STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a federal home health recertification and state re-licensure survey with four complaint investigations. The survey was fully extended on 2/17/21 at 9:58 AM. Complaint #IN00277591; Substantiated with findings Complaint #IN00329600; Substantiated with findings Complaint #IN00329995: Substantiated with findings Complaint #IN00344993; Substantiated with findings Survey Dates: February 10, 11, 12, 15, 16, 17, 18, 19, 22, 23; 2021 Facility Number: 014255 Provider Number: 15K162 Unduplicated admissions past 12 months: 55 Skilled patients: 11 Home Health Aide Only Patients: 23 Personal Service Only Patients: 0 Total Active Patients: 34 Based on the Condition-level deficiencies during the February 23, 2021 survey, Helping Angels d/b/a Right at Home was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on February 17, 2021. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, Helping Angels d/b/a Right at Home is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for the two	G 000		

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

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G 000	Continued From page 1 years beginning February 23, 2021, and continuing through February 23, 2023 for being found out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive assessment and 484.60 Care Planning, coordination, quality of care. These deficiencies reflect State findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings. Quality Review Area 2 on 3/26/21	G 000		
G 510	Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This Condition is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment contained a complete and thorough health, psychosocial, functional, and cognitive status (See Tag G528); failed to ensure the comprehensive assessment included the patient's individual progress towards goals (See Tag G530); failed to ensure the comprehensive assessment included the patient's medical, nursing, and discharge planning needs (See Tag G534); failed to ensure the comprehensive assessment contained a medication list which was accurate and complete (See Tag G536); and included the presence or absence of a primary caregiver, the primary	G 510		

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G 510	Continued From page 2 caregiver's willingness and ability to provide care, and the primary caregiver's availability and schedules (See Tag G538). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive assessment.	G 510		
G 528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment contained a complete and thorough health, psychosocial, functional, and cognitive status for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 11 records. Findings include: 1. An agency policy titled "Assessment - Nursing," revised 1/15/18, stated "Purpose ... To ensure that the patient's current needs and/or problems are continuously evaluated and the care, treatment and/or services provided are adjusted accordingly. Policy: ... The patient shall be assessed and reassessed during each skilled visit ... Procedure: ... the Comprehensive Assessment will be completed by the RN [Registered Nurse] ... Includes the following information ... The patient's problems, needs and strengths ... Pertinent physical findings ... The patient's functional status, including mobility, continence [ability to control urination and/or bowel elimination] ... The patient's psychosocial status, including emotional/psychological barriers	G 528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 528	Continued From page 3 to treatment, cognitive limitations, memory ...." 2. An undated agency job description titled "Registered Nurse" stated " ... Essential Functions: ... Performs comprehensive subjective and objective ... ongoing assessment of client status that includes physical, psychosocial, and environmental parameters ...." 3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a disease of the lungs). The record included a comprehensive assessment completed on 1/7/21 by Former RN I for the recertification period 1/8/21 - 3/8/21. The comprehensive assessment indicated a pain assessment was conducted, which stated the patient's pain "location" was the "low[er] spine." The assessment failed to evidence an assessment of the patient's bilateral knee pain (as listed in the patient's diagnoses). The comprehensive assessment contained a section titled "Cardiopulmonary" which indicated the patient did not have a cough, and "becomes SOB [short of breath] when ambulating 20 ft [feet]. Moderate exertion also causes SOB." The assessment failed to evidence if the patient exhibited any further symptoms of COPD (wheezing, tightness in the chest, tiredness, etc). The assessment also failed to evidence if the patient's COPD symptoms were at baseline, better, or worse, and failed to evidence the presence or absence of edema (swelling).	G 528		

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G 528	Continued From page 4 The comprehensive assessment contained a section titled "Endocrine/Hematology," which indicated the patient had a diagnosis of "Diabetic poorly controlled," the patient was to check his blood sugar three times a day, and the patient received "sliding scale insulin [a method of dosing rapid or fast-acting insulin based on the patient's blood sugar prior to eating a meal]." The assessment failed to evidence the patient's blood sugar ranges and the patient's compliance with diabetes treatment, such as diabetic diet, blood sugar checks, medication administration, etc. The comprehensive assessment contained a section titled "Elimination Status," which indicated the patient had a diagnosis of urinary "Incontinence" (inability to control urination). The assessment failed to indicate when the urinary incontinence occurred (day only, night only, during the day and night, etc). The comprehensive assessment contained a section titled "Genitalia," which indicated a "Prostrate problem ... BPH [benign prostrate hyperplasia, enlargement of the prostate gland]." The assessment failed to indicate if the patient had symptoms of BPH, such as frequent urination, nocturia (urination at night), difficulty in starting urination, etc. The comprehensive assessment included a section titled "Neuro," which indicated the patient had diagnoses of "PTSD [Post-traumatic Stress Disorder, a mental health disorder resulting from trauma] ... Depression." A section titled "Mental Status" within the comprehensive assessment stated " ... [Increased] anxiety and agitation [with changes] or conflict. Requires routine and structure in a stress-free setting." The comprehensive assessment also contained a	G 528		

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G 528	Continued From page 5	G 528		

section titled "Depression Screening," which contained a PHQ-2 scale (Patient Health Questionnaire - 2, a medical screening for the frequency of a depressed mood in a patient). The patient's score on the PHQ-2 was "0" (the lowest score possible, indicating the patient had no days within the past two weeks where he experienced symptoms of a depressed mood). The comprehensive assessment failed to evidence a thorough evaluation of the patient's PTSD and depression (was the patient's anxiety and agitation at baseline, worse, or better; were any other symptoms of either condition present, etc).

The comprehensive assessment included a "Medication Profile," signed as reviewed by on 1/7/21 by Former RN I. The medication list included the medications pantoprazole (used to treat gastro-esophageal reflux disease (GERD)), atorvastatin (used to lower cholesterol), benzonatate (used to treat cough), clotrimazole betamethasone 1% - 0.05% (used to treat fungal infections of the skin), and Strattera (used to treat attention-deficit hyperactivity disorder (ADHD)). The comprehensive assessment failed to evidence diagnoses or conditions related to the above medications.

4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record contained a comprehensive assessment, completed on 1/21/21 by Former RN I, for the recertification period 1/24/21 - 3/24/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 528	Continued From page 6 A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2. During the home visit, Patient #2 was noted to have a suprapubic catheter (drain placed into a surgically created stoma in the lower abdomen to empty the bladder), and was observed self irrigating the suprapubic catheter with acetic acid. Patient #2 was observed to have redness to her sacrum (lowest area of the spine, directly above the coccyx) and both buttocks, one Stage 2 pressure ulcer (wound caused by prolonged pressure, resulting in damage to the first layers of the skin) to the right buttock, two or three (surveyor unable to distinguish number of wounds due to area covered with white medicated cream) Stage 2 pressure ulcers to the left buttocks, and one Stage 2 pressure ulcer to a skin fold on the right posterior thigh. The patient reported the wounds were "shearing" wounds. The left and right buttock wounds were covered with a dry ABD pad (type of gauze dressing) and tape, and the wound to the right posterior thigh did not have a dressing or topical cream noted. Patient #2 indicated her suprapubic catheter and wounds were managed by another home health agency, and Home Health Aide (HHA) #1 indicated she would apply Coloplast Hydrophilic Wound Cream (a medicated ointment which assists with wound healing) to the wounds on the patient's sacrum and buttocks. HHA #1 also stated she changed the dressing to the patient's sacrum and bilateral buttocks every day with the patient's bath, and did not apply any dressing or ointments to the wound on the patient's right thigh. HHA #1 stated the right thigh wound "comes and goes." Patient #2 also indicated she had no sensation "below my belly button." The comprehensive assessment failed to evidence an assessment of the patient's urine (color, clarity, etc), frequency the catheter	G 528		

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	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 528	Continued From page 7	G 528		

was changed, the frequency the catheter was to be irrigated with acetic acid, the presence and assessment of the patient's wounds (location, type of wound, type of dressing, etc), and the patient's decreased sensation to her lower extremities.

The comprehensive assessment included a section titled "Cardiopulmonary," which indicated there was "no [change]" in the patient's status. The comprehensive assessment failed to evidence an assessment of the patient's heart tones was completed, and failed to evidence an assessment of the patient's asthma (presence or absence of symptoms such as shortness of breath, wheezing, chest tightness, etc).

The comprehensive assessment contained a "Medication Profile," which included the medications Lasix (used to remove extra fluid from the body), fluocinonide 0.1% cream (used to decrease inflammation and itching caused by a variety of skin conditions), Nystatin powder (used to treat fungal infections of the skin), and Riley Butt Cream (compound used to treat fungal infections or other conditions of the skin). The comprehensive assessment failed to evidence diagnoses or conditions related to the above medications.

5. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a comprehensive assessment completed on 1/8/21 by RN #1 for the recertification period 1/9/21 - 3/9/21.

The comprehensive assessment included a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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G 528	Continued From page 8 section titled "Assessment and Observation Signs/Symptoms," which indicated the patient's pain was the "same ... chronic," located to the patient's "back," and the patient rated as "3" out of 10 on a 0-10 pain scale (method of assessing pain where patient assigns a number to their pain, from zero to ten, with zero being "no pain" and ten being "the most severe pain"). The comprehensive assessment failed to evidence a pain goal was established with the patient, which would evidence if the patient's tolerable or needed further intervention. The "Assessment and Observation Signs/Symptoms" section of the comprehensive assessment also stated " ... Mental Status: ... Oriented ... Forgetful ... Depressed." The comprehensive assessment included a section titled "Depression Screening," which contained a PHQ-2 scale. The patient's score on the PHQ-2 was "2" (score range 0 - 6), due to the patient indicating she had "little interest or pleasure in doing things" and "feeling down, depressed, or hopeless" for "Several days: 2 - 6 days" over the past two weeks. The comprehensive assessment also included a section titled "Comprehensive Assessment Summary" which stated " ... The patient's mental/cognitive status is ... anxious ... forgetful, memory deficit (at times)." The comprehensive assessment failed to evidence a thorough assessment of the patient's mental status (what was extent of patient's forgetfulness and memory deficit, was patient's depression at baseline, better, or worse, did patient exhibit any further symptoms of depression, etc). The comprehensive assessment included a section titled "Cardiopulmonary," which indicated the presence of "Dyspnea" (shortness of breath). The comprehensive assessment failed to	G 528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 528	Continued From page 9	G 528		

evidence if the patient's dyspnea was with exertion and/or at rest and failed to evidence if the patient exhibited any further symptoms of COPD (wheezing, tightness in the chest, tiredness, etc). The assessment also failed to evidence if the patient's COPD symptoms were at baseline, better, or worse.

The comprehensive assessment included a section titled "Genitourinary," which indicated the patient had urinary "incontinence." The assessment failed to evidence the frequency of incontinence (during the day only, during the night only, continuous) and the treatment for incontinence (incontinence pads and briefs).

The clinical record contained a plan of care for the certification period of 1/9/21 - 3/9/21. The plan of care included a medication list with the medications Alendronate (given to treat osteoporosis), Amlodipine (given to treat high blood pressure), Atorvastatin (given to treat high cholesterol), Docusate Sodium (given to treat constipation), Metoprolol Tartrate (given to treat high blood pressure), Trazodone HCL (given to treat insomnia), Meclizine (given to treat dizziness), Spironolactone (given to treat high blood pressure). The comprehensive assessment failed to evidence diagnoses or conditions related to the above medications.

6. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record contained a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 528	Continued From page 10 comprehensive assessment completed on 1/6/2021 by the Clinical Manager. The comprehensive assessment included a section titled "Assessment and Observation Signs/Symptoms," which indicated the patient's pain was the "same ... Origin: muscle spasms, neuropathy ... Location: left upper and lower extremities ... Intensity 0-10: 6 [out of 10 on a 0 - 10 pain scale] ... Relief Measures: medication, turn, reposition." The comprehensive assessment's summary stated " ... Limitations: ... Chronic pain impacts ability to participate in self care [at] times ...." The comprehensive assessment failed to evidence a pain goal was established with the patient, which would evidence if the patient's tolerable or needed further intervention. The comprehensive assessment's "Assessment and Observation" stated " ... Mental Status: No change ... Depressed - managed [with] meds ...." The "Comprehensive Assessment Summary" stated " ... The patient's mental/cognitive status is ... forgetful, depressed ... Limitations: Depression [related to] loss of independence impacts motivations and coping [at] times ...." The comprehensive assessment failed to evidence a thorough and complete assessment of the patient's depression and forgetfulness. The comprehensive assessment included a section titled "Interventions/Instructions," which stated " ... Instructed on disease mgmt. [management] of Type II DM [Diabetes Mellitus] including healthy food selections, importance of maintaining blood glucose WNL [within normal limits] ...." The assessment indicated the patient's blood sugar at the time of the visit was "146." The comprehensive assessment failed to evidence the patient's frequency of blood sugar	G 528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 528	Continued From page 11	G 528		

checks and the patient's goal range of blood sugars.

The comprehensive assessment included a "Medication Profile" with the medications Cetirizine (given to treat allergy symptoms), Diltiazem (given to treat heart rhythm irregularities), Ferrous Sulfate (given to treat conditions related to low iron levels), Melatonin (given to treat insomnia), Polyethylene Glycol (Miralax, given to treat constipation), and Tamsulosin (given to treat BPH). The comprehensive assessment failed to evidence diseases or conditions related to the above medications.

An interview was conducted on 2/11/2021 at 1:45 PM with the Clinical Manager. During the interview, the Clinical Manager indicated Patient #4 did not use his Hoyer lift to transfer, and would only transfer out of bed when his "friend" was present. The comprehensive assessment failed to evidence the patient's ambulation and mobility status.

7. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel and Bladder Incontinence (inability to control bowel movements and urination). The record contained a comprehensive assessment completed on 12/4/2020 by RN #3 for the recertification period 12/6/2020 - 2/3/2021. The comprehensive assessment included a section titled "Nutritional Status," which indicated the patient had a "G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 528	Continued From page 12	G 528		

tube" (gastrostomy tube surgically placed into the stomach to assist with administering nutrition and medication administration). The assessment failed to evidence a complete and thorough assessment of the G tube (assessment of the skin surrounding the tube, the frequency the tube was to be changed, etc).
The comprehensive assessment included a section titled "Neuro," which indicated the patient had a "history of seizures." The assessment failed to evidence a complete and thorough assessment of the patient's seizure history (type of seizures, date of most recent seizure, etc).

The comprehensive assessment included a "Medication Profile" with the medications Reglan (given to treat various gastrointestinal conditions related to slowed digestion), Loratadine (given to relive allergy symptoms), Miralax, Fleet Glycerin suppository (given rectally to treat constipation), Phenergan (given to treat nausea and/or vomiting), Sudafed (given to treat congestion and sinus pain and/or pressure), Simethicone (given to treat excess gas), Preparation H (given to treat hemorrhoids), Benzoyl Peroxide (given to treat acne), Percussion Vest (type of respiratory treatment which vibrates the chest to aid in mucus expulsion), Mupirocin (ointment used to treat a variety of bacterial skin infections), and Esomeprazole (used to treat GERD). The comprehensive assessment failed to evidence diseases or conditions related to the above medications.

8. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated the comprehensive assessment should include the patient's current health, psychosocial, functional,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 528	Continued From page 13 and cognitive status. 17-14-1(a)(1)(B)	G 528		
G 530	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment included the patient's individual progress towards goals for 4 of 5 active records reviewed (#1, 2, 3, 4), in a total sample of 11 records. Findings include: 1. An agency policy titled "Interdisciplinary Patient Assessments and Reassessments," dated 7/24/17, stated " ... Procedure: Right at Home strives to meet patient needs for care, treatment, and/or services by providing the following services under the direction of a physician. Skilled Nursing: ... Evaluates the patient's response to the plan of care ... Reassesses the patient to determine the ongoing needs for care, treatment and/or services and progression toward goals ...." 2. An undated agency job description titled "Registered Nurse" stated " ... Essential Functions: ... Performs comprehensive subjective and objective ... ongoing assessment of client status that includes physical, psychosocial, and environmental parameters ...	G 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 530	Continued From page 14 Provides skilled interventions aimed at achieving realistic outcomes within a specified time period. Modifies and updates plan of care to reflect progress towards outcomes ...." 3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The record included a comprehensive assessment completed on 1/7/21 by Former Registered Nurse (RN) I for the recertification period 1/8/21 - 3/8/21. The comprehensive assessment included a section titled "Care Preferences," which stated " ... [The patient] already have a goal(s) they are working at this time. Other: All goals are ongoing ... Document what the patient reports/says about their progress towards their personal goal(s) (if applicable) and the [home health agency] measurable goals since prior assessment? Patient states goals are appropriate. SN [Skilled Nurse] and patient set goals for short-term and long term. SN goals for pt [patient] to be compliant via assist [with] med container set. HHA [Home health aide] continue to ensure safety [with] ADL [and] IADLs [and] personal hygiene." The clinical record included a plan of care (POC) for the certification period of 11/9/2020 - 1/7/2021. The POC contained a section titled "Goals/Rehabilitation Potential/Discharge Plans," which stated "Goals: Demonstrate compliance with medication by 30 days. Demonstrate competence in following medical regimen by 60 days. Patient's hygiene will be maintained with assist of HHA by 30 days. Patient's safety will be	G 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 530	Continued From page 15	G 530		

enhanced with assist of HHA as evidenced by no falls or injuries by 60 days." The comprehensive assessment failed to indicate which goals were "short-term" and which were "long-term" and failed to evidence if the patient had met the previous certification period's goals.

4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record contained a comprehensive assessment, completed on 1/21/21 by Former RN I, for the recertification period 1/24/21 - 3/24/21. The comprehensive assessment contained a section titled "Rehabilitation Potential/Goals" which stated " ... Discipline Goals and Date will be achieved ... Pt's safety will be enhanced by HHA assisting AEB [as evidenced by] no falls or injury by 60 days ... Pt's hygiene and personal care needs will be met [with] assist of HHA by 30 [days] ...." The comprehensive assessment failed to evidence the patient's progress towards their goals.

5. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a comprehensive assessment completed on 1/8/21 by RN #1 for the recertification period 1/9/21 - 3/9/21. The comprehensive assessment included a section titled "Rehabilitation Potential/Goals," which stated " ... Discipline Goals and Date will be Achieved ... Aide: Safety / [prevent] falls / prevent injuries in 30 [days] ... Hygiene / personal care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 530	Continued From page 16 needs met per aide in 60 days ...." The comprehensive assessment failed to evidence the patient's progress towards their goals. 6. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record contained a comprehensive assessment completed on 1/6/2021 by the Clinical Manager for the recertification period 1/11/21 - 3/11/21. The assessment included a section titled "Rehabilitation Potential/Goals," which stated " ... Discipline Goals and Date will be Achieved. Nursing: Demonstrate compliance with medication by 30 [sic] ... Demonstrate competence in following medical regime by 60 [sic] ... Other ... Client safety will be enhanced per assist of [HHA] AEB [no] falls [with] injury [by] 30 days ... Client's personal care/hygiene will be met per assist of [HHA] by 60 days ...." The comprehensive assessment failed to evidence the patient's progress towards their goals. 7. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Alternate Administrator indicated the comprehensive assessment should include the patient's progress towards their goals.	G 530		
G 534	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs;	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 534	Continued From page 17 This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the comprehensive assessment included the patient's medical, nursing, and discharge planning needs for 5 of 5 active records (#1, 2, 3, 4, 5) in a total sample of 11 records. Findings include: 1. An agency policy titled "Assessment - Nursing," revised 1/15/18, stated "Purpose ... To ensure that the patient's current needs and/or problems are continuously evaluated and the care, treatment and/or services provided are adjusted accordingly. Policy: ... The patient shall be assessed and reassessed during each skilled visit ... Procedure: ... the Comprehensive Assessment will be completed by the RN [Registered Nurse] ... Includes the following information ... The patient's problems, needs and strengths ... Anticipated discharge needs ...." 2. An agency policy titled "Interdisciplinary Patient Assessments and Reassessments," dated 7/24/17, stated " ... Policy: ... Right at Home provides and modifies care, treatment and/or services to meet the patient's needs as identified through assessments and reassessments ... Procedure: ... Skilled Nursing: ... Reassesses the patient to determine the ongoing needs for care, treatment, and/or services ...." 3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 534	Continued From page 18 (COPD, a respiratory disease). The record included a comprehensive assessment completed on 1/7/21 by Former RN I for the recertification period 1/8/21 - 3/8/21. The comprehensive assessment contained a section titled "Rehabilitation Potential/Anticipated Discharge for Plan of Care" which stated " ... Anticipated discharge status: Client will D/C [discharge] when Home Care Services are adequate for his needs. Clients issues are chronic and goals are on-going. Thus no D/C is planned until client reaches a level of care that Right at Home cannot provide." The comprehensive assessment failed to evidence individualized and patient-specific discharge planning needs for Patient #1. 4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record contained a comprehensive assessment, completed on 1/21/21 by Former RN I, for the recertification period 1/24/21 - 3/24/21. The comprehensive assessment contained a section titled "Rehabilitation Potential/Goals" which stated " ... Discharge Plans ... No D/C [discharge] date planned. [The patient has] Ongoing needs ... Client will D/C when home care can no longer meet client's needs or higher level of care is needed ...." The comprehensive assessment failed to evidence individualized and patient-specific discharge planning needs for Patient #2. A home visit observation was conducted on	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 19 2/11/21 at 9:15 AM with Patient #2. During the home visit, Patient #2 was observed to have redness to her sacrum (lowest area of the spine, directly above the coccyx) and both buttocks, one Stage 2 pressure ulcer (wound caused by prolonged pressure, resulting in damage to the first layers of the skin) to the right buttock, two or three (surveyor unable to distinguish number of wounds due to area covered with white medicated cream) Stage 2 pressure ulcers to the left buttocks, and one Stage 2 pressure ulcer to a skin fold on the right posterior thigh. The left and right buttock wounds were covered with a dry ABD pad (type of gauze dressing) and tape, and the wound to the right posterior thigh did not have a dressing or topical cream noted. Patient #2 indicated her wounds were managed by another home health agency. The comprehensive assessment failed to evidence the patient's wound care needs, including the wound dressing to be applied, the frequency the dressing was to be changed, and the supplies needed for the wound care. 5. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a comprehensive assessment completed on 1/8/21 by RN #1 for the recertification period 1/9/21 - 3/9/21. The comprehensive assessment included a section titled "Rehabilitation Potential / Goals," which stated " ... Discharge Plans ... When services no longer needed ... Higher level of care required ...." The comprehensive assessment also included a section titled "Summary," which stated " ... Discharge Planning: ... when services no longer needed." The comprehensive assessment failed to evidence individualized and	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 20 patient-specific discharge planning needs for Patient #3. 6. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record contained a comprehensive assessment completed on 1/6/2021 by the Clinical Manager for the recertification period 1/11/21 - 3/11/21. The assessment included a section titled "Rehabilitation Potential/Goals," which stated " ... Discharge Plans ... When services are no longer needed or higher level of care is needed ...." The comprehensive assessment failed to evidence individualized and patient-specific discharge planning needs for Patient #4. The comprehensive assessment included a section titled "Interventions/Instructions," which stated " ... Instructed on disease mgmt. [management] of Type II DM [Diabetes Mellitus] including healthy food selections, importance of maintaining blood glucose WNL [within normal limits] ...." The assessment indicated the patient's blood sugar at the time of the visit was "146." The comprehensive assessment failed to evidence the patient's frequency of blood sugar checks and the patient's goal range of blood sugars. 7. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 21 of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a comprehensive assessment completed on 12/4/2020 by RN #3 for the recertification period 12/6/2020 - 2/3/2021. The assessment included a section titled "Rehabilitation Potential/Anticipated Discharge for Plan of Care," which stated " ... Anticipated discharge status: When services no longer needed or higher level of care is required ...." The comprehensive assessment failed to evidence individualized and patient-specific discharge planning needs for Patient #5. The comprehensive assessment included a section titled "Nutritional Status," which indicated the patient had a "G tube" (gastrostomy tube surgically placed into the stomach to assist with administering nutrition and medication administration). The assessment failed to evidence the frequency the nurse was to change the patient's G tube. 8. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated the comprehensive assessment should include the patient's medical, nursing, and discharge needs. 17-14-1(a)(1)(B)	G 534		
G 536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse	G 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 536	Continued From page 22 effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment contained a medication list which was accurate and complete for 4 of 5 active records reviewed (#1, 2, 4, 5), in a total sample of 11 records. Findings include: 1. An agency policy titled "Medication Management - Patient Information," dated 7/24/17, which stated "Purpose: To facilitate continuity of care, treatment and/or services for Right at Home patients by providing accurate and comprehensive information about patients' medications. To create and maintain an accurate medication history and current medication profile while the patient is receiving care, treatment and/or services from Right at Home ... Procedure: ... the Registered Nurse shall generate a list of the patient's current medications ... The information ... and includes at least the following information: ... Dosage, route, and frequency of administration of the medication ... The patient's medications are reviewed and assessed during each skilled visit ... The completeness and accuracy of the medication record is audited quarterly and as needed or requested ...." 2. An agency policy titled "Medication Orders and Administration," dated 7/24/17, stated " ... Policy: ... Acceptable Specific Medication Orders/Prescriptions: All medication orders must contain all the elements of a complete and clear	G 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 536	Continued From page 23	G 536		

medication order ... As Needed (PRN) Orders: Must include the specific indications for use ... All prescribed and OTC [Over the Counter] medications ... are to be documented on the patient's Medication Profile ... Procedure: Medication orders include the following information: ... indications for use"

3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The record included a comprehensive assessment completed on 1/7/21 by Former Registered Nurse (RN) I for the recertification period 1/8/21 - 3/8/21. The comprehensive assessment contained a "Medication Profile" which stated " ... Novolog [short-acting insulin given to lower the blood sugar in diabetic patients]. Humalog Kwikpen [short-acting insulin given to lower the blood sugar in diabetic patients], subQ [subcutaneous], 3xdly [three times a day] ...." The medication list failed to indicate if the patient was taking Novolog or Humalog.

4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record contained a comprehensive assessment, completed on 1/21/21 by Former RN I, for the recertification period 1/24/21 - 3/24/21. The comprehensive assessment contained a "Medication Profile"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 536	Continued From page 24	G 536		

which stated " ... Fluocinonide 0.1% cream [used to decrease inflammation and itching caused by a variety of skin conditions], topical [applied to the skin], Apply twice daily as needed for itching/rash ...." The medication list failed to evidence the specific location to apply the Fluocinonide.

5. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record contained a comprehensive assessment completed on 1/6/2021 by the Clinical Manager for the recertification period 1/11/21 - 3/11/21. The comprehensive assessment included a "Medication Profile" which stated " ... Lidocaine 5% Patch [given to treat pain], Topical, ½ patch to skin PRN [as needed] ...." The medication list failed to evidence the specific location to apply the Lidocaine.

6. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a comprehensive assessment completed on 12/4/2020 by RN #3 for the recertification period 12/6/2020 - 2/3/2021. The comprehensive assessment included a "Medication Profile" which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 536	Continued From page 25 stated " ... Antibiotic Oint. [Ointment, applied on the skin to treat bacterial infections] ... Topical. [Three times] daily as needed ... Percussion Vest [type of respiratory treatment which vibrates the chest to aid in mucus expulsion] ... 20 min [minutes] 2x daily as needed ... Resinol diaper rash cream [applied to the skin to treat fungal infections] ... Topical. [Apply] To skin ...." The medication list failed to evidence the specific location to apply the Antibiotic Ointment and Resinol diaper rash cream, and failed to evidence the indication for use of the percussion vest. 7. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated the patient's medication list documentation of a PRN medication should include indication for administration and documentation of a topical medication should include directions on where to apply the medication. 17-14-1(a)(1)(B)	G 536		
G 538	Primary caregiver(s), if any CFR(s): 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment included the presence or absence of a primary caregiver, the primary caregiver's willingness and ability to provide care, and the primary caregiver's availability and schedules for 5 of 5 active records (#1, 2, 3, 4, 5), in a total sample of 11 records.	G 538		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 538	Continued From page 26 Findings include: 1. An agency policy titled "Assessment - Nursing," revised 1/15/18, stated " ... Procedure: ... the Comprehensive Assessment will be completed by the RN [Registered Nurse]: ... Includes the following information ... The patient's family or support system and the care they are capable and willing to provide. The patient's / family's ... abilities, motivation, and readiness to learn ...." 2. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The record included a comprehensive assessment completed on 1/7/21 by Former Registered Nurse (RN) I for the recertification period 1/8/21 - 3/8/21. The comprehensive assessment contained a section titled "Living Arrangements/Supportive Assistance," which stated "Primary Caregiver: Patient provides their own care: Total, Partial [selection left blank]. Primary caregiver(s) other than patient: N/A, None available [selection left blank] ...." The comprehensive assessment failed to evidence if the patient had a primary caregiver or if the patient provided their own care. 3. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary	G 538		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 538	Continued From page 27	G 538		

system), and asthma. The record contained a comprehensive assessment, completed on 1/21/21 by Former RN I, for the recertification period 1/24/21 - 3/24/21. The comprehensive assessment contained a section titled "Comprehensive Assessment Summary," which stated " ... [Patient #2] lives alone or lives (with) no one who is unable to assist with patient's care due to not being there .... [sic]" The comprehensive assessment failed to evidence if the patient had a primary caregiver or if the patient provided their own care.

4. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a comprehensive assessment completed on 1/8/21 by RN #1 for the recertification period 1/9/21 - 3/9/21. The comprehensive assessment contained a section titled "Comprehensive Assessment Summary," which stated " ... [Patient #3] lives alone ...." The comprehensive assessment failed to evidence if the patient had a primary caregiver or if the patient provided their own care.

5. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record contained a comprehensive assessment completed on 1/6/2021 by the Clinical Manager for the recertification period 1/11/21 - 3/11/21. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 538	Continued From page 28	G 538		

comprehensive assessment failed to evidence if the patient had a primary caregiver or if the patient provided their own care.

6. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a comprehensive assessment completed on 12/4/2020 by RN #3 for the recertification period 12/6/2020 - 2/3/2021. The comprehensive assessment included a section titled "Living Arrangements/Supportive Assistance," which indicated Family Member K, family member of Patient #5, was the patient's primary caregiver. The comprehensive assessment failed to evidence the Family Member K's willingness and ability to provide care, as well as the caregiver's availability and schedules.

7. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Alternate Administrator stated if the patient did not have a primary caregiver, "it's a given" the patient provided their own care. The Alternate Administrator indicated the comprehensive assessment should exhibit if a primary caregiver was present or if the patient provided their own care. The Alternate Administrator also indicated Patients #1, 2, and 3 did not have a primary caregiver, Patients #4 and 5 had a primary caregiver, and the comprehensive assessment should include the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 538	Continued From page 29 primary caregiver's availability and schedule. The Clinical Supervisor indicated the comprehensive assessment should include the primary caregiver's willingness and ability to provide care.	G 538		
G 570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This Condition is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the plan of care included all pertinent diagnoses, the patient's mental and psychosocial status, all supplies and agency services required, the frequency and duration of visits to be made, a complete and accurate list of the patient's medications, patient-specific and individualized interventions to address the patient's underlying risk factors for emergency department visits and hospital re-admission, patient and/or caregiver education to facilitate timely discharge,	G 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 570	Continued From page 30 measurable and patient-specific goals, advance directive information, and call parameters for vital signs (see Tag G574); failed to ensure all drugs and services were administered only as ordered by a physician (see Tag G580); failed to ensure all verbal orders were authenticated and dated by the ordering provider (see Tag G584); failed ensure the patient's medical provider was notified of a change in the patient's condition (see Tag G590); failed to ensure the revised plan of care contained the patient's progress towards their goals (see Tag G592); failed to ensure care was coordinated with shared patient home care agencies (see Tag G608); failed to provide the patient with a visit schedule (see Tag 614); failed to provide a plan of care within the patient's home and to ensure the patient's record and home binder contained the manufacturer's instructions for specialty transfer equipment (see Tag 618); and failed to ensure the patient's home binder contained up-to-date contact information for the agency's clinical supervisor (see Tag G622). 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, and quality of care.	G 570		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis;	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 31 (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the plan of care (POC) included all pertinent diagnoses, the patient's mental and psychosocial status, all supplies and agency services required, the frequency and duration of visits to be made, a complete and accurate list of the patient's medications, patient-specific and individualized interventions to address the patient's underlying risk factors for emergency department visits and hospital re-admission, patient and/or caregiver education to facilitate timely discharge, measurable and patient-specific goals, advance directive information, and call parameters for vital signs for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 11 records. Findings include:	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 32 1. An agency policy titled "Care Planning," dated 7/24/17, stated " ... Policy: ... An individualized plan of care is developed for each patient ... Procedure: ... The plan of care includes at least the following information: ... Measurable, objective goal statements ... Measurable patient outcomes ... The plan of care covers the following: All pertinent diagnoses. Mental status. Types of services ... Frequency of visits ... Medications and treatments. Safety measures. Instructions for timely discharge ... Other items as appropriate ...." 2. An undated agency policy titled "MD Call Parameters Process," stated "1. Temperature: greater than 101 [degrees Fahrenheit]. 2. Pulse (BPM [beats per minute]): greater than 100. 3. O2 Sats [oxygen saturation, the percentage of blood which contained oxygen]: less than 89%. 4. Respirations (per minute): greater than 24 [or] less than 12. 5. Blood Pressure (Systolic) [the first of the two numbers of a blood pressure reading]: greater than 180 or less than 90. 6. Blood Pressure (Diastolic) [the second of the two numbers of a blood pressure reading]: greater than 90 or less than 60. 7. BGL [Blood Glucose Level]: less than 60 or greater than 350. 8. Pain Level: greater than 7 [on a 0 - 10 scale]." 3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The record contained a plan of care for the recertification period 1/8/21 - 3/8/21. The plan of care included a medication list with the medication orders for " ... Atorvastatin [given to lower cholesterol] ...	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 33 Pantoprazole [given for Gastroesophageal Reflux Disease (GERD)] ... Strattera [given to treat Attention Deficit Hyperactivity Disorder (ADHD)] ...." The clinical record also contained a comprehensive assessment completed on 1/7/21 by Former Registered Nurse (RN) I, which indicated the patient had diagnoses of "HTN [hypertension, elevated blood pressure]," Post-traumatic Stress Disorder (PTSD), anxiety, right sided carpal tunnel syndrome (a compressed nerve in the wrist which causes numbness, tingling, and weakness in the arm and hand), benign prostate hyperplasia (BPH, enlargement of the prostate in males), and urinary incontinence (inability to control urination). The POC failed to evidence diagnoses related to the medications Atorvastatin, Pantoprazole, and Strattera, and the diagnoses noted in the comprehensive assessment of HTN, PTSD, anxiety, carpal tunnel syndrome, BPH, and urinary incontinence. The POC contained a section titled "Mental/Cognitive Status," which stated " ... Other (Specify): Alert and oriented times three. Forgetful & periods of increased anxiety with agitation." The comprehensive assessment completed on 1/7/21 included a section titled "Neuro," which indicated the patient had diagnoses of PTSD and depression. The POC failed to evidence a complete mental and psychosocial status. The POC contained a medication list with included the medication orders for " ... Lisinopril 20 mg one tablet po [by mouth] daily ... Hydroxyzine 25mg 1 tablet po every 8 hours as needed for anxiety ...." The comprehensive assessment's medication list, signed as reviewed on 1/7/21 by Former RN I, indicated the patient's	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 34 Lisinopril was discontinued on 12/23/2020 and the dosage of hydroxyzine was changed on 11/13/2020 to " ... Hydroxyzine 25 mg tab, po, 2 tab every 8 [hours] as needed for anxiety ...." The POC failed to contain an accurate and up-to-date medication list. The POC contained a section titled "Risk Factors (past and present fort health status/ED use/hospitalization): ... Obesity ... Poly Pharmacy (medications associated with falls) ... Impaired Mobility ... Incontinence ... Sensory Impairment ...." The POC's summary stated " ... Hospital Risk Score: 3. Is at risk for return to hospital. Plan for prevention of hospital return is in place (Education of Disease Process, Pain Management, compliance with medication) ...." The POC failed to evidence patient-specific and individualized interventions related to the patient's risk factors for ED visits and hospitalizations. The POC contained a section titled "Goals/Rehabilitation Potential/Discharge Plans," which stated " ... Goals: Demonstrate compliance with medication by 30 days. Demonstrate competence in following medical regimen by 60 days. Patient's hygiene will be maintained with assist of HHA [Home Health Aide] by 30 days. Patient's safety will be enhanced with assist of HHA as evidenced by no falls or injuries by 60 days ... Discharge: Patient to be discharged when agency can no longer meet the patient's needs or the patient requires a higher level of care." The POC failed to evidence patient-specific, measurable goals and patient education to facilitate discharge. The POC contained a section titled "Orders for Discipline and Treatments," which stated " ... Code Status: Full Code. Discussed Advance	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 35	G 574		

Directive. Voiced understanding ...." The POC failed to evidence patient-specific information on if advance directives were present or not.

The POC included an order for skilled nurse visits 1 hour per visit, 3 visits per day, 7 days per week. The skilled nurse was to conduct "Skilled Assessment and Evaluation of all Systems ..." at every visit. The plan of care failed to evidence vital sign call parameters for Patient #1.

4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record contained a plan of care for the recertification period 1/24/21 - 3/24/21. The POC included a medication list with the orders for "Lasix [used to remove extra fluid from the body] 20 mg one tablet po daily ... Fluocinonide 0.1% cream [used to decrease inflammation and itching caused by a variety of skin conditions] topically [applied to the skin] to skin two times daily as needed for itching/rash ... Omeprazole [used to treat GERD] 40 mg one tablet po daily ... Tizanidine [used to treat muscle spasms] 2 mg one tablet po two times daily ... Nystatin Powder [used to treat fungal infections of the skin] 100,000 [units] / Gram topically to breast and abdominal folds three times daily as needed for rash ... Riley Butt Cream [compound used to treat fungal infections or other conditions of the skin] topically to affected area on buttocks three times daily as needed for rash ... Coloplast Hydrophilic Wound Cream [a medicated topical cream which assisted with wound healing] topically to superficial rash areas on buttocks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 36	G 574		

three times daily as needed for rash ...." The clinical record also included a comprehensive assessment completed on 1/21/21 by Former RN I. The comprehensive assessment indicated the patient had a history of a torn rotator cuff (muscles and tendons of the shoulder), chronic pain of both shoulders, and bowel incontinence (inability to control bowel elimination). The POC failed to evidence diagnoses related to the use of the medications Lasix, Fluocinonide, Omeprazole, Tizanidine, Nystatin, Riley Butt Cream, and Coloplast Hydrophilic Wound Cream, and failed to evidence diagnoses of torn rotator cuff, chronic shoulder pain, and bowel incontinence as noted in the comprehensive assessment.

A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #1. During the home visit, Patient #1 was observed to have redness to her sacrum (lowest area of the spine, directly above the coccyx) and both buttocks, one Stage 2 pressure ulcer (wound caused by prolonged pressure, resulting in damage to the first layers of the skin) to the right buttock, two or three (surveyor unable to distinguish number of wounds due to area covered with white medicated cream) Stage 2 pressure ulcers to the left buttocks, and one Stage 2 pressure ulcer to a skin fold on the right posterior thigh. The left and right buttock wounds were covered with a dry ABD pad (type of gauze dressing) and tape, and the wound to the right posterior thigh did not have a dressing or topical cream noted. Patient #1 indicated her suprapubic catheter and wounds were managed by another home health agency, and Home Health Aide (HHA) #1 indicated she would apply Coloplast Hydrophilic Wound Cream (a medicated ointment which assists with wound healing) to the wounds on the patient's sacrum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 37	G 574		

and buttocks. The POC included a section titled "DME and Supplies," which stated " ... wound care supplies managed by [Home Health J], wound care managed by Wound Care Clinic [name of clinic not specified]." The POC failed to evidence a diagnosis related to the patient's wounds and failed to evidence the patient supplies needed related to her wound care.

The POC contained service orders for HHA visits 4-7 hours per day, 5-7 days per week. The POC also included HHA tasks to be completed for a morning, afternoon, and evening visit. The POC failed to evidence HHA service orders with detailed visit frequency, including the number or range of visits per day.

The POC contained a section titled "Risk Factors (past and present for health status/ED use/hospitalization): ... Obesity ... Poly Pharmacy (medication associated with falls) ... Impaired Mobility ... Incontinence ... Sensory Impairment ...." The POC also stated " ... Hospital Risk Score: 2. [Patient #2] is at risk for return to hospital. Plan is in place to prevent return to hospital (Education of Disease process, Pain Mgt [management], Compliance with Medications) ...." The POC failed to evidence patient-specific and individualized interventions related to the patient's risk factors for ED visits and hospitalizations.

The POC contained a section titled "Goals/Rehabilitation Potential/Discharge Plans," which stated " ... Goals: Patient's safety will be enhanced by assist of HHA as evidenced by no falls and/or injuries by 60 days. Patient's hygiene and personal care needs will be met with assist of HHA by 30 days ... Discharge: When agency can no longer meet patient's needs or patient requires

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 38	G 574		

a higher level of care." The POC failed to evidence patient-specific, measurable goals and patient education to facilitate discharge.

The POC contained a section titled "Orders for Disciple and Treatments," which stated " ... Code Status: Full. Discussed Advance Directives. Patient voiced understanding ...." The POC failed to evidence patient-specific information on if advance directives were present or not.

5. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a plan of care for the recertification period 1/9/21 - 3/9/21. The POC included a medication list with the medication orders " ... Alendronate [given to treat osteoporosis] ... Amlodipine [given to treat high blood pressure] ... Atorvastatin [given to treat high cholesterol] ... Docusate Sodium [given to treat constipation] ... Lidocaine 5% Patch [given to treat pain] apply one patch topically to skin every day for up to 12 hrs [hours] (on for 12hrs, off for 12hrs) within 24hr period as needed for pain ... Menthol/M-Salicylate 10-15% [given to treat pain] Topical cream apply small amount topically to skin two times daily as needed for pain ...Metoprolol Tartrate [given to treat high blood pressure] ... Trazodone HCL [given to treat insomnia] ... Meclizine [given to treat dizziness] ... Spironolactone [given to treat high blood pressure] ...." The POC failed to evidence diagnoses related to the medications Alendronate, Amlodipine, Atorvastatin, Docusate Sodium, Metoprolol Tartrate, Trazodone, Meclizine, and Spironolactone, and failed to evidence detailed instructions on where to administer the topical medications Lidocaine and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 39 Menthol/M-Salicylate. The POC contained a section titled "Risk Factors (past and present for health status/ED use/hospitalization)," which stated " ... Poly Pharmacy (medications associated with falls) ... Impaired Mobility. Incontinence. Sensory Impairment. History of Falls in Past 3 Months ...." The POC's "Summary" also stated " ... Hospital Risk Score: 3. Patient is at risk for hospitalization. Has not been hospitalized in the past 60 days. Plan for prevention of return to hospital is in place. (Education of Disease Process, Pain Mgt, Compliance with Medication) ...." The POC failed to evidence patient-specific and individualized interventions related to the patient's risk factors for ED visits and hospitalizations. The POC contained a section titled "Goals/Rehabilitation Potential/Discharge Plans," which stated "Goals: Patient's safety/prevent falls will be met with assist of HHA as evidenced by no falls/injuries by 30 days. Patient's hygiene and personal care needs will be met with assist of HHA by 60 days ... Discharge: When services no longer needed or a higher level of care is required." The POC failed to evidence patient-specific, measurable goals and patient education to facilitate discharge. The POC contained a section titled "Orders for Discipline and Treatment," which stated " ... Code Status: Full. Discussed Advance Directive. [Patient] voiced understanding ...." The POC failed to evidence patient-specific information on if advance directives were present or not. 6. The two clinical records of Patient #4 were reviewed on 2/16/21 and 2/18/21, and indicated	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 574	Continued From page 40	G 574		

two separate starts of care. The first record's start of care was 5/22/19, and contained a plan of care for the recertification period 1/11/21 - 3/11/21, with service orders for skilled nursing and respite HHA. The second record's start of care was 6/19/19, and contained a recertification period 12/20/2020 - 12/7/21, with service orders for HHA. Both clinical records indicated patient diagnoses included: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record failed to evidence one POC with all agency services required by the patient (Skilled Nursing, HHA, and Respite HHA).

An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Administrator indicated Patient #4's clinical record with the start of care of 5/22/19 was for the services billed under the patient's Veteran Affairs (VA) insurance, and the clinical record with the start of care of 6/19/19 was for the services billed under the patient's Medicaid insurance.

The two POCs included medication lists with the medications " ... Cetirizine [given to treat allergy symptoms] ... Diltiazem [given to treat heart rhythm irregularities] ... Ferrous Sulfate [given to treat conditions related to low iron levels] ... Melatonin [given to treat insomnia] ... Polyethylene Glycol [Miralax, given to treat constipation] ... Tamsulosin [given to treat BPH] ...." The POCs failed to evidence diagnoses related to the above medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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G 574	Continued From page 41 The two POCs included a section titled "Risk Factors (past and present for health status/ED use/hospitalization)," which stated " ... Obesity ... Poly Pharmacy (medication associated with falls) ... Impaired Mobility. Incontinence. Sensory Impairment ... Diagnosis of: [History] Left CVA, Left side hemiparesis ...." The POC's summary stated " ... Hospital Risk Score: 3. Is a risk for return to hospital. No hospital stays in the past 60 days. Plan for prevention of return to hospital is in place (Education on Disease Process, Pain Management, Compliance with Medication) ...." The POCs failed to evidence patient-specific and individualized interventions related to the patient's risk factors for ED visits and hospitalizations. The two POCs included a section titled "Goals/Rehabilitation Potential/Discharge Plans," which stated " ... Discharge: When services are no longer needed or when higher level of services are needed ...." The POCs failed to evidence patient and/or caregiver education to facilitate discharge. The two POCs included a section titled "Orders for Discipline and Treatments," which stated " ... Code Status: Full. Discussed Advance Directive. Voiced understanding. POA [Power of Attorney, legal document which names an individual to make legal decisions on the person's behalf]. Copy of Advance Directive requested ...." The POCs failed to indicate the identity of the patient's POA and failed to indicate if the POA included the ability to make medical decisions for the patient. The POC for the recertification period 1/11/21 - 3/11/21 included service orders which indicated the patient was to receive Skilled Nursing services for 1 hour per day every other week, and stated " ... Every Visit ... Full Assessment and	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 574	Continued From page 42 Vital Signs ...." The POC failed to evidence vital sign call parameters for Patient #4. The clinical record for Patient #4 with a start of care date of 6/19/19 included a POC for the recertification period 12/10/2020 - 2/18/2021, which indicated service orders for HHA visits 5 - 9 hours per day, 2 - 5 days per week. The clinical record also included HHA visit notes which indicated HHA #2 provided HHA services to Patient #4 from 10 AM - 1 PM and HHA #3 provided HHA services to Patient #4 from 1 PM - 6 PM on 1/4/21, 1/5/21, 1/6/21, 1/7/21. 1/8/21, 1/11/21, 1/12/21, 1/13/21, 1/14/21, 1/15/21, 1/18/21, 1/19/21, 1/20/21, 1/21/21, 1/22/21, and 2/2/21. The visit notes also indicated HHA #2 provided HHA services from 9 AM - 1 PM and HHA #3 provided HHA services from 1 PM - 6 PM on 2/1/21, 2/3/21, 2/4/21, and 2/5/21. The POC failed to evidence the frequency and duration of daily HHA visits. The POC for the recertification period 12/10/2020 - 2/18/2021 included a medication list with the medication orders " ... Lidocaine 5% [given to treat and relieve pain] apply ½ patch topically to skin daily as needed for pain ... Metoprolol Succinate SA 24 hour [given to treat high blood pressure] 10 mg [milligrams] take ½ tablet to equal 50 mg po daily ...." The clinical record included a "Medication Profile," signed as reviewed by the Clinical Manager on 12/8/2020, which indicated the order for the patient's Metoprolol Succinate was " ... 100 mg ... ½ tab daily ...." The POC failed to evidence clear directions on where to apply the Lidocaine patch, and failed to evidence correct dosage of the Metoprolol Succinate. The POC for the recertification period 1/11/21 -	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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G 574	Continued From page 43 3/11/21, with service orders for Skilled Nurse and Respite HHA visits, included patient goals " ... Demonstrate compliance with medication by 30 days. Demonstrates competence in following medical regime by 60 days. Patient safety will be enhanced per assist of HHA as evidenced by no falls with injury by 30 days. Patient's personal care/hygiene needs will be met per assist of HHA by 60 days ...." The POC for the recertification period 12/10/2020 - 2/18/2021, with service orders for HHA visits, included patient goals " ... Patient's safety will be met per assist of HHA as evidenced by no falls with injury by 60 days. Patient's personal care needs will be met by assistance of HHA by 30 days ...." The POCs failed to evidence patient-specific and measurable goals. 7. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a plan of care for the recertification period 12/6/2020 - 2/3/2021. The POC included a medication list with the medication " ... Reglan [given to treat various gastrointestinal conditions related to slowed digestion] ... Loratadine [given to relive allergy symptoms] ... Miralax ... Fleet Glycerin suppository [given rectally to treat constipation] ... Phenergan [given to treat nausea and/or vomiting] ... Sudafed [given to treat congestion and sinus pain and/or pressure] ... Simethicone [given to treat excess gas] ... Preparation H [given to treat hemorrhoids] ... Benzoyl Peroxide	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 44 [given to treat acne] ... Mupirocin [ointment used to treat a variety of bacterial skin infections] ...." The POC failed to evidence diagnoses related to the above medications. The clinical record contained a comprehensive assessment with a "Medication Profile" which indicated the patient had an order for " ... Ibuprofen 100 mg / 5 ml [milliliters]. 25 mls. Route: GT [G-tube]. Frequency: Daily ..." that was discontinued on 11/21/2020. The POC's medication list included an order for Ibuprofen 100 mg / 5 ml, 25 mls per G-tube daily. The POC's medication list failed to evidence a current and up-to-date medication list. The POC included a section titled "Risk Factors (past and present for health status/ED use/hospitalization): ... Poly Pharmacy (Medications associated with falls) ... Impaired Mobility. Incontinence ...." The POC's summary stated " ... Hospital Risk Factor: 2. Is at risk for return to hospital. No hospital stays in past 60 days. Plan for prevention of return to hospital is in place (Education on Disease Process, Pain Management, Compliance with Medication) ...." The POC failed to evidence patient-specific and individualized interventions related to the patient's risk factors for ED visits and hospitalizations. The POC included a section titled "Goals / Rehabilitation Potential / Discharge Plans," which stated " ... Goals: Patient will be free from signs/symptoms of infection as evidenced by no infection by 30 days. Patient's safety will be enhanced with assist of skilled nurse as evidenced by no falls or injuries by 60 days ... Discharge: When services no longer needed or higher level of care is required ...." The POC failed to evidence patient-specific, measurable	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 45 goals and patient education to facilitate discharge. 8. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated the plan of care should contain all pertinent diagnoses, the patient's mental and psychosocial status, supplies and equipment needed, all medications and treatments, patient-specific interventions related to the patient's risk for ED visits and hospitalization, patient and/or caregiver education to facilitate timely discharge, patient-specific and measurable goals, and advance directive information. The Alternate Administrator indicated call parameters for vital signs were not required to be on the POC unless they were patient-specific, as the agency had a policy which indicated the parameters (see Finding #2). The Alternate Administrator also indicated if a patient had multiple visits from one service per day, this should be included within the patient's frequency and duration of services on the POC, however Patient #4's multiple visits per day were considered one shift by the agency, as the two HHAs provided "continuous" HHA services. 17-13-1(a)(1)(B) 17-13-1(a)(1)(C)(i, ii, iii, ix, xi, xiii)	G 574		
G 580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to	G 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 46	G 580		

ensure all drugs and services were administered only as ordered by a physician for 4 of 5 active records reviewed (#1, 2, 4, 5), in a total sample of 11 records.

Findings include:

1. An agency policy titled "Telephone / Verbal Orders," dated 7/24/17, stated " ... Policy: Right at Home provides care, treatment and / or services to patients in accordance with current physician orders ... Care, treatment and/or services are provided according to the most recent order/prescription ... Original and/or new / updated orders are transcribed onto a physician Order / Prescription form ... and mailed or faxed to the physician for signature ...."

2. An agency policy titled "Medication Orders and Administration," dated 7/24/18, stated "Purpose: ... To ensure accurate, safe and effective administration of prescribed medications by qualified [Home Health agency] staff ... Procedure: ... Prior to administering any medication, the nurse verifies the following information based on the medication order ...: Correct medication ... Correct dose ...."

3. An agency policy titled "Medication Management - Patient Information," dated 7/24/17, stated "Purpose: To safely order, dispense, administer and monitor Right at Home patients' medications. To minimize the opportunity for ... medication errors ... Procedure ... The patient's medications are reviewed and assessed during each skilled visit. Any changes to the medications ... are conveyed to the ordering physician ...."

4. The clinical record of Patient #1 was reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 47 on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The clinical contained a plan of care (POC) for the recertification period 11/9/2020 - 1/7/2021. The record also contained a "Medication Profile," which indicated the frequency of the patient's Hydroxyzine (used to treat anxiety and/or itching) was increased from 25 mg (milligrams), one tablet every 8 hours as needed for anxiety, to 25 mg, two tablets every 8 hours as needed for anxiety, effective 11/13/2020; the dosage of Hydrochlorothiazide (given to treat high blood pressure) was increased from 12.5 mg daily to 25 mg daily, effective 12/23/2020; the patient's Lisinopril (given to treat high blood pressure) was discontinued, effective 12/23/2020; and the patient was started on a new medication, Strattera (given to treat Attention Deficit Hyperactivity Disorder (ADHD)), effective 1/1/2021. The clinical record failed to evidence physician orders were obtained to confirm these medication changes. The clinical record included a plan of care for the recertification period 1/8/21 - 3/8/21, which contained the medication orders " ... Novolog Kwikpen [short-acting insulin used to decrease blood sugar in diabetic patients] SQ [subcutaneous, injected directly underneath the skin] per Sliding Scale - Glucometer check using finger stick method three times daily in the AM, Noon and PM ... 80 - 120 = 2 units, 121 - 130 = 4 units, 131 - 180 = 6 units, 181 - 240 = 8 units, 241 - 300 = 10 units ... Glucose [sugar] 1 tablet po [by mouth] as needed for blood sugar of less than 80. Call MD if follow up Blood Sugar reading still	G 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 48 [less than] 80 ...." A "Nursing Visit Note" for the skilled nurse visit completed on 2/5/21 from 5:20 PM - 6:20 PM by Licensed Practical Nurse (LPN) #1 indicated the patient's glucometer blood sugar check was 64. The nurse documented " ... BS [Blood Sugar] = 64 ... No s/s [signs or symptoms] any distress. [Patient #1] eating glucose tablet - will be eating dinner in 5 minutes ...." The nurse failed to evidence the patient's blood sugar was rechecked 15 minutes after administration of the glucose tablet according to the physician order. A "Nursing Visit Note" for the skilled nurse visit completed on 1/29/21 from 11:30 AM -12:30 PM by LPN #1 indicated the patient's glucometer blood sugar check was 225 and he received 10 units of Novolog (instead of 8 units per the physician order). LPN #1 failed to administer the correct dose of insulin according to the physician's orders. A "Nursing Visit Note" for the skilled nurse visit completed on 1/25/21 from 11:30 AM - 12:30 PM by LPN #1 indicated the patient's glucometer blood sugar reading was 240 and he received 10 units of NovoLog (instead of 8 units per the physician order). LPN #1 failed to administer the correct dose of insulin according to the physician's orders. A "Nursing Visit Note" for the skilled nurse visit completed on 1/13/21 from 5:20 PM - 6:20 PM by LPN #1 indicated the patient's glucometer blood sugar reading was 248 and he received 8 units of Novolog (instead of 10 units per the physician order). LPN #1 failed to administer the correct dose of insulin according to the physician's orders.	G 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 49	G 580		

The clinical record contained "Nursing Visit Notes" for the skilled nurse visits completed by LPN #2 on 2/4/21 from 8:10 AM - 9:10 AM (blood sugar was 77), 1/21/21 from 8:10 AM - 9:10 AM (blood sugar was 75), 1/19/21 8:10 AM - 9:10 AM (blood sugar was 77), and 1/15/21 from 8:10 AM - 9:10 AM (blood sugar was 76). During the visits, LPN #2 failed to administer a glucose tablet for the patient's blood sugar readings less than 80 according to the physician orders.

The clinical record contained "Nursing Visit Notes" for the skilled nurse visits completed by LPN #1 on 2/1/21 from 5:20 PM - 6:20 PM (blood sugar was 78), 1/26/21 from 11:30 AM - 12:30 PM (blood sugar was 70), 1/26/21 from 5:20 PM - 6:20 PM (blood sugar was 75), 1/21/21 from 11:30 AM - 12:30 PM (blood sugar was 77), 1/9/21 from 11:30 AM - 12:30 (blood sugar was 79), 1/9/21 from 5:20 PM - 6:20 PM (blood sugar was 62). During the visits, LPN #1 failed to administer a glucose tablet for the patient's blood sugar readings less than 80 according to the physician orders.

The clinical record contained "Nursing Visit Notes" for the skilled nurse visits completed by LPN #3 on 1/31/21 from 11:45 AM - 12:45 PM (blood sugar was 69), 1/17/21 from 11:45 AM - 12:45 PM (blood sugar was 70). During the visits, LPN #3 failed to administer a glucose tablet for the patient's blood sugar readings less than 80 according to the physician orders.

5. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 50	G 580		

lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record contained a comprehensive assessment, completed on 1/21/21 by Former RN I, for the recertification period 1/24/21 - 3/24/21. The comprehensive assessment included a section titled "Medication" which indicated the patient's medications Vitamin C, Vitamin E, and Tylenol Extra-Strength were discontinued, and Ibuprofen 200 milligram (mg), 1 tablet by mouth twice a day, was added to the patient's medication list. Patient #2's clinical record failed to evidence physician orders were obtained by the nurse to verify the medication changes.

6. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The record contained a plan of care for the recertification period 12/10/2020 - 2/7/2021, which included service orders for Home Health Aide (HHA) visits 5 - 8 hours per day for 2 - 5 days per week. The clinical record included HHA visit notes which indicated HHA #2 provided HHA services from 9 AM - 1 PM and HHA #3 provided HHA services from 1 PM - 6 PM, for a total of 9 hours of HHA services per day, on 2/1/21, 2/3/21, 2/4/21, and 2/5/21. The clinical record failed to evidence the home health agency obtained a physician order to provide HHA services for more than the ordered 5 - 8 hours per day on the above dates.

7. The clinical record of Patient #5 was reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 51 on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a plan of care for the recertification period 12/6/2020 - 2/3/2021. The plan of care included orders which stated " ... Oxygen at 0.5 L/min [liters per minute, also expressed as LPM, how oxygen administration is dosed] via Mask PRN [as needed]. May titrate to 1L to keep O2 SAT [Oxygen Saturation, also expressed as SpO2, a vital sign which measures the percentage of blood which contains oxygen] > 93%. Notify MD if Resp [respirations] < 11 per min [minute], or if patient is showing signs or symptoms of dyspnea and if HR > 110, SBP [systolic blood pressure, the first of two numbers in a blood pressure reading] < 80 ... Respite SN [Skilled Nurse] 60 Hours per Month ... SN or [patient's family member] to do Wound Care to Surgical Wound on Back 2 times a Week or as Needed for Soilage or Dislodgement of Dressing (Cleanse Wound Mid Spine with NS [Normal Saline], Cover with ABD pad [type of gauze wound dressing] and Secure with Hypafix [type of medical adhesive] / Tape) ...." The clinical record indicated the patient received respite skilled nursing services for 8 hours on 1/2/21, 8 hours on 1/3/21, 12 hours on 1/9/21, 8 hours on 1/10/21, 8 hours on 1/16/21, 8 hours on 1/17/21, 12 hours on 1/23/21, 8 hours on 1/24/21, 8 hours on 1/30/21, and 8 hours on 1/31/21, for a total of 88 hours from 1/1/21 - 1/31/21. The record failed to evidence a physician order was obtained to provide respite nursing services for more than the ordered 60	G 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 52	G 580		

hours.

The clinical record included "Nursing Visit" notes, documented by LPN #3 on 12/8/2020, 12/9/20, 12/10/20, 12/11/20, 12/12/20, 12/15/20, 12/16/20, 12/17/20, 12/18/20, 12/19/20, 12/22/20, 12/23/20, 12/29/20, 12/30/20, 12/31/20, 1/1/2021, 1/2/21, 1/5/21, 1/6/21, 1/7/21, 1/8/21, 1/9/21, 1/12/21, 1/13/21, 1/14/21, 1/15/21, 1/16/21, 1/19/21, 1/20/21, 1/21/21, 1/22/21, 1/23/21, 1/26/21, 1/27/21, 1/28/21, 1/29/21, 1/30/21, 2/2/21, and 2/3/21, indicated the nurse changed Patient #5's surgical wound dressing. The clinical record also included "Nursing Visit" notes, documented by LPN #4 on 12/6/20, 12/7/20, 12/13/20, 12/14/20, 12/20/20, 12/21/20, 12/24/20, 12/25/20, 12/28/20, 1/4/21, 1/10/21, 1/11/21, 1/17/21, 1/18/21, 1/24/21, 1/25/21, 1/31/21, and 2/1/20, indicated the nurse changed Patient #5's surgical wound dressing. The clinical record failed to evidence an order was obtained to change the surgical wound dressing more frequently than twice a week and/or the patient's dressing was changed each visit due to soilage or dislodgement.

A "Nursing Visit Note," documented on 2/3/21 by LPN #3, indicated the patient's heart rate was "118," oxygen was administered at "3" L/min and the SpO2 was "96%." LPN #3 documented the patient exhibited "Dyspnea [shortness of breath] ... At rest." The nursing note failed to evidence an order was obtained to increase the patient's oxygen up to 3 L/min and failed to evidence the nurse informed the doctor of the patient's heart rate above the call parameters (HR > 110).

A "Nursing Visit Note," documented on 2/2/21 by LPN #3, indicated the patient's oxygen was administered at "3" L/min and SpO2 was "95%." The nursing note failed to evidence an order was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 53 obtained to increase the patient's oxygen to 3 L/min. A "Nursing Visit Note," documented on 2/1/21 by LPN #4, indicated the patient's oxygen was administered at "3" L/min and SpO2 was "97%." The visit note summary stated " ... [Patient #5 had a] rough night. Labored breathing," and indicated the patient's blood pressure prior to end of the shift was "77/63." The nursing note failed to evidence an order was obtained to increase the patient's oxygen to 3 L/min and failed to evidence the nurse notified the patient's physician of the systolic blood pressure below the call parameters (SBP < 90). A "Nursing Visit Note," documented on 1/31/21 by LPN #4, indicated the patient's oxygen was administered at "3" L/min and SpO2 was "98%." The nursing note failed to evidence an order was obtained to increase the patient's oxygen to 3 L/min. A "Nursing Visit Note," documented on 1/30/21 by LPN #3, indicated the patient's oxygen was administered at "3" L/min, SpO2 was 96%, heart rate was "120,", and blood pressure was "84/53." LPN #3 documented the patient had "crackles" to all lung lobes and dyspnea at rest. The nursing note failed to evidence an order was obtained to increase the patient's oxygen to 3 L/min and the nurse notified the patient's physician of the heart rate and systolic blood pressure above the call parameters. A "Nursing Visit Note," documented on 1/29/21 by LPN #3, indicated the patient's oxygen was administered at "3" L/min via nasal cannula, SpO2 was "99%," and heart rate was "125." The nursing note failed to evidence an order was	G 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 54	G 580		

obtained to increase the patient's oxygen to 3 L/min and administer through a nasal cannula, and failed to evidence the nurse notified the patient's physician of the heart rate reading above the call parameters.

A "Nursing Visit Note," documented on 1/28/21 by LPN #3, indicated the patient's oxygen was administered at "2.5" L/min, SpO2 was "97%," heart rate was "115," and blood pressure was "83/45." LPN #3 documented the patient had "crackles" to all lung lobes (abnormal sound heard during auscultation of the lungs, normally resulting from infection and/or inflammation) and dyspnea at rest. The nursing note failed to evidence an order was obtained to increase the patient's oxygen to 2.5 L/min and failed to evidence the nurse notified the patient's physician of the heart rate and blood pressure reading above the call parameters.

A "Nursing Visit Note," documented on 1/27/21 by LPN #3, indicated the patient's oxygen was administered at "2.5" L/min via nasal cannula, SpO2 was "98%," respiratory rate was "22," and heart rate was "143." LPN #3 documented the patient had "crackles" to both lower lung lobes, and dyspnea at rest. The nursing note failed to evidence an order was obtained to increase the patient's oxygen to 2.5 L/min and administer through a nasal cannula, and failed to evidence the nurse notified the patient's physician of the heart rate reading above the call parameters.

A "Nursing Visit Note," documented on 1/26/21 by LPN #3, indicated the patient's oxygen was administered at "2" L/min, SpO2 was "97%," respiratory rate was "23," heart rate was "123," and blood pressure was "83/59." LPN #3 documented the patient had "crackles" to the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 55	G 580		

lower lung lobe, there were no breath sounds to the right lower lung lobe (meaning no air getting to this area), and dyspnea at rest. The nursing note summary indicated the patient's oxygen was administered at "2.5" L/min. The nursing note failed to evidence an order was obtained to increase the patient's oxygen to 2-2.5 L/min and failed to evidence the nurse notified the patient's physician of the heart rate and blood pressure reading above the call parameters.

A "Nursing Visit Note," documented on 1/25/21 by LPN #4, indicated the patient's oxygen was administered at "2.5" L/min, SpO2 was "95-96%," heart rate was "122." The nursing note summary stated "9 AM [beginning of shift] ... Client O2 sat was 88% on Room Air [no supplemental oxygen] briefly for turning ... Following routine meds and nebulizer, percussion [treatment] ... [Patient] currently on [oxygen at] 2.5 [L/min] per [patient's family member] ...." Later in the shift (specific time not documented), the nurse documented the patient's respiratory rate was 28 breaths per minute and heart rate was 140. The patient's oxygen was titrated down by the nurse to 1.5 L/min. At 4 PM, the nurse documented the patient's heart rate was 140, and at 4:30 PM, the nurse documented the patient's heart rate was 136. The nursing note failed to evidence an order was obtained to increase the patient's oxygen to 2.5 L/min and the patient's physician was notified of the patient's respiratory rate and heart rate above call parameters.

A "Nursing Visit Note," documented on 1/24/21 by LPN #4, indicated during the visit (no specific time documented) the patient's respiratory rate was 24 breaths per minute, heart rate was 140, and SpO2 was 92 - 94%. The nursing summary stated " ... 5:45 PM: [Patient's family member]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 56 stopped feeding in progress. Lift transfer to bed ...," and indicated the patient's follow up vital sign check at 6:30 PM was SpO2 92%, respiratory rate of 24, and the patient had "labored breathing." LPN #4 documented oxygen was started at 1 L/min (route not documented), and the patient's follow up vital sign check at 7 PM was SpO2 97%, respiratory rate 20, blood pressure 88/56, heart rate 125, and the patient was exhibiting no "distress." The nursing note failed to evidence the patient's physician was notified of the patient's respiratory rate, heart rate, and blood pressure above call parameters. 8. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated all services and treatments should be administered only as ordered by the patient's medical provider. The Clinical Supervisor also indicated the nurse was not expected to obtain a physician's order when a patient's medication was changed if the patient had a medication bottle within the home. The Alternate Administrator stated the medication bottle "is the [physician] order." 17-13-1(a)	G 580		
G 584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner	G 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 584	Continued From page 57 responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all verbal orders were authenticated and dated by the ordering provider for 1 of 1 active record reviewed which evidenced verbal orders were received (#5), in a total sample of 11 records. Findings include: An agency policy titled "Telephone / Verbal Orders," dated 7/24/17, stated " ... Policy: Right at Home ensures the accuracy of telephone / verbal orders ... Original and/or new / updated orders are transcribed onto a Physician Order / Prescription form ... and mailed or faxed to the physician for signature ... Procedure: ... All orders for medications shall include the following: Date and time of the order ... Name of prescriber ... The staff member who accepts the order: Reduces the order to writing ... Signs and dates the order ... A copy of the Physician Telephone / Verbal Orders Form is filed in the patient's medical record ...." An agency policy titled "Medication Management - Patient Information," dated 7/24/17, stated "Purpose: To safely order, dispense, administer and monitor Right at Home patients' medications. To minimize the opportunity for ... medication errors ... Procedure ... The patient's medications	G 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 584	Continued From page 58	G 584		

are reviewed and assessed during each skilled visit. Any changes to the medications ... are conveyed to the ordering physician ...."

The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a plan of care for the recertification period 12/6/2020 - 2/3/2021, which included service orders for skilled nursing visits 8 hours per day, 5 days per week. The record included a "Nursing Visit Note," documented on 2/1/21 by LPN #4, which stated " ... [Patient #5 had a] rough night. Labored breathing, client tearful ... Current ATB [antibiotic] not effective enough. [Family Member K, family member of Patient #5] put in call to N.P [Nurse Practitioner] to go to another ATB ... [Verbal order] received [for] Azithromycin [antibiotic] ...." The record failed to evidence the name of the ordering provider and the verbal order was authenticated and dated by the ordering provider.

A "Nursing Visit Note," documented on 1/27/21 by LPN #3, stated " ... Medications. New or changed since last visit ... Doxycycline [antibiotic] ...." The record failed to evidence the name of the ordering provider, the date and time the order was received, and the order was authenticated and dated by the ordering provider.

A "Nursing Visit Note," documented on 1/25/21 by LPN #4, stated "9 AM [beginning of shift] ... Client O2 sat was 88% on room air [no oxygen]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 584	Continued From page 59 briefly for turning ... [Family Member K] called N.P waiting [for] return call ... 12 PM: ... N.P returned call - portable CXR [chest X-ray] ordered ...." The record failed to evidence the name of the ordering provider and the verbal order was authenticated and dated by the ordering provider. A "Nursing Visit Note," documented on 1/14/21 by LPN #3, stated " ... Medications. New or changed since last visit ... Esomeprazole [given to treat Gastroesophageal Reflux Disease (GERD)] ...." The record failed to evidence the name of the ordering provider, the date and time the order was received, and the order was authenticated and dated by the ordering provider. A "Nursing Visit Note," documented on 1/13/21 by LPN #3, stated " ... Medications. New or changed since last visit ... Tramadol [given to treat or relieve pain] ...." The record failed to evidence the name of the ordering provider, the date and time the order was received, and the order was authenticated and dated by the ordering provider. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated all verbal orders should be authenticated and dated by the ordering provider. 17-14-1(a)(1)(H)	G 584		
G 590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.	G 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 60 This Element is not met as evidenced by: Based on record review and interview, the home health agency failed ensure the patient's medical provider was notified of a change in the patient's condition for 1 of 1 active records with a noted change in patient condition (#5), in a total sample of 11 records. Findings include: An agency policy titled "Coordination of Patient Services," dated 7/24/17, stated " ... Procedure: ... Right at Home staff promptly contacts the physician: When there are changes in the patient's condition ...." An undated agency policy titled "MD Call Parameters Process" stated "1. Temperature: greater than 101 [degrees Fahrenheit]. 2. Pulse (BPM [beats per minute]): greater than 100 ... 4. Respirations (per minute): greater than 24 [or] less than 12 ...." An undated agency policy titled "Wound Documentation and Measurements," policy number G-261, stated " ... Procedure: 1. Wounds are to be measured either weekly or bi-weekly per [Skilled Nurse] visit order ... 4. All significant changes will be reported to the MD the same day as noted on visit ...." The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel	G 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 61	G 590		

movements). The record contained a plan of care for the recertification period 12/6/2020 - 2/3/2021, which included service orders for Skilled Nursing 8 hours per day, 5 days per week, and Respite Skilled Nursing for up to 60 hours per month. The plan of care included also included orders which stated " ... Oxygen at 0.5 L/min [liters per minute, also expressed as LPM, how oxygen administration is dosed] via Mask PRN [as needed]. May titrate to 1 [LPM] to keep O2 SAT [Oxygen Saturation, also expressed as SpO2, a vital sign which measures the percentage of blood which contains oxygen] > 93%. Notify MD if Resp [respirations] < 11 per min [minute], or if patient is showing signs or symptoms of dyspnea [shortness of breath] and if HR > 110, SBP [systolic blood pressure, the first of two numbers in a blood pressure reading] < 80 ... Measure [spinal surgical] wound weekly ...."

A "Nursing Visit Note," documented on 2/3/21 by LPN #3, indicated the patient's heart rate was "118," oxygen was administered at "3" L/min and the SpO2 was "96%." LPN #3 documented the patient exhibited "Dyspnea ... At rest." The clinical record failed to evidence the medical provider was notified the patient's heart rate was outside the call parameters and the patient required more oxygen than the current order.

A "Nursing Visit Note," documented on 2/2/21 by LPN #3, indicated the patient's oxygen was administered at "3" L/min and SpO2 was "95%." The clinical record failed to evidence the medical provider was notified the patient required more oxygen than the current order.

A "Nursing Visit Note," documented on 2/1/21 by LPN #4, indicated the patient's oxygen was administered at "3" L/min and SpO2 was "97%."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 62 The visit note summary stated " ... [Patient #5 had a] rough night. Labored breathing ... Current ATB [antibiotic] not effective enough. Mom put in call to N.P [Nurse Practitioner] to go to another ATB ... [Order] received [for] Azithromycin ATB ...." and indicated the patient's blood pressure prior to end of the shift was "77/63." The clinical record failed to evidence if the medical provider was notified the patient had labored breathing, the blood pressure was outside the call parameters, and required more oxygen than the current order. A "Nursing Visit Note," documented on 1/31/21 by LPN #4, indicated the patient's oxygen was administered at "3" L/min and SpO2 was "98%." The clinical record failed to evidence the medical provider was notified the patient required more oxygen than the current order. A "Nursing Visit Note," documented on 1/30/21 by LPN #3, indicated the patient's oxygen was administered at "3" L/min, SpO2 was 96%, heart rate was "120,", and blood pressure was "84/53." LPN #3 documented the patient had "crackles" (abnormal sound heard during auscultation of the lungs, normally resulting from infection and/or inflammation) to all lung lobes and dyspnea at rest. The clinical record failed to evidence the medical provider was notified the patient's heart rate and blood pressure were outside of call parameters, the patient had abnormal breath sounds and dyspnea at rest, and the patient required more oxygen than the current order. A "Nursing Visit Note," documented on 1/29/21 by LPN #3, indicated the patient's oxygen was administered at "3" L/min via nasal cannula, SpO2 was "99%," and heart rate was "125." The clinical record failed to evidence the nurse	G 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 590	Continued From page 63 notified the medical provider of the patient's heart rate was outside of call parameters, the patient required more oxygen than the current order, and the patient was receiving oxygen through a different route than ordered. A "Nursing Visit Note," documented on 1/28/21 by LPN #3, indicated the patient's oxygen was administered at "2.5" L/min, SpO2 was "97%," heart rate was "115," and blood pressure was "83/45." LPN #3 documented the patient had "crackles" to all lung lobes and dyspnea at rest. The clinical record failed to evidence the nurse notified the medical provider the patient's heart rate and blood pressure were outside of call parameters, the patient had abnormal lung sounds and dyspnea at rest, and the patient required more oxygen than the current order. A "Nursing Visit Note," documented on 1/27/21 by LPN #3, indicated the patient's oxygen was administered at "2.5" L/min via nasal cannula, SpO2 was "98%," respiratory rate was "22," and heart rate was "143." LPN #3 documented the patient had "crackles" to both lower lung lobes and dyspnea at rest. The clinical record failed to evidence the nurse notified the medical provider the patient's respiratory rate and heart rate were outside of call parameters, the patient had abnormal lung sounds and dyspnea at rest, the patient required more oxygen than the current order, and the patient was receiving oxygen through a different route. A "Nursing Visit Note," documented on 1/26/21 by LPN #3, indicated the patient's oxygen was administered at "2" L/min, SpO2 was "97%," respiratory rate was "23," heart rate was "123," and blood pressure was "83/59." LPN #3 documented the patient had "crackles" to the left	G 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 64	G 590		

lower lung lobe, there were no breath sounds to the right lower lung lobe (meaning no air getting to this area), and dyspnea at rest. The nursing note summary indicated the patient's oxygen was administered at "2.5" L/min. The clinical record failed to evidence the nurse notified the medical provider the patient's respiratory rate, heart rate and blood pressure were outside of call parameters, the patient had abnormal lung sounds and dyspnea at rest, and the patient required more oxygen than the current order.

A "Nursing Visit Note," documented on 1/25/21 by LPN #4, indicated the patient's oxygen was administered at "2.5" L/min, SpO2 was "95-96%," heart rate was "122." The nursing note summary stated "9 AM [beginning of shift] ... Client O2 sat was 88% on Room Air [no supplemental oxygen] briefly for turning ... Following routine meds and nebulizer, percussion [treatment] ... [Patient] currently on [oxygen at] 2.5 [L/min] per [patient's family member] ...." Later in the shift (specific time not documented), the nurse documented the patient's respiratory rate was 28 breaths per minute and heart rate was 140. The patient's oxygen was titrated down by the nurse to 1.5 L/min. At 4 PM, the nurse documented the patient's heart rate was 140, and at 4:30 PM, the nurse documented the patient's heart rate was 136. Later during the visit (specific time not documented), the patient's temperature was noted to be "102.3 [degrees Fahrenheit]." The clinical record failed to evidence the nurse notified the medical provider the patient's respiratory rate, heart rate, blood pressure and temperature were outside of call parameters and the patient required more oxygen than the current order.

A "Nursing Visit Note," documented on 1/24/21 by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 65	G 590		

LPN #4, indicated during the visit (no specific time documented) the patient's respiratory rate was 24 breaths per minute, heart rate was 140, and SpO2 was 92 - 94%. The nursing summary stated " ... 5:45 PM: [Patient's family member] stopped feeding in progress. Lift transfer to bed ...," and indicated the patient's follow up vital sign check at 6:30 PM was SpO2 92%, respiratory rate of 24, and the patient had "labored breathing." LPN #4 documented oxygen was started at 1 L/min (route not documented), and the patient's follow up vital sign check at 7 PM was SpO2 97%, respiratory rate 20, blood pressure 88/56, heart rate 125, and the patient was exhibiting no "distress." The clinical record failed to evidence the nurse notified the medical provider the patient's respiratory rate and heart rate were outside of call parameters and the patient had labored breathing.

A "Nursing Visit Note," documented on 12/18/21 by LPN #3, indicated the patient's spinal surgical wound was measured and the wound's depth was 1.9 centimeters (cm). A "Nursing Visit Note," documented on 12/23/21 by LPN #3, indicated the patient's spinal surgical wound's depth was 2.3 cm, an increase of 0.4 cm from the previous measurement. A "Nursing Visit Note," documented on 1/15/21 by LPN #3, indicated the patient's spinal surgical wound's depth was 1.6 cm. A "Nursing Visit Note," documented on 1/22/21 by LPN #3, indicated the patient's spinal surgical wound's depth was 2.0 cm, an increase of 0.4 cm from the last measurement. The wound's measurements also included tunneling of 1.5 cm at both 12 o'clock and 6 o'clock. A "Nursing Visit Note," documented on 1/29/21 by LPN #3, indicated the patient's spinal surgical wound's tunneling was 2.0 cm at 12 o'clock and 1.7 cm at 6 o'clock, an increase of 0.5 cm and 0.3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 66 cm respectively from the previous measurement. A "Nursing Visit Note," documented on 2/5/21 by LPN #3, indicated the patient's spinal surgical wound's tunneling was 2.1 cm at 6 o'clock, an increase of 0.6 cm over the past two wound measurements. The clinical record failed to evidence the patient's medical provider was notified of the increase in wound measurements. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated the nurse should notify the patient's medical provider for any change in patient condition, and this should be documented on a "Nurse's Note" or "Communication Note." The Alternate Administrator indicated Patient #5's spinal surgical wound was "nonhealing." 17-13-1(a)(2)	G 590		
G 592	Revised plan of care CFR(s): 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the revised plan of care (POC) contained the patient's progress towards their goals for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 11 records. Findings include:	G 592		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 592	Continued From page 67 1. An agency policy titled "Care Planning," dated 7/24/17, stated " ... Procedure ... The plan of care is reviewed, updated and/or modified ... Each member of the healthcare team reviews the plan of care ... to evaluate the appropriateness of the plan and the patient's progress toward goals ...." 2. An undated agency job description titled "Registered Nurse" stated "... Essential Functions: ... Modifies and updates plan of care to reflect progress towards outcomes ...." 3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21, and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The record included a plan of care for the recertification period 1/8/21 - 3/8/21. The POC failed to evidence the patient's progress towards their goals. 4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record contained a plan of care for the recertification period 1/24/21 - 3/24/21. The POC failed to evidence the patient's progress towards their goals. 5. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of	G 592		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 592	Continued From page 68 care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a plan of care for the recertification period 1/9/21 - 3/9/21. The POC failed to evidence the patient's progress towards their goals. 6. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record contained a plan of care for the recertification period 1/11/21 - 3/11/21. The POC failed to evidence the patient's progress towards their goals. 7. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a plan of care for the recertification period 12/6/2020 - 2/3/2021. The POC failed to evidence the patient's progress towards their goals. 8. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Supervisor. During the interview, the Clinical Supervisor indicated the plan of care should indicate the patient's progress towards their goals.	G 592		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 608	Continued From page 69	G 608		
G 608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure care was coordinated with shared patient home care agencies for 1 of 4 active records reviewed of patients who received care from multiple home care agencies (#2), in a total sample of 11 records. Findings include: An agency policy titled "Coordination of Patient Services," dated 7/27/17, stated "Purpose: To ensure effective and appropriate coordination and continuity of care, treatment and services ... Policy: ... When the patient is receiving care, treatment and/or services from other organizations/providers, Right at Home ensure that the responsibilities of the [Home Health Agency] and the other organizations/providers are collaborative and exclusive. Communication is maintained between those providing services regarding changes in the patient's needs, services or care to be provided or goals that impact the overall care, treatment and/or services ...." An undated agency job description titled "Registered Nurse" stated " ... Essential Functions: ... 4. Coordinates delivery of care along health care continuum ... collaborates with other health care providers to achieve expected outcomes of patient care ... 5. Communicates	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 70	G 608		

effectively ... Relays significant changes in status to physician and other members of the team ...."

The survey's Entrance Conference was conducted on 2/10/21 at 10:57 AM with the Administrator, Alternate Administrator, and Clinical Manager. During the Entrance Conference, the Clinical Manager indicated the agency coordinated care with shared patient agencies through sending the patient's POC to the shared patient agency and communicating any patient changes with the other agency.

The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The clinical record included a "Case Conference" note, signed by Former Registered Nurse (RN) I and Home Health Aide (HHA) #2 on 1/21/21, which stated " ... Care Coordination: Skilled Nursing [provided by Home Health Entity J], primary care provider, Home Health aid [sic] ...." The Case Conference note failed to evidence how care was coordinated during this conference between Right at Home and Home Health Entity J.

The clinical record contained a plan of care (POC) for the recertification period 1/24/21 - 3/24/21. The POC included a medication list with the medications " ... Tizanidine [used to treat muscle spasms] ... Ibuprofen ... Nystatin Powder 100,000 units / Gram topically to breast and abdominal folds three times daily as needed for rash [used to treat fungal infections of the skin] ... Riley Butt Cream [compound used to treat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 71 fungal infections or other conditions of the skin] ... Coloplast Hydrophilic Wound Cream [a medicated cream which assisted with wound healing] ...." The clinical record also contained aide care plans for the patient's morning, afternoon, and evening HHA visits, signed as reviewed by Former RN I on 1/21/21. The aide care plans stated " ... Assignment: ... Inspect, Reinforce Dressing ... [Frequency:] Every visit ... Comments/Instructions: If dressing has loosened, may apply tape or new dry [dressing] with tape to coccyx [tailbone] when in place ...." Home Health Entity J's clinical record of Patient #2's was reviewed on 2/17/21, and indicated a start of care of 8/13/18. The record contained a plan of care for the recertification period of 1/29/21 - 3/29/21. The POC included a medication list with the medications " ... Acidophylis [probiotic given as a supplement, can help prevent infections] ... Albuterol - Ipratropium [given to improve airflow caused by respiratory disorders] ... B 100 Complex [Vitamin B supplement] ... Baclofen [used to treat muscle spasms] ... Co-Q-10 [Coenzyme Q10, a supplement which can assist with various heart conditions] ... Diflucan [given to treat fungal infections] ... Dulcolax [given to treat constipation] ... Iron-180 [iron supplement, given to treat various conditions related to low iron levels] ... Miralax [given to treat constipation] ... Mucinex [cough suppressant] ... Nystatin 100, 000 units / [Gram] topical cream, Apply topically to affected area, BID [twice a day] ... Tramadol [given to treat pain] ...." Home Health Entity J's POC also include a section titled "Orders for Discipline and	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 72	G 608		

Treatments" which stated " ... Wound Treatment for Wound #11 ... Location: Rt Upper Buttox [sic]. Type: Pressure Ulcer [wound caused by prolonged pressure, staged from 1 to 4] ... Appropriate Skilled Caregiver to Cleanse with NS [Normal Saline], pat dry, apply thin layer of Duoderm paste [medicated topical cream which assists with wound healing]. HHA [Home Health Aide, service provided by Right at Home] may apply daily ... Wound #12, Location: Rt Lower Buttox, Type: Pressure Ulcer ... Appropriate Skilled Caregiver to Cleanse with NS, pat dry, apply thin layer of Duoderm paste. HHA may apply daily ... Wound #7, Location: Left Glute [group of muscles which are located in the buttocks and upper thigh], Type: Pressure Ulcer .... Appropriate Skilled Caregiver to Cleanse with NS, pat dry, apply thin layer of Duoderm paste to areas on glutes. HHA may apply daily ...."

A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2. During the home visit, Patient #2 was observed to have redness to her sacrum (lowest area of the spine, directly above the coccyx) and both buttocks, one Stage 2 pressure ulcer to the right buttock, two or three (surveyor unable to distinguish number of wounds due to area covered with white medicated cream) Stage 2 pressure ulcers to the left buttocks, and one Stage 2 pressure ulcer to a skin fold between the patient's right buttocks and posterior thigh. The patient reported the wounds were "shearing" wounds. The left and right buttock wounds were covered with a dry ABD pad (type of gauze dressing) and tape, and the wound to the right posterior thigh did not have a dressing or topical cream noted. Patient #2 indicated her wound care was managed by Home Health Entity J, and HHA #1 indicated she would apply Coloplast Hydrophilic Wound Cream daily to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 73 wounds on the patient's sacrum and buttocks. HHA #1 also stated she changed the dressing to the patient's sacrum and bilateral buttocks every day with the patient's bath, and did not apply any dressing or ointments to the wound on the patient's right thigh. Home Health Entity J's medication list failed to evidence the orders for Tizanidine, Ibuprofen, Nystatin, Riley Butt Cream, and Coloplast Hydrophilic Wound Cream included within Right at Home's POC. The Right at Home POC failed to evidence the orders for Acidophylis, Albuterol - Ipratropium, B 100 Complex, Baclofen, Co-Q-10, Diflucan, Dulcolax, Iron-180, Miralax, Mucinex, and Tramadol included within Home Health Entity J's POC. The medication lists from the two home health agencies contained conflicting type and frequency of administration for Nystatin ("powder" to be applied three times a day per Right at Home's medication list and "cream" to be applied two times a day per Home Health Entity J's medication list). The clinical records of Patient #2 from Right at Home and Home Health Entity J also failed to evidence care was coordinated regarding the orders and directions for the patient's wound care (were the patient's wounds to be covered by a dressing or left open to air, which wound care ointment was to be applied to the wound, what was the HHA's role in wound care, etc). 17-12-2(g) 17-14-1(a)(1)(F)	G 608		
G 614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.	G 614		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 614	Continued From page 74 This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to provide the patient with a visit schedule for 3 of 3 home visit observations performed (#1, 2, 3). Findings include: 1. An agency policy titled "Care Plan Implementation," dated 7/24/17, stated "Purpose: ... To ensure patient / legal guardian involvement, whenever possible, in decisions about the patient's care, treatment and/or services. Policy: Right at Home provides care, treatment, and/or services consistent with the type and frequency identified and documented in the plan of care and on the days and at the times scheduled with the patient / family ...." 2. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21 and indicated a start of care of 9/16/19. The record included a plan of care for the recertification period 1/8/21 - 3/8/21, which indicated the patient was to receive Skilled Nursing services 1 hour per visit, 3 visits per day (AM, Afternoon, and PM), 7 days per week, and Home Health Aide (HHA) services 4 - 5 hours per day, 5 - 7 days per week. The clinical record also included a "Scheduling Form" for the certification period 1/8/21 - 3/8/21, signed by the Clinical Manager on 1/5/21. The form indicated LPN #1 was to complete the Skilled Nursing services for the afternoon and PM visits Monday thru Friday, the AM and afternoon visit every other Saturday opposite LPN #3, and the PM visit every other Saturday opposite LPN #2; LPN #2 was to provide Skilled Nursing for the AM visits Monday thru Friday and the PM visit every other Saturday (opposite LPN #1); and LPN #3 was to provide Skilled Nursing for the AM, afternoon, and PM	G 614		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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G 614	Continued From page 75 visits every Sunday and AM and afternoon visits every other Saturday (opposite LPN #1). The form also indicated HHA #4 was to provide HHA services 8 AM - 1 PM, Monday thru Friday and every other Saturday and Sunday (opposite HHA #5) and HHA #5 was to provide HHA services 8 AM - 1 PM every other Saturday and Sunday (opposite HHA #4). A home visit observation was conducted on 2/10/2021 at 4:07 PM with Patient #1. The home visit observation failed to evidence a Scheduling Form or visit schedule within the patient's home or home health binder. 3. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18. The record contained a plan of care for the recertification period 1/24/21 - 3/24/21, which indicated the patient was to receive HHA services 4 - 7 hours per day, 5 - 7 days per week. A review of the HHA visits for the certification period indicated the daily HHA hours were divided into three shifts (AM, Afternoon, and PM). The clinical record included a "Scheduling Form" for the certification period 1/24/21 - 3/24/21, signed by the Clinical Manager on 1/15/21. The form indicated HHA #1 was to perform HHA services for the AM visit Monday thru Saturday and the PM shift on Wednesdays; HHA #6 was to perform HHA services for the afternoon shift Tuesdays and Thursdays; HHA #7 was to perform HHA services for the afternoon shift Mondays, Wednesdays, and Fridays; HHA #8 was to provide HHA services for the PM shift all days except Wednesdays and the AM shift on Sundays; and the afternoon shift on Saturdays and Sundays were "open" (no staff scheduled). A home visit observation was conducted on	G 614		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 614	Continued From page 76	G 614		

2/11/21 at 9:15 AM with Patient #2. The home visit observation failed to evidence a Scheduling Form or visit schedule within the patient's home or home health binder. During the visit, Patient #2 indicated she had a set schedule with same agency staff and did not receive a visit schedule from the agency.

4. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21 and indicated a start of care date of 7/17/19. The record contained a plan of care for the recertification period 1/9/21 - 3/9/21, which indicated the patient was to receive HHA services 1 - 2 hours per day, 2 - 4 days per week. The clinical record included a "Scheduling Form" for the certification period 1/9/21 - 3/9/21, signed by the Clinical Manager on 1/5/21. The form indicated the patient was to receive HHA services 9 AM - 12 PM Tuesdays and Thursdays and 9 AM - 11 AM on Saturdays. The form also indicated HHA #9 was the "Primary HHA," but failed to evidence if HHA #9 was to provide all the patient's services, or if any other HHAs were scheduled with the patient.

A home visit observation was conducted on 2/12/21 at 9:05 AM with Patient #3. The home visit observation failed to evidence a Scheduling Form or visit schedule within the patient's home or home health binder.

An interview was conducted with Patient #3 on 2/12/21 at 9:20 AM. During the interview, Patient #3 indicated she did not receive a visit schedule from the home health agency.

5. An interview was conducted on 2/12/21 at 1:40 PM with the Alternate Administrator and Clinical Manager. During the interview the Clinical Manager indicated on admission, all patients

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 614	Continued From page 77 received a "schedule" of the days of the week visits were to be provided as well as the "hour ranges" the visits were to last. The Clinical Manager also indicated the agency did not provide patients with a visit schedule with the specific employee assigned to each visit, and the Scheduling Forms were not provided to the patients.	G 614		
G 618	Treatments and therapy services CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to provide and maintain a plan of care within the patient's home for 3 of 3 home visit observations (#1, 2, 3), and failed to ensure the patient's record and home binder contained the manufacturer's instructions for specialty transfer equipment for 3 of 3 patients with specialty transfer equipment (#2, 4, 5), in a total sample of 11 records. Findings include: 1. An agency policy titled "Coordination of Patient Services," dated 7/24/17, stated "Purpose: To ensure effective and appropriate coordination and continuity of care, treatment and/or services ... Procedure: The individualized plan of care should be available to all appropriate staff ... Coordination of service activities is documented in the patient's home care record. Each record shall contain up-to-date information regarding: The services that are being provided. The responsibilities of each service / discipline. The interventions provided along with the patient /	G 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 618	Continued From page 78 family response ...." 2. An undated job description titled "Registered Nurse" stated " ... Essential Functions: ... 2 ... Implements teaching appropriate to the patient's needs ... Plans, teaches, supervises, and counsels patient and family regarding physical care ... 4. Coordinates delivery of care along health care continuum ... Utilizes supplies ... and equipment in a responsible ... manner to achieved desired outcomes ...." 3. A complete list of active patients with Hoyer lifts in the home was provided by the Clinical Manager on 2/11/21 at 1:00 pm. The list indicated three active patients (#2, 4, 5) had Hoyer lifts in their homes. 4. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21 and indicated a start of care of 9/16/19. The record included a plan of care (POC) for the recertification period 1/8/21 - 3/8/21, which indicated the patient was to receive Skilled Nursing services 1 hour per visit, 3 visits per day (AM, Afternoon, and PM), 7 days per week, and Home Health Aide (HHA) services 4 - 5 hours per day, 5 - 7 days per week. A home visit observation was conducted on 2/10/2021 at 4:07 PM with Patient #1. The home visit observation failed to evidence a plan of care within the patient's home or home health binder. 5. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18. The record contained a plan of care for the recertification period 1/24/21 - 3/24/21, which indicated the patient was to receive HHA services 4 - 7 hours per day, 5 - 7 days per week. The POC also indicated the patient's "Activities	G 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 618	Continued From page 79	G 618		

Permitted" included transfer from bed to chair with a Hoyer lift (type of durable medical equipment which aides in transferring non-ambulating patients).

A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2. During the visit, HHA #1 was observed transferring Patient #2 from the bed to a manual wheelchair using a Drive manual Hoyer lift. Patient #2 reported she was not provided a copy of the manufacturer's instructions for the Hoyer lift by the DME supplier or the home health agency. The home visit observation failed to evidence a plan of care within the patient's home or home health binder.

6. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21 and indicated a start of care date of 7/17/19. The record contained a plan of care for the recertification period 1/9/21 - 3/9/21, which indicated the patient was to receive HHA services 1 - 2 hours per day, 2 - 4 days per week.

A home visit observation was conducted on 2/12/21 at 9:05 AM with Patient #3. The home visit observation failed to evidence a plan of care within the patient's home or home health binder.

7. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19. The clinical record contained plan of care for the recertification period 1/11/21 - 3/11/21. The POC indicated the patient's "Activities Permitted" were transfer from bed to chair and stated the patient was "primarily bedfast." The POC also indicated the patient's "DME [Durable Medical Equipment] And Supplies" included a Hoyer lift. The clinical record failed to evidence a copy of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 618	Continued From page 80 manufacturer's instructions for the patient's Hoyer lift. An interview was conducted on 2/11/2021 at 1:45 PM with the Clinical Manager. During the interview, the Clinical Manager indicated Patient #4 did not use his Hoyer lift to transfer, and would only transfer out of bed when his "friend" was present. The Clinical Manger was unable to report the specific brand or type (manual or electric) of Hoyer lift. 8. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19. The record contained a plan of care for the recertification period 12/6/2020 - 2/3/2021. The POC indicated the patient's "Activities Permitted" were "Up as Tolerated ... Transfer Bed [to] Chair with Hoyer Lift." The clinical record failed to evidence a copy of the manufacturer's instructions for the patient's Hoyer lift. 9. An interview was conducted on 2/12/21 at 1:40 PM with the Alternate Administrator and Clinical Manager. During the interview, the Clinical Manager indicated the care plan did not need to be provided to the patient and maintained in the home, as all agency nurses were provided copies of the plans of care for patients they were managing or providing services. The Clinical Manager stated if a patient had a Hoyer lift, the manufacturer's instructions for the Hoyer lift should be present in a patient's home, and the agency had not provided the manufacturer's instructions to any of their patients with a Hoyer lift. The Clinical Manager also indicated the agency did not have the manufacturer's instructions for Hoyer lifts within Patient #2, 4, or 5's clinical records.	G 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 622	Continued From page 81	G 622		
G 622	Name/contact information of clinical manager CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the patient's home binder contained up-to-date contact information for the agency's clinical supervisor for 3 of 3 home visit observations (#1, 2, 3). Findings include: 1. An undated agency job description titled "Administrator" stated " ... Essential Functions: ... 5. Ensures the accuracy of public information materials ...." 2. A home visit observation was conducted on 2/10/2021 at 4:07 PM with Patient #1 (start of care 9/16/19). During the home visit, the patient's home binder was reviewed, and indicated the agency's clinical supervisor was Former Employee H. 3. A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2 (start of care 4/10/18). During the home visit, the patient's home binder was reviewed, and indicated the agency's clinical supervisor was Former Employee H. 4. A home visit observation was conducted on 2/12/21 at 9:05 AM with Patient #3 (start of care 7/17/19). During the home visit, the patient's home binder was reviewed, and indicated the agency's clinical supervisor was Former Employee H.	G 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 622	Continued From page 82 5. The personnel file of Former Employee H was reviewed on 2/23/21. The personnel file indicated Former Employee H's termination date was 6/15/2020. 6. An interview was conducted on 2/12/21 at 1:40 PM with the Alternate Administrator and Clinical Manager. During the interview, the Clinical Manager indicated the patient's home binder should include up-to-date and accurate contact information for the Clinical Manager, including the name of the employee.	G 622		
G 642	Program scope CFR(s): 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. This Standard is not met as evidenced by: Based on record review and interview, the home health agency failed to evidence its quality assurance and performance improvement (QAPI) program documented which quality indicators it would track, failed to evidence the frequency and method in which quality indicators were to be measured, analyzed, and tracked, and failed to evidence analysis of its quality indicators, with an emphasis of infection control due to the public health emergency related to COVID-19.	G 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 642	Continued From page 83 Findings include: 1. An agency policy titled "Performance Management," dated 7/24/17, stated "Policy: ... Performance measures are selected by QI [the agency's QAPI committee] based on their impact on patient care, services offered, clinical practice, fiscal accountability and cost effectiveness ... The [Home Health Agency] shall also collect data on evaluation and improvement of conditions in the environment, infection prevention and control, and the medication management system. Procedure: ... Data is collected to measure performance of each of the following: Significant medication errors. Significant adverse drug reactions. Patient perception of the safety and quality of care, treatment, or services delivered by the [Home Health Agency]. Patient satisfaction with and complaints about products and services. The timeliness of response to patient questions, problems, and concerns. The impact of the organization's business practices on the adequacy of patient access to equipment, items, services, and information. Adverse events involving patients due to inadequate or malfunctioning equipment, supplies, or services, i.e., injuries, accidents, signs and symptoms of infection, hospitalizations. Staff opinions and needs. Staff perceptions of risk to individuals. Staff suggestions for improving patient safety. Staff willingness to report adverse events (conditions in the organization or patient environment that are related to care, treatment or services) ... Multiple internal / external data sources are organized to monitor and assess home health services for quality of healthcare. Internal data sources include, but are not limited to, the following: Patient clinical records. Patient accident / incident reports. Medication error reports, including reports of near misses.	G 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 642	Continued From page 84 Infection prevention and control reports. Patient perception of care / satisfaction questionnaires. Patient letters and/or comments regarding services. Staff competency assessments ... Performance improvement activity form. Staff orientation, in-service and continuing education records ... Other data relating directly / indirectly to patient care. External data sources include, but are not limited to, the following: Professional organizations. Regulatory agencies ...." 2. An agency document titled "Right at Home Board of Directors Meeting Minutes," dated 12/18/2020, stated " ... QAPI Annual Evaluation will be completed after the final QAPI meeting scheduled [1/21/21] ...." 3. The agency's QAPI binder was reviewed on 2/23/21. The binder included a document titled "Right at Home Quality Improvement Quarterly Meeting for Fourth Quarter 2020," which included the QAPI meeting minutes for the agency's QAPI meeting held on 1/21/2021 at 11:00 AM. Staff present included the Administrator, Alternate Administrator, Clinical Manager, LPN #4, and HR Director #1. The meeting minutes indicated the quality indicators were divided into eight categories, which included: Human Resources, Workplace Safety / OSHA, Scheduling Coordinator, Satisfaction Survey Reports, Employee Suggestions, Clinical / Nursing, and Clinical Audits. The "Human Resources" quality indicators included: "Number of Employees ... Number of New Hire Employees ... Number of HHA [Home Health Aide] Class Participants ... Number of Participants from HHA Class that are still working ... Turnover Report ... % of Employee Competency Evaluations Completed Timely ... % of Annual Employee Competency Evaluations Completed ... % of HHA 12Hour	G 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 642	Continued From page 85 Inservice Completed ... % of Annual Inservice Completed ... % of HHA 12 Hour mandated Inservice Completed ... % of Employee Evaluations Completed ... % of TB [Tuberculosis] Skin Tests Completed Timely ... % of Personnel File Audits that show compliance with content ...." The "Workplace Safety / OSHA" quality indicators included "Workmen Compensation Claims ... Needle or Sharp Injury ... Medical Device Issues ... Number of Employee Infections ... Reportable Events ... Sentinel Events ... Disaster Drills ...." The "Scheduling Coordinator" quality indicators included "Number of Scheduled Visit Hours for SN [Skilled Nursing] and HHA ... Number of Completed Visit Hours for SN and HHA ... Number of Missed Visits ...." The "Satisfaction Survey Reports" quality indicators included "Net Promoter Scores: Staff ... Net Promoter Scores: Patient (Question asked: How likely are you to recommend services from this agency?) ... Patient Satisfaction ... Employee Satisfaction ... Communication from provider improved ... Employee Complaints ... Employee Complaints Resolved ...." The "Employee Suggestions" quality indicator included only "Employee Suggestions." The "Clinical / Nursing" quality indicators included "Number of Patient Admissions and Diagnosis ... Number of Patients Admitted within 48 hours of Referral or MD Order for Start of Care ... Number of Patient Census ... Number of Patients Admitted to Hospital and Reason / Diagnosis ... Number of Patient Discharges with Reasons ... % of Patients Assessed for Pain (Admission, ROC [Resumption of Care], Recertification, SN visit, etc) ... Number of Nutritional Risk Assessments Completed ... Number and Type of Wound Care Patients with Healing Process ... Number of Patients Recertified ... Number of Medication Profiles Completed ... Number and Type of Patient	G 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 642	Continued From page 86	G 642		

Infections Acquired Following Admission ... Number of Patient Incidents / Falls and Type ... Number of Medication Errors ... Number of Medication Adverse Reactions ... % of MD Plans of Care and or Verbal Orders Signed and Returned to [Home Health Agency] Office within 30 days of Receipt of Order ... [Veteran Affairs, VA] Patient Orders are Tracked Weekly with report to VA ... % of Supervisory Visits Completed within Appropriate Time Frame ...." The "Clinical Audits" quality indicators included "Home Health Aide Note (Findings) ... Nurses Notes (Findings) ...." The meeting minutes stated " ... New Business: ... Process of tracking infections for employees and patients reviewed. Process for tracking COVID exposure and COVID immunizations for employees and patients reviewed. Protocol for tracking employees and patients with signs / symptoms of COVID and or a positive COVID test reviewed ...." The QAPI meeting minutes failed to evidence an analysis was conducted of the quality indicators, including monitoring and assessing for COVID-19 infections and risk factors. The agency's QAPI documentation failed to evidence a governing-body agreed upon plan for the specific quality indicators to be tracked, the frequency and method of tracking quality indicators, and frequency and method of analyzing the quality indicators.

4. An interview was conducted on 2/23/21 at 3:46 PM with the Administrator, Alternate Administrator, and Clinical Manager. During the interview, the Alternate Administrator indicated she was responsible for the agency's QAPI program. The Alternate Administrator indicated the agency's QAPI quality indicators were "all of the indicators" within the QAPI meeting minutes and were analyzed quarterly during the QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 642	Continued From page 87 meeting. The Alternate Administrator stated the quality indicators were analyzed by the staff present "talking about" each indicator. The Alternate Administrator also indicated the agency's Governing Body reviewed and approved the QAPI program annually, and this included approving the quality indicators tracked and the method used to track each indicator. 17-12-2(a)	G 642		
G 656	Improvements are sustained CFR(s): 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure its quality assurance and performance improvement (QAPI) program measured and analyzed its performance improvement projects (PIP) for success and sustained improvements. Findings include: 1. An agency policy titled "Organizational Performance Improvement Plan," dated 7/24/17, stated "Purpose: ... Evaluate, monitor, improve and resolve areas of concern ... Goals: ... The status of identified problems is monitored to assure improvement or resolution ... Methodology: The Plan, Do, Check, Act (PDCA) methodology is utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization ... Do: Data is collected to determine: Whether design specifications for new	G 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 656	Continued From page 88	G 656		

processes were met ... Act: Take actions to correct identified problem areas or improve performance. Evaluate the effectiveness of the actions taken and document the improvement in care ... Reporting Format: ... Results of the outcomes of performance improvement activities ... will be reported to the Performance Improvement Committee on a quarterly basis as designated ...."

2. The agency's QAPI binder was reviewed on 2/23/21. The binder included an undated document titled "PDSA Worksheet for Testing Change," which was indicated by agency staff as Performance Improvement Plan (PIP) documentation. The document stated "3 Fundamental Questions for Improvement: 1. What are we trying to accomplish? ... All Care Plans for HHA [Home Health Aide] are accurate [and] reflective of patient needs. 2. How will we know that a change is an improvement? ... HHA notes will be accurate according to Care Plan. 100% of audited notes will be accurate. Patient will receive care necessary to enhance quality of life and meet needs ... Plan: ... Due Date: 4/1/2020 ... Do: Describe what happened when you conducted the [PIP]: 1. HHA notes audited weekly for accuracy of duties. Two HHAs identified [with] need for further education. Study: Describe how the measured results and observations compared with predictions: Improvements noted in documentation by HHA on notes of care given. Act: Determine the steps (e.g., modify the idea and retest ... spread the idea ... test a new idea). 1. Will continue [with] weekly audits of HHA notes. 2. If HHA note not completed correctly will continue with ongoing education of HHA. Education to include one on one teaching, follow up performance and return demonstration. 3 ... HHA note ... created for

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	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 656	Continued From page 89 each individual patient ... reviewed [every] 60 days and updated as needs change." The PIP documentation failed to evidence the date the PIP was enacted, the percentage of accurate HHA notes found during chart audits (indicated within the documentation as the method of measuring the success of the PIP), and the date the PIP was completed. The agency's QAPI binder included a document titled "Right at Home Quality Improvement Quarterly Meeting for First Quarter of 2020 (January, February and March)," dated 4/22/2020 at 1:30 PM. The QAPI meeting minutes indicated the Administrator, Alternate Administrator, Clinical Manager, HR Director #1, QI Assistance #1, and Former Employee H were present for the meeting. The meeting minutes stated " ... Home Health Aide Notes (Findings): The amount of HHA note corrections has recently increased due to aides not following the client's care plan. [Alternate Clinical Manager] / HR has helped create notes for each individual client that only allows the HHA to mark tasks that follow that client's care plan. This has been recently implemented and we hope it will solve and limit the amount of note corrections ...." The QAPI meeting minutes failed to evidence specific measurement and analysis of the agency's PIP (was the PIP continued, modified, or completed). The agency's QAPI binder included a document titled "Quality Improvement Quarterly Meeting for Second Quarter of 2020," dated 7/17/2020 at 10:00 AM. The document indicated the Administrator, Alternate Administrator, Clinical Manager, HR Director #1, and QI Assistant #1 were present for the meeting. The meeting minutes stated " ... Home Health Aide Notes (Findings): Now using 90% of new formatted	G 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 656	Continued From page 90 Home Health Aide Notes. More accurate documentation now ...." The QAPI meeting minutes failed to evidence specific measurement and analysis of the agency's PIP. The agency's QAPI binder included a document titled "Quality Improvement Quarterly Meeting for Third Quarter of 2020," dated 10/23/2020 at 10:00 AM. The document indicated the Administrator, Alternate Administrator, Clinical Manager, HR Director #1, Scheduling Coordinator #1, and QI Assistant #1 were present for the meeting. The meeting minutes stated " ... Home Health Aide Notes (Findings): [Section blank] ...." The QAPI meeting minutes failed to evidence if the agency PIP had been completed, and if so, failed to evidence if the PIP resulted in sustained improvement in HHA documentation accuracy. 3. An interview was conducted on 2/23/21 at 3:46 PM with the Administrator, Alternate Administrator, and Clinical Manager. During the interview, the Alternate Administrator indicated the agency evaluated the success of its PIPs "through audits," and these were discussed during the QAPI quarterly meetings. The Alternate Administrator also indicated the agency's PIP regarding HHA documentation accuracy was determined as completed and closed by the QAPI committee. 17-12-2(a)	G 656		
G 682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of	G 682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 682	Continued From page 91	G 682		

infections and communicable diseases.
This Standard is not met as evidenced by:
Based on observation, record review and interview, the home health agency failed to ensure all employees followed agency infection control policies and procedures and standard precautions for 3 of 3 home visit observations (#1, 2, 3).

Findings include:

1. An undated agency policy titled "Hand Washing," policy number C-130, stated " ... The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: ... After caring for a client ... Procedure: ... 9. Wet hands ... 10. Apply soap to hand, lathering thoroughly. 11. Wash hands, using plenty of lather and friction for at least 10 to 15 seconds ... 13. Rinse hands and wrists thoroughly ..."

2. An undated agency document titled "Handwashing: at Home, at Play, and Out and About," indicated as written by the CDC, stated " ... What is the right way to wash your hands? ... Scrub all surfaces of your hands ... Keep scrubbing for at least 20 seconds ...."

3. An undated agency policy titled "Nursing Bag," policy number N-120, stated " ... Guidelines: The inside of the bag and its contents are considered clean. Therefore: Hand washing must occur before entering the bag for any reason. All items removed from the bag should be cleaned before returning to the bag ...."

4. Centers for Disease Control and Prevention (Updated 2/10/21). "Infection Control Guidance." Retrieved 3/9/21 from www.cdc.gov. " ... CDC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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G 682	Continued From page 92 recommends using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those suspected or confirmed SARS-CoV-2 infection ... Implement Universal Use of Personal Protective Equipment [PPE] ... HCP [Health Care Providers] should use PPE as described below: HCP should follow Standard Precautions ... One of the following should be worn by HCP for source control ... and for protection during patient care encounters: ... A well-fitting face mask (e.g., selection of a facemask with a nose wire ... use of a cloth mask over the facemask to help it conform to the wearer's face) ...." 5. Healthwise Staff (7/17/2020). "Caregiving: How to Give a Bed Bath." Obtained 3/9/2021 from www.peacehealth.org. " ... Some things to remember: After you or your loved one washes an area, turn the washcloth so you can use a new, clean part of it for the next area. Use a new washcloth when you need one ... How to help with or give the bath: ... 7. Start with the cleanest areas of the body and finish with the areas that are less clean ... Using a new washcloth, clean ... the anal area ...." 6. A home visit observation was conducted on 2/10/2021 at 4:07 PM with Patient #1 (start of care 9/16/19) and Licensed Practical Nurse (LPN) #1. During the visit, the LPN washed her hands, donned a pair of gloves, and removed a blood pressure cuff and stethoscope from her nursing bag. The LPN obtained the patient's blood pressure and heart rate using the blood pressure cuff, wiped the cuff with an alcohol cleansing wipe, and immediately placed the blood pressure	G 682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 682	Continued From page 93 cuff into a plastic bag within her nursing bag. The LPN then removed a thermometer and SpO2 (oxygen saturation, measurement of the percentage of blood with oxygen) from the nursing bag with gloved hands, obtained the patient's SpO2 and temperature, wiped the SpO2 monitor and thermometer with an alcohol cleansing wipe, and placed them with gloved hands immediately into the plastic bag within her nursing bag. After obtaining the patient's vital signs, the LPN auscultated the patient's anterior and posterior chest and abdomen with a stethoscope, cleaned the stethoscope with an alcohol cleansing wipe, and placed the stethoscope with gloved hands into the plastic bag within the nursing bag. The nurse then reached into her pocket with gloved hands, took out her phone, observed the patient's respiratory rate (number of breaths per minute), wiped the phone with an alcohol cleansing wipe, and immediately placed the phone with gloved hands into her pocket. Later in the visit, LPN #1 reached into her nursing bag with the same gloved hands, removed her stethoscope from the plastic bag in the nursing bag, auscultated Patient #1's abdomen again, cleaned the stethoscope with an alcohol cleansing wipe, and immediately with gloved hands placed the stethoscope back into the plastic bag within her nursing bag. At the end of the visit, LPN was observed removing her gloves, retrieving her nursing bag, and leaving the patient's home. The LPN failed to allow the alcohol to dry on the vital sign equipment and stethoscope before placing them into her nursing bag, failed to enter the nursing bag or pocket with clean hands (hand wash or use hand sanitizer prior), failed to allow the alcohol to dry on her phone before returning it to her pocked, and failed to perform hand hygiene after removing her gloves.	G 682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 682	Continued From page 94 7. A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2 (start of care 4/10/18) and HHA #1. During the visit, the HHA was observed performing a bed bath to Patient #2, and was wearing a cloth mask during the visit. HHA #1 donned gloves, prepared the patient's bath supplies and water, removed her gloves, and performed hand hygiene with soap and water by turning on the faucet, applied soap, scrubbed her hands for 6 seconds, ran her hands under the water for 1 second, scrubbed her hands again for 5 seconds, rinsed, and then dried her hands (total scrubbing time was 11 seconds). After the patient washed her arms and chest independently, the HHA took the water basin to the bathroom, performed hand hygiene using ABHS, donned gloves, obtained new bath water, removed gloves, immediately donned new gloves, took the basin back to the patient's bedside, and began washing the patient's back. After HHA #1 washed the patient's back, she removed her gloves, placed a towel behind the patient's back, and handed the patient a bottle of lotion. The HHA then donned new gloves, handed deodorant to the patient, removed her gloves, and immediately donned new gloves. The patient continued her bathing process and the HHA obtained new bath water, then removed her gloves, started to don new gloves, stopped part way through donning the gloves, removed the gloves, performed hand hygiene using alcohol-based hand sanitizer (ABHS), then donned the same pair of gloves. The HHA continued gathering supplies for the patient's bath, removed her gloves, and performed hand hygiene with soap and water by turning on the faucet, applied soap, scrubbed her hands for 10 seconds, ran her hands under the running water for 2 seconds, scrubbed her hands again for 10	G 682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 682	Continued From page 95	G 682		

seconds (total scrubbing time 20 seconds), rinsed and then dried her hands. HHA #1 returned to the patient's bedside, moved the patient's cell phone out of the way of the bath supplies, removed her gloves, and immediately donned new gloves. The HHA set up the patient's bath items on the bedside table, removed her gloves, performed hand hygiene with soap and water by applying soap, scrubbed her hands under running water for 21 seconds, rinsed and dried her hands, then donned new gloves. Later during the bath, the HHA obtained fresh bathing water, removed her gloves, pulled up her pants, and donned new gloves. One glove broke while the HHA was donning. HHA #1 removed the broken glove and donned a new one. The HHA continued to assist Patient #2 with her bath. Later during the bath, the HHA assisted Patient #2 to turn on her left side. The patient had stool on her rectum and linens from an episode of bowel incontinence (inability to control bowel movements). HHA #1 wiped the stool from the patient's rectum and exposed buttocks using a washcloth, removed her gloves, performed hand hygiene using soap and water, donned new gloves, and removed a dressing which covered the patient's bilateral (both sides of body) buttocks and posterior pelvic area. Patient #1 was noted to have multiple pressure ulcer wounds to her bilateral buttocks and pelvic area. The HHA used the same washcloth to clean the patient's wounds that was used to clean the stool from the patient's rectum. HHA #1 completed the patient's bath, put up the bath supplies, assisted the patient with passive Range of Motion (ROM) exercises, applied compression stockings to the patient's legs, removed her gloves, performed hand hygiene using ABHS and soap and water, then donned new gloves. The HHA then had an alarm begin to signal on her phone. The HHA reached into her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 682	Continued From page 96	G 682		

pocked, retrieved her phone, turned off the alarm, removed her gloves, adjusted the settings on the patient's tablet, pulled up her hands, then performed hand hygiene with ABHS and donned new gloves. The HHA then began to assist the patient to transfer from the bed to her wheelchair using the Hoyer lift. HHA #1 assisted the patient to roll onto the Hoyer sling, removed her gloves, applied ABHS to her hands, began to rub her hands together, adjusted her mask with her hands, then completed rubbing her hands together until the ABHS and her hands were dry. The HHA failed to wear appropriate Personal Protective Equipment (PPE), failed to perform hand washing per agency policy, failed to perform hand hygiene immediately after removing gloves and in between glove changes, failed to use a clean washcloth to wash the patient's wounds, and failed to perform hand hygiene using ABHS according to agency policy.

An interview was conducted on 2/11/21 at 11:20 AM with HHA #1. During the interview, the HHA indicated she wore cloth masks instead of surgical masks during home visits due to personal preference.

8. A home visit observation was conducted on 2/12/21 at 9:05 AM with Patient #3 (start of care 7/17/19) and HHA #10. During the visit, HHA #10 was observed assisting Patient #3 with a shower. The HHA performed hand hygiene using soap and water, donned gloves, and washed the patient's bath when requested by the patient. Patient #3 completed the shower, exited the shower, dried herself, and then put on her shirt. HHA #10 removed her gloves and scratched her nose and abdomen. The patient completed dressing, brushed her hair, walked to her living room, and sat down. The HHA was not observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 682	Continued From page 97 performing hand hygiene prior to the surveyors leaving the home visit observation (the HHA remained in the home, as the visit was not completed). HHA #10 failed to perform hand hygiene after removing gloves. 9. An interview was conducted on 2/12/21 at 1:40 PM with Alternate Administrator and Clinical Manager. During the interview, the Clinical Manager indicated equipment should be dried after cleaning with alcohol cleansing wipes before returning the nursing bag, staff should remove gloves and perform hand hygiene prior to obtaining items from the nursing bag, and staff should perform hand hygiene immediately after removing gloves. The Clinical Manager also indicated staff should perform hand hygiene in between glove changes, staff should not use the same washcloth used to clean the patient's rectum on another part of the body, and when performing hand hygiene by washing hands with soap and water, staff should scrub their hands with soap for "at least 20 seconds" outside of running water and should not rinse their hands under running water in the middle of scrubbing with soap. 17-12-1(m)	G 682		
G 684	Infection control CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include:	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 98 (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This Standard is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure an agency-wide infection control program was maintained for the surveillance, identification, prevention, control, and investigation of patient and staff infections for 7 of 7 infection control log entries of patients with documented symptoms of COVID-19 (#1, 5, 8, 13, 14, 15, 16), 1 of 1 infection control log entries for patients with no symptoms but a diagnosis of "respiratory infection" (#12), 3 of 12 infection control log entries of employees with potential or suspected COVID-19 (HHAs #11, 12; Former Employee L), 1 of 1 active records reviewed which indicated the patient developed symptoms of COVID-19 (#5), and 1 of 3 home visit observations (#1), which had the potential to effect all agency patients and employees. Findings include: 1. An agency policy titled "Exposure to Corona Virus (2019-nCoV)," dated 3/11/2020 and policy number 5001-A, stated " ... The purpose of this policy is to follow the recommendations of the CDC [Centers for Disease Control and Prevention] by supplementing the agency's existing policies and procedures pertaining to infection prevention and control, and by providing guidance on effective and legally compliant response to reports of potential [COVID-19] exposure ... Recommendations for the Screening	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 99 and Assessment of Patients for [COVID-19] ... 3. Clinicians should assess patients based on the following: a. Does the patient have fever or symptoms of lower respiratory infection, such as cough or shortness of breath ... 4. Patients who report having these symptoms and meet the criteria of the clinical features for PUI [Person Under Investigation] should be asked to wear a surgical mask ... Staff involved in the care should also follow standard precautions, contract precautions, and airborne precautions ...." 2. An agency policy titled "Infection Prevention and Control Program," dated 7/24/17 and policy number 5001, stated " ... Policy: Right at Home's Infection Prevention and Control Program ensures that this organization develops implements [sic] and maintains an active, organizationwide [sic] program for the prevention, control and investigation of infection and communicable diseases ... The Infection Prevention and Control Program at Right at Home incorporates the following ... Surveillance, prevention and control of infections throughout the organization ... Evaluation and monitoring results ... Activities: Infection prevention and control activities include ... Monitoring and evaluation of key performance aspects of infection preventi9on and control surveillance, prevention and management: ... Other communicable diseases. Staff health trends ... Continuously collecting and/or screening data to identify isolated incidents or potential infectious outbreaks. Analyzing data for problems or undesired trends. Determining if infections are organization acquired or community acquired. Examining data for common factors related to the [agency's] processes, systems, or functions that could have resulted in infection transmission ... Program Elements: Review and evaluation of	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 100 confirmed infections to assure correct implementation of Standard Precautions ...." 3. CDC (Updated 2/23/21). "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic." Retrieved 3/9/21 from www.cdc.org. " ... CDC recommends using additional infection prevention and control practices during the COVID-19 pandemic, along with standard practices recommended as a part of routine healthcare delivery to all patients. These practices are intended to apply to all patients, not just those with suspected or confirmed [COVID-19] ... Facilities should develop policies and procedures to ensure recommendations are appropriately applied in their setting (e.g., ... home healthcare delivery) ... Re-evaluate admitted patients for signs and symptoms of COVID-19. Screening for fever and symptoms should also be incorporated into daily assessments of all admitted patients. All fevers and symptoms consistent with COVID-19 among admitted patients should be properly managed and evaluated) ... Create a Process to Respond to [COVID-19] Exposures about HCP [Health Care Personnel] and Others. Healthcare facilities should ... establish a plan ... for how exposures in a healthcare facility will be investigated and managed and how contract tracing will be performed. The plan should address the following: Who is responsible for identifying contacts ... and notifying potentially exposed individuals? How will such notifications occur? What actions and follow up are recommended for those who were exposed ...." 4. CDC (Updated 2/22/2021). "Symptoms of Coronavirus." Retrieved 3/9/2021 from www.cdc.gov. " ...People with COVID-19 have	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 684	Continued From page 101	G 684		

had a wide range of symptoms reported ... People with these symptoms may have COVID-19: Fever or chills. Cough. Shortness of breath or difficulty breathing. Fatigue [tiredness]. Muscle or body aches. Headache. New loss of taste or smell. Sore throat. Congestion or runny nose. Nausea or vomiting. Diarrhea ... Look for emergency warning signs for COVID-19 ... Trouble breathing ... New confusion ...."

5. Centers for Medicare & Medicaid Services (Revised 4/23/2020). "Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Home Health Agencies ...." Retrieved 3/9/21 from www.cdc.org. " ... Per CDC, prompt detection, triage, and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients, healthcare personnel ... When making a home visit ... [staff] should ask patients about the following: 1. International travel within the last 14 days to countries with sustained community transmission ... 2. Signs or symptoms of a respiratory infection, such as a fever, cough, and shortness of breath ... 3. In the last 14 days, has had contact with someone with or under investigation for COVID-19, or who is ill with respiratory illness. 4. Residing in a community where widespread community-based transmission of COVID-19 is occurring ... How should [Home Health Agencies] monitor or restrict home visits for health care staff? ... Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should: ... Inform the [home health agency] clinical manager of information on individuals, equipment, and locations the person came in contact with ...."

6. The survey's Entrance Conference was conducted on 2/10/21 at 10:57 AM with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 102 Administrator, Alternate Administrator, and Clinical Manager. During the Entrance Conference, the Alternate Administrator indicated she oversaw the tracking of infections for patients and employees. The Alternate Administrator indicated prior to each Home Health Aide (HHA) shift, the aide would conduct a COVID-19 screening of themselves and the patient. The screening was performed using the agency's EVV (Electronic Visit Verification), and would send an alert to the agency if the HHA or patient had a positive screening. The Alternate Administrator stated the agency nurses did not conduct a formal COVID-19 screening as they were "assessing for the [COVID-19] signs and symptoms" during the nurse assessment portion of the visit. The Clinical Manager indicated if a patient was diagnosed with COVID-19, the agency would complete a "14-day tracking form," and the agency had only had two employees exposed to patients with suspected COVID-19. 7. A home visit observation was conducted on 2/10/2021 at 4:07 PM with Patient #1 and LPN #1. During the visit, LPN #1 failed to screen the patient for COVID-19 according to CMS guidelines (see Finding #5). 8. The agency's Infection Control binder from 1/1/2020 - 2/10/2021 was reviewed on 2/23/21. The binder contained agency documents titled "Patient Infection Control Log," and "Employee Infection Log." The agency's "Employee Infection Log" included an unsigned entry, dated 12/1/2020, which indicated HHA #11 had COVID-19 symptoms (specific symptoms not stated," the employee quarantined and had a negative COVID-19 test on 12/1/2020. The log failed to evidence the date the employee's symptoms started, if any patients were exposed	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 684	Continued From page 103	G 684		

to the employee two days prior to the onset of symptoms and/or while the employee was experiencing symptoms, the date the employee's symptoms resolved, and the date the employee returned to work.

The "Patient Infection Control Log" included an entry by LPN #4, dated 11/2/2020, which indicated Patient #5 (start of care (SOC) 2/15/19) developed a "URI [Upper Respiratory Infection]," and was noted to have a temperature of "103 [degrees Fahrenheit]." No other symptoms were logged. The log entry indicated the physician was notified and the patient's treatment was "Azithromycin [an antibiotic given to treat bacterial infections]." The infection control log failed to evidence if the patient was screened for other COVID-19 symptoms (cough, shortness of breath, chills, etc), failed to indicate the date, time, and employee who notified the physician, failed to evidence if the patient was tested for COVID-19 or the physician declined to order a test, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the "Resolution" of the infection (did patient's symptoms resolve, and if so, what was the date?).

The agency's "Patient Infection Control Log" included an entry by LPN #4, dated 10/27/2020, which indicated Patient #1 (SOC 9/16/19) had a "Sinus Infection" with reported symptoms of nasal drainage and head congestion. The log entry indicated the patient's physician was notified, the patient was prescribed Azithromycin, and the infection was "resolved." The infection log failed to evidence if the patient was screened for other COVID-19 symptoms, failed to indicate the date, time, and employee who notified the physician, failed to evidence if the patient was tested for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 684	Continued From page 104 COVID-19 or the physician declined to order a test, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the specific "Resolution" of the infection. The agency's "Employee Infection Log" included an unsigned entry, dated 9/10/2020, which indicated HHA #12 had "suspected coronavirus," the employee completed a "self quarantine," and had a negative COVID-19 test. The log failed to evidence the date the employee's symptoms started, if any patients were exposed to the employee two days prior to the onset of symptoms and/or while the employee was experiencing symptoms, the number of days the employee quarantined, the date the employee's symptoms resolved, the date the patient was tested, the date the test results were received, and the date the employee returned to work. The agency's "Patient Infection Control Log" included an entry by LPN #4, dated 8/9/2020, which indicated Patient #8 (discharge date 11/13/2020) developed "Pneumonia [an infection of the lungs]" with reported symptoms of "diminished lung sounds [to] all [lung] lobes." The entry indicated the patient's physician was notified, the patient was admitted to the hospital, and the infection was "resolved." The infection log failed to evidence if the patient was screened for other COVID-19 symptoms, failed to indicate the date, time, and employee who notified the physician, failed to evidence if the patient was tested for COVID-19 during hospitalization, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the specific "Resolution" of the infection.	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 684	Continued From page 105 The agency's "Patient Infection Control Log" included an entry by LPN #4, dated 8/7/2020, which indicated Patient #12 (SOC 6/9/2020) developed a "Resp [Respiratory]" infection but was "Asymptomatic [without symptoms]." The log indicated the patient's physician ordered a Chest Xray during an office visit, the patient was prescribed "Levofloxacin [an antibiotic], and the infection was "resolved." The infection log failed to evidence if the patient was screened for other COVID-19 symptoms, failed to evidence if the patient was tested for COVID-19 or the physician declined to order a test, failed to evidence the results of the Chest Xray, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the specific "Resolution" of the infection. The agency's "Employee Infection Log" included an unsigned entry, dated 7/23/2020, which indicated Former Employee L had "suspected coronavirus," the employee completed a "self quarantine," and had a negative COVID-19 test. The log failed to evidence the date the employee's symptoms started, if any patients were exposed to the employee two days prior to the onset of symptoms and/or while the employee was experiencing symptoms, the number of days the employee quarantined, the date the employee's symptoms resolved, the date the patient was tested, the date the test results were received, and the date the employee returned to work. The agency's "Patient Infection Control Log" included an entry by LPN #4, dated 6/8/2020, which indicated Patient #13 (Discharge Date 8/1/2020) developed "Pneumonia," with symptoms of "Altered mental status. Difficulty breathing." The log entry indicated the patient's	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 106	G 684		

physician was notified, the patient was admitted to the hospital and treated, and the infection was "Resolved." The infection log failed to evidence if the patient was screened for other COVID-19 symptoms, failed to evidence if the patient was tested for COVID-19 during hospitalization, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the specific "Resolution" of the infection.

The agency's "Patient Infection Control Log" included an entry by LPN #4, dated 5/13/2020, which indicated Patient #14 (Discharge Date 6/1/2020) developed a "Resp. Infection," with the symptoms of dyspnea (shortness of breath), swelling to the lower legs and feet, and weight gain. The log indicated the patient's physician was notified, the patient was admitted to the hospital and treated, and the infection was "resolved." The infection log failed to evidence if the patient was screened for other COVID-19 symptoms, failed to evidence if the patient was tested for COVID-19 during hospitalization, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the specific "Resolution" of the infection.

The agency's "Patient Infection Control Log" included an entry by LPN #4, dated 4/24/2020, which indicated Patient #15 (SOC 2/20/2020) developed a "Sinus Infection," with symptoms of "facial flushing and diaphoresis [excessive sweating]." The log entry indicated the patient's physician was notified, the patient was treated with Doxycycline (an antibiotic given to treat bacterial infections), Zyrtec (given to treat allergies), and Mucinex (given to treat cough), and the infection was resolved. The infection log

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 107	G 684		

failed to evidence if the patient was screened for other COVID-19 symptoms, failed to evidence if the patient was tested or if the physician declined to order a test, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the specific "Resolution" of the infection.

The agency's "Patient Infection Control Log" included an entry by LPN #4, dated 3/24/2020, which indicated Patient #16 (Discharge Date 10/7/2020) developed a respiratory infection with the symptom of a "productive cough." The log entry indicated the patient's physician was notified, the patient was prescribed Cefdinir (antibiotic given to treat bacterial infections), and the infection was indicated as "Resolved." The infection log failed to evidence if the patient was screened for other COVID-19 symptoms, failed to evidence if the patient was tested for COVID-19 or if the physician declined to order the test, failed to evidence if any agency employees were exposed to the patient and tracked for symptoms, and failed to indicate the specific "Resolution" of the infection.

9. The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: Cerebral Palsy (group of movement disorders which result from brain damage prior to birth or early childhood), Neurologic Neglect (inability for patient to sense or move one side of the body), and Bowel Incontinence (inability to control bowel movements). The record contained a plan of care for the recertification period 12/6/2020 - 2/3/2021. The plan of care included orders which stated " ... Oxygen at 0.5 L/min [liters per minute, also expressed as LPM, how oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 684	Continued From page 108 administration is dosed] via Mask PRN [as needed]. May titrate to 1L to keep O2 SAT [Oxygen Saturation, also expressed as SpO2, a vital sign which measures the percentage of blood which contains oxygen] > 93%. Notify MD if Resp [respirations] < 11 per min [minute], or if patient is showing signs or symptoms of dyspnea and if HR > 110, SBP [systolic blood pressure, the first of two numbers in a blood pressure reading] < 80 ...." The plan of care also included orders for Skilled Nurse (SN) services with visits 8 hours per day, 5 days a week and Respite SN services up to 60 hours per month. A "Nursing Visit Note," documented on 2/3/21 by LPN #3, indicated the patient's heart rate was "118," oxygen was administered at "3" L/min and the SpO2 was "96%." LPN #3 documented the patient exhibited "Dyspnea [shortness of breath] ... At rest." The nursing note failed to evidence the nurse screened the patient for COVID-19 and failed to evidence the nurse notified the patient's physician and the agency's clinical manager of the patient's symptoms. A "Nursing Visit Note," documented on 2/1/21 by LPN #4, indicated the patient's oxygen was administered at "3" L/min and SpO2 was "97%." The visit note summary stated " ... [Patient #5 had a] rough night. Labored breathing," and indicated the patient's blood pressure prior to end of the shift was "77/63." LPN #3 indicated the patient's family member contacted the patient's physician as the patient's "current ATB [antibiotic] not effective enough," and the patient was started on Azithromycin. The nursing note failed to evidence the nurse screened the patient for COVID-19 and failed to evidence the nurse notified the patient's physician and the agency's clinical manager of the patient's symptoms and new antibiotic.	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 109 A "Nursing Visit Note," documented on 1/30/21 by LPN #3, indicated the patient's oxygen was administered at "3" L/min, SpO2 was 96%, heart rate was "120,", and blood pressure was "84/53." LPN #3 documented the patient had "crackles" to all lung lobes and dyspnea at rest. The nursing note failed to evidence the nurse screened the patient for COVID-19 and failed to evidence the nurse notified the patient's physician and the agency's clinical manager of the patient's symptoms. A "Nursing Visit Note," documented on 1/28/21 by LPN #3, indicated the patient's oxygen was administered at "2.5" L/min, SpO2 was "97%," heart rate was "115," and blood pressure was "83/45." LPN #3 documented the patient had "crackles" to all lung lobes (abnormal sound heard during auscultation of the lungs, normally resulting from infection and/or inflammation) and dyspnea at rest. The nursing note failed to evidence the nurse screened the patient for COVID-19 and failed to evidence the nurse notified the patient's physician and the agency's clinical manager of the patient's symptoms. A "Nursing Visit Note," documented on 1/27/21 by LPN #3, indicated the patient's oxygen was administered at "2.5" L/min via nasal cannula, SpO2 was "98%," respiratory rate was "22," and heart rate was "143." LPN #3 documented the patient had "crackles" to both lower lung lobes, and dyspnea at rest. The nurse also documented the patient was started on Doxycycline. The nursing note failed to evidence the nurse screened the patient for COVID-19 and failed to evidence the nurse notified the patient's physician and the agency's clinical manager of the patient's symptoms and new antibiotic.	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 110 A "Nursing Visit Note," documented on 1/26/21 by LPN #3, indicated the patient's oxygen was administered at "2" L/min, SpO2 was "97%," respiratory rate was "23," heart rate was "123," and blood pressure was "83/59." LPN #3 documented the patient had "crackles" to the left lower lung lobe, there were no breath sounds to the right lower lung lobe (meaning no air getting to this area), and dyspnea at rest. The nursing note failed to evidence the nurse screened the patient for COVID-19 and failed to evidence the nurse notified the patient's physician and the agency's clinical manager of the patient's symptoms. A "Nursing Visit Note," documented on 1/25/21 by LPN #4, indicated the patient's oxygen was administered at "2.5" L/min, SpO2 was "95-96%," heart rate was "122." The nursing note summary stated "9 AM [beginning of shift] ... Client O2 sat was 88% on Room Air [no supplemental oxygen] briefly for turning ... Following routine meds and nebulizer, percussion [treatment] ... [Patient] currently on [oxygen at] 2.5 [L/min] per [patient's family member] ...." LPN #3 documented she contacted the Clinical Manager at 11 AM to inform her of the patient's condition, and the patient's family member contacted the patient's medical provider. The patient's medical provider returned the call (specific time not documented) and a Chest Xray was ordered. Later in the shift (specific time not documented), the nurse documented the patient's respiratory rate was 28 breaths per minute and heart rate was 140. The patient's oxygen was titrated down by the nurse to 1.5 L/min. At 4 PM, the nurse documented the patient's heart rate was 140, and at 4:30 PM, the nurse documented the patient's heart rate was 136. The nursing note failed to evidence the nurse screened the patient for COVID-19 and	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 111	G 684		

failed to evidence the nurse requested an order from the medical provider for the patient be tested for COVID-19.

A "Nursing Visit Note," documented on 1/24/21 by LPN #4, indicated during the visit (no specific time documented) the patient's respiratory rate was 24 breaths per minute, heart rate was 140, and SpO2 was 92 - 94%. The nursing summary stated " ... 5:45 PM: [Patient's family member] stopped feeding in progress. Lift transfer to bed ...," and indicated the patient's follow up vital sign check at 6:30 PM was SpO2 92%, respiratory rate of 24, and the patient had "labored breathing." LPN #4 documented oxygen was started at 1 L/min (route not documented), and the patient's follow up vital sign check at 7 PM was SpO2 97%, respiratory rate 20, blood pressure 88/56, heart rate 125, and the patient was exhibiting no "distress." The nursing note failed to evidence the nurse screened the patient for COVID-19 and failed to evidence the nurse notified the patient's physician and the agency's clinical manager of the patient's symptoms.

The agency's infection control log failed to evidence documentation and tracking of Patient #5's infections, including the dates she was prescribed an antibiotic (1/27/21 and 2/1/21).

10. An interview was conducted on 2/23/21 at 3:46 PM with the Administrator, Alternate Administrator, Clinical Manager, and HR Director #1. During the interview, HR Director #1 indicated if an agency employee reported symptoms of COVID-19, she did not document the patients and/or other employees potentially exposed to the employee. HR Director indicated if the employee tested positive, she would contact patients potentially exposed to the patient and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 112 "educate on [COVID-19] symptoms."	G 684		
G 706	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This Element is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct and document a complete and thorough assessment per professional and agency standards for 1 of 1 skilled nurse visit observations (#1) and failed to assess the patient's skin and wound condition for 1 of 2 active patient records with the presence of a wound (#2), in a total sample of 11 records. Findings include: 1. An agency policy titled "Assessment - Nursing," revised 1/15/18 and policy number 10008, stated " ... Policy: ... The patient shall be assessed and reassessed during each skilled visit ... The Comprehensive Assessment ... includes the following information ... Pertinent physical findings ...." 2. An undated agency job description titled "Licensed Practical Nurse [LPN]," stated "Job Summary: Performs nursing care to patient in accordance with an established plan of care ...." 3. An undated agency job description titled "Registered Nurse [RN]," stated " ... Essential Functions: ... Performs comprehensive subjective and objective ... ongoing assessment of client status that includes physical ... parameters ...." 4. The clinical record of Patient #1 was reviewed	G 706		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 706	Continued From page 113	G 706		

on 2/16/21 and 2/17/21 and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes. The record included a plan of care for the recertification period 1/8/21 - 3/8/21, and included orders for Skilled Nurse (SN) visits 1 hour per visit, 3 visits per day, 7 days per week. The plan of care stated SN interventions were to include "Every Visit: Skilled Assessment and Evaluation of all Systems ... Diabetic Foot Exam daily per Patient or SN ...."

A home visit observation was conducted on 2/10/2021 at 4:07 PM with Patient #1 and LPN #1. During the visit, LPN #1 was observed performing a nursing assessment of the patient. LPN #1 assisted Patient #1 with removing his slippers, pressed on the middle anterior portion of the patient's feet with her pen, and continued with the visit. The nurse failed to conduct a complete and thorough diabetic foot exam on the patient.

5. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord) and paraplegia (inability to move the lower portion of the body). The record contained a comprehensive assessment, completed on 1/21/21 by Former RN I, for the recertification period 1/24/21 - 3/24/21. The comprehensive assessment included a section titled "Skin / Wound / Ostomy," which was marked out by the nurse, indicating the patient had no skin issues or wounds.

A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2. During the home visit, Patient #2 was #2 was observed to have redness to her sacrum (lowest area of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 706	Continued From page 114 spine, directly above the coccyx) and both buttocks, one Stage 2 pressure ulcer (wound caused by prolonged pressure, resulting in damage to the first layers of the skin) to the right buttock, two or three (surveyor unable to distinguish number of wounds due to area covered with white medicated cream) Stage 2 pressure ulcers to the left buttocks, and one Stage 2 pressure ulcer to a skin fold on the right posterior thigh. The patient reported the wounds were "shearing" wounds. The left and right buttock wounds were covered with a dry ABD pad (type of gauze dressing) and tape, and the wound to the right posterior thigh did not have a dressing or topical cream noted. Home Health Aide (HHA) #1 indicated she would apply Coloplast Hydrophilic Wound Cream (a medicated ointment which assists with wound healing) to the wounds on the patient's sacrum and buttocks. HHA #1 also stated she changed the dressing to the patient's sacrum and bilateral buttocks every day with the patient's bath, and did not apply any dressing or ointments to the wound on the patient's right thigh. The comprehensive assessment failed to evidence the nurse assessed the patient's wounds (location, type of wound, type of dressing, etc). 6. An interview was conducted on 2/12/21 at 1:40 PM with the Alternate Administrator and Clinical Manager. During the interview, the Clinical Manager indicated the nurse should conduct a foot exam "every" visit by assessing for wounds and "cracks ... in between toes" and on the bottom of the feet. 17-12-2(g)	G 706		
G 768	Competency evaluation CFR(s): 484.80(c)(1)(2)(3)	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 768	Continued From page 115 Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. This Standard is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure home health aides (HHA) were oriented and competency checked on the proper use of Hoyer lifts for 1 of 1 HHAs observed transferring a patient with a Hoyer lift (HHA #1) and were trained on patient-specific Hoyer lifts via manufacturer's instructions for use in 1 of 3 active patients with Hoyer lifts (Patients #2, 4, 5) which had the potential to affect the safety of all 3 patients who used a Hoyer lift in their home. Findings include:	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 768	Continued From page 116 1. An agency policy titled "Certified Home Health Aide Competency Evaluation Program" dated 7/24/17, policy number 4050, stated " ... Policy: In order to comply with state and federal regulations, which mandate that individuals providing home health aide services must have copleted a training and competency and evaluation program before furnishing home health aide services, the following steps will be taken: ... A newly hired Home Health Aide will receive a minimum of 1 hours of orientation ... Procedure: ... Each newly hired Home Health Aide will be determined to be competent before being allowed to provide care or services ... The Home Health Aide's competency will be demonstrated in each task to be performed before the Home Health Aide provides the specific care independently ... A Home Health Aide will not perform tasks in which he/she has not demonstrated competency ...." 2. An undated agency policy titled "Use of a Hoyer / Hydraulic Lift," policy number M-140, stated " ... Procedure: ... 8. Attach chains or straps to holes in the sling ... 10 ... pump the jack enough for the mat to clear the bed about 6 inches and tighten the release valve. 11. Determine if client is fully supported and can maintain head support ...." 3. An undated agency job description titled "Home Health Aide" stated " ... Essential Functions: ... 4. Performs other assigned activites that are taught by a nurse for a specific patient. These include but not limited to: ... c. Assisting with the use of devices for aid to daily living ... lift device ...." 4. Drive Medical (No Date). "Patient Lift: Owners	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 768	Continued From page 117	G 768		

Manual & Instructions." Retrieved 2/22/21 from www.drivemedical.com. " ... Safety Summary: .... Thoroughly read the instructions in this Owner's Manual, observe a trained team of experts perform the lifting procedures and then perform the entire lift procedure several times with proper supervision ... Transferring to a Wheelchair: ... 2. The wheelchair is moved into position ... Wheelchair wheel locks must be in a locked position before lowering the patient into the wheelchair for transport. 3. The rear wheel locks are locked to further prevent movement of the chair. 4. The patient is positioned over the sear with their back against the back of the chair. 5. Begin to lower the patient either by opening the control valve or by turning the crank counterclockwise 6 ... the attendant behind the chair will pull back on the handle or sides of the sling to place the patient into the back of the chair ...."

5. California Department of Social Services (No Date). "How to Use a Hoyer Lift." Retrieved 3/11/21 from www.cdss.ca.gov. " ... The Sling: ... The U-Sling is the most commonly used sling for transferring [the patient] from [the] bed ... These U-Sling wraps around the thigh and cross between the legs. This gives the consumer a secure feel and prevents consumer [from] sliding out of the sling ...."

6. A list of all active patients with Hoyer lifts was received on 2/11/21. The list indicated Patient #2 (start of care 4/10/18), Patient #4 (start of care 5/22/19), and Patient #5 (start of care 2/15/19) had Hoyer lifts.

The clinical record of Patient #5 was reviewed on 2/12/21 and 2/16/21. The clinical record indicated the patient received Skilled Nurse and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

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G 768	Continued From page 118 Respite Skilled Nurse services only from the home health agency. An interview was conducted on 2/11/2021 at 1:45 PM with the Clinical Manager. During the interview, the Clinical Manager indicated Patient #4 did not use his Hoyer lift to transfer, and would only transfer out of bed when his "friend" was present. 7. A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2 (start of care 4/10/18) and HHA #1. During the home visit, HHA #1 was observed transferring the patient from the bed to the wheelchair using a Drive manual Hoyer. The HHA #1 assisted the patient with turning from side to side, positioned the Hoyer sling underneath the patient, moved the Hoyer to the patient's bedside, positioned the swivel bar above the patient, and connected the sling's hooks to the swivel bar. The HHA used the Hoyer crank to lift the patient out of the bed, moved the Hoyer and patient to the wheelchair, went to the back of the wheelchair, positioned the patient above the wheelchair seat, tipped the wheelchair slightly forward, and lowered the patient from the Hoyer into the wheelchair. HHA #1 failed to cross the sling straps underneath the patient's thighs when connecting the Hoyer sling to the swivel bar, failed to check the Hoyer straps when the patient was slightly off the bed to see if they were secure, and failed to properly position the wheelchair when lowering the patient into it. An interview was conducted on 2/11/21 at 11:20 AM with HHA #1. During the interview, the HHA indicated she was registered as a HHA prior to being hired by the agency. The HHA indicated when she was hired by the agency, her orientation included verbally "reviewing" how to	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 768	Continued From page 119 use a Hoyer lift with the Registered Nurse (RN), but she did not perform an RN-observed demonstration of a Hoyer lift transfer of a patient or pseudo-patient. HHA #1 also indicated she did not have a nurse competency check on Patient #2's Drive manual Hoyer prior to transferring the patient with the Hoyer. 8. The personnel file of HHA #1 was reviewed on 2/23/21. The personnel file failed to evidence an RN competency check of HHA #1 using Patient #2's Hoyer lift was conducted. 9. An interview was conducted on 2/12/21 at 1:40 PM with the Alternate Administrator and Clinical Manager. During the interview, the Clinical Manager indicated when connecting a Hoyer sling to the Hoyer lift, the sling's leg straps should be crossed under the patient's thighs, and staff should not tilt a patient's wheelchair forward when lowering the patient from a Hoyer lift to a wheelchair. The Clinical Manager stated upon hire the agency conducted an HHA competency check of both a manual and electric Hoyer lift through RN direct observation of a transfer of a patient or pseudo patient, and all HHAs who perform transfers of a patient with a Hoyer lift are competency checked by an RN in the home, using the patient's specific Hoyer lift, prior to the HHA performing the transfer. The Clinical Manager stated the in-home Hoyer competency check was documented in the employee's personnel file. 17-14-1(l)(A)	G 768		
G 798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties.	G 798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 798	Continued From page 120 Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This Standard is not met as evidenced by: Based on observation, record review and interview, the Registered Nurse (RN) failed to develop a home health aide (HHA) care plan which was specific to the patient's needs for 4 of 4 active records reviewed of patients with HHA services (#1, 2, 3, 4), in a total sample of 11 records. Findings include: 1. An undated agency job description titled "Registered Nurse" stated " ... Essential Functions: 4. Coordinates delivery of care along health care continuum ... 6. Demonstrates teamwork and effective communication to accomplish patient and agency goals / outcomes ... 7. Uses professional nursing judgement to delegate selected nursing tasks when determined safe and appropriate ... Retains responsibility and authority for determining appropriateness of plan and implements corrective actions when necessary ...." 2. An undated agency job description titled "Home Health Aide," stated " ... Essential Functions: ... 2. Performs work under the supervision of the Nursing Supervisor. 3. Performs personal care activities contained in a written assignment by the Nursing Supervisor ...."	G 798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 798	Continued From page 121 3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21 and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The record included a plan of care for the recertification period 1/8/21 - 3/8/21. The plan of care contained service orders for HHA visits 4-5 hours per day, 5-7 days per week. The record also included a HHA care plan, signed as reviewed on 1/7/21 by Former RN I. The aide care plan stated " ... Precautions and Other Pertinent Information: ... Watch for hyper / hypoglycemia [hyperglycemia is elevated blood sugar; hypoglycemia is low blood sugar] ... Assignment ... Assist with Elimination ... Assist with W/C [wheelchair] / Walker / Cane ... Mobility Assist: Chair / Bed / Dangle / Commode ...." The aide care plan failed to evidence specific blood sugar values and/or signs and symptoms of hyperglycemia and hypoglycemia the HHA was to report, failed to evidence specific assistance the patient needed with elimination (did patient void in the bathroom, with the use of a bedside commode, wear incontinence briefs, etc), failed to evidence detailed directions on which mobility assistance device the patient was to use, and failed to evidence detailed assistance instructions for the HHA to assist the patient with mobility. 4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record included a plan	G 798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 798	Continued From page 122	G 798		

of care for the recertification period 1/24/21 - 3/24/21, which contained service orders for HHA visits 4 - 7 hours per day, 5 - 7 days per week. The record also included three HHA care plans, titled "AM Care Plan," "Afternoon Care Plan," and "PM Care Plan," all signed as reviewed on 1/21/21 by Former RN I. All three care plans included the task "Assist with Elimination." The "PM Care Plan" also included "Bleeding Precautions." The aide care plans failed to evidence specific assistance the patient needed with elimination, and the night care plan failed to evidence detailed instructions regarding which precautions the HHA was to perform for the patient's increased risk of bleeding (avoid use of razors, report any bleeding, etc).

5. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a plan of care for the recertification period 1/9/21 - 3/9/21, which included service orders for HHA visits 1-2 hours per day, 2-4 days per week. The clinical record also included a HHA care plan signed as reviewed on 1/8/21 by RN #1. The aide care plan included the task " ... Assist with Ambulation ... Walker / Cane ... Stand By Assist." The care plan failed to detail which ambulation assistance device should be used the patient.

6. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIGHT AT HOME, INC	1125 BROADWAY STREET SUITE B ANDERSON, IN 46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 798	Continued From page 123	G 798		

by damage to the outlying nerves), and high blood pressure. The clinical record contained a plan of care for the recertification period 1/11/21 - 3/11/21, which included the service orders for respite HHA visits 2 - 6 hours per day, up to 30 days per calendar year. The plan of care included HHA tasks were to include "Every visit give shower, if [patient] refuses shower give complete or partial bed bath ... empty trash as needed ...." The record also included an HHA care plan, signed as reviewed on the Clinical Manager on 1/6/21, which stated " ... Precautionary and Other Pertinent Information ... Watch for hyper / hypoglycemia. Bleeding Precautions ... Assignment: ... Bed Bath - Partial / Complete. Complete or partial bed bath if [patient] refuses shower ... Assist with Elimination ... Mobility Assist: Chair / Bed ... Commode / Shower ...." The aide care plan failed to evidence specific blood sugar values and/or signs and symptoms of hyperglycemia and hypoglycemia the HHA was to report, failed to evidence detailed instructions regarding which precautions the HHA was to perform for the patient's increased risk of bleeding, failed to evidence when the patient was to receive a complete bed bath versus partial bed bath, failed to evidence specific assistance the patient needed with elimination, and failed to evidence detailed assistance instructions for the HHA to assist the patient with mobility.

7. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Manager. During the interview, the Clinical Manager indicated the home health aide care plan should be detailed and patient specific. The Clinical Manager also stated the HHAs were "trained to not do things that are not on care plan. They've been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 798	Continued From page 124 competency checked to know what is included [within bleeding precautions and hyper/hypoglycemia monitoring]." 17-13-2(a)	G 798		
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This Element is not met as evidenced by: Based on record review and interview, the home health aide (HHA) failed to complete all tasks included on the aide care plan for 4 of 4 active records reviewed of patients with HHA services (#1, 2, 3, 4), and failed to complete only tasks as written on the aide care plan and within the scope of their practice for 2 of 4 active records reviewed of patients with HHA services (#2, 3), in a total sample of 11 records. Findings include: 1. An agency policy titled "Care Plan Implementation," dated 7/24/17 and policy number 10020, stated " ... Policy: Right at Home provides care, treatment, and/or services consistent with the type and frequency identified and documented in the plan of care ... Right at Home provides care, treatment and /or services for each patient according to accepted professional standards and applicable laws and regulations ...." 2. An undated agency job description titled	G 800		

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	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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G 800	Continued From page 125 "Home Health Aide," stated " ... Essential Functions: ... 2. Performs work under the supervision of the Nursing Supervisor. 3. Performs personal care activities contained in a written assignment by the Nursing Supervisor ... 4. Performs other assigned activities that are taught by a nurse for a specific patient. These include be not limited to: ... b. Reinforcement of dressings (non - sterile) ... 5. The Home Health Aide will NOT perform any of the following: a. Sterile dressing changes ... e. Administration of ... medicated skin ointments ... l. Any personal health services that has not been included on the paraprofessional task sheet ...." 3. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21 and indicated a start of care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral (both sides of the body) knee pain, low back pain, and Chronic Obstructive Pulmonary Disease (COPD, a respiratory disease). The record included a plan of care for the recertification period 1/8/21 - 3/8/21. The plan of care contained service orders for HHA visits 4-5 hours per day, 5-7 days per week. The record also included a HHA care plan, signed as reviewed on 1/7/21 by Former RN I. The aide care plan included the tasks " ... Shower ... Meal Preparation ... Wash clothes ... Take out trash ...," which indicated the tasks were to be completed "per [patient] request." The clinical record included a document titled "Aide Weekly Visit Record," which indicated HHA #4 provided HHA services to Patient #1 on 1/25/21, 1/26/21, 1/27/21, 1/28/21, 1/29/21, and 1/30/21. The visit record failed to evidence the tasks of "Shower ... Empty Trash" were completed by the HHA or declined by the patient	G 800		

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G 800	Continued From page 126 on the visit dates. The clinical record included a document titled "Aide Weekly Visit Record," which indicated HHA #5 provided HHA services to Patient #1 on 1/24/21. The visit record failed to evidence the tasks of "Meal Preparation ... Wash clothes ... Equipment Care ..." were completed by the HHA or declined by the patient on this visit date. The clinical record included a document titled "Aide Weekly Visit Record," which indicated HHA #5 provided HHA services to Patient #1 on 1/23/21. The visit record failed to evidence the tasks of "Wash Clothes ... Empty Trash ..." were completed by the HHA or declined by the patient on this visit date. The clinical record included a document titled "Aide Weekly Visit Record," which indicated HHA #4 provided HHA services to Patient #1 on 1/17/21, 1/18/21, 1/19/21, 1/20/21, 1/21/22, 1/22/21. The visit record failed to evidence the tasks of "Shower" on all the above dates, "Wash Clothes" on all dates except 1/20/21, and "Empty Trash" on 1/17/21, 1/19/21, and 1/21/21 were completed by the HHA or declined by the patient. The clinical record included a document titled "Aide Weekly Visit Record," which indicated HHA #4 provided HHA services to Patient #1 on 1/11/2, 1/12/21, 1/13/21, 1/14/21, 1/15/21, 1/16/21. The visit record failed to evidence the tasks of "Shower" and "Empty Trash" on all the above dates and "Wash Clothes" on all the above dates except 1/12/21 were completed by the HHA or declined by the patient. 4. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of	G 800		

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G 800	Continued From page 127 4/10/18, with patient diagnoses including but not limited to: transverse myelitis (inflammation of the spinal cord), paraplegia (inability to move the lower portion of the body), history of urinary tract infections (UTI, an infection of the urinary system), and asthma. The record included a plan of care for the recertification period 1/24/21 - 3/24/21, which contained service orders for HHA visits 4 - 7 hours per day, 5 - 7 days per week. The record also included three HHA care plans, titled "AM Care Plan," "Afternoon Care Plan," and "PM Care Plan," all signed as reviewed on 1/21/21 by Former RN I. All three care plans indicated the tasks " ... Meal Preparation ... Wash clothes ... Light Housekeeping ...," were to be competed every visit per the patient's request. The three care plans also included the tasks " ... Inspect / Reinforce Dressing. If dressing has loosened, may apply tape or new dry [dressing with] tape to coccyx [tailbone] when in place ...." The "AM Care Plan" indicated the tasks " ... Hair Care. Shampoo ..." were to be completed with each morning shift visit per the patient's request. The "Afternoon Care Plan" indicated the tasks " ... Hair Care ... Shampoo ... Skin Care ... Wash Clothes ..." were to be completed with each afternoon shift visit per the patient's request. The "PM Care Plan" indicated the task " ... Bed Bath - Partial ..." was to be completed with each evening shift visit per the patient's request. The record included a document titled "Aide Weekly Visit Record" which indicated HHA #8 provided HHA services to Patient #2 for the AM shift on 1/24/21. The visit note failed to evidence the tasks " ... Hair Care ... Shampoo ... Wash Clothes ... Light Housekeeping ..." were completed by the HHA or declined by the patient on the above date.	G 800		

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G 800	Continued From page 128 The record included a document titled "Aide Weekly Visit Record" which indicated HHA #1 provided HHA services to Patient #2 for the AM shift on 1/25/21, 1/26/21, 1/27/21, 1/28/21, 1/29/21, and 1/30/21. The visit note failed to evidence the task "Wash Clothes" on all the above dates and "Hair Care ... Shampoo" on all above dates except 1/28/21 were completed by the HHA or declined by the patient. The record included a document titled "Aide Weekly Visit Record," which indicated HHA #8 provided HHA services to Patient #2 for the PM shift on 1/24/21, 1/25/21, 1/26/21, 1/28/21, 1/29/21, 1/30/21. The visit note failed to evidence the tasks "Bed Bath: Partial ... Meal Preparation ... Wash Clothes ... Light Housekeeping ..." were completed by the HHA or declined by the patient on the above dates. The record included a document titled "Aide Weekly Visit Record" which indicated HHA #7 provided HHA services to Patient #2 for the afternoon shift on 1/25/21, 1/27/21, and 1/29/21. The visit note failed to evidence the tasks "Bed Bath: Partial ... Hair Care ... Shampoo ... Skin Care ... Wash Clothes ..." were completed by the HHA or declined by the patient on the above dates. The record included a document titled "Aide Weekly Visit Record" which indicated HHA #6 provided HHA services to Patient #2 for the afternoon shift on 1/26/21 and 1/28/21. The visit note failed to evidence the tasks "Bed Bath - Partial ... Hair Care ... Shampoo ... Skin Care ... Wash Clothes" were completed by the HHA or declined by the patient on the above dates.	G 800		

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G 800	Continued From page 129 The record included a document titled "Aide Weekly Visit Record" which indicated HHA #1 provided HHA services to Patient #2 for the evening shift on 1/27/21. The visit note failed to evidence the tasks " ... Meal Preparation ... Wash Clothes ..." were completed by the HHA or declined by the patient on the above dates. The record included a document titled "Aide Weekly Visit Record" which indicated HHA #1 provided HHA services to Patient #2 for the afternoon shift on 1/30/21. The visit note failed to evidence the tasks " ... Hair Care ... Shampoo ... Skin Care ... Wash Clothes ..." were completed by the HHA or declined by the patient on the above date. A home visit observation was conducted on 2/11/21 at 9:15 AM with Patient #2. During the home visit, Patient #2 was observed to have redness to her sacrum (lowest area of the spine, directly above the coccyx) and both buttocks, one Stage 2 pressure ulcer (wound caused by prolonged pressure, resulting in damage to the first layers of the skin) to the right buttock, two or three (surveyor unable to distinguish number of wounds due to area covered with white medicated cream) Stage 2 pressure ulcers to the left buttocks. The patient reported the wounds were "shearing" wounds. The left and right buttock wounds were covered with a dry ABD pad (type of gauze dressing) and tape. Patient #2 indicated Home Health Entity J managed her wound care, and HHA #1 indicated she would apply Coloplast Hydrophilic Wound Cream (a medicated ointment which assists with wound healing) to the wounds on the patient's sacrum and buttocks and then cover with a dry ABD pad every day with the patient's bath. HHA #1 indicated she was advised she could change the	G 800		

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G 800	Continued From page 130 patient's dressing and apply the Coloplast cream daily by a nurse employed by Home Health Entity J (HHA #1 was unable to name the employee). Home Health Entity J's clinical record of Patient #2's was reviewed on 2/17/21, and indicated a start of care of 8/13/18. The record contained a plan of care for the recertification period of 1/29/21 - 3/29/21, which included a section titled "Orders for Discipline and Treatments" which stated " ... Wound Treatment for Wound #11 ... Location: Rt Upper Buttox [sic]. Type: Pressure Ulcer ... Appropriate Skilled Caregiver to Cleanse with NS [Normal Saline], pat dry, apply thin layer of Duoderm paste [medicated topical cream which assists with wound healing]. HHA [service provided by Right at Home] may apply daily ... Wound #12, Location: Rt Lower Buttox, Type: Pressure Ulcer ... Appropriate Skilled Caregiver to Cleanse with NS, pat dry, apply thin layer of Duoderm paste. HHA may apply daily ... Wound #7, Location: Left Glute [group of muscles which are located in the buttocks and upper thigh], Type: Pressure Ulcer .... Appropriate Skilled Caregiver to Cleanse with NS, pat dry, apply thin layer of Duoderm paste to areas on glutes. HHA may apply daily ...." HHA #1 failed to perform tasks only as written on the aide care plan and within their scope of practice. 5. The clinical record of Patient #3 was reviewed on 2/12/2021 and 2/18/21, and indicated a start of care date of 7/17/19, with patient diagnoses including: low back pain, COPD, fibromyalgia, depression, and anxiety. The record contained a plan of care for the recertification period 1/9/21 - 3/9/21, which included service orders for HHA visits 1-2 hours per day, 2-4 days per week. The clinical record also included a HHA care plan signed as reviewed on 1/8/21 by RN #1.	G 800		

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G 800	Continued From page 131 The record included an "Aide Weekly Visit Record" which indicated HHA #9 provided HHA services to Patient #3 on 1/12/21, 1/14/21, and 1/16/21. The aide visit note indicated HHA #9 performed the task "Encourage Fluids" during each of the above visit dates, failed to evidence the HHA performed or the patient declined the task " ... Nail Care ...." during the visits 1/12/21 and 1/16/21, and failed to evidence the HHA performed or the patient declined the task " ... Wash Clothes ..." during the visit on 1/12/21. The HHA care plan failed to evidence the task "Encourage Fluids" was to be performed by the aide, and the visit note failed to evidence the HHA completed all tasks only as instructed on the aide care plan. The record included a "Aide Weekly Visit Record" which indicated HHA #9 provided HHA services to Patient #3 on 1/19/21. The aide visit note indicated HHA #9 performed the task "Encourage Fluids" during the visit, and failed to evidence the HHA performed the task or the patient declined the task " ... Assist with Dressing ...." The visit note failed to evidence the HHA completed all tasks only as instructed on the aide care plan. 6. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record contained a plan of care for the recertification period 1/11/21 - 3/11/21, which included the service orders for respite HHA visits 2 - 6 hours per day, up to 30	G 800		

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G 800	Continued From page 132	G 800		

days per calendar year. The record also contained a HHA care plan which included the aide was to assist the patient with showering and slide board transfer with every visit, and the tasks " ... Shampoo ... Mobility Assist: Chair / Bed ... Commode / Shower ..." were to be completed every visit per the patient's request.
The clinical record included an "Aide Weekly Visit Record" which indicated HHA #2 provided respite HHA services to Patient #4 on 2/1/21 and 2/6/21. The visit note failed to evidence the tasks " ... Shower ... Hair Care ... Mobility Assist ... Slideboard Transfer ..." were performed by the HHA or the patient declined the tasks.

The clinical record included an "Aide Weekly Visit Record" which indicated HHA #2 provided respite HHA services to Patient #4 on 1/25/21, 1/26/21, 1/27/21, 1/28/21, and 1/29/21. The visit note failed to evidence the tasks " ... Shower ... Mobility Assist ..." were performed by the HHA or the patient declined the tasks.

7. An interview was conducted on 2/12/21 at 1:40 PM with the Alternate Administrator and Clinical Manager. During the interview, the Clinical Manager indicated HHAs were able to "secure or replace" a wound dressing and the agency had received a physician's order that the HHA could perform this task as needed for Patient #2. The Clinical Manager also indicated HHAs should not apply a medication cream to a wound.

8. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Manager. During the interview, the Alternate Administrator indicated the HHA was not expected to document "patient refused" on tasks ordered to be completed "per patient request." The Clinical Manager stated the

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G 800	Continued From page 133 agency did not validate if the HHAs asked the patient if they would like the "per patient request" tasks to be performed as the aides were "trained" to do this with every patient during each visit.	G 800		
G 978	Must have a written agreement CFR(s): 484.105(e)(2)(i-iv) An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure written agreements were in place which delineated the services each agency was to provide for 3 of 3 active shared patient records reviewed (#1, 2, 4), which had the potential to affect 16 of 16 patients identified as receiving services from at least one other entity (#1, 2, 4, 6, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27). Findings include: 1. An agency policy titled "Coordination of Patient Services," dated 7/24/17, policy number 10021, stated " ... Policy: Care, treatment and/or services	G 978		

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G 978	Continued From page 134 are provided by Right at Home in an interdisciplinary, collaborative manner ... The clinical services provided by Right at Home staff and/or providers under contractual arrangement with Right at Home shall complement one another and shall be coordinated by Right at Home to assure quality patient care/services and to promote positive patient outcomes. When the patient is receiving care, treatment and/or services from other organizations / providers, Right at Home ensures that the responsibilities of the [agency] and other organizations / providers are collaborative and exclusive. Communication is maintained between those providing services regarding ... services or care to be provided ... Procedure: ... Coordination of service activities is documented in the patient's home care record. Each record shall contain up-to-date information regarding: The services that are being provided. The responsibilities of each services / discipline ... Communication between involved parties ...." 2. The survey's Entrance Conference was conducted on 2/10/2021 at 10:57 AM with the Administrator, Alternate Administrator, and Clinical Manager. During the Entrance Conference, the Alternate Administrator indicated the agency did not have shared patient agreements with agencies who also provided home care services as most shared patients were shared with Personal Service Agencies (PSA), "most PSA agencies don't know what to do" with shared patient agreements, and some of the agencies had "refused to sign" a shared patient agreement. 3. A list of all active patients shared with PSA Entity P was received on 2/10/21. The list indicated Patients #1 (start of care (SOC) 9/16/19), #2 (SOC 4/10/18), #4 (SOC 5/22/19),	G 978		

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G 978	Continued From page 135 #15 (2/20/21), #17 (SOC 9/14/2020), #18 (SOC 11/19/2020), #19 (SOC 4/9/19), #20 (SOC 5/6/2020), #21 (SOC 10/18/19), #22 (SOC 5/10/18), #23 (SOC 8/6/19), and #24 (SOC 10/23/18). 4. A list of all active patients shared with another entity other than PSA Entity P was received on 2/10/21. The list indicated Patient #2 received home care services from Home Health Entity J, Patient #25 (SOC 6/19/2020) received home care services from PSA Entity Q, Patient #26 (SOC 5/16/19) received home care services from Home Health Entity R, and Patient #27 (SOC 9/23/19) received home care services from Home Health Entity S. 5. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21. The record included a comprehensive assessment completed on 1/7/21 by Former Registered Nurse (RN) I for the recertification period 1/8/21 - 3/8/21. The comprehensive assessment stated the patient received 75 hours per month of attendant care services and 11 hours per month of homemaker services. The clinical record failed to evidence a shared patient agreement was enacted between the home health agency and PSA Entity P. 6. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18. The clinical record included a "Case Conference" note, signed by Former Registered Nurse (RN) I and Home Health Aide (HHA) #2 on 1/21/21, which stated " ... Care Coordination: Skilled Nursing [provided by Home Health Entity J] ...." The clinical record failed to evidence a shared patient agreement was enacted between the agency and Home Health Entity J.	G 978		

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G 978	Continued From page 136 7. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record failed to evidence documentation the patient received home care services from PSA Entity P, and failed to evidence a shared patient agreement was enacted between the home health agency and PSA Entity P. 17-12-2(d)	G 978		
G 980	Primary HHA is responsible for patient care CFR(s): 484.105(e)(3) The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure written agreements were in place which delineated which agency was the primary agency for 3 of 3 active shared patient records reviewed (#1, 2, 4), which had the potential to affect 16 of 16 patients identified as receiving services from at least one other entity (#1, 2, 4, 6, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27). Findings include: 1. An agency policy titled "Coordination of Patient Services," dated 7/24/17, policy number 10021, stated " ... Policy: Care, treatment and/or services are provided by Right at Home in an	G 980		

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	15K162	A. BUILDING _____ B. WING _____	C 02/23/2021

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G 980	Continued From page 137 interdisciplinary, collaborative manner ... The clinical services provided by Right at Home staff and/or providers under contractual arrangement with Right at Home shall complement one another and shall be coordinated by Right at Home to assure quality patient care/services and to promote positive patient outcomes. When the patient is receiving care, treatment and/or services from other organizations / providers, Right at Home ensures that the responsibilities of the [agency] and other organizations / providers are collaborative and exclusive. Communication is maintained between those providing services regarding ... services or care to be provided ... Procedure: ... Coordination of service activities is documented in the patient's home care record. Each record shall contain up-to-date information regarding: The services that are being provided. The responsibilities of each services / discipline ... Communication between involved parties ...." 2. The survey's Entrance Conference was conducted on 2/10/2021 at 10:57 AM with the Administrator, Alternate Administrator, and Clinical Manager. During the Entrance Conference, the Alternate Administrator indicated the agency did not have shared patient agreements with agencies who also provided home care services as most shared patients were shared with Personal Service Agencies (PSA), "most PSA agencies don't know what to do" with shared patient agreements, and some of the agencies had "refused to sign" a shared patient agreement. 3. A list of all active patients shared with PSA Entity P was received on 2/10/21. The list indicated Patients #1 (start of care (SOC) 9/16/19), #2 (SOC 4/10/18), #4 (SOC 5/22/19), #15 (2/20/21), #17 (SOC 9/14/2020), #18 (SOC	G 980		

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G 980	Continued From page 138 11/19/2020), #19 (SOC 4/9/19), #20 (SOC 5/6/2020), #21 (SOC 10/18/19), #22 (SOC 5/10/18), #23 (SOC 8/6/19), and #24 (SOC 10/23/18). 4. A list of all active patients shared with another entity other than PSA Entity P was received on 2/10/21. The list indicated Patient #2 received home care services from Home Health Entity J, Patient #25 (SOC 6/19/2020) received home care services from PSA Entity Q, Patient #26 (SOC 5/16/19) received home care services from Home Health Entity R, and Patient #27 (SOC 9/23/19) received home care services from Home Health Entity S. 5. The clinical record of Patient #1 was reviewed on 2/16/21 and 2/17/21. The record included a comprehensive assessment completed on 1/7/21 by Former Registered Nurse (RN) I for the recertification period 1/8/21 - 3/8/21. The comprehensive assessment stated the patient received 75 hours per month of attendant care services and 11 hours per month of homemaker services. The clinical record failed to evidence a shared patient agreement which indicated the primary agency was enacted between the home health agency and PSA Entity P. 6. The clinical record of Patient #2 was reviewed on 2/12/21 and indicated a start of care date of 4/10/18. The clinical record included a "Case Conference" note, signed by Former Registered Nurse (RN) I and Home Health Aide (HHA) #2 on 1/21/21, which stated " ... Care Coordination: Skilled Nursing [provided by Home Health Entity J] ...." The clinical record failed to evidence a shared patient agreement which indicated the primary agency was enacted between the agency and Home Health Entity J.	G 980		

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G 980	Continued From page 139 7. The clinical record of Patient #4 was reviewed on 2/16/21 and 2/18/21, and indicated a start of care of 5/22/19, with patient diagnoses including: CVA (Cerebrovascular Accident, loss of blood flow to the brain) with left hemiparesis (weakness to one side of the body), Type 2 Diabetes, neuropathy (series of medical conditions caused by damage to the outlying nerves), and high blood pressure. The clinical record failed to evidence documentation the patient received home care services from PSA Entity P, and failed to evidence a shared patient agreement which indicated the primary agency was enacted between the home health agency and PSA Entity P. 17-12-2(e)	G 980		
G1008	Clinical records CFR(s): 484.110 Condition of participation: Clinical records. The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. This Condition is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all patients had one clinical record, including one start of care date, for 1 of 1 active patients with multiple clinical records and starts of care (#4), in a total sample of 11 records.	G1008		

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G1008	Continued From page 140 Findings include: An agency policy titled "Maintenance and Retention of Clinical Records," dated 7/24/17 and policy number 11010, stated " ... Policy: ... QI Coordinator / Department is responsible for maintaining and retaining patients' clinical records in a manner consistent with the [home health agency's] policies and procedures, and applicable laws, regulations and standards ...." The clinical records of Patient #4 were reviewed on 2/16/21 and 2/18/21. The agency held two separate clinical records for Patient #4, which were separated by the patient's payer source (Veteran's Affairs (VA) and Medicaid). The first clinical record indicated the patient's start of care was 5/22/19 and included a plan of care for the recertification period 1/11/21 - 3/11/21. The plan of care indicated the patient's payer source was VA, and the services ordered were skilled nurse and respite home health aide. The second clinical record indicated the patient's start of care was 6/19/19 and included a plan of care for the recertification period 12/10/20 - 2/7/21. The plan of care indicated the patient's payer source was Medicaid, and the service ordered was home health aide. Each clinical record included separate initial and recertification comprehensive assessments, verification of patient's rights, and physician orders. An interview was conducted on 2/22/21 at 1:15 PM with the Administrator, Alternate Administrator, and Clinical Manager. During the interview, the Administrator indicated Patient #4 had two separate clinical records since he had two separate payer sources. The Administrator stated the patient was admitted to the agency	G1008		

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G1008	Continued From page 141 under the VA payer source for skilled nursing and respite home health aide services and the first day of the patient received care from the agency was 5/22/19. The Administrator indicated the patient had been receiving home health aide services from another home health agency until the patient's family member decided to transfer the HHA services to Right at Home, and the patient began receiving home health aide services from the agency on 6/19/19. The Administrator also indicated a second clinical record for Patient #4 was started when the patient began receiving home health services because the patient's payer source was different. A follow up interview was conducted on 2/23/21 at 10:50 AM with the Clinical Manager. During the interview, the Clinical Manger indicated Patient #4 was the only active patient with more than one clinical record and start of care.	G1008		