STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K076	A. BUILDING 00 B. WING	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEAVEN SENT HOME HEALTH CARE LLC	10484 N STATE ROAD 13 ELWOOD, IN 46036

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G 0000 Bldg. 00		G 0000		

This was a Post Condition revisit for the federal home health recertification survey completed on January 16, 2019.

Survey Date: May 28, 29, 30; 2019

Facility Number: 012612

Provider Number: 15K076

Unduplicated Skilled Census: 6
Home Health Aide Only Census: 49
Personal Service Only Patients: 14
Total Census: 69

Sample:
Record Review With Home Visits: 2
Record Review Without Home Visits: 2
Total Home Visits: 2
Total Records Reviewed: 4

During this survey, four conditions of participation and fourteen (14) standard level deficiencies were found corrected, one (1) condition and fourteen (14) standard level deficiencies were re-cited, and one (1) new condition and eleven (11) new standard level deficiencies were cited.

Heaven Sent Home Health LLC continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning January 16, 2019 to January 16, 2021 for being found out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights, 484.55 Comprehensive

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

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	Assessment of Patients, 484.60 Careplanning, coordination, quality of care, 484.75 Skilled Professional Services, and 484.110 Clinical records. Quality Review completed 6/26/19			
G 0422 Bldg. 00	Based on record review and interview, the agency failed to ensure that personal service only patient's received the new updated patient rights information for 13 of 13 personal service patients (#5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17). Findings include: Review of the agency's plan of correction that was submitted to Indiana State Department of Health, indicated "All patients will receive revised policy 1.40 ...The signed document will be placed in patient chart to ensure evidence of adhering to this corrective action." This corrective action completion date indicateed 2/25/19. The clinical record of patient #5 was reviewed on 5/30/19 and indicated a start of care date of 9/14/18. A client care agreement was present and dated 9/14/18. The record failed to evidence documentation to show the patient received updated patient right information The clinical record of patient #6 was reviewed on 5/30/19 and indicated a start of care date of 12/14/18. A client care agreement was present and dated 12/14/18. The record failed to evidence documentation to show the patient received	G 0422	G-0422 100% of personal service patients received new updated patient rights information the patients sign a Client Information sheet stating to this. 100% of all new admissions will be audited x 3 months for evidence patients receive new updated patients rights information. Administrator will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and will not recur.	06/28/2019

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	updated patient right information. The clinical record of patient #7 was reviewed on 5/30/19 and indicated a start of care date of 6/2/14. A client care agreement was present and dated 12/14/18. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #8 was reviewed on 5/30/19 and indicated a start of care date of 11/24/17. A client care agreement was present and dated 11/24/17. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #9 was reviewed on 5/30/19 and indicated a start of care date of 1/5/18. A client care agreement was present and dated 1/5/18. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #10 was reviewed on 5/30/19 and indicated a start of care date of 9/19/18. A client care agreement was present and dated 9/19/18. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #11 was reviewed on 5/30/19 and indicated a start of care date of 10/10/17. A client care agreement was present and dated 10/10/17. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #12 was reviewed on 5/30/19 and indicated a start of care date of 2/7/19. A client care agreement was present and dated			

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	2/7/19. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #13 was reviewed on 5/30/19 and indicated a start of care date of 11/19/18. A client care agreement was present and dated 11/19/18. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #14 was reviewed on 5/30/19 and indicated a start of care date of 3/19/19. A client care agreement was present and dated 3/19/19. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #15 was reviewed on 5/30/19 and indicated a start of care date of 4/11/18. A client care agreement was present and dated 4/11/18. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #16 was reviewed on 5/30/19 and indicated a start of care date of 11/6/17. A client care agreement was present and dated 11/6/17. The record failed to evidence documentation to show the patient received updated patient right information. The clinical record of patient #17 was reviewed on 5/30/19 and indicated a start of care date of 11/17/16. A client care agreement was present and dated 11/17/16. The record failed to evidence documentation to show the patient received updated patient right information. During an interview on 5/28/19 at 3:03 PM, the			

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	director of nursing (DON) stated with homemaker only admissions the DON or another registered nurse (RN) will complete a brief waiver admission. The homemaker patients get all the same patient right information that the home health patients get. When asked if the homemaker only patients received the new updated patient rights that the home health patients received the DON stated she did not know they were too busy getting the other home health patients completed to worry about the homemaker only.			
G 0528 Bldg. 00	Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment was accurate and contained specific current health status for 1 of 4 patient records reviewed (#1). Findings include: The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19. The RN failed to ensure the comprehensive assessment reflected the patient's current health status as evidenced by: A hospital admission history and physical dated 3/5/19 from the patient's primary physician stated that the patient "... is found to have an ejection fraction of only 20% ... The patient is felt to need a biventricular pacemaker but Medicare will not approve this for an additional 3 months. ...." The start of care comprehensive assessment	G 0528	G-0528 CFR Clinical Director has educated/inserviced nursing staff on CFR 484.60 and comprehensive assessment for accurate documentation. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify any missing specific current health status 100% of new admissions and 50% of recert's comprehensive assessments and Plan of Care will be audited for missing specific current health status and coded x 6 months by Sharon McNight (consultant) for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 6 months to implement any changes	06/28/2019

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	dated 5/28/19 stated the patient had a 25% ejection fraction and a pacemaker placed in April of 2017. During an interview on 5/30/19 at 10:06 AM, patient #1 stated that a 1 lead pacemaker was placed in 2017 and needs "a bigger one." Patient #1 stated the surgery should be occurring at any time. During an interview on 5/30/19 at 12:08, the administrator stated that the comprehensive assessment needed to have updated information.		Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	
G 0530 Bldg. 00	Based on record review and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained individual patient strengths for 1 of 4 records reviewed (#4). Findings include: The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19. The comprehensive start of care assessment dated 5/14/19 failed to evidence patient strengths. During an interview on 5/30/19 at 11:58 AM, the director of nursing stated that the patient strengths were barely ever completed by her.	G 0530	N-530 Agency reviewed verbal order policy and specifies of this care to determine how it could have been better handled. All patients cited at survey have been corrected Clinical Director and Jean MacDonald has educated/inserviced on obtaining and sending verbal orders to physician. 100% of clinical records were reviewed for compliance. Omissions, clarifications and verbal orders obtained if needed. A new form was implemented to audit new admissions and recerts within 15 days from the start of care or Recert date to evidence verbal orders will be obtained, documented and sent to the	06/28/2019

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G 0536 Bldg. 00	Based on record review, and interview, the registered nurse (RN) failed to ensure the medication lists were accurately maintained for 1 of 4 records reviewed (#4). Findings include: An agency policy dated 3/22/19 titled "Medication Reconciliation," Policy # 2.56 stated "...9. Medications will be reviewed with the client on each home visit to determine if other prescriptions or non-prescription drugs are being taken ...." The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19. The RN failed to ensure that medication lists were kept accurate and up to date as evidenced by: During a home visit on 5/29/19 at 1:50 PM, with patient #4, employee H, home health aide (HHA), the patient stated that he / she did not take the	G 0536	physician 100% Recerts will be audited at recert with Care Plan Audit tool x 3 months with any adverse findings reported to QAPI Clinical Director will responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur N-0536 All employees providing homemaking services only were counseled to only provide those services assigned and to report to any client requests for variances in assignment to case manager. Employee D was educated and counseled on her non medical care job description for Homemaking services. 100% of Homemaking records will be audited weekly for compliance to tag N-0536 Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency does not recur	06/28/2019

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G 0570 Bldg. 00	blood pressure medication that was ordered. During an interview on 5/30/19 at 11:36 AM, the administrator and director of nursing stated the case manager was responsible for medication updates on the medication profile. Based on record review and interview, the agency failed to ensure the skilled nurse set up a medication planner accurately so that medications were taken at correct times by the patient (See Tag G570); homemaker and attendant care services were not provided absent of a physicians order (See Tag G572); failed to ensure the plan of care (POC) included all pertinent diagnoses, treatments and goals (See Tag G574); the agency failed to ensure that verbal orders were put into writing and sent to the physician for signature (See Tag G584); the registered nurse (RN) failed to notify the physician of changes related to the care of the patient (See tag G590); failed to ensure the registered nurse (RN) coordinated with an anticoagulant clinic to assure correct anticoagulant dosages for weekly medication sets by the skilled nurse (See Tag G606) and failed to ensure that a plan of care was provided to the patient (See Tag G620). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care planning, coordination, quality of care. In regards to G570, the findings include: The clinical record of patient #1 was reviewed on	G 0570	G-570 Responded to under G572,G574, G584, G590 and G606 In regards to G570 CFR 484.60 100% of current charts were audited using the Care plan audit tool for compliance. Omissions, clarifications and V.O obtained. All records cited at survey have been corrected. A new Care plan Audit tool form was implemented to adhere to this corrective action. Our agency is aware of the need for more education and oversight of Employee E (a new employee). Clinical director or designee will monitor employee E x 3 months. Staff reviewed G570/N520 and the need for accuracy in medication compliance 100% of patients visits involving medication set up or reminders will document for patient compliance. Physician will be notified of noncompliance or variance and documented.	06/28/2019

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	5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated orders for the skilled nurse to "fill client's medication box every week." The plan of care contained medication orders for three times per day and bedtime medications. The agency failed to ensure that the needs of the patient were being met to ensure medications were being taken at correct times as evidenced by: The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated orders for the skilled nurse to "fill client's medication box every week." The plan of care contained medication orders for three times per day and bedtime medications. The agency failed to ensure that the needs of the patient were being met to ensure medications were being taken at correct times as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, with patient #1, employee E, registered nurse (RN), was observed providing skilled care. The patient had medications in the living room, two places in the kitchen, and bathroom. The RN was observed filling the patient's medication box. The patient had a pill box with times for morning and evening. When employee E placed oscal in the medication box, there was not enough tablets for the whole week. There was no Oscal (calcium tablets) left in Monday morning and evening and Tuesday morning slots. The RN placed a sticky note on the medication box of which days were missing Oscal and instructed the patient to place the medication in the medication box when the medication was obtained. Medications viewed in the home also contained an inhaler in the		Audits of documentation of medication compliance/noncompliance will be conducted monthly. Any adverse findings will be reported to QAPI Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur.	

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	bathroom, and liquid medication in one area of the kitchen. The agency failed to ensure all medications were managed and taken by the patient at the correct times. During an interview with the patient at the home visit on 5/28/19 at 12:00 PM, patient #1 stated they were supposed to take torsemide 3 times per day [Torsemide 20 mg 1 tablet 3 times per day per bottle]. The patient stated he / she takes 2 pills in the morning (nurse placed in pillbox for morning) and the aide reminded the patient to take the third dose of that medication in the afternoon (from the bottle). The patient stated he / she had a muscle relaxer [Zanaflex 4mg ½-1 tablet as needed at bedtime per bottle] that is not put into the pill container which is taken one a night, but not always taken. The patient stated an ordered cream [triamcinolone ointment 0.1% to back one time daily] isn't used because he/ she cannot reach back to apply it. Lastly, the patient stated the reglan [metoclopramide 10 mg ½ tablet 3 times per day with meals per bottle] was not placed in the medication box.			
G 0572 Bldg. 00	Based on record review and interview, the agency failed to ensure homemaker and attendant care services were not provided absent of a physicians order for 1 of ** records reviewed of patients receiving said services in a sample of 4. (#3) Findings include: The clinical record of patient #3 was reviewed on 05/28/19 and indicated a start of care date of 04/25/19. The record contained a plan of care for	G 0572	G-0572 SN staff were educated on obtaining physicians orders for services provided. All patients cited at survey have been corrected 100% of clinical records were reviewed for compliance. Omissions, clarifications and verbal orders will be obtained if needed.	06/28/2019

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	the certification period of 04/25/19-06/23/19, which indicated a HHA frequency of ..."1 hr [hour] day 2 days week 1, 1 hr day 6 days wk [week] x 8 weeks... Life Streams: Waiting on NOA [notice of action] ...." The plan of care failed to evidence physician orders for Homemaker and attendant care services as evidenced by the following: An agency document titled "Doctor Authorization" dated 04/25/2019 and signed by DON [director of nursing], stated, " SN [skilled nurse] ... HHA 1 hr day 6 days wk ...." Agency documents titled "Homemaker Week Note" for dates: 04/28, 04/29, 05/01, 05/05, 05/06, 05/07, 05/08, 05/12, 05/13, 05/14, 05/15, 05/16, 05/17/19 evidenced homemaker services were provided each of the aforementioned days 12:45 PM to 1:45 PM. The agency failed to evidence physician orders for the homemaker services. Agency documents titled "ATTC [attendant care] Weekly Note for dates: 04/25, 04/26, 04/28, 04/29/19 evidenced services were provided from 11:15 AM to 12:45 PM, and 04/30 11:45 AM to 12:45 PM, 05/01, 05/02, 05/03, 05/05, 05/06, 05/07, 05/08, 05/09, 05/10, 05/12, 05/13, 05/14, 05/15, 05/16, 05/17/ 19 evidenced ATTC services were provided each of the aforementioned days from 11:15 AM to 12:45 PM. The agency failed to evidence physician orders for ATTC services. During an interview on 05/28/19 at 10:58 AM the DON and the Administrator indicated attendant care and homemaker services should not be provided to the patient without physician order.		A new form was implemented to audit new admissions and recerts within 15 days from the start of care or recert date to evidence physician orders were obtained. 100% of recerts will be audited at recert with Care Plan tool x 3 months with any adverse findings reported to QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and will not recur	
G 0574 Bldg. 00				

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	Based on record review and interview, the agency failed to ensure the plan of care (POC) included all pertinent diagnoses, treatments and measurable goals in 2 of 4 records reviewed (#1, 3). Findings include: 1. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated orders for the skilled nurse to "fill client's medication box every week"and goals of "The client's safety will be enhanced throughout home care service as evidenced by use of fall precautions ... The client / caregiver will verbalize understanding of CHF [congestive heart failure] and all aspects of associated care ...." The start of care comprehensive assessment completed on 5/21/19, indicated the patient had dyspnea with minimal exertion, was on oxygen at 2-3 liters, and a need for medication set up every week. The plan of care failed to evidence measurable goals and goals based on the needs identified on the comprehensive assessment for medication management, oxygen use, and shortness of breath. 2. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19, which indicated a goal that the client would be able to walk at least a 1/2 block and at least 50 feet outside. The POC failed to evidence interventions for staff to assist patient to accomplish that goal. During an interview on 5/30/19 at 12:18 PM, the	G 0574	G-0574 Clinical Director has educated/inserviced nursing staff on G574 including all pertinent diagnoses, treatments and measurable outcomes assessments for accurate documentation. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify any missing pertinent diagnoses, treatments and measurable goals. Measurable outcomes and goals will be discussed with patient at each skilled nursing encounter and documented. 100% of new admissions and 50% of recert's comprehensive assessments and Plan of Care will be audited for missing pertinent diagnoses, treatments and measurable goals and coded x 6 months by Sharon McNight (consultant) for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 6 months to implement any changes New Care plan audit tool form has been implemented to use on new admissions and recerts adhering to this corrective action. Any adverse findings will be reported to QAPI	06/28/2019

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	director of nursing stated that employee E "is still learning and so are we, " in response to inquiry if goals should be measurable on the plan of care.		Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	
G 0584 Bldg. 00	Based on record review and interview, the agency failed to ensure that verbal orders were put into writing and sent to the physician for signature for 1 of 4 records reviewed (#2). Findings include: The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care date of 03/28/19. The record contained a plan of care for the certification period of 03/28/19-05/26/19, which indicated "...Orders ... Med Set 1 time week x 9 weeks ... Medications ... Metoprolol 5 mg by mouth 2 times day .... " An agency document titled "Medication Record" provided by Employee G on 5/28/19 at 3:00 PM dated and signed by Employee A on 03/28/19 indicated, Metoprolol 5 mg tablet by mouth 2 times day, with a straight line drawn through the 5 on the record. An untitled document dated 03/29/19 by the DON (director of nursing) indicated, " ... Metoprolol 5 mg [milligram]{line crossed through 5} tablet by mouth 2 times daily. Additionally, hand written to the right of the entry: "Double check dose! 2.5mg	G 0584	G-0584 Agency reviewed verbal order policy and specifies of this care to determine how it could have been better handled Clinical Director and Jean McDonald has educated/inserviced on obtaining and sending verbal orders to physician. 100% of clinical records were reviewed for compliance. Omissions, clarifications and verbal orders obtained if needed. A new form was implemented to audit new admissions and recerts withing 15 days from the start of care or Recert date to evidence verbal orders will be obtained, documented and sent to the physician 100% Recerts will be audited at recert with Care Plan Audit tool x 3 months with any adverse findings reported to QAPI	06/28/2019

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	BID [twice daily]?" signed by patients primary care physician on 04/03/2019. An agency document titled "Medication Record" provided by Employee G on 5/28/19 at 3:00 PM dated and signed the DON on 04/05/19 indicated, "Metoprolol 100 mg by mouth 2 times day .... " A line was drawn through the number two for the metoprolol. An agency document titled "Medication Record" provided by Employee G on 5/29/19 at 12:27 PM dated and signed by the DON on 4/12/19 indicated, "... 3/28/19 Metoprolol 100 mg tablet by mouth 1 times daily; D/C [discontinue] 4/12/19 ... 4/12/19 Metoprolol 2.5 mg 1 tab po 2 x day (go back to original) ... Drug regimen review 04/12/19 (med set) .... " An agency document titled "Medication Record" provided by Employee G on 5/29/19 at 12:29 PM, signed and dated by the DON on 4/12/19 indicated Metoprolol 100 mg by mouth 1 times daily. During an interview on 05/30/19 at 11:27 AM, the DON indicated she did not know why the line was drawn through the number 5 on the medication record and was unable to ascertain the dosage of Metoprolol from the Medication record dated 03/28/19. However, the DON stated that the line drawn through the number two indicated the medication was to be taken 1 time daily. Further, when asked if there had been a physician order for the medication changes, she indicated there were no orders.		Clinical Director will responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur	
G 0590 Bldg. 00				

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	Based on observation, record review and interview, the registered nurse (RN) failed to notify the physician of changes related to the care of the patient for 3 of 4 records reviewed (#1, 3, 4). Findings include: 1. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated skilled nurse orders to fill the patients medication box weekly, instruct patient on medication regimen and assess pain level at every visit. The clinical record failed to evidence documentation that the RN notified the physician that the patient was not taking medications as prescribed, or that the patient was having pain and nausea as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, employee E, RN, was observed filling medication box and assessed the patient. The patient had complaints of nausea, stated was not taking reglan (routine per instructions on bottle) or xanax (routine per instructions on bottle), taking lactulose one time per day (bottle indicated order for 2 times per day), and triamcinolone cream not taking because cannot reach back to apply it to self, complained of shoulder pain when reaching for something and stated the pain injections were not effective. A physician notification was sent to the physician on 5/28/19 by employee E that reported what medications were left in the box after the week end to show missed doses, a low blood pressure, and new physicians identified during the visit.	G 0590	G-0590 Clinical Director has educated/inservices nursing staff on notifying the physician of variances in parameter or changes in conditions immediately and document in narrative. All records cited at survey have been corrected. 100% of clinical charts were audited for compliance. Omissions, clarifications and verbal orders obtained if needed. All records cited at survey have been corrected. A new form was implemented to audit new admissions and recert within 15 days from start of care or Recert date to ensure documentation of physicians notification related to patients care. 100% of records will be reviewed at recert for compliance using Care Plan Audit tool for evidence of compliance Clinical Director will be responsible for monitoring these corrective actions to ensure this deficiency does not recur.	06/28/2019

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	2. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19, which indicated blood pressure parameters to call the physician if systolic was greater than 160 or less that 90, or the diastolic is greater than 95 or less than 60. The clinical record failed to evidenced that the registered nurse (RN) reported a blood pressure of 91/56 on 5/14/19 to the physician.3. The clinical record of patient #3 was reviewed on 05/28/19 and indicated a start of care date of 04/25/19. The record contained a plan of care for the certification period of 04/25/19-06/23/19 that indicated client specific parameters for notifying physician of changes in vital signs "... Systolic >160 <90, Diastolic >95 <60 .... " The record failed to evidence the physician was notified of blood pressure below the client specific parameters for notifying the physician on the day of the assessment as evidenced by: A Comprehensive Adult Assessment Start of care dated 04/25/19 by the DON [director of nursing] indicated the patient's blood pressure was 89/61 and O2 [oxygen] saturation rate was 89%. The record failed to evidence the physician was notified of the blood pressure outside the established call perimeters and the low oxygen saturation . An agency document titled "Supervisor Visit" dated and signed by Employee E on 05/09/19 indicated the patient's blood pressure was 97/58. The record failed to evidence documentation that the physician was notified of a blood pressure outside the established call perimeters. During an interview on 05/30/19 at 11:00 AM, the DON indicated vital signs outside the call			

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	perimeters should be called to the physician for notification.			
G 0606 Bldg. 00	Based on record review and interview, the agency failed to ensure the registered nurse (RN) coordinated with an anticoagulant clinic to assure correct anticoagulant dosages for weekly medication sets by the skilled nurse for 1 of 1 patient's receiving coumadin (#2) in a sample of 4. Findings include: An agency policy dated 3/4/19 titled "Care Coordination Policy," Policy# 2.30 stated "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support objectives outlined in the Plan of Care. ... After the initial assessment, the admitting registered nurse shall discuss findings of the initial visit with the clinical manager to ensure ... coordination with other agencies and institutions, if the need arises ...." The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care date of 03/28/19. The record contained a plan of care for the certification period of 03/28/19-05/26/19, which indicated "... Medications ... warfarin 5 mg [milligram] 1 tab by mouth daily or by clinic instruction ... SN [skilled nurse] Interventions: SN: Med Set 1 time week x 9 weeks ..." The record failed to evidence documenation of coordination between the RN with the patient's anticoagulant clinic for correct dosage of warfarin to assure correct dosage of the anticoagulant for weekly medication set up by the agency.	G 0606	G0606: Clinical Director has educated/inserviced nursing staff on CFR 484.60 and reviewed policy 2.30 on care coordination with other providers. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physicians to clarify any missing care coordination with other providers. 100% of new admissions and 50% of recert's will be audited for coordination of care and coded x 6 months by Sharon McNight (consultant) for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 6 months to implement any changes Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	06/28/2019

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	During an interview on 5/30/19 at 11:00 AM with the Director of Nursing [DON], was asked if patient #2 had an anticoagulant clinic that coordinated the dose of warfarin, the DON stated " I don't know if she has one or not."			
G 0620 Bldg. 00	Based on observation and interview, the agency failed to ensure that a plan of care was provided to the patient for 1 of 2 home visits observed (#1). Findings include: During a home visit observation on 5/28/19 at 12:00 PM, with patient #1, employee E, registered nurse (RN) was observed providing skilled care. The patient home health folder was observed and it failed to evidence plan of care or any pertinent instructions related to the patient's care provided by the agency. The administrator and director of nursing were notified of this concern on 5/28/19 at 4:45 PM, during the daily conference, and they had no comment or anything to submit for review.	G 0620	G-0620 100% of patients home folder was check to ensure care plan and all pertinent information was present in home folder SN documented in patient record At each skilled visit encounter home folder will be checked for compliance and documented Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and will not recur	06/28/2019
G 0680 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure all staff followed infection control policies and standard precautions (See Tag G682); and failed to ensure that an infection control program included tuberculosis (TB) / communicable diseases was	G 0680	Responded to under G682 and G684	06/28/2019

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	established, that policies were in place to govern the plan, and that the policies were followed to ensure staff and patients were protected against the spread of infections (See Tag G684). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.70 Infection Prevention and Control			
G 0682 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure all staff followed infection control policies and standard precautions for 2 of 2 home visits observed (#1, 4). Findings include: 1. The agency policy revised 3/22/19 titled "Medication Set Up Policy," Policy #: 2.52 stated "... Hand washings completed prior to setting up medications. Gloves may be worn, but are not required. ... " 2. An agency job description from 2017 titled "RN [registered nurse]," stated "...Position responsibilities. Assumes responsibility and accountability for the practice of professional nursing in accordance with state nurse practice act and standards for home health nursing ...." 3. Pershing, J., PhD. (2004). Living in the Community: Medication Administration Manual. Division of Disability, Aging and Rehabilitative Services. "For a multi-dose bottle, remove the cap; without touching the medicine, pour required	G 0682	G-682 Clinical Director has inserviced staff on revised policy #2.52 always using glove procedure, hand hygiene and educated on gel use. Clinical Director has educated and reviewed with nursing staff CFR 484.70 Clinical Director will do monitoring of nursing staff x 2 months for evidence nursing staff are following State nurse practice act and standards and agency policies and procedures and documented in employee HR file. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	06/28/2019

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	capsules or tablets into cap and then into the paper cup or directly into the individual's hand ...." 4. United States of America, Centers for Disease Control. (2019). Wash Your Hands. Retrieved from https://www.cdc.gov/features/handwashing/index .html "How to Use Hand Sanitizer: Apply the gel product to the palm of one hand (read the label to learn the correct amount). Rub your hands together. Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds ...." 5. During a home visit observation on 5/28/19 at 12:00 PM, with patient #1, employee E, registered nurse (RN), was observed providing skilled care. Employee E started the visit with hand hygiene using hand sanitizer. Then with ungloved hands filled pill box touching all pills with bare hands. Employee E failed to follow standard precautions when filling medication box. During an interview on 5/28/19 at 4:48 PM, the administrator stated the consultant had advised the agency that nurses did not have to wear gloves when handling pills. 6. During a home visit observation on 5/29/19 at 1:50 PM, with patient #4, employee H, home health aide (HHA), was observed providing personal care. Employee H started the visit with hand hygiene using hand sanitizer. After applying hand sanitizer to the hands, she would rub hands together and then shook hands vigorously to dry the hand sanitizer. Employee H failed to vigorously rub hands together during hand sanitizer use until hands were dry. During an interview on 5/29/19 at 3:40 PM, the			

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	administrator stated that she saw employee H shaking hands after applying hand sanitizer. The director of nursing stated employee H should have rubbed hands together until the gel was dry.			
G 0684 Bldg. 00	Based on observation, record review, and interview the agency failed to ensure that an infection control program included tuberculosis (TB) / communicable diseases and failed to ensure policies were established to govern the plan to ensure staff and patients were protected against the spread of infections for 1 of 1 agency. Findings include: An undated agency policy titled "Tuberculosis Evaluation Policy," Policy # HA-122 stated "... Instructions ... 12. The agency is responsible to have policies and procedures for the control of communicable disease in compliance with applicable federal and state laws ...." An agency job description from 2017 titled "RN [registered nurse]," stated "...Position responsibilities. Assumes responsibility and accountability for the practice of professional nursing in accordance with state nurse practice act and standards for home health nursing ...." On 5/29/19 at 10:47 AM, the refrigerator where the tuberculin solution was stored was observed. Inside the refrigerator was a box of solution that was opened but no date present as to when it was opened. The box stated "Tuberculin Purified Protein Derivative (Mantoux) TUBERSOL ... Store at 35-46 degrees Fahrenheit ... discard opened	G 0684	G-684 Our agency destroyed the old Tubersol, bought a new refrigerator and researched proper handling of TB solution Our agency wrote new policy governing infection control program including tuberculosis (TB)/communicable diseases. Clinical Director inserviced/educated nursing staff on policy and procedures Implemented weekly log documenting dates and temperature of refrigerator for evidence that a written log will be checked by the clinical director to adhere to these corrective actions The Clinical director will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur	06/28/2019

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	product after 30 days ...." The solution had a lot number of C5563AB with an expiration of 3/14/21. The temperature in the refrigerator was 59 degrees Fahrenheit. During an interview on 5/29/19 at 10:47 AM, employee H, registered nurse, a nurse who administer the TB skin tests to agency employees, was asked where the TB solution was stored in which employee H stated that the TB solution was kept in a refrigerator in the nurses office, the solutions was ordered by the administrator. Employee H stated if the seal was broken, then the nurses were aware that it was open, and it was kept in the refrigerator after being opened until was it gone. When employee H was asked if she was aware how long the tuberculin solution was good for, she indicated that it would be good until the expiration on the box even if it was open then stated "I'm not the only one who gives them." During an interview on 5/29/19 at 10:52 AM, the administrator stated she was not aware of the storage instructions for the tuberculin solution and the agency was unsure when the current solution had been opened.			
G 0706 Bldg. 00	Based on record review and interview, the skilled nurse failed to ensure they obtained a patient's temperature as part of their heard to toe assessments for 1 of 2 home visit observations. (#1) Findings include: During a home visit observation at patient #1's	G 0706	G-0706 Clinical Director and Jean MacDonald (Consultant) educated/inservice employee E on obtaining a patients temperature for head to toe assessment and reviewed CFR 484.75 Clinical director will mentor/educate employee E x 3	06/28/2019

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	home on 5/28/19 at 12:00 PM, employee E, RN, was observed filling medication box and assessed the patient. The patient had complaints of nausea. The RN failed to take the patient's temperature. During an interview on 5/30/19 at 12:15 PM, the director of nursing stated that nurses should be taking patient's temperatures.		months to assure skills competency and document in HR file Employee E was counseled on listening to patients concerns and symptoms to implement appropriate care and notify physician if needed. Clinical Director or designee will oversee Employee E for the next 30 days on Skilled Nursing visits. Any adverse findings will be reported to QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and does not recur	
G 0710 Bldg. 00	Based on observation, record review and interview, the registered nurse (RN) failed to follow the plan of care for 3 of 4 records reviewed receiving skilled nursing services (#1, 2, 4). Findings include: 1. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19 which indicated skilled nurse orders to fill the patients	G 0710	G-710 Clinical Director has inserviced/educated on CFR 484.75(b)(3) with nursing staff providing services ordered by physician and clinical documentation. Special emphasis given to employee E who is new. All patients cited was discussed with employee E. On return visit employee E educated patients on compliance with taking medications and completed a pain	06/30/2019

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	medication box weekly, instruct patient on medication regimen and assess pain level at every visit. The RN failed to follow the plan of care as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, employee E, RN, was observed filling medication box and assessed the patient. The patient had complaints of nausea, stated was not taking reglan (routine per instructions on bottle) or xanax (routine per instructions on bottle), taking lactulose one time per day (bottle indicated order for 2 times per day), and triamcinolone cream not taking because cannot reach back to apply it to self, complained of shoulder pain when reaching for something and stated the pain injections were not effective. The RN failed to complete medication teaching about importance of taking medications as prescribed and failed to complete a pain assessment. A skilled nurse visit note completed on 5/28/19 failed to evidence medication teaching or a pain assessment. During an interview on 5/30/19 at 12:15 PM, the director of nursing stated that nurses should be asking about pain. 2. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19 that indicated blood pressure parameters to call the physician if systolic is greater than 160 or less that 90, or the diastolic is greater than 95 or less than 60. The registered nurse (RN) failed to report a blood pressure of 91/56 on 5/14/19 to the physician.3. The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care		assessment. All patients cited at survey have been corrected Employee E was counseled on documentation, clinical charting and educating patient Employee E charts are audited for compliance with orders 100% of all cases were reviewed to make sure that nurses were following the Plan of care and Verbal orders obtained if needed Clinical director or designee will mentor/educate employee E x 3 months to assure skills competency and document in HR file for evidence of adhering to employee clinical charting and patient education. Any adverse findings will be reported to QAPI Charts will be audited every 30 days for adherence to this correct actions Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and does not recur 100% of all cases were reviewed to make sure that nurses were following the PoC and VO obtained if needed	

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	date of 03/28/19. The record contained a plan of care for the certification period of 03/28/19-05/26/19 which indicated "... SN [skilled nurse] Interventions...Med Set 1 time week x 9 weeks and instruct & train clients husband to complete a blood glucose draw, Signs and symptoms of Hypo, Hyper glucose. Instruct on Blood Pressure monitoring ... Goals ... Client's [family member] will be able to do blood glucose testing on wife with SN [skilled nurse] assist wk 2 wk 3 will be able to complete on own with some coaching wk 4 able to do with no prompting. Clients [family member] will be able to state what 4 meds are for and amount of dose and side effects by next recert ...." The SN failed to follow the plan of care as evidenced by: SN visit notes dated 3/28/19 and 04/05/19 failed to evidence education of the caregiver on blood pressure monitoring or procedure to perform blood glucose testing.			
G 0716 Bldg. 00	Based on record review and interview, the agency failed to ensure education to the caregiver about medications, blood sugar testing and blood pressures including progress toward those goals identified by the caregiver upon admission were documented for 1 of 1 patients ordered to receive diabetic education (#2). Findings include: The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care date of 03/28/19. The record contained a plan of care for the certification period of 03/28/19-05/26/19 that	G 0716	G-716 All clinical staff reviewed 484.75(b)(6) knowledge obtained during using comprehensive assessment, patient and family admission to develop the plan of care which includes patient and family education stressing documentation of education to caregiver/patient progress towards goals and reaction treatments 100% records were reviewed to ensure nursing staff education of patient and caregiver towards goals identified by the caregiver.	06/28/2019

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	indicated diagnoses of "HTN [hypertension]... SN [skilled nurse] Interventions...Med Set 1 time week x 9 weeks and instruct & train clients husband to complete a blood glucose draw, Signs and symptoms of Hypo, Hyper glucose. Instruct on Blood Pressure monitoring ... Goals ... Client's [family member] will be able to do blood glucose testing on wife with SN assist wk 2 wk 3 will be able to complete on own with some coaching wk 4 able to do with no prompting. Clients [family member] will be able to state what 4 meds are for and amount of dose and side effects by next recert ...." The skilled nurse failed to document education or progress as evidenced by: The agency' comprehensive start of care assessment dated 03/28/19, performed by the director of nursing [DON], identified "...Goals Identified by Patient ... [family member] wants to learn about meds so he feels comfortable about giving...." A skilled nurse visit note dated 04/05/19, performed by the DON, failed to evidence education of the caregiver on blood pressure monitoring or procedure to perform blood glucose testing. A skilled nurse visit note dated 04/12/19, performed by the DON, failed to evidence education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. A skilled nurse visit note dated 04/19/19 performed by Employee E failed to evidence blood glucose reading or performance of education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing.		any omissions, clarifications verbal orders will be obtained if needed A Plan of care addendum was sent to MD stating patients husbands unwillingness to be educated on medications, Diabetes, blood sugar testing and blood pressures. Clinical Director will review all Skilled clinical notes for continue education x 3 months any findings will be documented in employee HR chart. Any corrective actions will be reported to Administrator Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur this	

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	A skilled nurse visit note dated 04/26/19 failed to evidence education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. Employee E indicated "... Assisted client to check blood sugar...Pt [patient] does not check regularly due to does not remember how to do. This nurse checks when present for medset ...." A skilled nurse visit note dated 05/10/19 failed to evidence blood glucose reading or performance of education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. A skilled nurse visit note dated 05/17/19 failed to evidence education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. Employee E indicated, " ...Assist client [with] bloodsugar check ...." During an interview on 5/30/19 at 11:18 AM the DON stated there was documentation regarding blood sugar and blood pressure. After she looked in the record she indicated "I'm sorry I don't see it" (documentation). The DON also stated she had contacted the physician about the husband not wanting to learn or be involved with the education from the homecare agency. This also failed to be documented in the clinical record.			
G 0754 Bldg. 00	Based on record review and interview, the agency failed to ensure that home health aides (HHA) were qualified to provide personal care for 1 of 1	G 0754	G-0754 Our agency has followed CFR 484.80(a) (d)i-iv and Clinical Director completed the IAHHC	06/28/2019

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	HHA placed on aide registry since 1/16/19. Findings include: During review of employee files on 5/29/19, the list of current employees included employee D, home health aide (HHA) hire date 2/7/19 and first patient contact date 2/9/19. The employee file failed to evidence the HHA was qualified. Employee D's application for employment was dated 1/31/19. A job description for home health aide was signed by employee D on 2/7/19. A agency document titled "Home Health-hospice Aide Written Competency assessment exam scoring sheet was completed, but not signed. A "competency skills check off," had the name of the employee but was not completed or signed. The agency document titled "Certified Home health aide check list," contained skills listed. None of the skills were checked of or completed. The document was signed by employee D, but not dated or signed by a nurse. A document from the Indiana State Department of Health (ISDH) contained the signature of employee D on 12/31/18. The document stated "I [director of nursing] swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that the home health aide applicant named in this application has satisfactorily completed a competency evaluation program as required by 42 CFR 484.36 ...." This was signed by the director of nursing on 12/31/18. The administrator also signed the application on 12/31/18.		train the trainer program and knows the proper procedures. The variance in employee D's file should not have occurred. The administrator discussed the situation with the Clinical Director. The employee was only to be hired as a homemaker. Employee was immediately removed from the registry and counseled on scope of job. Our agency is aware that it is forbidden from competency our own aides for the next two years unless our agency has a contract with a qualified registered nurse. 100% of aide HR records were reviewed for compliance of G754 No new employee may be placed on a case until unless the the employee check list is signed by administrator. Employee records will be audited for completeness every 30 days x 3 months then every ninety days Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

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	During an interview on 5/29/19 at 12:07 PM, employee D, HHA stated that she was a new employee as of February of 2019. Employee D stated that her job duties were homemaking such as cleaning, running errands, shopping, changing linens. Employee D stated she was a certified nursing assistant in Kentucky but had let her license lapse. Employee D stated her current clients were patient #13 and #15. Employee D was asked if personal care had ever been completed and employee D stated that patient #13 had sores on feet and legs and was a large man. Employee D stated she assisted him with washing, soaking, drying feet, applied lotion, and put socks on. Employee D stated that the client had asked her to do this. Employee D stated that she had never applied as a home health aide in Indiana and had never undergone any training in Indiana for that. Employee D was showed her signature as it appeared on the ISDH application for home health aide. Employee stated that it was her signature, and she had signed that when she filled out the application for employment on 1/31/19. During an interview on 5/28/19 at 2:15 PM, the director of nursing (DON) stated that employee D was just a homemaker not a home health aide. When told that the agency placed the aide on the registry on 12/31/18 she stated "No she didn't go on the registry, I don't remember, might ask [administrator]." When the DON was asked why the HHA was placed on the registry in December of 2018 if she wasn't hired until February of 2019 she stated "You'd have to ask [administrator]. At 2:26 PM, the administrator stated employee D had never done personal care as she was a homemaker and they did not know why she had been put on the aide registry.			

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G 0768 Bldg. 00	Based on record review and interview, the agency failed to ensure that home health aides were competencied prior to providing hands on care to the patient for 1 of 1 home health aides (HHA) hired after 1/16/19 (employee D). Findings include: During review of employee files on 5/29/19, the list of current employees included employee D, home health aide (HHA) hire date 2/7/19 and first patient contact date 2/9/19. The employee record failed to evidence the HHA had been competencied. A agency document titled "Home Health-hospice Aide Written Competency assessment exam scoring sheet was completed, but not signed. A "competency skills check off," had the name of the employee but was not completed or signed. The agency document titled "Certified Home health aide check list," contained skills listed. None of the skills were checked of or completed. The document was signed by employee D, but not dated or signed by a nurse. A document from the Indiana State Department of Health (ISDH) contained the signature of employee D on 12/31/18. The document stated "I [director of nursing] swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that the home health aide applicant named in this application has satisfactorily completed a competency evaluation program as required by 42 CFR 484.36 ...." This was signed	G 0768	G-0768 Heaven Sent Home Health Care, LLC administrator and clinical leadership reviewed G768 the competency requirements for aides and scope of practice. Employee D was removed from the field. Clinical director counseled Employee D non medical care homemaking job description. Administrator contacted Darlene Jones at ISDH explained we mistakenly registered an aide without this agency ensuring the aide was competency to do hands on care. Employee D was taken off HHA registry per E-mail from Darlene Jones. 100% of aide HR files were reviewed for compliance with G768 No employee will be placed on the registry until employee check list is signed by Adminstrator All new employee files will be audited within 30 days for adherence for this deficiency.Any corrective findings will be reported to QAPI Administrator will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does not recur	06/28/2019

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	by the director of nursing on 12/31/18. The administrator also signed the application on 12/31/18. During an interview on 5/29/19 at 12:07 PM, employee D, HHA stated that she had never applied as a home health aide in Indiana and had never undergone any training in Indiana for that. During an interview on 5/28/19 at 2:15 PM, the director of nursing (DON) stated that employee D was just a homemaker not a home health aide. When told that the agency placed the aide on the registry on 12/31/18 she stated "No she didn't go on the registry, I don't remember, might ask [administrator]." When the DON was asked why the HHA was placed on the registry in December of 2018 if she wasn't hired until February of 2019 she stated "You'd have to ask [administrator]. At 2:26 PM, the administrator stated employee D had never done personal care as she was a homemaker and they did not know why she had been put on the aide registry.			
G 0772 Bldg. 00	Based on record review and interview, the agency failed to ensure proof of initial competency and test for home health aides (HHA) was obtained from the issuing agency for 1 of 1 HHA's reviewed with issued certifications from another agency. Findings include: During review of employee Files on 5/29/19, the file for employee J, HHA was reviewed. The employees date of hire 5/1/17, first patient contact 5/8/17, and HHA license issued on 6/14/11. The	G 0772	G-0772 Employee J file was reviewed by our agency and consultant. A completed competency test for date of 5-08-17 was found in HR file. However 484.80 (c)(5) was reviewed and discussed. 100% of aide HR files were reviewed for for compliance of G-722 All new employee records will require signature of Administrator	06/28/2019

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	employee file failed to evidence the initial competency and HHA test from the issuing agency for the HHA certification. During an interview on 5/28/19 at 2:35 PM, the administrator stated they were unaware they had to obtain the initial competency and tests from the issuing agency. She stated if upon hire, the HHA is on the registry they did not go back and get that information.		An annual audit of all employee files will be gone every June Any corrective actions will be reported to QAPI Administrator will be responsible for monitoring these corrective actions to ensure this deficiency does not recur.	
G 0798 Bldg. 00	Based on record review and interview, the home health aide (HHA) failed to follow the aide care plan for 2 of 4 records reviewed (#1, 4) and the registered nurse (RN) failed to identify all safety measures for the home health aide on the aide plan of care for 1 of 1 records reviewed (#3). Findings include: 1. An agency policy dated 11/2018 titled "Home health aide: Document policy," Policy # 2.51 stated "...Care / Services provided should be in accordance with direction provided in the Home health aide care plan ...." 2. An agency job description dated 2017 and titled "Home Health Aide," stated "...Tasks to be performed by a HHA must be assigned by and performed under the supervision of a RN [registered nurse] who will be responsible for the patient's care provided by the HHA ...." 3. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for	G 0798	G-798 Clinical Director inserviced on how to base the aide assignments on the comprehensive assessment including safety measures, how to educate the aides on the assignments and patient needs, and the importance of notifying the case manager of changes in the patient's condition. the case managers educated the aides to only do what is on the assignment, to call the case manager if the patient wants or needs changes in care, and observations to report. The specific aide was counseled. Aide notes are being audited for compliance. Case managers will document compliance with the aide assignments at each supervisory visit and each contact with the aide. Clinical director will audit supervisory notes x 3 months	06/28/2019

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	the certification period of 5/21/19-7/19/19. The HHA failed to follow the aide care plan and complete only the tasks assigned in their entirety as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, patient #1 was interviewed. The patient stated that the home health aide took the patient's blood pressure and reminded him / her to take medications during visits. The aide care plan failed to evidence medication reminders or taking patient's blood pressure as tasks for the HHA to complete. HHA documentation completed on 5/21/19 and 5/25/19, failed to evidence documentation if the HHA completed a partial bath as per aide care plan. 4. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19. The HHA failed to follow the aide care plan to complete only tasks assigned as evidenced by: During an interview on 5/29/19 at 1:50 PM, patient #4 stated they like when the HHA took blood pressures while in the home and logged it. The patient showed the log of blood pressures that were written down. Blood pressures had been documented by the HHA daily with the exception of 5/19/19 since start of care date. The aide care plan failed to evidence a clients signature or taking patient's blood pressure as a task for the HHA to complete. 5. The clinical record of patient #3 was reviewed on 05/28/19 and indicated a start of care date of 04/25/19. The record contained a plan of care for the certification period of 04/25/19-06/23/19 which indicated diagnoses of		Clinical Director will responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur	

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	: "COPD [chronic obstructive pulmonary disease] ... dependence on oxygen ... Safety measures: Universal precautions, fall precautions, clear / well-lit walkways, emergency plan developed, safety in ADL's [activities of daily living], use of assistive devices, slow position change, proper position while eating, Anticoagulant precautions, O2 [oxygen] precautions .... HHA frequency and service plan (aide care plan) ... use universal precautions ... observe rollator for safety factors, do ROM [range of motion] (ball exercises) ...." An Agency document titled "HHA Service Plan" dated 04/24/19 and signed by the patient and the DON [director of nursing] failed to evidence anticoagulant precautions and O2 precautions with indication of the skills or equipment needed for those precautions. During an interview on 05/29/19 at 11:24 AM with Employee E, indicated all safety measures on the plan of care should be reflected on the aide care plan that were initially determined upon admission by the DON and then updated by the Case Managers as needed.			
G 0828 Bldg. 00	Based on record review and interview, the agency failed to ensure that homemaker only patients did not receive personal care for 1 of 13 homemaker only records reviewed (#13). Findings include: An agency policy dated 11/2018 titled "Home health aide: Document policy," Policy # 2.51 stated "...Care / Services provided should be in	G 0828	G828 All employees providing homemaking services only were counseled to only provide those services assigned and to report to any client requests for variances in assignment to case manager. Employee D was educated and counseled on her non medical	06/28/2019

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	accordance with direction provided in the Home health aide care plan ...." The clinical record of patient #13 was reviewed on 5/29/19 and indicated a start of services date of 11/19/18. The service plan for patient #13 indicated tasks staff were to complete were: Clean / file nails and soak feet one time per week and feed / set up meals every visit. The service plan had been reviewed and signed by the director of nursing on 5/18/19. Homemaker documentation from 1/19/19-5/3/19 indicated that employees D and F had soaked and cleaned feet, and assisted patient with a body suit during homemaker visits. The agency failed to ensure that homemaker staff only completed tasks within their scope of practice. During an interview on 5/29/19 at 12:07 PM, employee D, HHA stated patient #13 had sores on their feet and legs and was a large person. Employee D stated she assisted with washing, soaking, drying feet, applied lotion, and put socks on when the client had asked her to do this.		care job description for Homemaking services. 100% of Homemaking records will be audited for evidence of compliance to tag G-828 Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency does not recur	
G 0948 Bldg. 00	Based on record review and interview, the administrator failed to include the homemaker only patients to the agency census upon initial request for 1 of 1 agency. Findings include: The administrator failed to manage the agency census and keep it up to date and accurate as evidenced by:	G 0948	G 948 Clinical Director & IT were educated on keeping an updated census at all times Census will be reviewed by the Clinical Director & Administrator for evidence of accuracy on patient count weekly. The Administrator & Clinical Director will be responsible for	06/28/2019

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	The agency census was requested during the entrance conference on 5/28/19 at 9:20 AM. At 10:25 AM, the director of nursing (DON) provided a census document which included 58 patients. During review of employee files on 5/29/19, the agency was asked for the names of the patients that an employee provided services to. At 3:00 PM the patient list for employee D, homemaker, was provided by the DON. During review of employee's patient list, patient #13 and #15 were observed on the patient list and not on the census document that was provided on 5/28/19. During an interview on 10/29/19 at 3:03 PM, the DON was asked if homemaker only patients were on the census list, in which the DON stated that the census document only included prior authorization (PA) Medicaid patients. A complete agency census was requested at that time. An updated census was provided by the Administrator at 3:42 PM which contained a list of 70 patients.		monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	
G 0952 Bldg. 00	Based on record review and interview, the administrator failed to ensure that agency home health aides (HHA) were qualified to provide personal care for 1 of 1 HHA placed on aide registry since 1/16/19. Findings include: During review of employee files on 5/29/19, the list of current employees included employee D, home health aide (HHA) hire date 2/7/19 and first patient contact date 2/9/19. The employee file failed to	G 0952	G-0952 Our agency has followed CFR 484.80(a) (d)i-iv and Clinical Director completed the IAHHC train the trainer program. The variance in employee D's file should not have occurred. The administrator discussed the situation with the Clinical Director. The employee was only to be hired as a homemaker. Employee was immediately	06/28/2019

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	evidence the HHA was qualified. Employee D's application for employment was dated 1/31/19. A job description for home health aide was signed by employee D on 2/7/19. A agency document titled "Home Health-hospice Aide Written Competency assessment exam scoring sheet was completed, but not signed. A "competency skills check off," had the name of the employee but was not completed or signed. The agency document titled "Certified Home health aide check list," contained skills listed. None of the skills were checked of or completed. The document was signed by employee D, but not dated or signed by a nurse. A document from the Indiana State Department of Health (ISDH) contained the signature of employee D on 12/31/18. The document stated "I [director of nursing] swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that the home health aide applicant named in this application has satisfactorily completed a competency evaluation program as required by 42 CFR 484.36 ...." This was signed by the director of nursing on 12/31/18. The administrator also signed the application on 12/31/18. During an interview on 5/29/19 at 12:07 PM, employee D, HHA stated that she was a new employee as of February of 2019. Employee D stated that her job duties were homemaking such as cleaning, running errands, shopping, changing linens. Employee D stated she was a certified nursing assistant in Kentucky but had let her license lapse. Employee D stated her current		removed from the registry and counseled on scope of job. Our agency is aware that it is forbidden from competency our own aides for the next two years unless our agency has a contract with a qualified registered nurse. 100% of aide HR records were reviewed for compliance of G754 No new employee may be placed on a case until unless the the employee check list is signed by administrator. Employee records will be audited for completeness every 30 days x 3 months then every ninety days Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

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	15K076	A. BUILDING 00 B. WING	05/30/2019

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	clients were patient #13 and #15. Employee D was asked if personal care had ever been completed and employee D stated that patient #13 had sores on feet and legs and was a large man. Employee D stated she assisted him with washing, soaking, drying feet, applied lotion, and put socks on. Employee D stated that the client had asked her to do this. Employee D stated that she had never applied as a home health aide in Indiana and had never undergone any training in Indiana for that. Employee D was showed her signature as it appeared on the ISDH application for home health aide. Employee stated that it was her signature, and she had signed that when she filled out the application for employment on 1/31/19. During an interview on 5/28/19 at 2:15 PM, the director of nursing (DON) stated that employee D was just a homemaker not a home health aide. When told that the agency placed the aide on the registry on 12/31/18 she stated "No she didn't go on the registry, I don't remember, might ask [administrator]." When the DON was asked why the HHA was placed on the registry in December of 2018 if she wasn't hired until February of 2019 she stated "You'd have to ask [administrator]. At 2:26 PM, the administrator stated employee D had never done personal care as she was a homemaker and they did not know why she had been put on the aide registry.			
G 0978 Bldg. 00	Based on record review and interview, the agency failed to to ensure all contracted agreements were authorized / signed by both parties for 1 of 1 agency.	G 0978	G-0978 N.Jean MacDonald signed the 3rd page of contact All contracts reviewed annually	06/28/2019

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	Findings include: An agency policy dated 1/4/16 titled "Independent Consultants," Policy # HD-215 stated "...After a specific consultant is approved, but before payments are made a written contract for services must be signed by an authorized representative...." A contract agreement between a consulting company and the agency was reviewed on 5/28/19. The contract was dated effective on 2/24/19. The contract failed to be signed by the administrator of the home health agency nor by a representative of the consulting company. During an interview on 5/28/19 at 4:47 PM, the director of nursing stated that the consultant had planned on making some corrections to the contract and it was going to be signed.		Any adverse findings will be reported to the Administrator	
G 1024 Bldg. 00	Based on record review and interview, the agency failed to ensure the Indiana Physician Orders for Scope of Treatment (POST) was completed, signed by the physician and in the home for emergency medical staff to utilize if summoned into the home for 1 of 4 records reviewed (#1). Findings include: The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19. The original pink POST form dated 5/21/19 by the patient indicated the patient's desired medical	G 1024	G-1024 Clinical director inserviced/educated nursing staff on ISDH form information for the Health Care Professionals about the (POST) Our agency new policy is to provide post forms as information only to patients. If patient has a post form signed by the patient and physician it will be place in patient record and recorded on all patient specific plans of care. All records cited at survey have been corrected	06/28/2019

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	interventions was "limited additional interventions." The document failed to be signed by the physician or be placed in the home.		Clinical Director will maintain a list of DNR, out of the Hospital DNR and post patients. Patient charts will be audited on a monthly basis for adherence for this correct action any adverse findings will be reported to QAPI Clinical Director will be responsible for monitoring these corrective actions that this deficiency is corrected and does not recur	
G 1028 Bldg. 00	Based on observation and interview, the agency failed to ensure they had a policy to ensure records were safeguarded against loss and for 1 of 1 agency. Findings include: Review of a professional article titled "How to Safeguard Paper Medical Records" dated 10/22/14 at http://recordsmanagement.tab.com/healthcare-patient-chart-services/ states " ... HIPAA and The Joint Commission require it. They specify that medical records must be adequately protected from fire and water damage, erroneous destruction and outright theft ... Ensure that all your paper medical records are protected from basic environmental hazards. This includes: storing them away from air conditioners, heaters, and	G 1028	G-1028 Corrective actions were taken files were moved into another area adhering to this compliance Policy 1.21 were revised to include safeguarding paper medical records Policy was given to all office staff to ensure compliance Quarterly observations of stored records. Any adverse findings will be reported to the Administrator.	06/28/2019

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	sources of water; and ensuring that they are stored at temperatures between 65 and 70 degrees Fahrenheit at 55% relative humidity .... " During an observation on 5/28/19 at 11:08 AM, the administrator revealed where the clinical records were stored. They were stored in the basement in a back storage room. The room had bankers boxes for storage of records. In one area 10 bankers boxes were on the floor, and another 1 box on the floor in another area. The agency failed to ensure that the records kept on the floor were safeguarded against loss due to the possibility of flooding in basement. banker's boxes are made of cardboard and would not protect records from loss if wet. During an interview on 5/28/19 at 11;10 AM, the administrator stated the records were on the floor because the staff had been reviewing records since the last survey and they must have not been put back up.			
N 0000 Bldg. 00	This was a revisit for the state licensure home health survey completed on January 16, 2019. Survey Date: May 28, 29, 30; 2019 Facility Number: 012612 Provider Number: 15K076 Unduplicated Skilled Census: 6 Home Health Aide Only Census: 49 Personal Service Only Patients: 14 Total Census: 69	N 0000		

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	Sample: Record Review With Home Visits: 2 Record Review Without Home Visits: 2 Total Home Visits: 2 Total Records Reviewed: 4 During this follow-up survey, the agency had eight (8) deficiecies corrected, eleven (11) deficiences were recited, and seven (7) new deficiencies were cited. Quality Review completed 6/26/19			
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on record review and interview, the administrator failed to include the homemaker only patients to the agency census upon initial request for 1 of 1 agency. Findings include: The administrator failed to manage the agency census and keep it up to date and accurate as evidenced by:	N 0444	N-0444 Clinical Director & IT were educated on keeping an updated census at all times Census will be reviewed by the Clinical Director & Administrator for evidence of accuracy on patient count weekly.	06/28/2019

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	The agency census was requested during the entrance conference on 5/28/19 at 9:20 AM. At 10:25 AM, the director of nursing (DON) provided a census document which included 58 patients. During review of employee files on 5/29/19, the agency was asked for the names of the patients that an employee provided services to. At 3:00 PM the patient list for employee D, homemaker, was provided by the DON. During review of employee's patient list, patient #13 and #15 were observed on the patient list and not on the census document that was provided on 5/28/19. During an interview on 10/29/19 at 3:03 PM, the DON was asked if homemaker only patients were on the census list, in which the DON stated that the census document only included prior authorization (PA) Medicaid patients. A complete agency census was requested at that time. An updated census was provided by the Administrator at 3:42 PM which contained a list of 70 patients.		The Administrator & Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	
N 0446 Bldg. 00	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on record review and interview, the administrator failed to ensure that agency home health aides (HHA) were qualified to provide	N 0446	N-0446 Our agency has followed CFR 484.80(a) (d)i-iv and Clinical Director completed the IAHHC	06/28/2019

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	personal care for 1 of 1 HHA placed on aide registry since 1/16/19. Findings include: During review of employee files on 5/29/19, the list of current employees included employee D, home health aide (HHA) hire date 2/7/19 and first patient contact date 2/9/19. The employee file failed to evidence the HHA was qualified. Employee D's application for employment was dated 1/31/19. A job description for home health aide was signed by employee D on 2/7/19. A agency document titled "Home Health-hospice Aide Written Competency assessment exam scoring sheet was completed, but not signed. A "competency skills check off," had the name of the employee but was not completed or signed. The agency document titled "Certified Home health aide check list," contained skills listed. None of the skills were checked of or completed. The document was signed by employee D, but not dated or signed by a nurse. A document from the Indiana State Department of Health (ISDH) contained the signature of employee D on 12/31/18. The document stated "I [director of nursing] swear and affirm under the penalties of perjury that the foregoing is true and accurate, and that the home health aide applicant named in this application has satisfactorily completed a competency evaluation program as required by 42 CFR 484.36 ...." This was signed by the director of nursing on 12/31/18. The administrator also signed the application on 12/31/18.		train the trainer program and knows the proper procedures. The variance in employee D's file should not have occurred. The administrator discussed the situation with the Clinical Director. The employee was only to be hired as a homemaker. Employee was immediately removed from the registry and counseled on scope of job. Our agency is aware that it is forbidden from competency our own aides for the next two years unless our agency has a contract with a qualified registered nurse. 100% of aide HR records were reviewed for compliance of N446 No new employee may be placed on a case until unless the the employee check list is signed by administrator. Employee records will be audited for completeness every 30 days x 3 months then every ninety days Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

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	During an interview on 5/29/19 at 12:07 PM, employee D, HHA stated that she was a new employee as of February of 2019. Employee D stated that her job duties were homemaking such as cleaning, running errands, shopping, changing linens. Employee D stated she was a certified nursing assistant in Kentucky but had let her license lapse. Employee D stated her current clients were patient #13 and #15. Employee D was asked if personal care had ever been completed and employee D stated that patient #13 had sores on feet and legs and was a large man. Employee D stated she assisted him with washing, soaking, drying feet, applied lotion, and put socks on. Employee D stated that the client had asked her to do this. Employee D stated that she had never applied as a home health aide in Indiana and had never undergone any training in Indiana for that. Employee D was showed her signature as it appeared on the ISDH application for home health aide. Employee stated that it was her signature, and she had signed that when she filled out the application for employment on 1/31/19. During an interview on 5/28/19 at 2:15 PM, the director of nursing (DON) stated that employee D was just a homemaker not a home health aide. When told that the agency placed the aide on the registry on 12/31/18 she stated "No she didn't go on the registry, I don't remember, might ask [administrator]." When the DON was asked why the HHA was placed on the registry in December of 2018 if she wasn't hired until February of 2019 she stated "You'd have to ask [administrator]. At 2:26 PM, the administrator stated employee D had never done personal care as she was a homemaker and they did not know why she had been put on the aide registry.			

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N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual			

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	was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the agency failed to ensure that a two-step tuberculin (TB) screening was completed for 1 of 3 employees with direct patient contact (D). Findings include: During review of employee files on 5/29/19, the list of current employees included employee D, home health aide (HHA) hire date 2/7/19 and first patient contact date 2/9/19. A TB skin test was administered on 2/7/19 and read on 2/9/19. The second step TB skin test was administered on 2/22/19 by employee I, registered nurse and failed to have result read. During an interview on 5/29/19 at 11:42 AM, employee I stated she had read employee D's TB test and forgot to write it down.	N 0464	N-0464 Employee I is no longer employed at our agency Clinical Director has inserviced nursing staff on policy and procedures tuberculin (TB) screening. 100% of tuberculin (TB) screening will be audited x 3 months for evidence of results read and documented Quarterly review after qmx3m. Clinical director will report QAPI findings to Administrator The Clinical director will be responsible for monitoring any corrective actions to ensure this deficiency is corrected and does not recur	06/28/2019
N 0470	410 IAC 17-12-1(m) Home health agency			

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Bldg. 00	administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the agency failed to ensure all staff followed infection control policies and standard precautions for 2 of 2 home visits observed (#1, 4). Findings include: 1. The agency policy revised 3/22/19 titled "Medication Set Up Policy," Policy #: 2.52 stated "... Hand washings completed prior to setting up medications. Gloves may be worn, but are not required. ... " 2. An agency job description from 2017 titled "RN [registered nurse]," stated "...Position responsibilities. Assumes responsibility and accountability for the practice of professional nursing in accordance with state nurse practice act and standards for home health nursing ...." 3. Pershing, J., PhD. (2004). Living in the Community: Medication Administration Manual. Division of Disability, Aging and Rehabilitative Services. "For a multi-dose bottle, remove the cap; without touching the medicine, pour required capsules or tablets into cap and then into the paper cup or directly into the individual's hand ...." 4. United States of America, Centers for Disease Control. (2019). Wash Your Hands. Retrieved from https://www.cdc.gov/features/handwashing/index	N 0470	N-0470 Clinical Director has inserviced staff on revised policy #2.52 always using glove procedure, hand hygiene and educated on gel use. Clinical Director has educated and reviewed with nursing staff CFR 484.70 Clinical Director will do monitoring of nursing staff x 2 months for evidence nursing staff are following State nurse practice act and standards and agency policies and procedures and documented in employee HR file. The Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	06/28/2019

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	.html "How to Use Hand Sanitizer: Apply the gel product to the palm of one hand (read the label to learn the correct amount). Rub your hands together. Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds ...." 5. During a home visit observation on 5/28/19 at 12:00 PM, with patient #1, employee E, registered nurse (RN), was observed providing skilled care. Employee E started the visit with hand hygiene using hand sanitizer. Then with ungloved hands filled pill box touching all pills with bare hands. Employee E failed to follow standard precautions when filling medication box. During an interview on 5/28/19 at 4:48 PM, the administrator stated the consultant had advised the agency that nurses did not have to wear gloves when handling pills. 6. During a home visit observation on 5/29/19 at 1:50 PM, with patient #4, employee H, home health aide (HHA), was observed providing personal care. Employee H started the visit with hand hygiene using hand sanitizer. After applying hand sanitizer to the hands, she would rub hands together and then shook hands vigorously to dry the hand sanitizer. Employee H failed to vigorously rub hands together during hand sanitizer use until hands were dry. During an interview on 5/29/19 at 3:40 PM, the administrator stated that she saw employee H shaking hands after applying hand sanitizer. The director of nursing stated employee H should have rubbed hands together until the gel was dry.			
N 0472	410 IAC 17-12-2(a) Q A and performance improvement			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on observation, record review, and interview the agency failed to ensure that an infection control program included tuberculosis (TB) / communicable diseases and failed to ensure policies were established to govern the plan to ensure staff and patients were protected against the spread of infections for 1 of 1 agency. Findings include: An undated agency policy titled "Tuberculosis Evaluation Policy," Policy # HA-122 stated "... Instructions ... 12. The agency is responsible to have policies and procedures for the control of communicable disease in compliance with applicable federal and state laws ...." An agency job description from 2017 titled "RN [registered nurse]," stated "...Position responsibilities. Assumes responsibility and accountability for the practice of professional nursing in accordance with state nurse practice act and standards for home health nursing ...." During an observation on 5/29/19 at 10:47 AM, the refrigerator where the tuberculin solution was	N 0472	N-0472 Our agency destroyed the old Tubersol, bought a new refrigerator and researched proper handling of TB solution Our agency wrote new policy governing infection control program including tuberculosis (TB)/communicable diseases. Clinical Director inserviced/educated nursing staff on policy and procedures Implemented weekly log documenting dates and temperature of refrigerator for evidence that a written log will be checked by the clinical director to adhere to these corrective actions The Clinical director will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and does	06/28/2019

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	15K076	A. BUILDING 00 B. WING	05/30/2019

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	stored was observed. Inside the refrigerator was a box of solution that was opened but no date present as to when it was opened. The box stated "Tuberculin Purified Protein Derivative (Mantoux) TUBERSOL ... Store at 35-46 degrees Fahrenheit ... discard opened product after 30 days ...." The solution had a lot number of C5563AB with an expiration of 3/14/21. The temperature in the refrigerator was 59 degrees Fahrenheit. During an interview on 5/29/19 at 10:47 AM, employee H, registered nurse, was asked where the TB solution is stored because she is one of the nurses who administer the TB skin tests to agency employees. She stated that the TB solution is kept in a refrigerator in the nurses office, it is ordered by the administrator, if the seal is broken then the nurses were aware that it was open, and it is kept in the refrigerator after being opened until is it gone. When employee H was asked if she was aware how long the tuberculin solution was good for she indicated that it would be good until the expiration on the box even if it was open then stated "I'm not the only one who gives them." During an interview on 5/29/19 at 10:52 AM, the administrator stated she was not aware of the storage instructions for the tuberculin solution and the agency was unsure when the current solution had been opened.		not recur	
N 0520 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.	N 0520	N-520	06/28/2019

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	Based on observation, record review and interview, the agency failed to ensure the needs of the patient were being met to ensure medications were being taken at correct times for 1 of 1 patients reviewed with medication set up (#1). Findings include: The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated orders for the skilled nurse to "fill client's medication box every week." The plan of care contained medication orders for three times per day and bedtime medications. The agency failed to ensure that the needs of the patient were being met to ensure medications were being taken at correct times as evidenced by: The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated orders for the skilled nurse to "fill client's medication box every week." The plan of care contained medication orders for three times per day and bedtime medications. The agency failed to ensure that the needs of the patient were being met to ensure medications were being taken at correct times as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, with patient #1, employee E, registered nurse (RN), was observed providing skilled care. The patient had medications in the living room, two places in the kitchen, and bathroom. The RN was observed filling the patient's medication box. The patient had a pill box with times for morning and evening. When employee E placed oscal in		100% of clinical records were audited for compliance, omissions, clarifications and V.O obtained. All records cited at survey have been corrected. Clinical Director and Consultant Jean MacDonald inserviced nursing staff on tags G570 and N520 and the need for medication compliance At all supervisor visit and/or medication setup med compliance is reviewed with patient and documented. Physicians are notified of variances non-compliance 100% of SN medication visits will document medication compliance and reviewed with patient. MD will be notified for non-compliance for evidence that the needs for the patient is being met. 50% of all SN visits will be audited monthly and any adverse effects reported to QAPI Clinical Director will be responsible for monitoring these corrective actions to ensure this deficiency will not recur.	

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	the medication box, there was not enough tablets for the whole week. There was no Oscal (calcium tablets) left in Monday morning and evening and Tuesday morning slots. The RN placed a sticky note on the medication box of which days were missing Oscal and instructed the patient to place the medication in the medication box when the medication was obtained. Medications viewed in the home also contained an inhaler in the bathroom, and liquid medication in one area of the kitchen. The agency failed to ensure all medications were managed and taken by the patient at the correct times. During an interview with the patient at the home visit on 5/28/19 at 12:00 PM, patient #1 stated they were supposed to take torsemide 3 times per day [Torsemide 20 mg 1 tablet 3 times per day per bottle]. The patient stated he / she takes 2 pills in the morning (nurse placed in pillbox for morning) and the aide reminded the patient to take the third dose of that medication in the afternoon (from the bottle). The patient stated he / she had a muscle relaxer [Zanaflex 4mg ½-1 tablet as needed at bedtime per bottle] that is not put into the pill container which is taken one a night, but not always taken. The patient stated an ordered cream [triamcinolone ointment 0.1% to back one time daily] isn't used because he/ she cannot reach back to apply it. Lastly, the patient stated the reglan [metoclopramide 10 mg ½ tablet 3 times per day with meals per bottle] was not placed in the medication box.			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or			

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	podiatrist, as follows: Based on record review and interview, the agency failed to ensure homemaker and attendant care services were not provided absent of a physicians order for 1 of 4 records reviewed of patients receiving skilled services in a sample of 4. (#3) Findings include: The clinical record of patient #3 was reviewed on 05/28/19 and indicated a start of care date of 04/25/19. The record contained a plan of care for the certification period of 04/25/19-06/23/19, which indicated a HHA frequency of ..."1 hr [hour] day 2 days week 1, 1 hr day 6 days wk [week] x 8 weeks... Life Streams: Waiting on NOA [notice of action] ...." The plan of care failed to evidence physician orders for Homemaker and attendant care services as evidenced by the following: An agency document titled "Doctor Authorization" dated 04/25/2019 and signed by DON [director of nursing], stated, " SN [skilled nurse] ... HHA 1 hr day 6 days wk ...." Agency documents titled "Homemaker Week Note" for dates: 04/28, 04/29, 05/01, 05/05, 05/06, 05/07, 05/08, 05/12, 05/13, 05/14, 05/15, 05/16, 05/17/19 evidenced homemaker services were provided each of the aforementioned days 12:45 PM to 1:45 PM. The agency failed to evidence physician orders for the homemaker services. Agency documents titled "ATTC [attendant care] Weekly Note for dates: 04/25, 04/26, 04/28, 04/29/19 evidenced services were provided from 11:15 AM to 12:45 PM, and 04/30 11:45 AM to 12:45 PM, 05/01, 05/02, 05/03, 05/05, 05/06, 05/07, 05/08, 05/09, 05/10, 05/12, 05/13, 05/14, 05/15,	N 0522	N-0522 SN staff were educated on obtaining physicians orders for services provided. All patients cited at survey have been corrected 100% of clinical records were reviewed for compliance. Omissions, clarifications and verbal orders will be obtained if needed. A new form was implemented to audit new admissions and recerts within 15 days from the start of care or recert date to evidence physician orders were obtained. 100% of recerts will be audited at recert with Care Plan tool x 3 months with any adverse findings reported to QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and will not recur	06/28/2019

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	05/16, 05/17/ 19 evidenced ATTC services were provided each of the aforementioned days from 11:15 AM to 12:45 PM. The agency failed to evidence physician orders for ATTC services. During an interview on 05/28/19 at 10:58 AM the DON and the Administrator indicated attendant care and homemaker services should not be provided to the patient without physician order.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure the plan of care (POC) included all	N 0524	N-0524 Clinical Director has educated/inserviced nursing staff	06/28/2019

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	pertinent diagnoses, treatments and goals in 2 of 4 records reviewed (#1, 4). Findings include: 1. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated orders for the skilled nurse to "fill client's medication box every week"and goals of "The client's safety will be enhanced throughout home care service as evidenced by use of fall precautions ... The client / caregiver will verbalize understanding of CHF [congestive heart failure] and all aspects of associated care ...." The start of care comprehensive assessment completed on 5/21/19, indicated the patient had dyspnea with minimal exertion, was on oxygen at 2-3 liters, and a need for medication set up every week. The plan of care failed to evidence measurable goals and goals based on the needs identified on the comprehensive assessment for medication management, oxygen use, and shortness of breath. 2. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19, which indicated a goal that the client would be able to walk at least a 1/2 block and at least 50 feet outside. The POC failed to evidence interventions for staff to assist patient to accomplish that goal. 3. During an interview on 5/30/19 at 12:18 PM, the director of nursing stated that employee E "is still learning and so are we, " in response to inquiry if goals should be measurable on the plan of care.		on CFR 484.60 and reviewed policy on strengths, goals and care plans. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physicians to clarify any missing strengths, goals, and care preferences. 100% of new admissions and 50% of recert's comprehensive assessments, Plan of care will be audited and coded x 6 months by Sharon McNight (consultant) for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 6 months to implement any changes Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

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N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on observation, record review and interview, the registered nurse (RN) failed to notify the physician of changes related to the care of the patient for 3 of 4 records reviewed (#1, 3, 4). Findings include: 1. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19, which indicated skilled nurse orders to fill the patients medication box weekly, instruct patient on medication regimen and assess pain level at every visit. The clinical record failed to evidence documentation that the RN notified the physician that the patient was not taking medications as prescribed, or that the patient was having pain and nausea as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, employee E, RN, was observed filling medication box and assessed the patient. The patient had complaints of nausea, stated was not taking reglan (routine per instructions on bottle) or xanax (routine per instructions on bottle), taking lactulose one time per day (bottle indicated order for 2 times per day), and triamcinolone cream not taking because cannot reach back to apply it to self, complained of shoulder pain when reaching for something and stated the pain	N 0527	N-0527 Clinical Director has educated/inservices nursing staff on notifying the physician of variances in parameter or changes in conditions immediately and document in narrative. All records cited at survey have been corrected. 100% of clinical charts were audited for compliance. Omissions, clarifications and verbal orders obtained if needed. All records cited at survey have been corrected. A new form was implemented to audit new admissions and recert within 15 days from start of care or Recert date to ensure documentation of physicians notification related to patients care. 100% of records will be reviewed at recert for compliance using Care Plan Audit tool for evidence of compliance Clinical Director will be responsible for monitoring these corrective actions to ensure this	06/28/2019

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	injections were not effective. A physician notification was sent to the physician on 5/28/19 by employee E that reported what medications were left in the box after the week end to show missed doses, a low blood pressure, and new physicians identified during the visit. 2. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19, which indicated blood pressure parameters to call the physician if systolic was greater than 160 or less that 90, or the diastolic is greater than 95 or less than 60. The clinical record failed to evidenced that the registered nurse (RN) reported a blood pressure of 91/56 on 5/14/19 to the physician.3. The clinical record of patient #3 was reviewed on 05/28/19 and indicated a start of care date of 04/25/19. The record contained a plan of care for the certification period of 04/25/19-06/23/19 that indicated client specific parameters for notifying physician of changes in vital signs "... Systolic >160 <90, Diastolic >95 <60 .... " The record failed to evidence the physician was notified of blood pressure below the client specific parameters for notifying the physician on the day of the assessment as evidenced by: A Comprehensive Adult Assessment Start of care dated 04/25/19 by the DON [director of nursing] indicated the patient's blood pressure was 89/61 and O2 [oxygen] saturation rate was 89%. The record failed to evidence the physician was notified of the blood pressure outside the established call perimeters and the low oxygen saturation . An agency document titled "Supervisor Visit"		deficiency does not recur.	

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	dated and signed by Employee E on 05/09/19 indicated the patient's blood pressure was 97/58. The record failed to evidence documentation that the physician was notified of a blood pressure outside the established call perimeters. During an interview on 05/30/19 at 11:00 AM, the DON indicated vital signs outside the call perimeters should be called to the physician for notification.			
N 0530 Bldg. 00	410 IAC 17-13-1(b) Patient Care Rule 13 Sec. 1(b) A home health agency may accept written orders for home health services from a physician, a dentist, a chiropractor, a podiatrist, or an optometrist licensed in Indiana or in any other state. If the home health agency receives an order from a physician, dentist, chiropractor, podiatrist, or optometrist who is licensed in another state, the home health agency shall take reasonable immediate steps to determine the following: (1) The order complies with the laws of the state where the order originated. (2) The individual who issued the order: (A) examined the patient; and (B) is licensed to practice in that state. Based on record review and interview, the agency failed to ensure that verbal orders were put into writing and sent to the physician for signature for 1 of 4 records reviewed (#2). Findings include: The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care date of 03/28/19. The record contained a plan of care for	N 0530	N-530 Agency reviewed verbal order policy and specifies of this care to determine how it could have been better handled. All patients cited at survey have been corrected Clinical Director and Jean MacDonald has educated/inserviced on obtaining and sending verbal orders to	06/28/2019

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	the certification period of 03/28/19-05/26/19, which indicated "...Orders ... Med Set 1 time week x 9 weeks ... Medications ... Metoprolol 5 mg by mouth 2 times day .... " An agency document titled "Medication Record" provided by Employee G on 5/28/19 at 3:00 PM dated and signed by Employee A on 03/28/19 indicated, Metoprolol 5 mg tablet by mouth 2 times day, with a straight line drawn through the 5 on the record. An untitled document dated 03/29/19 by the DON (director of nursing) indicated, " ... Metoprolol 5 mg [milligram]{line crossed through 5} tablet by mouth 2 times daily. Additionally, hand written to the right of the entry: "Double check dose! 2.5mg BID [twice daily]?" signed by patients primary care physician on 04/03/2019. An agency document titled "Medication Record" provided by Employee G on 5/28/19 at 3:00 PM dated and signed the DON on 04/05/19 indicated, "Metoprolol 100 mg by mouth 2 times day .... " A line was drawn through the number two for the metoprolol. An agency document titled "Medication Record" provided by Employee G on 5/29/19 at 12:27 PM dated and signed by the DON on 4/12/19 indicated, "... 3/28/19 Metoprolol 100 mg tablet by mouth 1 times daily; D/C [discontinue] 4/12/19 ... 4/12/19 Metoprolol 2.5 mg 1 tab po 2 x day (go back to original) ... Drug regimen review 04/12/19 (med set) .... " An agency document titled "Medication Record" provided by Employee G on 5/29/19 at 12:29 PM, signed and dated by the DON on 4/12/19 indicated Metoprolol 100 mg by mouth 1 times		physician. 100% of clinical records were reviewed for compliance. Omissions, clarifications and verbal orders obtained if needed. A new form was implemented to audit new admissions and recerts within 15 days from the start of care or Recert date to evidence verbal orders will be obtained, documented and sent to the physician 100% Recerts will be audited at recert with Care Plan Audit tool x 3 months with any adverse findings reported to QAPI Clinical Director will responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur	

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	daily. During an interview on 05/30/19 at 11:27 AM, the DON indicated she did not know why the line was drawn through the number 5 on the medication record and was unable to ascertain the dosage of Metoprolol from the Medication record dated 03/28/19. However, the DON stated that the line drawn through the number two indicated the medication was to be taken 1 time daily. Further, when asked if there had been a physician order for the medication changes, she indicated there were no orders.			
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.	N 0533	N-0533	06/28/2019

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	Based on record review and interview, the home health aide (HHA) failed to follow the aide care plan for 2 of 4 records reviewed (#1, 4) and the registered nurse (RN) failed to identify all safety measures for the home health aide on the aide plan of care for 1 of 1 records reviewed (#3). Findings include: 1. An agency policy dated 11/2018 titled "Home health aide: Document policy," Policy # 2.51 stated "...Care / Services provided should be in accordance with direction provided in the Home health aide care plan ...." 2. An agency job description dated 2017 and titled "Home Health Aide," stated "...Tasks to be performed by a HHA must be assigned by and performed under the supervision of a RN [registered nurse] who will be responsible for the patient's care provided by the HHA ...." 3. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19. The HHA failed to follow the aide care plan and complete only the tasks assigned in their entirety as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, patient #1 was interviewed. The patient stated that the home health aide took the patient's blood pressure and reminded him / her to take medications during visits. The aide care plan failed to evidence medication reminders or taking patient's blood pressure as tasks for the HHA to complete. HHA documentation completed on 5/21/19 and		Clinical Director inserviced on how to base the aide assignments on the comprehensive assessment including safety measures, how to educate the aides on the assignments and patient needs, and the importance of notifying the case manager of changes in the patient's condition. the case managers educated the aides to only do what is on the assignment, to call the case manager if the patient wants or needs changes in care, and observations to report. The specific aide was counseled. Aide notes are being audited for compliance. Case managers will document compliance with the aide assignments at each supervisory visit and each contact with the aide. Clinical director will audit supervisory notes x 3 months Clinical Director will responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur	

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	5/25/19, failed to evidence documentation if the HHA completed a partial bath as per aide care plan. 4. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19. The HHA failed to follow the aide care plan to complete only tasks assigned as evidenced by: During an interview on 5/29/19 at 1:50 PM, patient #4 stated they like when the HHA took blood pressures while in the home and logged it. The patient showed the log of blood pressures that were written down. Blood pressures had been documented by the HHA daily with the exception of 5/19/19 since start of care date. The aide care plan failed to evidence a clients signature or taking patient's blood pressure as a task for the HHA to complete.5. The clinical record of patient #3 was reviewed on 05/28/19 and indicated a start of care date of 04/25/19. The record contained a plan of care for the certification period of 04/25/19-06/23/19 which indicated diagnoses of : "COPD [chronic obstructive pulmonary disease] ... dependence on oxygen ... Safety measures: Universal precautions, fall precautions, clear / well-lit walkways, emergency plan developed, safety in ADL's [activities of daily living], use of assistive devices, slow position change, proper position while eating, Anticoagulant precautions, O2 [oxygen] precautions .... HHA frequency and service plan (aide care plan) ... use universal precautions ... observe rollator for safety factors, do ROM [range of motion] (ball exercises) ...." An Agency document titled "HHA Service Plan" dated 04/24/19 and signed by the patient and the DON [director of nursing] failed to evidence			

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	anticoagulant precautions and O2 precautions with indication of the skills or equipment needed for those precautions. During an interview on 05/29/19 at 11:24 AM with Employee E, indicated all safety measures on the plan of care should be reflected on the aide care plan that were initially determined upon admission by the DON and then updated by the Case Managers as needed.			
N 0536 Bldg. 00	410 IAC 17-13-3(d) Service Plan Rule 13 Sec. 3(d) Personal care services provided by a personal services agency operated under a home health agency license must meet the requirements of IC 16-27-4. Based on record review and interview, the agency failed to ensure that homemaker only patients did not receive personal care for 1 of 13 homemaker only records reviewed (#13). Findings include: An agency policy dated 11/2018 titled "Home health aide: Document policy," Policy # 2.51 stated "...Care / Services provided should be in accordance with direction provided in the Home health aide care plan ...." The clinical record of patient #13 was reviewed on 5/29/19 and indicated a start of services date of 11/19/18. The service plan for patient #13 indicated tasks staff were to complete were: Clean / file nails and soak feet one time per week and feed / set up meals every visit. The service plan had been reviewed and signed by the director of nursing on 5/18/19. Homemaker documentation from 1/19/19-5/3/19 indicated that employees D	N 0536	N-0536 All employees providing homemaking services only were counseled to only provide those services assigned and to report to any client requests for variances in assignment to case manager. Employee D was educated and counseled on her non medical care job description for Homemaking services. 100% of Homemaking records will be audited weekly for compliance to tag N-0536 Administrator will be responsible for monitoring these corrective actions to ensure that this	06/28/2019

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	and F had soaked and cleaned feet, and assisted patient with a body suit during homemaker visits. The agency failed to ensure that homemaker staff only completed tasks within their scope of practice. During an interview on 5/29/19 at 12:07 PM, employee D, HHA stated patient #13 had sores on their feet and legs and was a large person. Employee D stated she assisted with washing, soaking, drying feet, applied lotion, and put socks on when the client had asked her to do this.		deficiency does not recur	
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on observation, record review and interview, the registered nurse (RN) failed to follow the plan of care for 3 of 4 records reviewed receiving skilled nursing services (#1, 2, 4). Findings include: 1. The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19 which indicated skilled nurse orders to fill the patients medication box weekly, instruct patient on medication regimen and assess pain level at every visit. The RN failed to follow the plan of care as evidenced by: During a home visit observation on 5/28/19 at 12:00 PM, employee E, RN, was observed filling	N 0537	N-537 Clinical Director has inserviced/educated on CFR 484.75(b)(3) with nursing staff providing services ordered by physician and clinical documentation. Special emphasis given to employee E who is new. All patients cited was discussed with employee E. On return visit employee E educated patients on compliance with taking medications and completed a pain assessment. All patients cited at survey have been corrected Employee E was counseled on documentation, clinical charting and educating patient Employee E charts are audited for compliance with orders	06/28/2019

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	medication box and assessed the patient. The patient had complaints of nausea, stated was not taking reglan (routine per instructions on bottle) or xanax (routine per instructions on bottle), taking lactulose one time per day (bottle indicated order for 2 times per day), and triamcinolone cream not taking because cannot reach back to apply it to self, complained of shoulder pain when reaching for something and stated the pain injections were not effective. The RN failed to complete medication teaching about importance of taking medications as prescribed and failed to complete a pain assessment. A skilled nurse visit note completed on 5/28/19 failed to evidence medication teaching or a pain assessment. During an interview on 5/30/19 at 12:15 PM, the director of nursing stated that nurses should be asking about pain. 2. The clinical record of patient #4 was reviewed on 5/30/19 and indicated a start of care date of 5/14/19. The record contained a plan of care for the certification period of 5/14/19-7/12/19 that indicated blood pressure parameters to call the physician if systolic is greater than 160 or less that 90, or the diastolic is greater than 95 or less than 60. The registered nurse (RN) failed to report a blood pressure of 91/56 on 5/14/19 to the physician.3. The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care date of 03/28/19. The record contained a plan of care for the certification period of 03/28/19-05/26/19 which indicated "... SN [skilled nurse] Interventions...Med Set 1 time week x 9 weeks and instruct & train clients husband to complete a blood glucose draw, Signs and symptoms of Hypo, Hyper glucose. Instruct on		100% of all cases were reviewed to make sure that nurses were following the Plan of care and Verbal orders obtained if needed Clinical director or designee will mentor/educate employee E x 3 months to assure skills competency and document in HR file for evidence of adhering to employee clinical charting and patient education. Any adverse findings will be reported to QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and does not recur 100% of all cases were reviewed to make sure that nurses were following the PoC and VO obtained if needed	

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	Blood Pressure monitoring ... Goals ... Client's [family member] will be able to do blood glucose testing on wife with SN [skilled nurse] assist wk 2 wk 3 will be able to complete on own with some coaching wk 4 able to do with no prompting. Clients [family member] will be able to state what 4 meds are for and amount of dose and side effects by next recert ...." The SN failed to follow the plan of care as evidenced by: SN visit notes dated 3/28/19 and 04/05/19 failed to evidence education of the caregiver on blood pressure monitoring or procedure to perform blood glucose testing.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the skilled nurse failed to ensure they obtained a patient's temperature as part of their heard to toe assessments for 1 of 2 home visit observations. (#1) Findings include: During a home visit observation at patient #1's home on 5/28/19 at 12:00 PM, employee E, RN, was observed filling medication box and assessed the patient. The patient had complaints of nausea. The RN failed to take the patient's temperature.	N 0541	N0541 G-0706 Clinical Director and Jean MacDonald (Consultant) educated/inservice employee E on obtaining a patients temperature for head to toe assessment and reviewed CFR 484.75 Clinical director or designee will mentor/educate employee E x 3 months to assure skills competency and document in HR file Employee E was counseled on listening to patients concerns and	06/28/2019

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	During an interview on 5/30/19 at 12:15 PM, the director of nursing stated that nurses should be taking patient's temperatures.		symptoms to implement appropriate care and notify physician if needed. Clinical Director or designee will oversee Employee E for the next 30 days on Skilled Nursing visits. Any adverse findings will be reported to QAPI Clinical Director will be responsible for monitoring these correct actions to ensure that this deficiency is corrected and does not recur	
N 0544 Bldg. 00	410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interview, the agency failed to ensure education to the caregiver about medications, blood sugar testing and blood pressures including progress toward those goals identified by the caregiver upon admission were documented for 1 of 1 patients ordered to receive diabetic education (#2). Findings include: The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care date of	N 0544	N-0544 All clinical staff reviewed 484.75(b)(6) knowledge obtained during using comprehensive assessment, patient and family admission to develop the plan of care which includes patient and family education stressing documentation of education to caregiver/patient progress towards goals and reaction treatments 100% records were reviewed to	06/28/2019

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	03/28/19. The record contained a plan of care for the certification period of 03/28/19-05/26/19 that indicated diagnoses of "HTN [hypertension]... SN [skilled nurse] Interventions...Med Set 1 time week x 9 weeks and instruct & train clients husband to complete a blood glucose draw, Signs and symptoms of Hypo, Hyper glucose. Instruct on Blood Pressure monitoring ... Goals ... Client's [family member] will be able to do blood glucose testing on wife with SN assist wk 2 wk 3 will be able to complete on own with some coaching wk 4 able to do with no prompting. Clients [family member] will be able to state what 4 meds are for and amount of dose and side effects by next recert ...." The skilled nurse failed to document education or progress as evidenced by: The agency' comprehensive start of care assessment dated 03/28/19, performed by the director of nursing [DON], identified "...Goals Identified by Patient ... [family member] wants to learn about meds so he feels comfortable about giving...." A skilled nurse visit note dated 04/05/19, performed by the DON, failed to evidence education of the caregiver on blood pressure monitoring or procedure to perform blood glucose testing. A skilled nurse visit note dated 04/12/19, performed by the DON, failed to evidence education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. A skilled nurse visit note dated 04/19/19 performed by Employee E failed to evidence blood glucose reading or performance of education of the caregiver on medications, blood pressure		ensure nursing staff education of patient and caregiver towards goals identified by the caregiver. any omissions, clarifications verbal orders will be obtained if needed A Plan of care addendum was sent to MD stating patients husbands unwillingness to be educated on medications, Diabetes, blood sugar testing and blood pressures. Clinical Director will review all Skilled clinical notes for continue education x 3 months any findings will be documented in employee HR chart. Any corrective actions will be reported to Administrator Clinical Director will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and does not recur this	

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	monitoring or procedure to perform blood glucose testing. A skilled nurse visit note dated 04/26/19 failed to evidence education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. Employee E indicated "... Assisted client to check blood sugar...Pt [patient] does not check regularly due to does not remember how to do. This nurse checks when present for medset ...." A skilled nurse visit note dated 05/10/19 failed to evidence blood glucose reading or performance of education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. A skilled nurse visit note dated 05/17/19 failed to evidence education of the caregiver on medications, blood pressure monitoring or procedure to perform blood glucose testing. Employee E indicated, " ...Assist client [with] bloodsugar check ...." During an interview on 5/30/19 at 11:18 AM the DON stated there was documentation regarding blood sugar and blood pressure. After she looked in the record she indicated "I'm sorry I don't see it" (documentation). The DON also stated she had contacted the physician about the husband not wanting to learn or be involved with the education from the homecare agency. This also failed to be documented in the clinical record.			
N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health			

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	setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the agency failed to ensure the registered nurse (RN) coordinated with an anticoagulant clinic to assure correct anticoagulant dosages for weekly medication sets by the skilled nurse for 1 of 1 patient's receiving coumadin (#2) in a sample of 4. Findings include: An agency policy dated 3/4/19 titled "Care Coordination Policy," Policy# 2.30 stated "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support objectives outlined in the Plan of Care. ... After the initial assessment, the admitting registered nurse shall discuss findings of the initial visit with the clinical manager to ensure ... coordination with other agencies and institutions, if the need arises ...." The clinical record of patient #2 was reviewed on 05/28/19 and indicated a start of care date of 03/28/19. The record contained a plan of care for the certification period of 03/28/19-05/26/19, which indicated "... Medications ... warfarin 5 mg [milligram] 1 tab by mouth daily or by clinic instruction ... SN [skilled nurse] Interventions: SN: Med Set 1 time week x 9 weeks ..." The record failed to evidence documenation of coordination between the RN with the patient's anticoagulant clinic for correct dosage of warfarin to assure correct dosage of the anticoagulant for weekly medication set up by the agency. During an interview on 5/30/19 at 11:00 AM with the Director of Nursing [DON], was asked if	N 0545	N-0545: Clinical Director has educated/inserviced nursing staff on CFR 484.60 and reviewed policy 2.30 on care coordination with other providers. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physicians to clarify any missing care coordination with other providers. 100% of new admissions and 50% of recert's will be audited for coordination of care and coded x 6 months by Sharon McNight (consultant) for evidence of additional insight and education of nursing staff. Clinical director and Administrator will review audits x 6 months to implement any changes Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	06/28/2019

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	patient #2 had an anticoagulant clinic that coordinated the dose of warfarin, the DON stated " I don't know if she has one or not."			
N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the agency failed to ensure the Indiana Physician Orders for Scope of Treatment (POST) was completed, signed by the physician and in the home for emergency medical staff to utilize if summoned into the home for 1 of 4 records reviewed (#1). Findings include: The clinical record of patient #1 was reviewed on 5/28/19 and indicated a start of care date of 5/21/19. The record contained a plan of care for the certification period of 5/21/19-7/19/19. The original pink POST form dated 5/21/19 by the patient indicated the patient's desired medical interventions was "limited additional interventions." The document failed to be signed by the physician or be placed in the home.	N 0610	N 610 Clinical director inserviced/educated nursing staff on ISDH form information for the Health Care Professionals about the (POST) Our agency new policy is to provide post forms as information only to patients. If patient has a post form signed by the patient and physician it will be place in patient record and recorded on all patient specific plans of care. All records cited at survey have been corrected Clinical Director will maintain a list of DNR, out of the Hospital DNR and post patients. Patient charts will be audited on a monthly basis for adherence for this correct action any adverse findings will be reported to QAPI Clinical Director will be responsible for monitoring these corrective actions that this	06/28/2019

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			deficiency is corrected and does not recur	
N 0614 Bldg. 00	410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service. Based on observation and interview, the agency failed to ensure they had a policy to ensure records were safeguarded against loss and for 1 of 1 agency. Findings include: Review of a professional article titled "How to Safeguard Paper Medical Records" dated 10/22/14 at http://recordsmanagement.tab.com/healthcare-patient-chart-services/ states " ... HIPAA and The Joint Commission require it. They specify that medical records must be adequately protected	N 0614	N-0614 Corrective actions were taken files were moved into another area adhering to this compliance Policy 1.21 were revised to include safeguarding paper medical records Policy was given to all office staff to ensure compliance Quarterly observations of stored records. Any adverse findings will be reported to the Administrator.	06/28/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K076	A. BUILDING 00 B. WING	05/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEAVEN SENT HOME HEALTH CARE LLC	10484 N STATE ROAD 13 ELWOOD, IN 46036

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	from fire and water damage, erroneous destruction and outright theft ... Ensure that all your paper medical records are protected from basic environmental hazards. This includes: storing them away from air conditioners, heaters, and sources of water; and ensuring that they are stored at temperatures between 65 and 70 degrees Fahrenheit at 55% relative humidity .... " During an observation on 5/28/19 at 11:08 AM, the administrator revealed where the clinical records were stored. They were stored in the basement in a back storage room. The room had bankers boxes for storage of records. In one area 10 bankers boxes were on the floor, and another 1 box on the floor in another area. The agency failed to ensure that the records kept on the floor were safeguarded against loss due to the possibility of flooding in basement. banker's boxes are made of cardboard and would not protect records from loss if wet. During an interview on 5/28/19 at 11;10 AM, the administrator stated the records were on the floor because the staff had been reviewing records since the last survey and they must have not been put back up.			