STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT CARE HOME HEALTH, INC	5435 EMERSON WAY STE 402, INDIANAPOLIS, IN, 46226

(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 Federal Recertification and State Re-licensure survey of a Home Health Care Agency. Survey Dates: 5/17/2022, 5/18/2022, and 5/19/222 Additional information requested was received on 5/27/2022 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. QR Completed 6/3/2022 A4	G0000	POC accepted on 7-1-2022 Deborah Franco, RN	2022-06-30
G0544	Update of the comprehensive assessment 484.55(d) Based on record review and interview agency failed to ensure the comprehensive assessment was completed as often as warranted according to changes in patient condition in 1 (Patient 2) of a total of 7 clinical records reviewed. Findings include:	G0544	On 6/2/2022 as part of the pre-existing QAPI to dischargeand readmit Patient 2, a SOC was performed that included a comprehensiveassessment with findings reported to Physician. Guardian, Agency and Physiciancollaborated on the plan of care to continue services. The Director of Clinical Services	2022-06-15

	Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Review of an undated agency policy titled 'CLIENT REASSESSMENT/UPDATE OF COMPREHENSIVE ASSESSMENT C-155' stated, "The comprehensive assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status...PURPOSE To identify decline or improvement in health status, modify the plan of care and document changes that may effect care...SPECIAL INSTRUCTION...2. Clients are reassessed when significant changes occur in their condition... 5. Each professional discipline will be responsible for reassessing care/services at least every fifty-six to sixty (56-60) days while the client is receiving skilled services. A marked improvement or worsening of a client's condition, which changes the plan of care needed and was not anticipated in the plan of care, would be considered a significant change... 12. Reassessments are conducted every visit based on physician orders, client conditions, and/or professional staff judgment." A review of the clinical record for Patient 2, revealed a start of care date of 6/11/21, with a certification period of 4/7/22 to 6/5/22, and diagnoses that included but were not limited to anoxic encephalopathy (or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning, as is the case, for example with carbon monoxide poisoning or drug overdose, vascular injury, or insult, or cardiac arrest. Many patients who suffer anoxic brain injury expire without regaining full consciousness, and many have very poor neurologic outcomes), quadriplegia (paralysis from the neck down, including the trunk, legs, and arms. The condition is typically caused by an injury to the spinal cord that contains the nerves that transmit messages of movement and sensation from the brain to parts of the body, and a gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach), was non-verbal and unable to make meaningful eye contact, had home health aides ordered for "Week 1 HHA[Home Health Aide] up to 10		determined that no additional patients are in need of an updatedcomprehensive assessment due to changes in condition. Educational information about regulations pertaining to thiscorrection and Agency policy CLIENT REASSESSMENT/UPDATE OF COMPREHENSIVEASSESSMENT and procedures will be reviewed with all RN’s no later than6/15/2022. Current Staff will receive in-service and future staff will receivetraining during orientation. The corrective action will be completed no later than6/15/2022. On-going supervision by the Director of Clinical Services ordesignee through review of clinician visit documentation on an ongoing basisfor a minimum of 6 months effective 6/2/2022. Monitoring will continue past thistime frame, for an equal amount of time if documentation is inconsistent and orcompliance falls below 100%.	

H[hours]/D[day] x 2 D[day]/W[week], Weeks 2-8: HHA[Home Health Aide] up tp 10 H[hours]/D[days] 5 D[days]/W[weeks] 5, Week 9 up to 10 H[hour]/D[day] 0xW[week], for, "assistance with bathing, grooming, dressing/undressing, skin care, incontinence care including condom catheters, repositioning, passive ROM, mechanical lift transfers, suctioning as needed, safety supervision, and light housekeeping as time permits."

Review of an agency document titled 'SKILLED NURSE VISIT NOTE' stated, "6/25/21...weight: 138.8". In an additional section of the same note titled 'REPORTING AND COMMUNICATION OF PATIENT CONCERNS, ABNORMAL FINDINGS OR A WORSENING OF PATIENT HEALTH CONDITION:' Nurse C documented, "no concerns noted/reported". Serial Skilled Nursing Visit Notes were as follows:

"7/2/21...weight: 134.5...no concerns noted/reported", "7/6/21...weight: 138.5...no concerns noted/reported", "7/9/21...weight: 139.7...no concerns noted/reported", "7/13/21...weight: 139.8lb...no concerns noted", "7/16/21...weight: 139.1", "7/20/21...weight: 138.21...no concerns noted/reported", "7/23/21...weight: 122.3", "7/28/22...weight:[blank]", "8/12/21...weight: unable to weigh", "8/19/21...weight: 128.2", and "8/26/21...weight: [blank]".

Review of an agency document titled 'PROGRESS NOTE' dated 7/6/21 at 3:57 PM, addressed to Dr. C, stated, "SN has been weighing patient via hospital bed scale. On 4/20/21 patient weighed 145 lbs, on 6/29/21 patient weighed 137.7. 8 lb loss in 2 months...Please send new orders if any to Great Care Home Health..."

Review of an agency document titled 'PHYSICIAN CONTACT' dated 7/6/21, authored by agency Nurse C, stated, "Faxed progress note to Dr. [C] informing of 8 lb weight loss from 4/30/21 to 6/29/21. Faxed confirmed 16:02."

The clinical record failed to evidence any subsequent documentation of follow-up on this notification of decreased weight and request for additional orders.

Review of an agency document titled 'Addendum to Plan of Treatment' dated 8/13/21, stated, "Weight - unable to weigh scale has malfunctioned". On 10/8/21, the 'Addendum to Plan of Treatment' stated the same. On 12/3/21, the 'Addendum to Plan of Treatment' stated the same. On 2/1/22, the 'Addendum to Plan of Treatment' stated the same. On 4/8/22, the 'Addendum to Plan of Treatment' stated the same.

The records failed to evidence any further action had been taken nor were any entities notified when the bed scale was found to be in disrepair, the weight of the patient has remained unknown from 8/31/21 to present.

Review of agency document titled 'RECERTIFICATION/FOLLOW-UP ASSESSMENT INCLUDING OASIS ELEMENTS AND PLAN OF CARE INFORMATION' stated the following: On 4/4/22, a section titled 'Systems Review' stated, "...Actual Weight: unable to weigh". A section titled 'Nutritional Status' completed by Nurse E, "NPO [nothing by mouth]" ...Nutritional Requirements (diet), "tube feeding". In the same section, a nutritional risk assessment is present which Nurse E completed, and subsequent scoring for the patient totaled "9" which was indicated as 'High Risk'. Interpretation stated, "6 or more High risk. Coordinate with physician, dietician, social services professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care." In the following section "Describe at risk intervention:" Nurse E further documented, "No nutritional concerns at this time".

The clinical record revealed Nurses C and E had continued to document "unable to obtain weight" for five (5) consecutive certification periods, ranging from 8/5/21 through 4/4/22 for a gastrostomy patient whose sole nutrition was obtained via tube feedings, was bedbound, non-verbal, and whose bed scale was in disrepair.

Additionally, the clinical record failed to evidence documentation of subsequent

attempts from clinical staff to follow-up after 7/6/21 with the physician, either by telephone or fax, regarding the patient's change in weight and nutritional status. The clinical record failed to evidence any additional reassessments were scheduled or performed related to the noted decrease in patient's weight. The clinical record also failed to include revisions or updates to the plan of care reflective of the patient's changes in weight and 'high risk' nutritional status, and reflective of the need to reassess the patient to ascertain improvement or decline.

In an interview on 5/19/22 at 2:56 PM, the administrator and clinical manager were informed of above concerns related to weight changes and nutritional status for Patient 2, and were queried as to what the agency expectation would be in the care of Patient 2. The clinical manager indicated she had recently noted the same concerns and she had already set up a telehealth visit with Dr. D on 5/17/22 but Dr. D had been running late and the clinical manager was unable to communicate with the physician that day. Stated she would be reaching out to MD again today to address the same, spoke of arranging for a dietary consult, and would additionally reach out to a case manager F of a local resource agency G for assistance in getting the bed scale repaired or finding an alternative for obtaining the patient's current weight, indicating this is what should have been done initially.

In an interview on 5/20/22 at 10:32 AM, in a return phone call from Person E, a nurse with Dr. D's office, stated there are no records of the fax dated 7/6/21 that informed the doctor of decreased weight nor a request for orders. Person E stated the only communication documented from the agency was: a request for ramp repair, a request for a wheelchair, and a request for repair for a Hoyer lift, but saw no documentation of a phone call or fax pertaining to Patient 2's weight loss, nor any information about patient's bed scale being broken. Person E stated the patient's last visit was 12/21/21 and informed weights were not collected at this visit. Person E stated the last weight of 154 lbs. was collected on 2/11/20.

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

G0590	Promptly alert relevant physician of changes 484.60(c)(1) Based on record review and interview the agency failed to ensure the physician was notified of a change in condition in 1 (Patient 2) of 3 home visits in a total sample of 7 clinical records reviewed. Findings include: The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Review of an undated agency policy titled 'Comprehensive Client Assessment C-145' stated, "...SPECIAL INSTRUCTIONS...3. Nutritional Status is assessed. Clients identified as being at moderate or high risk are referred to the appropriate resource for follow-up and treatment as indicated. This may include the physician, registered dietician, or other qualified professional. High risk indicators may include: a. weight loss of ten (10) pounds in thirty (30) days...e, nutritional-related disorders...ASSESSMENT STRATEGIES Interview, Interaction, Direct Observation, Inspection, Clinical Measurements, Clinical Reasoning, MD or facility information... 10. Client needs are assessed and care guidelines established based on assessment data...12. Reassessment are conducted based on client needs, physician orders, professional judgement and/or OASIS or other regulatory requirement, and for any changes in the plan of care will be sent to the physician." A review of an undated agency policy titled 'SKILLED PERSONAL SERVICES C-200' stated, "POLICY Skilled professional services include skilled nursing services...PURPOSE To abide by state/federal guidelines and offer guidelines to the agency staff...for the appropriate utilization of professionally skilled professional services. To assure that skilled professional services are...delivered and supervised only by health professionals who meet the appropriate qualifications specified under 484.115 and who practice according to the agency's policies and procedures...	G0590	On 5/24/2022, patient was able to be weighed on hospital bed.Weight of 137.5 was reported to physician via message on nurses voicemail. Aspart of the pre-existing QAPI to discharge and readmit this patient, a SOC wasperformed on 6/2/2022 that included a comprehensive assessment with findingsreported to Physician. Guardian, Agency and Physician collaborated on the planof care to continue services. The Clinical Manager reviewed all patient charts anddetermined that no additional patients are at risk of Physicians not being notifiedof patient change of conditions. The Agency has modified the Progress Note to requirephysician signature as proof of receipt. The Agency will also track signed returnreceipt of the Progress Note in the EMR. All RNCM will be in-serviced on the documentand process change by 6/13/2022. The Director of Clinical Services or designeewill monitor the outstanding Progress Notes on a weekly basis to follow up on returnreceipt from Physician offices. In effort to reach 100% compliance, Director ofClinical services or designee will be responsible for the on-going monitoring fora minimum of 6 months, effective 6/13/2022.	2022-06-13

	SPECIAL INSTRUCTIONS 1. Skilled professionals must assume responsibility for, but not be restricted to the following: a . Ongoing interdisciplinary assessment of the client... f. Preparing clinical notes...g. Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care." A review of the clinical record for Patient 2, revealed a start of care date of 6/11/21, with a certification period of 4/7/22 to 6/5/22, and diagnoses that included but were not limited to anoxic encephalopathy (or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning, as is the case, for example with carbon monoxide poisoning or drug overdose, vascular injury, or insult, or cardiac arrest. Many patients who suffer anoxic brain injury expire without regaining full consciousness, and many have very poor neurologic outcomes), quadriplegia (paralysis from the neck down, including the trunk, legs, and arms. The condition is typically caused by an injury to the spinal cord that contains the nerves that transmit messages of movement and sensation from the brain to parts of the body, and a gastrostomy tube ('g-tube', a tube, surgically placed through the abdomen, to help deliver medications, liquids, and liquid food directly into the stomach), was non-verbal and unable to make meaningful eye contact, had home health aides ordered for "Week 1 HHA[Home Health Aide] up to 10 H[hours]/D[day] x 2 D[day]/W[week], Weeks 2-8: HHA[Home Health Aide] up tp 10 H[hours]/D[days] 5 D[days]/W[weeks] 5, Week 9 up to 10 H[hour]/D[day] 0xW[week], for, "assistance with bathing, grooming, dressing/undressing, skin care, incontinence care including condom catheters, repositioning, passive ROM, mechanical lift transfers, suctioning as needed, safety supervision, and light housekeeping as time permits."		Monitoring will continue past thistime frame, for an equal amount of time, if observations are inconsistent ornon-compliance is found.	

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G0682	Infection Prevention 484.70(a) Based on observation, record review and interview the agency failed to ensure that home health aides followed proper infection control practices in 2 (Patients 1 and 2) out of 3 home visits, in a total sample of 7 clinical records reviewed. Findings include: 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. 1. A review of an undated agency policy titled 'Standard Precautions for All Health Care Workers D-245' stated, "2. WASH HANDS - SEE HAND HYGIENE POLICY...Gloves should be changed after each client contact...16. Soiled linens should be handled as little as possible and with minimal agitation to prevent gross microbial contamination of the air and of persons handling the linen." A review of an undated agency policy titled 'Recommended Equipment for Home Care (PPE) D-250' stated, "Recommended Clinical Practices 1. Hand washing: Before and after client contact... 2. Gloves: Use if there is a possibility of contact transmission. Nonsterile gloves may be used when performing procedures, which may expose the staff member/caregiver to blood or body	G0682	Employee I was re-competencied on Infection ControlPrevention on 5/20/2022. Employee H was re-competencied on Infection ControlPrevention on 06/08/2022. The Clinical Manager reviewed all patient charts and determinedthat all active patients require Infection Control Prevention practices. On6/8/2022 RN Case Managers were instructed to provide Infection ControlPrevention education and observe handwashing during all home visits. New employee orientation competency material updated to includemore robust handwashing and Infection Control Prevention instruction. Director ofClinical Services or designee will be responsible for active roster in-serviceof home health aids, to be completed by 06/30/2022. One Hundred percent (100%)of active and	2022-06-30

	substances. A review of an undated agency policy titled 'Handwashing/Hand Hygiene D-330' stated, "POLICY In an effort to reduce the risk of infection in clients and staff members, through hand washing/hand antisepsis is required of all employees...PURPOSE To improve hand-hygiene practices of agency staff and to reduce transmission of pathogenic microorganisms to clients and personnel in the home setting. SPECIAL INSTRUCTIONS 1. The hand hygiene procedure will be clearly outlined in the agency procedure manual...3. Indications for hand washing and hand antisepsis: c. When there is prolonged or intense contact with the client (bathing the client). d. Between tasks on the same client...f. after removing gloves g. After touching objects that are potentially contaminated... o. Decontaminate hands before having direct contact with clients...p. Decontaminate hands after contact with client's intact skin...r. Decontaminate hands after removing gloves." 2. During a home visit observation on 5/17/22 for Patient 1, staff member I, a home health aide (HHA), was observed assisting Patient 1 in undressing and preparing to shower. HHA I, while performing hand hygiene at the sink with soap and water, touched the faucet (to stop the flow of running water) with bare hands before drying hands with a paper towel, and did so at several intervals throughout the visit. This was also witnessed and acknowledged by the clinical manager, who was present for the visit. 3. During a home visit observation on 5/18/22 for Patient 3, staff member H, a home health aide (HHA), was observed assisting Patient 3 in undressing and preparing for a shower. HHA H, with gloves donned, had the patient sit on the bathroom commode with a riser which had been prepared with a large bath towel draped across the commode which also covered the riser's handles. The patient was assisted to a standing position to help aid the removal of a disposable brief. While the patient was standing in front of the commode, the aide assisted the patient in sliding the disposable brief down to the patient's knees, the aide then assisted the patient into a seated position on the commode, the patient's bottom then making contact with the towel draped over the commode and riser, the aide then assisted the patient to slide the brief down to		educated with updated InfectionControl Prevention materials and have handwashing skills observed. On 6/8/2022 one hundred (100%) of active roster home healthaids will begin receiving updated handwashing and infection control prevention instructionmaterial and completed no later than 06/30/2022. In effort to reach 100% compliance, Director of ClinicalServices or designee will be responsible for the on-going monitoring ofInfection Control Prevention practices as required during in-home supervisoryvisits for a minimum of 6 months, effective 6/8/2022. Monitoring will continuepast this time frame, for an equal amount of time, if observations areinconsistent or non-compliance is found.	

her feet for easy removal. The brief was noted to have a smearing of bowel movement, approximately two inches wide and six inches long of medium brown fecal matter, on it. The aide removed his/her gloves and performed appropriate hand hygiene. HHA H then assisted the patient into the shower and proceeded to assist with showering, the aide failed to don gloves for the showering of the patient and remained bare-handed for the duration. When the patient had completed the shower, HHA H assisted the patient with drying off and assisted with transferring to a seated position on the commode with the original towel draped over it and still in place, thereby making contact with an area highly likely to be contaminated with fecal matter.

4. In an interview on 5/18/22 @ 3:38 PM with the clinical manager and administrator, when queried as to what the clinical manager's expectations for the visit with Patient 1 would have been, acknowledged the aide failed to perform proper handwashing, and indicated acknowledgment that ideally, the aide should have washed hands with soap and water, dried hands with paper towel, then using the same paper towel shut off the faucet.

410 IAC 17-12-1(m)

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