STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200857640A	A. BUILDING B. WING	07/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LMR INDIANA HOME CARE INC	7863 BROADWAY STE 124, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a Federal Recertification and State Re-licensure Survey of a Home Health provider. Survey Dates: 7/5/2022 to 7/8/2022 Census: 17	N0000		2022-12-31
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure Survey of a Home Health provider. Survey Dates: 7/5/2022 to 7/8/2022 Census: 17	G0000		2022-12-31
E0000	Initial Comments An Emergency Preparedness survey was	E0000		2022-12-31

	conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider and Supplier. Survey Dates: 7/5/2022 to 7/8/2022 Census: 17 At this Emergency Preparedness survey, LMR Indiana Home Care was found to be in compliance with Conditions of Participation 42 CFR 484.102, Emergency Preparedness requirements for Medicare Participating Providers and Suppliers. QR Completed 7/21/2022 A4			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.	N0458	The Administrator/Director ofNursing has reviewed CFR(s): 410 IAC 17-12-1(f) and agency policies titled “PersonnelRecords” and “Record Retention”. The Administrator/DON discussed with AlternateAdministrator/Alternate Director of Nursing about the missing documentation ofreceipt of her job description. Signed job descriptions for AlternateAdministrator and Alternate Director of Nursing were signed immediately on July 6, 2022, as soon as deficiency was noted while survey was still on going . Copyof job descriptions	2022-07-11

	Based on record review and interview, the home health agency failed to ensure personnel records included documentation of receipt of the job description in 1 of 2 administrative personnel records reviewed (#2). The findings include: Record review on 7/8/2022 evidenced an undated agency policy titled, "RECORD RETENTION", which stated, " ... A review of administrative, financial and personnel records produced by LMR Indiana Home Health Care, Inc. will be completed to determine which records meet criteria for inclusion in local, state and federal regulations...." During an interview on 7/5/2022 at 10:22 AM, the administrator indicated administrative staff member 2 was the alternate administrator and the alternate clinical supervisor. Personnel record review on 7/7/2022 failed to evidence a signed job description for the positions of alternate administrator and alternate clinical supervisor. When queried on 7/7/2022 at 12:35 PM, the administrator indicated the personnel record for administrative staff member 2 failed to evidence signed job descriptions for the positions of alternate administrator and alternate clinical supervisor and offered no further documentation.		attached as Exhibit 0458-1. The Administrator/Director of Nursingwill be responsible to ensure compliance with CFR(s): 410 IAX 17-12-1(f). Monitoring Process: TheAdministrator/DON will conduct quarterly review of personnel records of activeemployees to ensure compliance Date Completed: July 06, 2022 (Survey Portal did not allow to enter date prior to 07/08/2022 so 07/11/2022 was used instead to enter in a value)	
G0572	Plan of care 484.60(a)(1)	G0572	TheAdministrator/Director of Nursing and Quality Assurance Team reviewed theStandard, 484.60(a)(1) - Plan of care, and	2022-07-19

	Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the plan of care was followed in 2 of 5 active clinical records reviewed (#4, 5). The findings include: 1. Record review on 7/8/2022 evidenced an agency policy titled, PLAN OF CARE , revised 2018, which stated, & Home care services are furnished under the supervision and direction of the patient s physician & Patient must receive home health services that are written in individualized Plan of Care &. 2. Record review evidenced an agency policy titled, POLICY ON MISSED VISIT , dated 2009, which stated, & Agency staff will be hired in sufficient numbers as to cover for each patient and illness, or unplanned absences. Should a situation arise that the visit cannot be completed as scheduled & The visit will be rescheduled for a time suitable to the patient. The missed visit will be documented in the patients record &. 3. Clinical record review on 7/6/2022 for patient #4, start of care 4/7/2022, certification period 6/6/2022 to 8/4/2022, primary diagnosis of Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar as fuel), evidenced an agency document titled, HOME HEALTH		company policies on "Plan ofCare" and "Missed Visits". TheAdministrator/DON conducted a one on one meeting with SN in charge of Patient#4 on 07/11/2022 to discuss survey findings of failing to address"Bleeding" and "Aspiration" precautions as included in thephysician signed plan of care dated 06/22/2022. The Administrator/DON discussedagency policy on "Plan of Care" and "Job Description for HomeHealth Nurse -RN", with focus on providing direct patient care withclinical competence according to the plan of treatment, nursing care plan, andestablished standards; as well as documenting nursing process, patient'sresponse to care, patient status and progress toward goal attainment completelyand accurately. Assigned RN admittedto failing to document “bleeding” and “aspiration” precautions on her SN visitnotes for 06/10/2022, 06/17/2022, 06/24/2022, and 06/30/2022. Administrator/DONreinstructed RN on the agency policy on	

	CERTIFICATION AND PLAN OF CARE , signed by the physician on 6/22/2022. The plan of care had a subsection titled, Safety , which stated, Bleeding Precautions & Aspiration Precautions & Clinical record review evidenced a group of agency documents titled, SN [skilled nurse] TEACHING / TRAINING VISIT , dated 6/10/2022, 6/17/2022, 6/24/2022 and 6/30/2022. Each of the visit notes failed to evidence bleeding and aspiration precautions. During an interview on 7/8/2022 at 11:50 AM, the administrator indicated safety should be addressed by all clinicians at every visit and documented in each visit note. When informed of the findings, the administrator reviewed the record and indicated the notes failed to evidence bleeding and aspiration precautions. 4. Clinical record review on 7/7/2022 for patient #5, start of care 5/17/2022, certification period 5/17/2022 to 7/15/2022, primary diagnosis of Transient cerebral ischemic attack (a brief episode during which parts of the brain do not receive enough blood), evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 6/22/2022. The plan of care had a subsection titled, Orders For Discipline and Treatment , which stated, SN Frequency: 1w9 [once a week for 9 weeks], and, PRN [as needed] to instruct / teach disease process, its management and treatment &. Clinical record review evidenced an agency document titled, MISSED VISIT , dated 5/24/2022 (Tuesday), signed by the alternate administrator, which stated, & Reason No Answer to Phone Call &. Clinical record review failed to evidence any		accurate documentation and followingplan of care. RN verbalized understanding. The Administrator/DON discussed withnursing, therapy, HHA, and Quality Assurance staff about the survey findingsand agency policy on "Plan of Care". An in-service on care planning wasconducted on 07/19/2022 with emphasis on the importance of formulating anindividualized plan of care for each patient, ensuring that said plan of careis followed throughout provision of home care services, and ensuring that documentationsare completed appropriately and accurately on the patient's clinical record. During thein-service, Administrator/DON emphasized to ensure safety and all types ofprecautions are addressed and documented for each patient as ordered in theplan of care, in addition to the standard assessment performed each visit.	

	5/22/2022 to 5/27/2022. During an interview on 7/8/2022 at 12:45 PM, the administrator indicated if a visit is missed, the clinician should reschedule the visit if possible. 410 IAC 17-13-1(a)		Monitoring Process: The Administrator/DON in coordinationwith the Quality Assurance staff will monitor field staff documentation toensure compliance with the regulation and agency's policy on following the planof care. As an on-going agency process, QA staff will review documentation for accuracyand compliance to each patient's plan of care. If there are any questionsregarding submitted documentation, the clinician will be asked to confirm andperform corrections if deemed necessary. Quarterly audit of all activepatients with focus on documentation of safety and all types of precautions will be performed by the Administrator/DON in coordination with Quality Assurance Team to ensure 100% compliance with regulation and policy on planof care. All field staffincluding nursing, therapy, and HHA had a mandatory in-service on	

			policy for missed visits. Administrator/DON discussed to ensurethat all ordered visit frequencies are followed and missed visits are avoided.Instructed all staff that if in case of a missed visit, attempts to reschedulevisit throughout the entire week with proper coordination withpatient/caregiver should be performed; reinstructed staff that the agency'swork week is from Sundays to Saturdays and that if a scheduled visit is missedin the beginning of the week, visits should be attempted to be rescheduleduntil Saturday of the same week. All field staff verbalized understanding. Monitoring Process: TheAdministrator/DON will be responsible to monitor all corrective actions toensure that this deficiency does not occur again. Quarterly review of all activepatients' clinical record with focus on missed visits will be conducted byAdministrator/DON in coordination with the Quality Assurance team to ensure policy onmissed visits is	

			followed.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and	G0574	G0574: TheAdministrator/Director of Nursing and Quality Assurance Team reviewed theStandard, 484.60(a)(2)(i-xvi) - The Individualized Plan of care and itscomponents and agency's policies entitled "Plan of Care" and"Advance Directives". TheAdministrator/DON conducted a one on one meeting with SN on 07/11/2022, who isboth in charge of Patient #3 and Patient #4, the survey findings of failing toindicate in the plan of care an individualized instructions for monitoringpatient's blood sugar. Addenda to Plan of Care were written for Patients #3 and#4 on 07/11/2022 to reflect who was checking each patient's blood sugar leveland frequency. Addendum order for Patient #3 was signed by Physician andreceived by agency on 07/26/2022. Administrator/DONalso discussed with SN the survey finding for Patient #4 regarding failure toinclude frequency of medication Nystatin in the plan	2022-07-19

	(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review and interview, the agency failed to ensure the individualized plan of care included complete orders for medications, treatments, safety measures, and advanced directives in 5 of 7 records reviewed (#1, 3, 4, 5, 6). The findings include: 1. Record review on 7/8/2022 evidenced an agency policy titled, PLAN OF CARE , revised 2018, which stated, & The individualized Plan of care is based on a comprehensive assessment and information provided by the patient / family and health team members. Planning for Care is a dynamic process that addresses the care, treatment and services to be provided & The Plan of Care shall be completed in full to include: & Medications, treatments, and procedures & Any safety measures to protect against injury & Information related to advance directives &. 2. Record review evidenced an undated agency policy titled, ADVANCE DIRECTIVES , which stated, & During the admission / evaluation visit, the admitting clinician / technician will ask the patient or his / her representative whether or not he / she has completed an Advance Directive & If an Advance Directive has been completed, the clinician / technician will ask for a copy of the Advance Directive so it will be placed in the clinical / service record &. 3. Clinical record review on 7/6/2022 for patient #4, start of care 4/7/2022, certification period 6/6/2022 to 8/4/2022, primary diagnosis of Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar as fuel), evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 6/22/2022. The plan of care had a subsection titled, Orders For		of care. SN wasreinstructed on agency policy on "Plan of Care" and"Administration of Medication Procedure"; SN verbalizedunderstanding. Addendum to plan of care for Patient #4 reflecting correctedmedication order for Nystatin with required frequency and where on the body itwas used was written on 07/11/2022 and waiting for Physician to send backsigned order. Medication was updated on Patient #4's clinical record and onpatient's home medication list. Administrator/DONdiscussed with SN, the survey finding for Patient #3, who has"Oxygen" listed under DME section of the plan of care, and of whichfailed to include "Oxygen Precautions" under "Safety"section. SN was reinstructed to ensure that plan of care is completedaccurately and in compliance with agency policy for plan of care. Addendum toPlan of care for Patient #3 to reflect "Oxygen Precautions" undersafety was written 07/11/2022.	

	Discipline and Treatment , which stated, & SN [skilled nurse] to monitor blood sugar levels to assess efficacy of medication and dietary therapy; coordinate care with physician for need to change plan of care &. Review of the plan of care failed to evidence who was checking the patient s blood sugar and at what frequency. During an interview on 7/8/2022 at 11:39, the administrator indicated the plan of care failed to evidence individualized instruction for monitoring the patient s blood sugar. Review of the plan of care evidenced a subsection titled, Medications , which stated, & NYSTATIN [an antifungal medication] & COMPOUNDING POWDER liberal Applied as instructed Topical & UREA [a medication used to treat itchy, dry skin] 20% TOPICAL CREAM liberal amount Applied as instructed Topical &. Review of the plan of care failed to evidence the frequency of the medication and where on the body it was used. During an interview on 7/8/2022 at 11:45 AM, the administrator indicated all topical medication orders should include the frequency of the medication and where on the body it was used. 4. Clinical record review on 7/6/2022 for patient #3, start of care 6/2/2022, certification period 6/2/2022 to 7/31/2022, primary diagnosis of Essential hypertension (abnormally high blood pressure), evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE . The plan of care had a subsection titled, Orders For Discipline and Treatment , which stated, & SN to assess diabetic status & SN to instruct patient on & Blood sugar monitoring &. Review of the plan of care failed to evidence who was checking the patient s blood sugar and at what frequency.		TheAdministrator/DON conducted a one on one meeting with Alternate Administrator(SN assigned for Patients #1 and #5) immediately after surveyors exited on07/08/2022, the survey findings of failing to indicate the affected area for asneeded usage of medication "Stopain" for Patient #1; and failing toindicate Foley catheter care in Patient #5's Plan of Care. Alternate Administrator was instructed onagency policies on "Plan of Care" and "Administration ofMedication Procedure". Addendum to Plan of Care for Patient #1 is attachedto reflect corrected medication order for Stopain. Addendum to Plan of Care forPatient #5 toreflect Foley catheter care instructions is attached. A mandatoryin-service on care planning was conducted on 07/19/2022 with emphasis on theimportance of formulating an individualized plan of care for each patient whichshould include all pertinent information in compliance with 484.60 (a)(2)(i-xvi). Staff were given printed copies ofagency policies	

	During an interview on 7/8/2022 at 12:24 PM, the administrator indicated the plan of care failed to evidence individualized instruction for monitoring the patient s blood sugar. Review of the plan of care evidenced a subsection titled, DME [durable medical equipment] and Supplies , which stated, DME: Oxygen &. Review of the plan of care evidenced a subsection titled, Safety , which failed to indicate oxygen precautions. Observation of a home visit for patient #3 on 7/7/2021 at 9:30 AM evidenced oxygen equipment in the patient s home. During an interview on 7/8/2022 at 12:30 PM, the administrator indicated if there is oxygen in a patient s home, the plan of care should include oxygen precautions. 5. Clinical record review on 7/7/2022 for patient #5, start of care 5/17/2022, certification period 5/17/2022 to 7/15/2022, primary diagnosis of Transient cerebral ischemic attack (a brief episode during which parts of the brain do not receive enough blood), evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE , signed by the physician on 6/22/2022. The plan of care had a subsection titled, Orders For Discipline and Treatment , which stated, & SN [skilled nurse] to monitor blood sugar levels to assess efficacy of medication and dietary therapy; coordinate care with physician for need to change plan of care &. Review of the plan of care failed to evidence who was checking the patient s blood sugar and at what frequency. During an interview on 7/8/2022 at 12:44 PM, the administrator indicated the plan of care failed to evidence individualized instruction for monitoring the patient s blood sugar.		on "Plan of Care", "Administration of MedicationProcedure", and "Advance Directives". All staff verbalizedunderstanding. The Administrator/DON reinstructed Quality Assurance Staff on agency policy forPlan of Care, Advance Directives, and Administration of Medication Process.Instructed and trained QA Staff to ensure all clinical records are complete andaccurate for each patient and in compliance with all agency policies. Monitoring Process: TheAdministrator/DON in coordination with the Quality Assurance staff will be responsible to monitor all Plan of Cares are individualized and are being followed; including evidence that all ordered medications have the corresponding route, frequency, and specific direction on where to apply if needed. The Administrator/DON in coordination with the Quality Assurance staff will also be responsible to monitor all	

	Clinical record review evidenced an agency document titled, SN TEACHING / TRAINING VISIT , dated 6/29/2022, signed by the alternate administrator. The visit note had a subsection titled, Visit Narrative , which stated, & foley catheter [a tube inserted through the urethra to drain the bladder] was inserted at [physician #1] office 6/24 &. Review of the plan of care failed to evidence any foley catheter care. During an interview on 7/8/2022 at 12:49 PM, the administrator indicated the plan of care should include the foley was being changed by the physician. The administrator indicated the plan of care should include interventions for nursing care of a patient with a foley, including assessing the catheter site and urine output, and what findings should be reported to the physician. 6. Clinical record review on 7/7/2022 for patient #6, start of care 9/21/2022, certification period 11/21/2021 to 1/19/2022, primary diagnosis of Parkinson s Disease, evidenced an agency document titled, HOME HEALTH CERTIFICATION AND PLAN OF CARE . The plan of care had a subsection titled, Orders For Discipline and Treatment , which stated, & SN to assess diabetic status & SN to instruct patient on & Blood sugar monitoring &. Review of the plan of care failed to evidence who was checking the patient s blood sugar and at what frequency. During an interview on 7/8/2022 at 12:44 PM, the administrator indicated the plan of care failed to evidence individualized instruction for monitoring the patient s blood sugar. Clinical record review evidenced an agency document titled, PATIENT SERVICE AGREEMENT , dated 9/22/2021. The document had a subsection titled, ADVANCE DIRECTIVES , which indicated the patient had a Living Will.		patients with Advance Directives to have a copy of the said Advance Directive on the patient's clinical record. To ensure that this deficiency does not occur again, quarterly chart review of all active patients will be conducted to ensure 100% compliance.	

	Review of the plan of care failed to evidence the patient s advance directive. Review of the patient s electronic clinical record (Axxess) failed to evidence the patient s advance directive. During an interview on 7/8/2022 at 1:20 PM, the administrator indicated if a patient had an advance directive, it should be included in the plan of care and a copy should be put into the patient s clinical record. The administrator indicated the clinical record failed to evidence the patient s advance directive. 7. Clinical record review for patient #1 on 7/6/2022, start of care 2/24/2022, certification period 6/24/2022 to 8/22/2022, evidenced an agency document titled, Home Health Certification and Plan of Care. This document had a subsection titled, Medications, which stated, &STOPAIN CLINICAL [used to provide temporary relief of minor arthritis pain, backache, muscles or joint pain, or painful bruises] 10% TOPICAL GEL Thin film to affected area Apply to affected area as needed for pain Topical (Top) U &. The plan of care failed to evidence an affected area for usage of the as-needed medication. During an interview on 7/8/2022 at 11:45 AM, the clinical manager indicated medication orders should have the medication name, dosage, frequency, route, and orders for topical medications should include where it goes on the patient s body. 410 IAC 17-13-1(a)(1)(D)(ix, x, xiii)			
G0592	Revised plan of care 484.60(c)(2)	G0592	TheAdministrator/Director of Nursing reviewed the Standard, CFR(s) 484.60(c)(2) –Revised Plan of Care and agency policy	2022-07-19

	A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the home health agency failed to revise the plan of care to reflect the current health status and needs in 1 of 5 active patient records reviewed. (#1) The findings include: An agency policy titled, Plan of Care, revised 2018, stated, & The individualized Plan of care is based on a comprehensive assessment and information provided by the patient/family and health team members. Planning for Care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every (60) days. & The Plan of Care shall be completed in full to include: & Type, frequency, and duration of all visits/services &. Clinical record review for patient #1 on 7/6/2022, start of care 2/24/2022, certification period 6/24/2022 to 8/22/2022, evidenced an agency document titled, Home Health Certification and Plan of Care. This document had a subsection titled, Medical Necessity, which stated, & Therapy services will be required for increased functional disability problems. & Physical therapy provided this episode this episode and well tolerated by patient &. Clinical record review on 7/6/2022 evidenced an agency document titled, OASIS-D1 Recertification, electronically signed by the alternate administrator. This document had a subsection titled, Therapy Need & Plan, which stated, &Therapy Need: In the home health		on “Plan of Care”. During a one onone meeting with the alternate administrator on 07/08/2022, immediately afterthe surveyors exited, the Administrator/DON discussed surveyor findingsregarding the documentation of need for therapy services during episode of care06/24/2022-08/22/2022 for Patient#1 and at the same time having entered “000”number of therapy visits indicated. The Alternate Administrator stated that itwas an oversight to have left the patient’s need for therapy services from theprevious episode’s OASIS entry and it was an error that should have not beenincluded which was reflected to the Plan of Care dated 06/23/2022. TheAdministrator/DON has discussed with Alternate Administrator the importance ofhaving accurate documentation. RN verbalized understanding and admitted themistake. The medical record has been corrected through an addendum to plan ofcare order dated 07/08/2022.	

	plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combine)? (Enter zero [000] if no therapy visits indicated.) Number of therapy visits indicated (total of physical, occupational, and speech-language pathology combined). 000 &. Clinical record review for patient #1 on 7/6/2022, start of care 2/24/2022, certification period 4/25/2022 to 6/23/2022, evidenced an agency document titled, PT [physical therapy] Discharge Summary, electronically signed by PT #2, dated 6/20/2022. This document stated, & Stable & Goals Met & Care coordination with RN [registered nurse], DON [director of nursing] and MD [medical doctor]. Notified about PT discharge. & Pt [patient] was able to meet all PT [physical therapy] goals and was discharged from skilled PT services &. During an interview on 7/8/2022 at 12:33 PM, the administrator indicated the note on the plan of care was carried over from the last episode and was an oversight.		During themandatory all employee post survey in-service meeting conducted on 07/19/2022,the Administrator/DON discussed the survey findings and agency policy on “Planof Care”. The Administrator/DON discussed the importance of verifying that allpatient information is accurate to the patient’s current status. Monitoring Process: The Administrator/DON in coordination with the Quality Assurancestaff will monitor field staff documentation to ensure compliance with theregulation and agency’s policy on care planning. The QA staff will continue to implement agency’son-going process of reviewing all OASIS to ensure that accurate information isincluded In the plan of care and not copied from the previous episode(s). TheAdministrator/DON in coordination with Quality Assurance Team will review all active charts quarterly, to ensure 100% compliance with accurate careplanning.	

G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation and interview, the agency failed to ensure patients were provided a current written patient medication list in 1 of 1 home visits conducted with a physical therapist (#3). The findings include: Record review on 7/8/2022 evidenced an undated agency policy titled, "MEDICATION PROFILE", which stated, " ... Each patient will receive appropriate written material for specific medications he / she is receiving. The material will contain information on actions of the medication, potential side effects, contraindications the patient should be aware of, and any special instructions when taking the specific medication...." Observation of a home visit for patient #3 was conducted on 7/7/2021 at 9:30 AM . Review of the patient's home folder evidenced a blank home medication list. Observation of the home visit failed to evidence a current medication list provided by the agency. During an interview on 7/7/2022 at 10:30 AM, patient #3 indicated they did not receive a written medication list from the agency.	G0616	TheAdministrator/Director of Nursing has reviewed CFR(s): 484.60(e)(2), PatientMedication Schedule/Instructions and agency policy titled “Medication Profile” and "Administration of Medication Process". During a one onone meeting with the RN in-charge of Patient #3 on 07/11/2022, theAdministrator/DON discussed surveyor findings of the patient having a blankhome medication list in the patient handbook provided by the agency. RN in-charge stated that she failed to update medicationlist because the patient was just discharged from the SNF and was scheduled tosee her primary care physician who, at time of SOC, might order medicationchanges. The Administrator/DON reinstructed RN on the agency policy on “MedicationProfile” to ensure that all patients are provided medication list in thepatient handbook/folder at time of start of care and regularly updated for allnew/discontinued/changed medications. RN verbalized understanding.Administrator/D	2022-07-22

	During an interview on 7/8/2022 at 12:21 PM, the administrator indicated the clinician who does the admission assessment should fill out the hand-written home medication list in the patient folder.		ON contacted Patient #3 via phone call on 07/22/2022 to ask ifshe has a medication list in her patient handbook and she confirmed that her RNwrote all her medications in her patient handbook. During themandatory all employee post survey in-service meeting conducted on 07/19/2022,the Administrator/DON discussed the survey findings and agency policy on “MedicationProfile” and Administration of Medication Procedure”. The Administrator/DONdiscussed the agency policy on ensuring that all patients have a medicationlist in their patient handbook which is to be updated for all new,discontinued, and/or changed medication(s). All employees were given copies ofpolicies discussed. Monitoring Process: The Administrator/DON will conduct monthly random home	

			visits or random phone calls interviewing 25% of all active patients or caregiversfor the presence of updated medication list in their patient handbook to ensure 100% compliance withcompleting medication profiles.	
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the agency failed to track adverse patient events in 1 of 2 patient records with documented falls (#6). The findings include: Record review on 7/8/2022 evidenced an agency policy dated 2009, titled, "PATIENT / EMPLOYEE INCIDENT REPORT PROCEDURES", which stated, "All patient / employee incidents should be reported immediately to the Director of Patient Services. The employee will complete the appropriate incident report...." Clinical record review on 7/7/2022 for patient #6, start of care 9/21/2022, certification period 11/21/2021 to 1/19/2022, primary diagnosis of Parkinson s Disease, evidenced an agency document titled, "COMMUNICATION NOTE" dated 10/30/2021, which stated, " ... [Physical Therapist 1] reported that [patient #6] fell	G0654	TheAdministrator/Director of Nursing has reviewed CFR(s): 484.65(c)(2) and agencypolicy titled “Patient/Employee Incident Report Procedures”. During themandatory all employee post survey in-service meeting conducted on 07/19/2022,the Administrator/DON discussed the survey findings and agency policy onincident reporting which states that all patients/employee incidents should bereported immediately to the Director of Nursing; and the employee is tocomplete appropriate incident report on the patient’s clinical record. ThePhysical Therapist in charge of Patient #6 verbalized understanding on thepolicies of incident reporting; and acknowledged that she forgot to complete anincident report after she reported the falls to	2022-07-19

	twice this week...." Review of the agency's incident log from January 2021 to present failed to evidence any entries for patient #6. During an interview on 7/7/2021 at 1:12 PM, the administrator indicated all falls, witnessed or reported, should be entered in the incident log. When informed of the findings on 7/8/2021 at 10:00 AM, the administrator indicated the reported falls should have been entered in the incident log. When queried, the administrator indicated the agency failed to record the reported falls in the incident log. 410 IAC 17-12-2(a)		the DON. The Administrator/DON, during the meeting, demonstrated on EMR-Axxess Software how to complete an "Incident Log". All staff verbalized understanding. Monitoring Process: The Administrator/DON in coordination with the Quality Assurancestaff will monitor field staff documentation to ensure compliance with theregulation and agency's policy on incident reporting. The QA staff will continue to implement agency'son-going process of reviewing all visit notes to ensure that all adversepatient events are properly tracked and documented on every patient's clinicalrecord. The Administrator/DON willreview all active charts with adverse events quarterly to ensure 100% compliance.	
G0800	Services provided by HH aide 484.80(g)(2)	G0800	The Administrator/Director ofNursing reviewed the Standard, 484.80(g)(2) - Services Provided by HHA, agencypolicies titled, "Job	2022-07-19

	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 the home health aide followed the care plan for active patients receiving home health aide services in 1 of 1 home health aide visits observed. (#2) The findings include: An agency policy titled, Job Description Title: Home Health Aide, revised 2018, stated, & Responsibilities: 1. Provides patient care in accordance with the written care plan. & 5. Assist patient with ambulation, transfer, and use of wheelchair, crutches, walker or other assisting devices. & 13. Maintains patient safety and the security of personal belongings. 14. Works cooperatively and communicates effectively with family members and other members of the health care team &. An undated agency policy titled, Mobility Transfer Techniques, received 7/8/2022, stated, & Body Mechanics: & Assist the patient at U [sic], i.e. waist with a gait belt [assistive device put on a patient who has mobility issues]. Don t hold the patients lit [sic] at the shoulder. Using a gait belt gives a good grip without restricting the use of the patient s arms. & Principles of Transfers: & Communication with the patient s physical therapist when possible is important to insure [sic] the transfer method is the same on the floor as in physical therapy. The therapist often is instrumental in offering tips that improve the patient s ability to transfer &.		Description: Home Health Aide" and"Mobility - Transfer Techniques". The Administrator/Director ofNursing discussed with HHA #1 the surveyor findings as well as the agency'spolicies on Home Health Aide Job Description and Mobility - Transfer techniques.HHA #1 verbalized understanding. The Administrator/DON provided HHA a total of 4-hourin-service training on "General Rules for Transfer Techniques" and"Safety with ADLs" on 07/15/2022; and "Review of Basic ADL Care.Therapeutic Sponge Bath, Tub Bath, Hair Shampoo, Perineal Care Policy andProcedure" on 07/19/2022. HHA #1 verbalized understanding and performedadequate return demonstration for each training subjects provided. Monitoring Process: The Administrator/DON will ensureHHA is following plan of care and providing services which is appropriate topatient’s overall status and maintaining	

	Clinical record review for patient #2 on 7/6/2022, start of care 6/10/2022, certification period 6/10/2022 to 8/8/2022, evidenced an agency document titled, HHA [home health aide] Care Plan, electronically signed by the administrator. The care plan had a subsection titled, Safety Precautions, which had the following categories checked off for the home health aide to provide: Keep Pathway Clear & Support During Transfer/Ambulation, Fall Precautions, Safety in ADLs, Use of Assistive Devices. The care plan had a subsection titled, Activities Permitted, which had the following items checked off for the home health aide to provide: & Cane, Other Human assistance. Clinical record review on 7/6/2022 evidenced an agency document titled, PT [physical therapy] Visit, electronically signed by PT #1, dated 6/27/2022. This document stated, & Gait Training: Assistive Device Standard cane & Assessment: & Pt [patient] has stooped posture, unsteady, wobbly & Pt is high risk of falls. Pt will continue to benefit from PT services to promote safety and independence. & Progress made towards goals: Pt tolerates ambulation with st [standard] cane and 1 hand on furniture for support, pt is unsteady, wobbly and has poor coordination. Pt is fall risk &. Clinical record review on 7/6/2022 evidenced an agency document titled, Communication Note, electronically signed by the administrator. This document stated, & Care coordinated with assigned RN [alternate administrator] regarding patient s fall incident 06/30/2022. Patient did not incur any apparent injury. SN [skilled nurse] notified Doctor #2 s office. Author notified PT regarding fall incident to reinforce home safety training and falls prevention instructions. During an observation on 7/6/2022 at 2:00 PM, a home visit with patient #2 was observed. HHA [home health aide] #1 brought a rollator		care.On-going monthly in-services for HHA will include reinforcements of trainingson “Safety with ADLs” and “Mobility andTransfer Techniques” for the next 3 months (August-October 2022) in addition to their on-going scheduled monthly in-services	

	frame with four legs but may have anywhere between two to four wheels and a built-in seat]to patient #2 to use. Patient #2 s spouse said the rollator had just arrived yesterday. Patient #2 was unable to stand, so the patient s spouse assisted them to the standing position. HHA #1 assisted patient #2 from the living room to the bathroom with the rollator walker. When they arrived at the bathroom doorway, it was discovered that the rollator would not fit through the door, so HHA #1 left the rollator in the hallway, held onto patient #2 s waistband and continued walking into the bathroom without the use of an assistive device. HHA #1 then had patient #2 hold on to the bathroom sink, let go of the patient s waistband, and proceeded to close the lid of the toilet, place a towel on top of the toilet, and helped the patient sit on the towel on top of the closed toilet. HHA #1 then walked out of the bathroom, leaving patient #2 sitting alone on top of the toilet to retrieve the items needed for the sponge bath. When the sponge bath was done, HHA #1 began to dress patient #2 in a t-shirt, then walked out of the bathroom, leaving the patient sitting on the toilet with only a t-shirt on, to ask the patient s spouse for an adult diaper, then came back into the bathroom to finish dressing the patient. Once patient #2 was dressed, HHA #1 went to the hallway and brought the rollator walker to the doorway of the bathroom and had patient #2 stand and walk to the rollator while holding the patient s waistband. Patient #2 s knees started to bend when they reached the rollator and HHA #2 grasped the waistband, pulling the patient upright to a standing position again, encouraging them to keep walking back to the recliner in the living room. During an interview on 7/8/2022 at 12:08 PM, the administrator indicated the chair bath should probably be done in the patient s recliner in the living room with the curtains closed. The administrator also indicated patient #2 is a very high fall risk and the patient was not yet trained on how to use the rollator walker at the time of the visit.			

G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the home health agency failed to ensure all entries in the clinical record were clear, complete and appropriately authenticated in 1 of 5 active patient records reviewed (#4). The findings include: Record review evidenced an agency policy titled, "POLICY ON CLINICAL RECORD DOCUMENTATION", dated 2/3/2020, which stated, "Consistent, current, accurate and complete documentation in the medical records is an essential component of quality patient care...." Clinical record review on 7/6/2022 for patient #4, start of care 4/7/2022, certification period 6/6/2022 to 8/4/2022, primary diagnosis of Type 2 Diabetes Mellitus (an impairment in the way the body regulates and uses sugar as fuel), evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in Medicare home health care]-D1 Recertification", dated 6/3/2022 and signed by RN [registered nurse] 1. The assessment had a subsection titled, "INTEGUMENTARY [skin] STATUS", which indicated the patient had no wounds. The assessment had a section titled,	G1024	TheAdministrator/Director of Nursing has reviewed the Standard, 484.110(b) –Authentication, agency policy titled, "Policy on Clinical RecordDocumentation", and the clinical records of Patient #4. TheAdministrator/DON has discussed with RN in charge of Patient #4 the surveyorfindings and the importance of having complete and accurate documentation. RNverbalized understanding and admitted the mistake. The medical record has beencorrected to the OASIS dated 06/03/2022 through a communication note dated07/11/2022 omittting Decubitus ulcer/open wound documentation under the Nutritional Health Screen and reflecting corrected height and weight. Monitoring Process: The Administrator/DON in coordination with the Quality Assurancestaff will monitor field staff documentation to ensure compliance with theregulation and agency’s policy on clinical record documentation. All fieldstaff was made aware of	2022-07-19

	the patient had an open wound. During an interview on 7/8/2022 at 11:44 AM, the administrator indicated the patient did not have a wound at the time of the OASIS assessment, and the documentation in the nutritional health screen was an error. Clinical record review evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] [the patient-specific, standardized assessment used in Medicare home health care to plan care] -D1 Recertification", dated 6/3/2022 and signed by RN [registered nurse]1. The assessment had a subsection titled, "Vital Signs", which stated, " ... Height: 72 inches Weight 432 lbs...." Clinical record review evidenced a group of agency documents titled, "SN [skilled nurse] TEACHING / TRAINING VISIT". Skilled nurse visit notes dated 6/17/2022 and 6/24/2022 indicated the patient's height was 430 inches, and weight was 72 lbs. During an interview on 7/8/2022 at 11:55 AM, the administrator indicated the patient's height was 72 inches and weight was 430 lbs. When queried, the administrator indicated the skilled nurse visit notes did not evidence the correct patient information. 410 IAC 17-15-1(a)(7)		possible errors that can take place when previousassessments are copied without updating and editing the note/assessments toreflect the current patient status. Once documentation has been authenticated,signed and dated by the clinician, the QA staff will confirm documentation for accuracy.If there are any questions regarding submitted documentation, the clinicianwill be asked to confirm and perform corrections if deemed necessary.	