, wheelchair, and encourage fluids, light laundry, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

During an interview on 06-21-2022, at 3:55 PM, the Clinical Manager confirmed that they did not document any communication notes or coordination of care notes or obtain a physician order to place services on hold until prior authorization was obtained.

During a home visit with Patient #6, on 06-22-22, at 1:50 PM, at an assisted living facility, Entity B, Patient #6 observed a studio apartment with a living area with a recliner and a bathroom and kitchen. Patient #6 was in the recliner in the living room. There is no bedroom or bed noted in Patient #6 s apartment. When queried, Patient #6

regarding their care confirmed that they only wear their dentures when going out of the apartment and always take care of them. Patient #6 further confirmed they only take showers. The clinical manager indicated that the patient always wears a gown and, no matter what season, has a heating pad in her recliner for pain.

4. The clinical record for patient #7 was reviewed and contained an aide care plan dated 05-20-22, which indicated the patient was to receive aide services 1 hour/day, 3-5 days/week, diabetic, do not cut nails, their diet was regular, alone most of the time, needs assistance for major ADLs, SOB on exertion, history of falls, up as tolerated, and has dentures partial upper. The aide care plan had parameters to notify the case manager of temperature > 100 and <96, temperature every visit, hair care every visit, shampoo weekly, skin care every visit file only, mouth/denture care every visit, foot care every visit, dressing every visit, light laundry every visit, bed linen change weekly, make the bed every visit, light housekeeping bedroom, bathroom, kitchen every visit, clean equipment weekly, dust weekly, sweep weekly, vacuum weekly, take out trash weekly, encourage fluids every visit, personal care every visit per pt request, shower every visit per pt request, sponge bath every visit per pt request, and assist with walker every visit rollator.

A review of the plan of care for the certification period of 05-18-22 to 07-16-22, with diagnoses that included, but were not limited to, type 2 diabetes mellitus, chronic pain, chronic obstructive pulmonary disease, essential hypertension, major depressive disorder, and gastroesophageal reflux disease. The plan of care indicated the patient was to receive a home health aide (HHA) 1 hour a day, 5 times a week, for 9 weeks for assistance with bathing, light housekeeping, and meal prep per the HHA care plan.

A review of agency documents titled, Aide Visit Note-Daily evidenced the following:

A. During the week of 05-18-22, only 3 home health aide visits were made.

1. A review of a visit note dated 05-18-22 from

patient had nail care, foot care, sponge bath, assistance with a walker, bed linen change, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 05-19-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, nail care, shower, assistance with a walker, light laundry, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 05-20-22 from 2:30 PM to 3:30 PM failed to evidence the patient had mouth/denture care, foot care, nail care, sponge bath, assistance with a walker, light laundry, bed linen change, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

B. During the week of 05-22-22, only 4 home health aide visits were made.

1. A review of a visit note dated 05-23-22 from 7:30 PM to 8:30 PM failed to evidence the patient had nail care, foot care, sponge bath, assistance with a walker, bed linen change, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 05-25-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, sponge bath, light laundry, bed linen change, light housekeeping, make the bed, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 05-26-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, shower, light laundry, bed linen change, make the bed, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

4. A review of a visit note dated 05-27-22 from 2:30 PM to 3:30 PM failed to evidence the patient had mouth/denture care, foot care, nail

care, sponge bath, light laundry, bed linen change, make the bed, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

C. During the week of 05-29-22, 5 home health aide visits were made.

1. A review of a visit note dated 05-30-22 from 7:30 PM to 8:30 PM failed to evidence the patient had nail care, foot care, sponge bath, bed linen change, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 05-31-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, shower, light laundry, bed linen change, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 06-01-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, shower, light laundry, bed linen change, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

4. A review of a visit note dated 06-02-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, sponge bath, encourage fluids, light laundry, bed linen change, make the bed, dust, sweep, take out the trash, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

5. A review of a visit note dated 06-03-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, nail care, sponge bath, light laundry, bed linen change, make the bed, light housekeeping, dust, sweep, vacuum, and take out the trash. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

D. During the week of 06-05-22, 5 home health aide visits were made.

1. A review of a visit note dated 06-06-22 from 7:30 PM to 8:30 PM failed to evidence the patient had hair care, shampoo, skincare,

mouth/denture care, nail care, foot care, shower, sponge bath, assistance with a walker, encourage fluids, light laundry, bed linen change, make the bed, dust, sweep, take out the trash and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 06-07-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, sponge bath, assistance with the walker, light laundry, bed linen change, make the bed, light housekeeping, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

3. A review of a visit note dated 06-08-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, sponge bath, light laundry, bed linen change, light housekeeping, dust, sweep, take out the trash, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

4. A review of a visit note dated 06-09-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, shower, assistance with the walker, light laundry, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

5. A review of a visit note dated 06-10-22 from 2:00 PM to 3:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, sponge bath, assistance with the walker, light laundry, bed linen change, make the bed, light housekeeping, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

E. During the week of 06-12-22, only 4 home health aide visits were made.

1. A review of a visit note dated 06-13-22 from 2:00 PM to 3:00 PM failed to evidence the patient had mouth/denture care, foot care, nail care, sponge bath, assistance with the walker, light laundry, bed linen change, make the bed, light housekeeping, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care.

2. A review of a visit note dated 06-14-22 from

	11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, nail care, sponge bath, light laundry, bed linen change, make the bed, light housekeeping, dust, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care. 3. A review of a visit note dated 06-15-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, sponge bath, light laundry, bed linen change, light housekeeping, dust, sweep, take out the trash, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care. 4. A review of a visit note dated 06-16-22 from 11:00 AM to 12:00 PM failed to evidence the patient had mouth/denture care, shampoo, nail care, shower, light laundry, dust, sweep, and vacuum. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During a home visit with Patient #7, on 06-22-22, at 11:25 AM, at an assisted living facility, Entity D, Patient #7 confirmed they only take showers three times a week. Patient #7 requires the assistance of the CNA to shave them daily due to their hand numbness, and they cannot grip items. Patient #7 further indicated they care for their dentures and only wear them when they go out.			
G0814	Non-skilled direct observation every 60 days 484.80(h)(2) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. Based on record review and	G0814	G0814 Director of Nursing in-servicednurses on requirement to supervise home health in a home health aide only caseat least every 30 days and at least every 60 days the nurse must be there whenaide is there and must observe aide provide some form personal care. Expecteddate of	2022-08-26

	interview, the agency failed to ensure nursing supervisory visits were made every 30 days (with or without a home health aide present) and every 60 days with the home health aide present to observe the personal care the home health aide provided in 4 of 8 active records reviewed. (Patients 3, 4, 9, 11) Findings Include: 1. A review of the clinical record for patient #3, for the certification period of 4/5/22 - 6/3/22, failed to evidence documentation of aide supervisory visits. 2. A review of the clinical record for patient #4, for the certification period of 4/25/22 - 6/23/22 failed to evidence documentation of aide supervisory visits. 3. A review of the clinical record for patient #9, for the certification period of 5/22/22 - 7/20/22, evidenced a document titled "Supervisory Visit Note," with a visit date of 4/8/22 and a date signed by the clinician of 4/25/22. The document failed to evidence the aide was present and failed to evidence the aide was observed performing patient care. A review of a "Supervisory Visit Note," dated 5/5/22, indicated "staff member present." A section titled "Patient/family comments" indicated "lotion applied to BLE [bilateral lower extremities], pt [patient] is happy with care, 1030-11a, 97.2, 84, 134/87, 18, 94% 92L)." The note failed to evidence who applied lotion and failed to evidence the aide was observed performing patient care. A review of a "Supervisory Visit Note," dated 5/27/22, failed to evidence the aide was present and failed to evidence the aide was observed performing patient care. 4. A review off the clinical record for Patient #11, for the certification period of 5/20/22 - 7/18/22, failed to evidence documentation of aide supervisory visits.		completion is 08-26-2022. Director of Nursing/designeewill review nursing schedule weekly to ensure supervisory visits are scheduledproperly to ensure sup visits are scheduled and done timely. (On-going) Director of Nursing/designeewill review all supervisory visits submitted weekly to ensure they are donetimely and reflect required documentation. Once 100% compliance is achieved 10%will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

	5. On 6/22/22 at 3:45 PM the administrator was asked for additional supervisory notes for patients #3, 4, 9, and 11. No further information was provided. The administrator indicated being unaware that the agency was non-compliant with supervisory visits, and indicated he was not currently tracking supervisory visits for compliance.			
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on document review and interview, the Governing Body failed to assume full responsibility and legal authority for the agency's overall management and operation, compliance with state and federal regulations, provision of all home health services, and implementation, analysis, and maintenance of the agency s plan of correction related to deficient practices for 1 of 1 Governing Body. Findings include:	G0942	G0942 Clinical documentation has always been audited through theAlora email system. The agency did nothave any skilled patients until May, therefore there were no OASIS/CASPERreports available to analyze. A firstquarter report was completed but the second quarter report was still notavailable until after June 30. A new audit tool has been created to trachthe content of comprehensive assessments, and plans of care. The governing body will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur.	2022-07-15

	On 6/22/22 at 1 PM, the surveyor reviewed the agency s Quality Assurance Performance Improvement (QAPI) plan and information, which failed to evidence any statistical information, tracking, analysis, measurable performance improvement plans, or follow-up related to the agency s plan to correct deficient practices. On 6/22/22 at 3:45 PM, the administrator was interviewed concerning audits and tracking related to the content of the comprehensive assessment and plans of care. The administrator indicated there were no audits to review and there was no further information available to show that compliance was being tracked in any area.			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review, observations in 2 home visits of home health aides, and interview, the Governing Body failed to ensure the administrator completed and executed their responsibilities for the day-to-day activities of the agency, including compliance with comprehensive assessment content and timing, plan of care content to include medication profiles, discharge summaries, and infection control. Findings include: 1. A review of agency documents such as comprehensive assessments (See G 510,) plans of care(See G 574,) medication profiles (See G 536,) discharge summaries (See G 564,) and infection prevention /control (See G 682,) the administrator failed to exercise supervision and management of agency processes, care	G0948	G0948 See G510, G574, G536, G564, and G682 The administrator will meet with the DON weekly to reviewprogress with and/or issues regarding comprehensive assessments, plans of care,medication profiles, discharge summaries, and infection prevention and control. The governing body will be responsible for monitoring thesecorrective actions to ensure this deficiency is corrected and will not recur.	2022-07-15

visits, and documentation for 11 of 13 patients in the sample.

2. On 6/22/22 at 3 PM, the administrator was asked for documentation of compliance tracking and follow-up related to the agency's deficient practices related to the content and timing of comprehensive assessments, plans of care, and supervisory visits. The administrator indicated he was not aware of the late assessments and plans of care, or of the problems with content such as goals, care preferences, frequency, duration, and medication reconciliation, and was not aware that supervisory visits were not done and indicated he was not tracking or auditing those items at this time. When asked if he was following the plan of correction submitted to correct the deficient practices, the administrator indicated again that there was no tracking or audit information available, including QAPI (Quality Assurance Performance Improvement) performance improvement plans and audits, to determine the effectiveness of any changes or areas needed for improvement.

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