Printed: 03/26/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	E CONSTRUCTION	(X3) DATE SUR\	D
		15K162		B. WING		02/23	
	OVIDER OR SUPPLIER HOME, INC				TREET SUITE B		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS			G 000			
	and state re-licensure investigations. The survey was fully of AM. Complaint #IN002775 findings Complaint #IN003296 findings Complaint #IN003449 findings Complaint #IN003449 findings Survey Dates: February 18, 19, 22, 23; 2021 Facility Number: 0142		9:58				
	Home Health Aide Or Personal Service Only Total Active Patients:	y Patients: 0					
	the February 23, 202 d/b/a Right at Home vextended survey purs (D) of the Social Section 2021. Therefore, and (3)(D)(iii) of the Act, Home is precluded frosite of a home health	on-level deficiencies du 1 survey, Helping Ange was subject to a partial suant to section 1891(c) urity Act on February 17 pursuant to section 189 delping Angels d/b/a Rig om operating or being t aide training and/or on programs for the two	ls or)(2) 7, 91(a) ght at he				
LABORATOR	V DIDECTOR'S OR DROVIDE	R/SLIPPLIER REPRESENTATIV	CIC CICNIATURE		TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		15K162		B. WING		C 02/23/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	STREET SUITE B 012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
G 000	years beginning Febric continuing through February found out of compliant Participation 42 CFR assessment and 484 coordination, quality of These deficiencies re	uary 23, 2021, and ebruary 23, 2023 for be not with the Condition of 484.55 Comprehensive 60 Care Planning, of care. flect State findings cited IAC 17. Refer to the State Findings.	of e d in	G 000		
G 510	provide, a patient-speassessment. For Medmust verify the patien home health benefit in both at the time of the at the time of the common This Condition is not Based on observation interview, the home hensure the comprehe a complete and thorofunctional, and cognit failed to ensure the coincluded the patient's goals (See Tag G530 comprehensive assessmedical, nursing, and (See Tag G534); failed comprehensive assessmedicals.	tion: Comprehensive ts. ceive, and an HHA must edific, comprehensive dicare beneficiaries, the ti's eligibility for the Medicular assessment visity in prehensive assessment with a end of the medicular assessment with a end of the medicular assessment with a end of the medicular assessment control and the alth agency failed to ensive assessment control and the alth, psychosocial assessment with a eath agency failed to ensure the assessment included the part of the ensure the end of the ensure the ensure the ensure the end of the ensure the ensure the ensure the end of the ensure the ensure the end of the ensure the ensur	e HHA dicare tatus, it and int. tained ial, 528); nent vards tient's	G 510		
	(See Tag G536); and	included the presence caregiver, the primary				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE S COMPLE	ETED
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NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
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G 510	caregiver's willingnes and the primary care schedules (See Tag of The cumulative effect resulted in the agence	es and ability to provide giver's availability and G538). It of this systemic problems being out of complian Participation 42 CFR 4	em ce	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 -		G 528				
	ensure that the patier problems are continued care, treatment and/or adjusted accordingly be assessed and reavisit Procedure: Assessment will be or [Registered Nurse] information The patrengths Pertiner patient's functional structional structional continence [ability to bowel elimination]	5/18, stated "Purpose nt's current needs and/o lously evaluated and the properties provided are reservices and patient by the RN reservices problems, need nt physical findings That tatus, including mobility control urination and/or the patient's psychosotional/psychological bases and the patient's psychological bases are reservices and reservices are reservices are reservices and reservices are reservices are reservices and reservices are reservices are reservices and reservices are reservices and reservices are reservices are reservices are reservices and reservices are reservices and reservices are reservices are res	or e s shall killed s and The				

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		15K162		B. WING		02	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 528	to treatment, cognitive 2. An undated agence "Registered Nurse" si Functions: Perform subjective and object of client status that in psychosocial, and en 3. The clinical record on 2/16/21 and 2/17/2 care date of 9/16/19, including but not limit (both sides of the bod and Chronic Obstruct (COPD, a disease of The record included a assessment complete for the recertification comprehensive asses assessment was compatient's pain "location The assessment faile assessment of the pa (as listed in the patient The comprehensive assessment did not ha SOB [short of breath] [feet]. Moderate exert assessment failed to exhibited any further (wheezing, tightness The assessment also patient's COPD sympation.	e limitations, memory by job description titled tated " Essential as comprehensive live ongoing assess cludes physical, vironmental parameters of Patient #1 was reviewed, and indicated a star with patient diagnoses ed to: diabetes, bilaterally) knee pain, low back live Pulmonary Disease the lungs). a comprehensive ed on 1/7/21 by Former period 1/8/21 - 3/8/21. It is sment indicated a pain ducted, which stated the n" was the "low[er] spind to evidence an tient's bilateral knee paint's diagnoses). assessment contained a bulmonary" which indicate a cough, and "become when ambulating 20 ft tion also causes SOB." evidence if the patient symptoms of COPD in the chest, tiredness, failed to evidence the failed to evidence the	ment s" ewed t of al pain, The e ee." iin	G 528			

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	OVIDER OR SUPPLIER HOME, INC		1125 BR	RESS, CITY, STAROADWAY SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 528	The comprehensive as section titled "Endocrindicated the patient poorly controlled," the blood sugar three tim received "sliding scal rapid or fast-acting in blood sugar prior to eassessment failed to sugar ranges and the diabetes treatment, sugar checks, medicated "Incontinence" (inabil assessment failed to incontinence" (inabil assessment failed to incontinence occurred during the day and nithe patient had a diagous "Incontinence occurred during the day and nithe patient had a diagous "Incontinence occurred during the day and nithe patient had a manager of the comprehensive as section titled "Genital "Prostrate problem hyperplasia, enlarger The assessment failed had symptoms of BP urination, nocturia (ur starting urination, etc.) The comprehensive as section titled "Neuro, had diagnoses of "PT Disorder, a mental he trauma] Depression Status" within the constated " [Increased changes] or conflict. structure in a stress-f	assessment contained a rine/Hematology," which had a diagnosis of "Dial e patient was to check hes a day, and the patie e insulin [a method of d sulin based on the patie e insulin [a method of d sulin based on the patie e ating a meal]." The evidence the patient's be patient's compliance wouch as diabetic diet, blood ation administration, etc. assessment contained a stion Status," which indignosis of urinary ity to control urination). indicate when the urinated (day only, night only, ight, etc). assessment contained a lia," which indicated a ment of the prostate glared to indicate if the patied to indicate	betic his hotolood vith bood cated The arry are hotolood tith bood tith bo	G 528			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K162		B. WING		02/	C 23/2021
RIGHT AT HOME, INC 1125			1125 BR	RESS, CITY, STAROADWAY S	TREET SUITE B		
(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 C (EACH CORRECTIVE ACTION (EROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 528	section titled "Depress contained a PHQ-2 so Questionnaire - 2, a requency of a depression of the patient's score of lowest score possible no days within the patienced symptom. The comprehensive a evidence a thorough PTSD and depression and agitation at base any other symptoms etc). The comprehensive as "Medication Profile," so 1/7/21 by Former RN included the medication treat gastro-esophagatorvastatin (used to be tamethasone 1% - infections of the skin) attention-deficit hyper The comprehensive as evidence diagnoses of above medications. 4. The clinical record on 2/12/21 and indicated 4/10/18, with patient of limited to: transverse spinal cord), paraples lower portion of the binfections (UTI, an infestions), and asthmacomprehensive assessions.	sion Screening," which cale (Patient Health medical screening for the seed mood in a patient) in the PHQ-2 was "0" (the indicating the patient is two weeks where he ins of a depressed mood assessment failed to evaluation of the patient in (was the patient's anxiline, worse, or better; work of either condition present included a signed as reviewed by one of the patient's anxiline, worse, or better; work of either condition present included a signed as reviewed by one of the patient's anxiline, worse, or better; work of either condition present included a signed as reviewed by one of the patient's anxiline, and Strattera (used to treat furth, and Strattera (used to treat furth, and Strattera (used to treat furth, and Strattera (used to treativity disorder (ADHE assessment failed to be conditions related to the process of the unitary of the patient with the patien	ne had d). It's ciety ere ent, on d to RD)), ole ngal treat D))). the ewed of a not of the extract a	G 528			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/2	C 23/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
G 528	28 Continued From page 6			G 528				
	2/11/21 at 9:15 AM whome visit, Patient #2 suprapubic catheter (created stoma in the bladder), and was obsuprapubic catheter was observed to have (lowest area of the specocyx) and both buttulcer (wound caused resulting in damage to to the right buttock, to distinguish number covered with white mpressure ulcers to the Stage 2 pressure ulce posterior thigh. The pwere "shearing" wour buttock wounds were (type of gauze dressift to the right posterior to or topical cream note suprapubic catheter aby another home head Health Aide (HHA) #1 Coloplast Hydrophilic medicated ointment whealing) to the wound and buttocks. HHA # the dressing to the patient's right thigh wound "coalso indicated she habelly button." The cofailed to evidence an	drain placed into a surglower abdomen to emp served self irrigating the with acetic acid. Patient e redness to her sacrundine, directly above the tocks, one Stage 2 preserved the first layers of the served or three (surveyor under the first layers of the served three (surveyor under the first layers of the served three (surveyor under the first layers of the served three (surveyor under the first layers of the served three dicated cream) Stage to a skin fold on the reported the words. The left and right covered with a dry ABI and tape, and the withigh did not have a dreed. Patient #2 indicated and wounds were manalith agency, and Home indicated she would a	gically ty the e t #2 n ssure , skin) nable a 2 right unds D pad vound essing her aged pply ad um ged teral nd did vound he at #2 my ent ent's					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
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	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B	•	
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G 528	was changed, the free be irrigated with acetic assessment of the patype of wound, type of patient's decreased sextremities. The comprehensive a section titled "Cardiop there was "no [chang The comprehensive a evidence an assessment of the patient of the patien	quency the catheter was cacid, the presence are tient's wounds (location of dressing, etc), and the ensation to her lower assessment included a culmonary," which indice!" in the patient's status assessment failed to enent of the patient's hear, and failed to evidence attent's asthma (presence is such as shortness of est tightness, etc).	ated as. art e an ce or a ded to ya used ey ever ever ever ever ever ever ever e	G 528			
	The comprehensive a	assessment included a					

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUF COMPLET	TED
	15K162		B. WING		02/2	C 3/ 2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 528 Continued From page section titled "Assessin Signs/Symptoms," whi pain was the "same patient's "back," and the of 10 on a 0-10 pain sepain, from zero to ten, and ten being "the most comprehensive assessing pain goal was established would evidence if the preeded further intervers. The "Assessment and Signs/Symptoms" sect assessment also state Oriented Forgetful comprehensive assessititled "Depression Screen PHQ-2 scale. The path was "2" (score range Condicating she had "little doing things" and "feel hopeless" for "Several past two weeks. The coalso included a section Assessment Summary patient's mental/cognit forgetful, memory deficit, was baseline, better, or wo further symptoms of definition titled "Cardiopit the presence of "Dysp The comprehensive assestion titled "Cardiopit the presence of "Dysp The comprehensive assestion as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as section titled "Cardiopit the presence of "Dysp The comprehensive as the patient the	ment and Observation ich indicated the patien. chronic," located to the patient rated as "3" cale (method of assessigns a number to their with zero being "no past severe pain"). The sment failed to evidenthed with the patient, we patient's tolerable or nation. Observation tion of the comprehented " Mental Status: Depressed." The sment included a section seening," which contain tient's score on the Pho - 6), due to the patient le interest or pleasure ling down, depressed, days: 2 - 6 days" over comprehensive assessing titled "Comprehensive," which stated " The sment failed to evident of the patient's mental at of patient's forgetful as patient's depression trick, and patient exhibit epression, etc).	he out sing rain" ce a which sive ion led a lQ-2 int in or rathe sment re e las ce a laness in at a any cated	G 528			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 .	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K162		B. WING		02/2	C 2 3/2021
RIGHT AT HOME, INC 112			1125 BF	RESS, CITY, STAROADWAY SON, IN 460	TREET SUITE B	•	
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G 528	evidence if the patient exertion and/or at rest the patient exhibited a COPD (wheezing, tig tiredness, etc). The a evidence if the patient baseline, better, or we section titled "Genitor patient had urinary "ir assessment failed to incontinence (during only, continuous) and incontinence (incontinence (incontinence (incontinence (incontinence), continuous) and incontinence (incontinence), and i	at's dyspnea was with at and failed to evidence any further symptoms of thress in the chest, assessment also failed at's COPD symptoms was orse. Assessment included a aurinary," which indicated a concontinence." The evidence the frequency the day only, during the attention to the day only, during the attention of the treatment for the ence pads and briefs). Antained a plan of care of the doi of 1/9/21 - 3/9/21. The amedication list with the tention of the tention o	of to ere at d the v of enight for le h high at reat n to gh ding: d cness used	G 528			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ĒD
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
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G 528	comprehensive assess 1/6/2021 by the Clinic comprehensive assess titled "Assessment ar Signs/Symptoms," why pain was the "same neuropathy Locati extremities Intensi 10 pain scale] Rel turn, reposition." The assessment's summa Chronic pain impacts care [at] times" The assessment failed to established with the pevidence if the patient further intervention. The comprehensive and Observation" stated " The patient forgetful, depresses [related to] loss of incomprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess thorough and comple patient's depression at The comprehensive assess the transfer at the transfer a	ssment completed on cal Manager. The sament included a section of Observation inch indicated the patient Origin: muscle spasmon: left upper and lowe ity 0-10: 6 [out of 10 on ief Measures: medication ability to participate in the comprehensive evidence a pain goal wo patient, which would ut's tolerable or needed assessment's "Assessment of the mental/cognitive stated" Mental Status: Indicated Limitations: Depressive Assessment Summat's mental/cognitive stated Limitations: Depressive Assessment of the assessment failed to evidence the assessment of the same forgetfulness. Assessment included a nations/Instructions," who on disease mgmt. In the selections, importance acces with a selections, importance acces with a selections, importance acces with a selections in the land forgetfulnes in the selections, importance acces with a selections, importance acces with a selections in the land forgetfulnes in the selections, importance acces with a selections in the land forgetfulnes in the selections, importance acces with a selections in the land forgetfulnes in the selections in the land forgetfulnes in the land forgetf	nt's ns, r a 0 - on, ns: self ras nent No ds mary" tus is ession ce a ich tus] e of nal was ed to	G 528			

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G 528	checks and the patier sugars. The comprehensive a "Medication Profile" w Cetirizine (given to tre Diltiazem (given to tre irregularities), Ferrous conditions related to le (given to treat insomn (Miralax, given to treat Tamsulosin (given to comprehensive assest diseases or conditions medications. An interview was cone PM with the Clinical Minterview, the Clinical Minterview, the Clinical Minterview, the Clinical H4 did not use his Horonly transfer out of be present. The compreto evidence the patier status. 7. The clinical record on 2/12/21 and 2/16/2 care date of 2/15/19, including but not limite of movement disorder damage prior to birth Neurologic Neglect (in or move one side of the Bladder Incontinence movements and urina a comprehensive ass 12/4/2020 by RN #3 from 12/6/2020 - 2/3/2021. assessment included	assessment included a with the medications eat allergy symptoms), eat heart rhythm is Sulfate (given to treat ow iron levels), Melatoraia), Polyethylene Glycolat constipation), and treat BPH). The essment failed to evidence is related to the above ducted on 2/11/2021 at Manager. During the Manager indicated Pat yer lift to transfer, and we when his "friend" was hensive assessment faint's ambulation and molecular molecular indicated a star with patient diagnoses ed to: Cerebral Palsy (grs which result from braior early childhood), mability for patient to see the body), and Bowel ar (inability to control bow it ion). The record contains a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated in the recertification per a section titled "Nutritical and indicated and indicated and indicated in the recertification per a section titled "Nutritical and indicated an	nin ol ce 1:45 cient would s iled bility ewed t of group cin nse nd vel ained riod onal	G 528	DEFICIENC	Υ)	
	Status," which indicat	ed the patient had a "G	i				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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RIGHT AT HOME, INC				ROADWAY S SON, IN 460	STREET SUITE B 012				
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPI	(5) LETION ATE		
G 528	tube" (gastrostomy to stomach to assist with medication administration administration assessment of the Gaskin surrounding the was to be changed, assessment of the gasterion titled "Neuro, had a "history of seiz failed to evidence a cassessment of the particle of seizures, date of many many many many many many many many	sube surgically placed into the administering nutrition action). The assessment complete and thorough tube (assessment of the tube, the frequency the etc). The assessment included a "which indicated the parties." The assessment complete and thorough actient's seizure history (construction recent seizure, etc) assessment included a with the medications Resignation (given services), Loratadine (givens), Miralax, Fleet Glycotally to treat constipation treat nausea and/or given to treat congestion (given to treat congestion), Simethicone (given to treat (g	e tube atient t type b. glan ions en to serin on), n and ven treat eat d to nd ce tt 1:15 ng ed the the	G 528					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/ 2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 46	TREET SUITE B 012		
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 528	Continued From page	e 13		G 528			
	and cognitive status.						
	17-14-1(a)(1)(B)						
G 530	Strengths, goals, and CFR(s): 484.55(c)(2)	care preferences		G 530			
	The patient's strength preferences, including	ns, goals, and care g information that may b	pe				
	used to demonstrate						
		of the goals identified by urable outcomes identif					
	This Element is not n	net as evidenced by:					
		ew and interview, the ho					
		o ensure the comprehe the patient's individual	ensive				
	progress towards goa	als for 4 of 5 active reco , in a total sample of 11					
	Findings include:						
	dated 7/24/17, stated Home strives to meet treatment, and/or serv following services und physician. Skilled Nu patient's response to Reassesses the patie	and Reassessments," " Procedure: Right a patient needs for care, vices by providing the der the direction of a rsing: Evaluates the the plan of care ent to determine the ong nent and/or services an	going				
200	"Registered Nurse" st Functions: Perforn subjective and objecti of client status that in	ns comprehensive ive ongoing assessn					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SI COMPLE	
		15K162		B. WING		02/	C / 23/2021
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE	•	
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 530	Provides skilled interrealistic outcomes wi Modifies and updates progress towards out 3. The clinical record on 2/16/21 and 2/17/care date of 9/16/19, including but not limit (both sides of the boand Chronic Obstruct (COPD, a respiratory included a comprehe completed on 1/7/21 (RN) I for the recertiff The comprehensive a section titled "Care P [The patient] alread working at this time Document what the their progress toward applicable) and the [Immeasurable goals sin Patient states goals a Nurse] and patient selong term. SN goals compliant via assist [HHA [Home health aisafety [with] ADL [and hygiene." The clinical record infor the certification per the POC contained a "Goals/Rehabilitation which stated "Goals: with medication by 30 competence in follow days. Patient's hygiere."	ventions aimed at achies thin a specified time personal goal(s) they a goal(s) they a goals for short-term a for pt [patient] representation of patient reports/says a goal for pt [patient] to be with] med container set de] continue to ensure de] IADLs [and] personal cluded a plan of care (Feriod of 11/9/2020 - 1/7, goals are ongenerated by the container set de] continue to ensure de] IADLs [and] personal cluded a plan of care (Feriod of 11/9/2020 - 1/7, goals are ongenerated and container set de] continue to ensure delication period of 11/9/2020 - 1/7, goals are ongenerated and container set delication period assessment?	riod. ewed rt of al spain, ee Nurse 8/8/21. ed "are going about of if willed and it. I POC) /2021. ans," ce / 60 vith	G 530			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER PLAN OF CORRECTION IDENTIFICATION NUM		CLIA		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/	C / 23/2021	
	OVIDER OR SUPPLIER	•		RESS, CITY, STA				
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 530	enhanced with assist falls or injuries by 60 assessment failed to "short-term" and wh failed to evidence if previous certification 4. The clinical record on 2/12/21 and indica 4/10/18, with patien limited to: transvers spinal cord), paraple lower portion of the infections (UTI, an insystem), and asthmicomprehensive assist/21/21 by Former Fiperiod 1/24/21 - 3/2 assessment contain "Rehabilitation Pote Discipline Goals and Pt's safety will be er AEB [as evidenced days Pt's hygien be met [with] assist comprehensive assist the patient's progression 2/12/2021 and 2 care date of 7/17/19 including: low back depression, and and comprehensive assist by RN #1 for the record 3/9/21. The comprehensive assist by RN #1 for the record section titled "Rehabilitation" as section titled "Rehabilitation" as a section titled "Reha	st of HHA as evidenced to days." The compreher of indicate which goals we ich were "long-term" and the patient had met the period's goals. In the patient #2 was reviewed a start of care date to diagnoses including but a myelitis (inflammation egia (inability to move the body), history of urinary infection of the urinary a. The record contained essment, completed on RN I, for the recertificatio 4/21. The comprehensive	ewed of the etract a n of the etract a of the et	G 530				

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CENTERS	FOR MEDICARE & I	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI		1 ' '	E CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K162		B. WING		02/2	C 2 3/2021
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
	HOME, INC		1125 BI	BOYDWAY 6.	TREET SUITE B		
KIGHT AT	HOME, INC			SON, IN 460			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
G 530	needs met per aide in comprehensive asses the patient's progress 6. The clinical record on 2/16/21 and 2/18/2 care of 5/22/19, with CVA (Cerebrovascula flow to the brain) with to one side of the bod neuropathy (series of by damage to the out blood pressure. The comprehensive asses 1/6/2021 by the Clinic recertification period assessment included "Rehabilitation Poten Discipline Goals and Nursing: Demonstrate medication by 30 [sic competence in follow [sic] Other Clie per assist of [HHA] A 30 days Client's per met per assist of [HHA] A 30 days Client's per per assist of the patient's progress the patient's progress of the interview was competence, and Clithe interview, the Alterindicated the compre	n 60 days" The ssment failed to evident is towards their goals. If of Patient #4 was revi 21, and indicated a star patient diagnoses includar Accident, loss of blocal left hemiparesis (wealt day), Type 2 Diabetes, if medical conditions calt diving nerves), and high clinical record containessment completed on cal Manager for the 1/11/21 - 3/11/21. The la section titled tial/Goals," which state Date will be Achieved. If a compliance with completed on compliance with complete the compliance with complete the compliance with safety will be enhanced in the safety will be enhanced in	ewed rt of iding: od kness used id a discould with the control of	G 530			
G 534	Patient's needs CFR(s): 484.55(c)(4)	-		G 534			
	social, and discharge	_	-				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/2021	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
RIGHT AT HOME, INC				ROADWAY S SON, IN 460	TREET SUITE B 012			
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
G 534	This Element is not in Based on observation interview, the home hensure the comprehe the patient's medical, planning needs for 5 (4, 5) in a total sample. Findings include: 1. An agency policy to Nursing," revised 1/15 ensure that the patient problems are continued care, treatment and/of adjusted accordingly, be assessed and reast visit Procedure: Assessment will be conformation The pastrengths Anticipated 2. An agency policy to Patient Assessments dated 7/24/17, stated Home provides and mand/or services to meidentified through ass reassessments Pro Reassesses the pastrength on 2/16/21 and 2/17/2 care date of 9/16/19, including but not limited (both sides of the body interview of the provides of the body including but not limited (both sides of the body including but not limited (both sides of the body including but not limited (both sides of the body interview of the provides of the body including but not limited (both sides of the body including but not l	net as evidenced by: a, record review and ealth agency failed to nsive assessment inclu- nursing, and discharge of 5 active records (#1, of 11 records. itled "Assessment - 5/18, stated "Purpose it's current needs and/o ously evaluated and the r services provided are Policy: The patient assessed during each sk the Comprehensive ompleted by the RN . Includes the following atient's problems, needs and discharge needs itled "Interdisciplinary and Reassessments," " Policy: Right at nodifies care, treatment et the patient's needs a essments and ocedure: Skilled Nu- tient to determine the	e 2, 3, To or e shall killed s and ." t as rsing:	G 534				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	.	
RIGHT AT HOME, INC 1				ROADWAY S SON, IN 460	STREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 534	(COPD, a respiratory included a comprehen completed on 1/7/21 recertification period comprehensive assestitled "Rehabilitation F Discharge for Plan of Anticipated discharge [discharge] when Horadequate for his need chronic and goals are planned until client re Right at Home canno comprehensive asses individualized and parplanning needs for Part 4. The clinical record on 2/12/21 and indicated 4/10/18, with patient climited to: transverse spinal cord), parapleg lower portion of the binfections (UTI, an infinity system), and asthmatic comprehensive asses 1/21/21 by Former Riperiod 1/24/21 - 3/24/assessment containe "Rehabilitation Potent Discharge Plans Nplanned. [The patien Client will D/C when it meet client's needs on needed" The confailed to evidence ind patient-specific discharge Platent #2.	disease). The record nsive assessment by Former RN I for the 1/8/21 - 3/8/21. The asment contained a sec Potential/Anticipated Care" which stated " a status: Client will D/C me Care Services are ds. Clients issues are et on-going. Thus no D/C aches a level of care that provide." The asment failed to evidence tient-specific discharge atient #1. If of Patient #2 was reviewed a start of care date diagnoses including but myelitis (inflammation of the urinary frection of the urinary frection of the urinary. The record contained asment, completed on N I, for the recertification (21. The comprehensive a section titled thas] Ongoing needs anome care can no longer higher level of care is inprehensive assessment.	C is at the ewed of a not of the extract and t	G 534			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		C 02/23/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
G 534	2/11/21 at 9:15 AM whome visit, Patient #2 redness to her sacrur directly above the coc Stage 2 pressure ulce prolonged pressure, r first layers of the skin three (surveyor unable wounds due to area or medicated cream) Staleft buttocks, and one skin fold on the right pright buttock wounds ABD pad (type of gausthe wound to the right a dressing or topical or indicated her wounds home health agency, assessment failed to wound care needs, in to be applied, the free be changed, and the wound care. 5. The clinical record on 2/12/2021 and 2/1 care date of 7/17/19, including: low back padepression, and anxiecomprehensive assess by RN #1 for the rece 3/9/21. The compreh a section titled "Reha which stated " Discontrolled included a section stated " Discharge no longer needed." T	ith Patient #2. During to was observed to have in (lowest area of the spaceyx) and both buttocks are (wound caused by esulting in damage to to) to the right buttock, two et o distinguish number overed with white age 2 pressure ulcers to Stage 2 pressure ulcers age 2 pressure ulcers were covered with a drize dressing) and tape, to posterior thigh. The left were covered with a drize dressing) and tape, to posterior thigh did not cream noted. Patient # were managed by ano The comprehensive evidence the patient's cluding the wound dresquency the dressing was supplies needed for the supplies needed for the supplies needed for the supplies needed for the supplies assessment incompleted on 1 riffication period 1/9/21 ensive assessment incompleted on 1 riffication Potential / Godharge Plans When eded Higher level of mprehensive assessment ittled "Summary," when sent titled "Summary," w	oine, s, one the yo or r of the r to a t and y and have 2 tther ssing as to e ewed tart of a, ned a /8/21 - luded als," f care ent ich vices	G 534			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		C 02/23/2021	
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET	
G 534	Patient #3. 6. The clinical record on 2/16/21 and 2/18/2 care of 5/22/19, with p CVA (Cerebrovascula flow to the brain) with to one side of the bod neuropathy (series of by damage to the out blood pressure. The comprehensive assess 1/6/2021 by the Clinic recertification period assessment included "Rehabilitation Potent Discharge Plans V needed or higher level comprehensive assess individualized and parplanning needs for Path The comprehensive assessindividualized and parplanning needs for Path The comprehensive assection titled "Interverstated" Instructed [management] of Typincluding healthy food maintaining blood glulimits]" The assess patient's blood sugar "146." The comprehensive assection titled sugars. 7. The clinical record on 2/12/21 and 2/16/2 care date of 2/15/19,	of Patient #4 was reviewed, and indicated a star patient diagnoses including Accident, loss of bloodeft hemiparesis (weaked), Type 2 Diabetes, medical conditions causelying nerves), and high clinical record containeds and Manager for the 1/11/21 - 3/11/21. The a section titled tial/Goals," which stated when services are no lost of care is needed' assessment failed to evidence the tialressment included a nations/Instructions," which disease mgmt. In the last of the	ewed t of ding: d ness used d a d " nger " The ce ich tus] e of ial vas ed to gar ewed t of	G 534			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
RIGHT AT	HOME, INC		1125 BF	ROADWAY S	TREET SUITE B			
			ANDER	SON, IN 460	012			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
G 534	Continued From page	e 21		G 534				
	of movement disorder damage prior to birth Neurologic Neglect (ir or move one side of the Incontinence (inability movements). The recomprehensive assess 12/4/2020 by RN #3 ft 12/6/2020 - 2/3/2021. a section titled "Rehal Potential/Anticipated which stated" Antic When services no lon of care is required assessment failed to design a section to be serviced in the services of the services o	rs which result from bra or early childhood), nability for patient to se he body), and Bowel to control bowel cord contained a ssment completed on or the recertification pe The assessment incl	riod uded Care," s: evel					
	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 536	A review of all current CFR(s): 484.55(c)(5)	medications		G 536				
		ations the patient is curr tify any potential advers						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		15K162		B. WING			C 3/2021
RIGHT AT HOME, INC 112			1125 BR	ESS, CITY, STA COADWAY S SON, IN 460	TREET SUITE B		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 536	effects and drug reach drug therapy, significating interactions, durnoncompliance with of This Element is not represent the alth agency failed the assessment contained was accurate and confect records reviewed (#1 11 records. Findings include: 1. An agency policy to Management - Patier 7/24/17, which stated continuity of care, tree Right at Home patien comprehensive informedications. To creat medication history and while the patient is reand/or services from Procedure: the Regenerate a list of the The information following information: frequency of administ The patient's medicate assessed during each completeness and accepted is audited quarrequested" 2. An agency policy to Administration," dated Acceptable Specifi Orders/Prescriptions:	tions, including ineffect ant side effects, significate drug therapy, andrug therapy. met as evidenced by: ew and interview, the hase ensure the comprehed a medication list whice mplete for 4 of 5 active, 2, 4, 5), in a total same titled "Medication at Information," dated 1 "Purpose: To facilitate atment and/or services to by providing accurate mation about patients' that and maintain an accord current medication proceiving care, treatment Right at Home egistered Nurse shall patient's current medication and includes at least the couracy of the medication of the medication at skilled visit The couracy of the medication of the	for e and urate rofile ations he and colicy:	G 536			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/23	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	STREET SUITE B 012		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 536	medication order A Must include the spec prescribed and OTC [medications are to patient's Medication F Medication orders inc information: indica 3. The clinical record on 2/16/21 and 2/17/2 care date of 9/16/19, including but not limite (both sides of the bod and Chronic Obstruct (COPD, a respiratory included a compreher completed on 1/7/21 I (RN) I for the recertific The comprehensive a "Medication Profile" w [short-acting insulin g sugar in diabetic patie [short-acting insulin g sugar in di	As Needed (PRN) Order indications for use Over the Counter] be documented on the Profile Procedure: lude the following tions for use of Patient #1 was reviewed, and indicated a star with patient diagnoses and to: diabetes, bilaterally) knee pain, low back ive Pulmonary Disease disease). The recorder assessment by Former Registered Notation period 1/8/21 - 3 assessment contained a which stated " Novolotiven to lower the blood ents]. Humalog Kwikper iven to lower the blood ents], subQ [subcutance and patient was taking Notated a start of care dated diagnoses including but myelitis (inflammation of itinia (inability to move the body), history of urinary the record contained	ewed tof all pain, and all pain, and all pain, and all pain and all pa	G 536			

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
15K162				B. WING			C 3/ 2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 536	which stated " Fluo to decrease inflamma variety of skin conditions skin], Apply twice dail" The medication lispecific location to apply the control of 2/16/21 and 2/18/2 care of 5/22/19, with proceed to the prain of	cinonide 0.1% cream [ation and itching caused ons], topical [applied to y as needed for itching st failed to evidence the ply the Fluocinonide. of Patient #4 was revied, and indicated a star patient diagnoses includer Accident, loss of bloodeft hemiparesis (weak by), Type 2 Diabetes, medical conditions caustying nerves), and high clinical record contained sament completed on the and Manager for the sament included a star pain], Topical, ½ pall	they a the //rash e ewed tof ding: d eness used d a ine tch to ist oly ewed t of group ewed tof group ain execution in exe	G 536			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	LE CONSTRUCTION	(X3) DATE SI COMPLE		
		15K162		B. WING		02/	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B	,	
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G 536	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.		G 536				
G 538	apply the medication. 17-14-1(a)(1)(B) 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.		ome ensive ce of ne s for	G 538			

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		EY)		
		15K162		B. WING 02/			2021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ADDRESS, CITY, STATE, ZIP CODE					
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012				
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G 538	3 Continued From page 26			G 538					
	Findings include:								

NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC STREET ADDRESS, CITY, STATE, ZIP CODE 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012 (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) PREFIX (FACH CORRECTIVE ACTION SHOULD BE			(X1) PROVIDER/SUPPLIER/C				(X3) DATE SUR			
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G 538 Continued From page 27 G 538	G 538	Continued From page 27			G 538					
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 carre due to not being there [sic]* The comprehensive assessment failed to evidence 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 7/11/19, with patient diagnoses including: low back pain, COPD, fibromysalgia, depression, and anxiety. The record contained a comprehensive assessment completed on 1/8/21 by RN #1 for the recertification period if 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 had a primary caregiver or if the patient provided their own care. 5. The clinical record of Patient #4 was reviewed on 2/18/21, 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 id 1/12/1 - 3/41/12/1. The	G 538	system), and asthmatic comprehensive assess 1/21/21 by Former RN period 1/24/21 - 3/24/ assessment containe "Comprehensive Assessated " [Patient #2 no one who is unable due to not being there comprehensive assess the patient had a primpatient provided their 4. The clinical record on 2/12/2021 and 2/1 care date of 7/17/19, including: low back padepression, and anxie comprehensive assess by RN #1 for the rece 3/9/21. The compreh contained a section tire Assessment Summar #3] lives alone" The sessment failed to primary caregiver or in own care. 5. The clinical record on 2/16/21 and 2/18/2 care of 5/22/19, with provided the brain on the brain of the boomer of the boomer of the boomer of the boomer of the out blood pressure. The comprehensive assess 1/6/2021 by the Clinical the co	The record contained ssment, completed on N I, for the recertification /21. The comprehensive as a section titled essment Summary," whe lives alone or lives (we to assist with patient's e [sic]" The ssment failed to evidence nary caregiver or if the rown care. If of Patient #3 was review 18/21, and indicated as with patient diagnoses ain, COPD, fibromyalgia ety. The record contains ssment completed on 1/2 rensive assessment itled "Comprehensive ry," which stated " [Patient of Patient #4 was review 1/21, and indicated a star patient diagnoses included the patient filter of Patient #4 was review 1/21, and indicated a star patient diagnoses included a comprehensive evidence if the patient had of Patient #4 was review 1/21, and indicated a star patient diagnoses included a condition caused with the patient provided the patient diagnoses included a condition caused with the patient diagnoses included a condition caused with the patient of patient was reviewed as the patient diagnoses included a condition caused with the patient diagnoses included a condition caused was a completed on call Manager for the comprehensive completed on call Manager for the comprehensive call was reviewed as the patient was reviewed	n /e ith) care ce if ewed tart of a, ned a /8/21 - atient had a neir ewed t of ding: d cness used	G 538					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/	C 23/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 538	comprehensive asset the patient had a prin patient provided their 6. The clinical record on 2/12/21 and 2/16/2 care date of 2/15/19, including but not limit of movement disorded damage prior to birth Neurologic Neglect (if or move one side of the Incontinence (inability movements). The recomprehensive asset 12/4/2020 by RN #3 12/6/2020 - 2/3/2021 assessment included Arrangements/Suppoindicated Family Men Patient #5, was the patient #6. An interview was evidence the Family lability to provide care availability and scheous PM with the Administrator, and Cl the interview, the Altesthe patient did not had a given" the patient patient patient did not had a given the patient patient of the patient of the patient of the patient patient of the patient patient of the patien	ssment failed to evidence hary caregiver or if the fown care. If of Patient #5 was reviewed a star with patient diagnoses and to: Cerebral Palsy (gars which result from brator early childhood), anability for patient to see the body), and Bowel by to control bowel cord contained a sament completed on for the recertification per a section titled "Living ortive Assistance," which have a section to section to section to s	ewed tof group ain nse riod n of eer. and er's tt 1:15 ng ted if "it's The fant and 3 4 and	G 538				

			(X3) DATE S COMPLE	ETED					
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	OVIDER OR SUPPLIER HOME, INC		1125 BI	DDRESS, CITY, STATE, ZIP CODE BROADWAY STREET SUITE B ERSON, IN 46012					
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G 538	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	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 570					

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CENTERS FOR MEDICAR	E & MEDICAID SERVICES	5			OMB N	<u>0. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLET	ΓED
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directive informate signs (see Tag of and services we by a physician (stall verbal orders) the ordering provensure the patie of a change in the G590); failed to contained the pagoals (see Tag of Coordinated with agencies (see Tag of Coordinated with a patient with a visit to provide a plant and to ensure the binder contained for specialty transpand failed to ensure the binder contained up-to-agency's clinical. The cumulative of resulted in the agwith the Condition Care planning, of Care planning, of Care planning, of Care planning; (i) All pertinent do (ii) The patient's cognitive status; (iii) The types of equipment requipage of the coordinate of the coordin	I patient-specific goals, advation, and call parameters for G574); failed to ensure all or eadministered only as ordere administered only as ordere administered only as ordere authenticated and davider (see Tag G584); failed to ensure authenticated and davider (see Tag G584); failed ent's medical provider was in a patient's condition (see ensure the revised plan of attent's progress towards the G592); failed to ensure care as G608); failed to provide est schedule (see Tag 614); nof care within the patient's ne patient's record and homed the manufacturer's instructions for equipment (see Tag 614); and the manufacturer's home binedate contact information for supervisor (see Tag G622) effect of this systemic probagency being out of compliant on of Participation 42 CFR coordination, and quality of st include the following (a)(2)(i-xvi) and plan of care must included diagnoses; mental, psychosocial, and it services, supplies, and	for vital drugs dered asure ated by d notified Tag care neir e was failed s home ne ctions of 18); der or the 2).	G 570			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		RVEY TED
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G 574	(vi) Rehabilitation pot (vii) Functional limitat (viii) Activities permitt (ix) Nutritional require (x) All medications and (xi) Safety measures (xii) A description of the emergency departmentere-admission, and all address the underlyind (xiii) Patient and care to facilitate timely disconstruction (xiv) Patient-specific in measurable outcome. HHA and the patient; (xv) Information related directives; and (xvi) Any additional literal allowed practitioner in This Element is not in Based on observation interview, the home hensure the plan of carpertinent diagnoses, a psychosocial status, a services required, the visits to be made, a context to the patient's medication individualized interversity and patient and/or careginal timely discharge, meaning goals, advance direct parameters for vital si	ential; ions; ed; ed; ments; d treatments; to protect against injury ne patient's risk for nt visits and hospital necessary intervention g risk factors. giver education and tra charge; nterventions and educa s and goals identified b ed to any advanced ems the HHA or physici nay choose to include. net as evidenced by: n, record review, and ealth agency failed to re (POC) included all the patient's mental and all supplies and agency of frequency and duratio complete and accurate I cons, patient-specific an	s to ining ation; y the ian or d n of ist of d cy se secific II cords	G 574			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER		CLIA ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		15K162		B. WING		02/2	C 2 3/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012			
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G 574	1. An agency policy to 7/24/17, stated " P plan of care is develor Procedure: The plathe following informatobjective goal statem outcomes The plathe following: All pertiner Types of services Medications and treat Instructions for timely as appropriate" 2. An undated agency Parameters Process, greater than 101 [deg (BPM [beats per minion of the period which contained 4. Respirations (per resist than 12. 5. Blood first of the two numbers and blood pressure (Diast numbers of a blood	itled "Care Planning," decolicy: An individualize ped for each patient alan of care includes at letion: Measurable, ments Measurable part of care covers the not diagnoses. Mental strequency of visits atments. Safety measure of discharge Other items of the covers of a letter of the covers of a blood pressure in 180 or less than 90. Covers of a blood pressure reading]: greater than 100. Covers of a blood pressure in 180 or less than 90. Covers of a blood pressure in 180 or less than 90. Covers of a blood pressure in 180 or less than 90. Covers of a blood pressure reading]: greater than 350. 8. Covers of greater than 350. 8. Covers of greater than 350. 8.	red reast reast reast reast reast reserver reser	G 574				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	15K162			B. WING			C 23/2021	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	T ADDRESS, CITY, STATE, ZIP CODE				
RIGHT AT	F HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
G 574	Pantoprazole [given for Disease (GERD)] Attention Deficit Hyper" The clinical reconcomprehensive assessibly Former Registered indicated the patient [hypertension, elevate Post-traumatic Stress right sided carpal tuncompressed nerve in numbness, tingling, and hand), benign prostate enlargement of the properties of the properti	for Gastroesophageal R Strattera [given to treat eractivity Disorder (ADF rd also contained a sement completed on 1. d Nurse (RN) I, which had diagnoses of "HTN red blood pressure]," is Disorder (PTSD), anxionel syndrome (a the wrist which causes and weakness in the arm the hyperplasia (BPH, rostate in males), and (inability to control urinal idence diagnoses related attain, Pantoprazole, gnoses noted in the essment of HTN, PTSD, a syndrome, BPH, and a section titled attus," which stated " of increased anxiety with the rehensive assessment included a section titled attained the patient had and depression. The PC complete mental and a medication list with on orders for " Lising	ety, n and ation). ed to and Other	G 574				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE				
RIGHT AT	HOME, INC			SON, IN 460	TREET SUITE B 012			
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G 574	the dosage of hydrox 11/13/2020 to " Hydrab every 8 [hours] as The POC failed to corup-to-date medication. The POC contained a (past and present fortuse/hospitalization): Pharmacy (medication Impaired Mobility Impairment" The Hospital Risk Score: Shospital. Plan for prein place (Education of Management, compliated The POC failed to evindividualized interverrisk factors for ED vis. The POC contained a "Goals/Rehabilitation which stated" Goa with medication by 30 competence in followidays. Patient's hygie assist of HHA [Home Patient's safety will be HHA as evidenced by days Discharge: Pwhen agency can no needs or the patient reare." The POC failed	inued on 12/23/2020 ar yzine was changed on droxyzine 25 mg tab, por a needed for anxiety	ctors) y i" orn is n" and tient's ance 60 vith s. of 60	G 574				
	Discipline and Treatm	section titled "Orders fents," which stated " de. Discussed Advance	.					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ D PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	15K162			B. WING 0			C 23/2021
	OVIDER OR SUPPLIER			RESS, CITY, STA			
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR) OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 574	Directive. Voiced ur failed to evidence paif advance directives The POC included a 1 hour per visit, 3 vis The skilled nurse wa Assessment and Every visit. The plan vital sign call paramed. 4. The clinical record on 2/12/21 and indicted to: transverse spinal cord), paraple lower portion of the linited to: transverse spinal cord), paraple lower portion of the linfections (UTI, an ir system), and asthmat plan of care for the result of the orders for "Lasix from the body] 20 me Fluocinonide 0.1% of inflammation and itc skin conditions] topic skin two times daily and material polystatin Powder [used to tablet po daily Tiz spasms] 2 mg one to tablet po daily Tiz spasms] 2 mg one to tablet podaily Tiz spasms] 100,000 [ur and abdominal folds for rash Riley But treat fungal infection skin] topically to affet times daily as needed Hydrophilic Wound (cream which assiste	nderstanding" The Policy atient-specific informations were present or not. In order for skilled nurse sits per day, 7 days per vas to conduct "Skilled aluation of all Systems of care failed to evidence."	visits week" at ce ewed of t not of the etract a 4/21 - t with luid / of I to sh e puscle ons of oreast eded ed to the aree	G 574			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 1					(X3) DATE SURVEY COMPLETED		
		15K162		B. WING		02/	C 23/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	ΓE, ZIP CODE	•		
RIGHT AT	HOME, INC		1125 BROADWAY STREET SUITE B ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 574	three times daily as no clinical record also in assessment complete. I. The comprehensive patient had a history (muscles and tendon pain of both shoulder (inability to control both failed to evidence dia the medications Lasis Omeprazole, Tizanidi Cream, and Coloplas and failed to evidence cuff, chronic shoulder incontinence as noted assessment. A home visit observation 2/11/21 at 9:15 AM whome visit, Patient #7 redness to her sacruf directly above the code Stage 2 pressure ulcoprolonged pressure, if first layers of the skin three (surveyor unabwounds due to area of medicated cream) Stage to the surveyor unabwounds due to area of medicated cream) Stage to the wounds due to area of medicated cream of the skin fold on the right right buttock, and one skin fold on the right right buttock wounds ABD pad (type of gauthe wound to the right a dressing or topical indicated her supraptive managed by an and Home Health Aidwould apply Coloplas (a medicated ointmer	needed for rash" The cluded a comprehensive do n 1/21/21 by Forme te assessment indicated of a torn rotator cuff s of the shoulder), chroes, and bowel incontiner owel elimination). The Pagnoses related to the unit, Fluocinonide, ine, Nystatin, Riley Butter Hydrophilic Wound Care diagnoses of torn rotar pain, and bowel d in the comprehensive tion was conducted on with Patient #1. During the was observed to have my (lowest area of the specyx) and both buttocks are (wound caused by resulting in damage to the to distinguish number to the domestic to the right buttock, two let to distinguish number of the specyx and both buttocks are to distinguish number of the specyx and both buttock, two let to distinguish number of the specyx and both buttock, two let to distinguish number of the specyx and both buttock, two let to distinguish number of the specyx and both buttock, two let to distinguish number of the specyx and both buttock, two let to distinguish number of the specyx and both buttock, two let to distinguish number of the specy and both buttock, two let to distinguish number of the specy and both buttock, two let to distinguish number of the specy and both buttock, two let to distinguish number of the specy and both buttock, two let to distinguish number of the specy and both buttock the spe	the end of	G 574				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM		CLIA ,		IDDING		(X3) DATE SURVEY COMPLETED			
			B. WING		02	C / 23/2021			
NAME OF PR	F PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	ΓE, ZIP CODE				
RIGHT AT	HOME, INC		1125 BROADWAY STREET SUITE B ANDERSON, IN 46012						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
G 574	and buttocks. The Pi "DME and Supplies," care supplies manage wound care manager [name of clinic not spevidence a diagnosis wounds and failed to supplies needed rela The POC contained s 4-7 hours per day, 5- also included HHA ta morning, afternoon, a failed to evidence Hi- detailed visit frequen- range of visits per da The POC contained a (past and present for use/hospitalization): Pharmacy (medication Impaired Mobility Impairment" The Hospital Risk Score: return to hospital. Pla return to hospital (Ed Pain Mgt [management Medications)" Th patient-specific and in related to the patient' and hospitalizations. The POC contained a "Goals/Rehabilitation which stated " Goa enhanced by assist of falls and/or injuries by and personal care nee HHA by 30 days E	oC included a section to which stated " wounded by [Home Health J], do by Wound Care Clinic secified]." The POC fails related to the patient's evidence the patient set of the her wound care. Service orders for HHA 7 days per week. The sks to be completed for and evening visit. The last service orders with cy, including the number y. As section titled "Risk Fare health status/ED Obesity Poly on associated with falls) Incontinence Senso POC also stated " 2. [Patient #2] is at risk an is in place to preven ucation of Disease procent], Compliance with the POC failed to eviden andividualized interventions risk factors for ED visite the policy in th	visits POC r a POC er or ctors ry for t cess, ce ons its ans," be ino giene sist of cy can	G 574					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE					(X3) DATE SURVEY COMPLETED			
	15K162			B. WING			C 3/ 2021		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
RIGHT AT	HOME, INC			BROADWAY STREET SUITE B ERSON, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
G 574	a higher level of care evidence patient-spee patient education to far The POC contained a Disciple and Treatme Status: Full. Discusse Patient voiced unders to evidence patient-speed advance directives with the status of the patient voiced unders to evidence patient-speed advance directives with the status of the patient voiced unders to evidence patient-speed advance directives with the status of the patient of the patient of the patient of the medication orders treat osteoporosis of the medication orders treat high cholesterol of treat constipation or given to treat pain or given to skin two tipain Metoprolol Tablood pressure or given or	"The POC failed to cific, measurable goals acilitate discharge. "A section titled "Orders ints," which stated " (ed Advance Directives. standing" The POC pecific information on if the present or not. I of Patient #3 was reviews. Standing" The POC pecific information on if the present or not. I of Patient #3 was reviews. All of Patient diagnoses ain, COPD, fibromyalgiately. The record contains certification period 1/9/2004 a medication list was " Alendronate [given to the complete of the poly one patch topically to 12 hrs [hours] (on fowithin 24hr period as new A-Salicylate 10-15% [given to 12 hrs [hours] (on fowithin 24hr period as new A-Salicylate 10-15% [given to 12 hrs [given to treat high standard to the poly one patch topically the period of the peri	for Code failed ewed tart of a, ned a '21 - with n to reat o [given / to or eeded even to t or th o treat ess]	G 574					

TAG OR LSC IDENTIFYING INFORMATION) 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 "			(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
RIGHT AT HOME, INC 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE D			15K162		B. WING			_
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 "				1125 BR	OADWAY S	TREET SUITE B		
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 "	PRÉFIX	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE
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	Menthol/M-Salicylate The POC contained a (past and present for use/hospitalization)," Pharmacy (medicatio Impaired Mobility. Inclingaired Mobility. Inclingaire	a section titled "Risk Fare health status/ED which stated " Poly ons associated with falls continence. Sensory of Falls in Past 3 Month amary" also stated " 3. Patient is at risk for not been hospitalized in or prevention of return to Education of Disease compliance with Medica to evidence patient-speterventions related to the for ED visits and a section titled a Potential/Discharge Planation of Care is realled to evidence awill be met with assist of Discharge: When service igher level of care is realled to evidence surable goals and paties a section titled "Orders in a secti	ans," t falls by no int for Code C n on	G 574			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 1	LE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		15K162		B. WING			C 3/2021
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			1125 BR	COADWAY S	TREET SUITE B		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 574	two separate starts or start of care was 5/22 care for the recertifica 3/11/21, with service and respite HHA. The care was 6/19/19, amperiod 12/20/2020 - 1 for HHA. Both clinical diagnoses included: Accident, loss of blochemiparesis (weakned Type 2 Diabetes, neuronditions caused by nerves), and high bloorecord failed to evide services required by HHA, and Respite HHA.	f care. The first record's 2/19, and contained a plation period 1/11/21 - orders for skilled nursing e second record's start dontained a recertifical 2/7/21, with service order records indicated pation CVA (Cerebrovascular and flow to the brain) with ess to one side of the bouropathy (series of medial and pressure. The clinical and pressure. The clinical cone POC with all and the patient (Skilled Nursing and pressure) and care of ervices billed under the patient of care of ervices billed under the patient of care of ervices billed under the patient's led medication lists with rizine [given to treat alled the linical supervisor. During the start of care of 6/19/1 billed under the patient's led medication lists with rizine [given to treat alled the linical supervisor. In the patient's led medication lists with rizine [given to treat alled the linical supervisor to treat alled the linical supervisor. In the patient's led medication lists with rizine [given to treat heart Ferrous Sulfate [given to treat alled to low iron levels] eat insomnia] Miralax, given to treat B to evidence diagnoses	lan of g of ation ders ent n left ody), ical g gency sing, 15 ng tient the 9 s	G 574			

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	CLIA		LE CONSTRUCTION	(X3) DATE SUF COMPLET	ED	
							C 3/2021	
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			1125 BF	EET ADDRESS, CITY, STATE, ZIP CODE 125 BROADWAY STREET SUITE B ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 574	The two POCs included Factors (past and preuse/hospitalization)," Poly Pharmacy (mediuse/hospitalization)," Poly Pharmacy (mediuse/hospitalization)," Poly Pharmacy (mediuse/hospitalization)," Impairment Diagnated to the stated " Hospital Resided " Hospital Resided " Hospital Resided Tecture to hospital. No days. Plan for prevering place (Education of Management, Complitation of Management, Complitation PoCs failed to evindividualized interversisk factors for ED visional The two PoCs included "Goals/Rehabilitation which stated " Discono longer needed or vare needed" The patient and/or careging discharge. The two PoCs included for Discipline and Tree Code Status: Full. Disconormal Disconorma	ed a section titled "Risk sent for health status/E which stated " Obesi ication associated with Incontinence. Sensory osis of: [History] Left C'" The POC's summisk Score: 3. Is a risk for hospital stays in the partition of return to hospital n Disease Process, Partiance with Medication) widence patient-specifications related to the partitions related to the partitions related to the partitions related to the partitions related to evidence with Medications and hospitalizations and hospitalizations when higher level of server education to facilitate as section titled "Ordinatments," which stated iscussed Advance Direct on the person's behalf pective requested" The term is an individual to another person's behalf pective requested" The term is an individual to the person's behalf pective requested" The term is an individual to the person's penalty of the particate if the POA includes all decisions for the patient indicate if the poation of the person of the particate orders which indicate in the person of the patient indicate if the poation of the particate if the poation of the person of the patient indicate in the person of the patient indicate in the person of the patient indicate in the person of the p	ity falls) VA, hary or ast 60 al is in" and tient's . ans," are rvices be ers " ctive. hey, hey, he tient's ed the ent. 11- ted	G 574				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C					(X3) DATE SURVEY COMPLETED	
	15K162			B. WING		02/2	C 3/ 2021
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			1125 BR	ESS, CITY, STA COADWAY S	TREET SUITE B		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 574	Vital Signs" The sign call parameters of the care date of 6/19/19 is recertification period which indicated service hours per day, 2 - 5 direcord also included lindicated HHA #2 propatient #4 from 10 AM provided HHA service 6 PM on 1/4/21, 1/5/2 1/11/21, 1/12/21, 1/13/21, 1/19/21, 1/12/2/21. The visit note provided HHA service HHA #3 provided HHA service HHA #3 provided HHA on 2/1/21, 2/3/21, 2/4 failed to evidence the daily HHA visits. The POC for the recession daily as needed succinate SA 24 hour pressure 10 mg [millied equal 50 mg po daily included a "Medication reviewed by the Clinic which indicated the own Metoprolol Succinate daily" The POC for directions on where to and failed to evidence Metoprolol Succinate	POC failed to evidence for Patient #4. T Patient #4 with a start included a POC for the 12/10/2020 - 2/18/2021 be orders for HHA visits lays per week. The clir HHA visit notes which evided HHA services to M - 1 PM and HHA #3 es to Patient #4 from 1 21, 1/6/21, 1/7/21. 1/8/28/21, 1/14/21, 1/15/21, 1/21/21, 1/21/21, 1/21/21, 1/22/21, es also indicated HHA #2 es from 9 AM - 1 PM and A services from 1 PM - 1/21, and 2/5/21. The Patification period 12/10/10 a medication list with the Lidocaine 5% [given to I given to treat high blood in I given to I	of , 55-9 nical PM - 1, and t2 nd 6 PM OC n of 2020 ne o y to 2020 ne o tab 2020, tab atch,	G 574			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER DEPLAY OF CORRECTION IDENTIFICATION NUMBER			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		15K162		B. WING		02/:	C 23/2021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 112				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA' OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 574	3/11/21, with service Respite HHA visits, in Demonstrate complia days. Demonstrates medical regime by 60 enhanced per assist falls with injury by 30 care/hygiene needs who so days" The period 12/10/2020 - 20 orders for HHA visits Patient's safety will be evidenced by no falls Patient's personal can assistance of HHA by failed to evidence par measurable goals. 7. The clinical record on 2/12/21 and 2/16/20 care date of 2/15/19, including but not limit of movement disorded damage prior to birth Neurologic Neglect (in or move one side of the Incontinence (inability movements). The recare for the recertification of the recertification	orders for Skilled Nurse included patient goals " ance with medication by competence in followin of days. Patient safety wof HHA as evidenced by days. Patient's person will be met per assist of POC for the recertificate 2/18/2021, with service, included patient goals e met per assist of HHA with injury by 60 days. The POC tient-specific and dof Patient #5 was revied 1, and indicated a star with patient diagnoses are do: Cerebral Palsy (or swhich result from brain or early childhood), nability for patient to sethe body), and Bowel	and	G 574					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	COMPLETE	(X3) DATE SURVEY COMPLETED	
	15K162			B. WING			C 3/ 2021	
RIGHT AT HOME, INC			1125 BR	ESS, CITY, STAR ROADWAY S SON, IN 460	TREET SUITE B			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 574	[given to treat acne] to treat a variety of bath the POC failed to evithe above medication. The clinical record coassessment with a "Nindicated the patient I lbuprofen 100 mg / 5 Route: GT [G-tube]. was discontinued on medication list include 100 mg / 5 ml, 25 mls POC's medication list and up-to-date medication list and up-to-date medications associa Mobility. Incontinent stated " Hospital R return to hospital. No days. Plan for prever in place (Education o Management, Complit The POC failed to evindividualized interverisk factors for ED vis The POC included a Rehabilitation Potentistated " Goals: Path signs/symptoms of in infection by 30 days. enhanced with assist evidenced by no falls Discharge: When serhigher level of care is	Mupirocin [ointment acterial skin infections] dence diagnoses relates. Intained a comprehensifiedication Profile" which ad an order for " ml [milliliters]. 25 mls. Frequency: Daily" the 11/21/2020. The POC's an order for Ibuprofes per G-tube daily. The failed to evidence a cuation list. Section titled "Risk Fact health status/ED Poly Pharmacy ted with falls) Impaire" The POC's sum isk Factor: 2. Is at risk to hospital stays in past of the pair in Disease Process, Palance with Medication) dence patient-specifications related to the pairs and hospitalizations section titled "Goals / al / Discharge Plans," vient will be free from fection as evidenced by Patient's safety will be	ed to ive h nat s en urrent tors red mary for 60 al is in" and tient's which y no I or C	G 574				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF DEPLAY OF CORRECTION IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED			
		15K162		B. WING		02	C 2/ 23/2021		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE	E, ZIP CODE				
RIGHT AT	HOME, INC			1125 BROADWAY STREET SUITE B ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIENCY N	Y STATEMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL RE CIDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
G 574	discharge. 8. An interview was PM with the Admin Administrator, and the interview, the Oplan of care should diagnoses, the pat status, supplies an medications and trainterventions relate visits and hospitalizeducation to facilita patient-specific and advance directive in Administrator indications were not required they were patient-spolicy which indicated if a patient service per day, the patient's frequency the POC, however day were considered the two HHAs proviservices.	education to facilitate as conducted on 2/22/21 a	ng ed the social ED egiver e vital nless ad a so one nin the on s per	G 574					
G 580	17-13-1(a)(1)(B) 17-13-1(a)(1)(C)(i, ii, iii, ix, xi, xiii) G 580 Only as ordered by a physician CFR(s): 484.60(b)(1)			G 580					
	only as ordered by practitioner. This Element is no Based on observat	nd treatments are administ a physician or allowed of met as evidenced by: tion, record review, and be health agency failed to	stered						

, ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	JLIA .		LE CONSTRUCTION	(X3) DATE SI COMPLE	ETED		
		15K162		B. WING		02/	C / 23/2021		
	RIGHT AT HOME, INC			T ADDRESS, CITY, STATE, ZIP CODE 25 BROADWAY STREET SUITE B NDERSON, 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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
G 580	ensure all drugs and only as ordered by a records reviewed (# 11 records. Findings include: 1. An agency policy Orders," dated 7/24/Home provides care to patients in accord orders Care, treat provided according order/prescription updated orders are Order / Prescription to the physician for sequalified [Home Heat Procedure: Prior medication, the nurs information based of Correct medication 3. An agency policy Management - Patien 7/24/17, stated "Pur dispense, administer patients' medication opportunity for medication opportunity for medications ordering physician and only as ordering physician in the control of the medications ordering physician are considered by a sequence of the medications ordering physician are considered by a sequence of the medications ordering physician are considered by a sequence of the medications ordering physician are considered by a sequence of the medications or ordering physician are considered by a sequence of the medications or ordering physician are considered by a sequence of the medications or ordering physician are considered by a sequence of the medications or ordering physician are considered by a sequence of the considered by a seque	d services were administ a physician for 4 of 5 acti 1, 2, 4, 5), in a total same of titled "Telephone / Verbout, stated" Policy: River, treatment and / or services at the most recent Original and/or new / transcribed onto a physician form and mailed or fasignature" If titled "Medication Ordered 7/24/18, stated "Purpote, safe and effective escribed medications by alth agency] staff to administering any se verifies the following in the medication order Correct dose" If titled "Medication ent Information," dated pose: To safely order, in and monitor Right at His. To minimize the edication errors Proceedings of the skilled visit. Any character are conveyed to the	al ght at ices cian axed axed axed axed axed axed axed axed	G 580					

OL: TI L: T	OT OIL MEDIO, WE WIT	· · · · · · · · · · · · · · · · · · ·				. OIVID IV	C. 0000-0001
· · ·		(X1) PROVIDER/SUPPLIER/O			LE CONSTRUCTION	(X3) DATE SU COMPLE	
	15K162			B. WING		02/2	C 2 3/2021
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	•	
RIGHT AT	HOME, INC				TREET SUITE B		
			ANDER	SON, IN 460	J12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
G 580	Continued From pag	e 47		G 580			
0 000			+ of	0 000			
		21, and indicated a star	LOI				
	care date of 9/16/19, with patient diagnoses including but not limited to: diabetes, bilateral						
	,	dy) knee pain, low back					
		tive Pulmonary Disease	,				
		disease). The clinical					
	contained a plan of c	• •	_ .				
	· ·	11/9/2020 - 1/7/2021.					
		d a "Medication Profile,"					
		requency of the patient' treat anxiety and/or ito					
		25 mg (milligrams), one	illig)				
		as needed for anxiety, t	o 25				
		8 hours as needed for					
		13/2020; the dosage of					
		(given to treat high bloc					
		sed from 12.5 mg daily					
	·	2/23/2020; the patient's	10 20				
	•	eat high blood pressure) was				
		e 12/23/2020; and the) was				
	patient was started or						
	Strattera (given to tre						
	Hyperactivity Disorde						
	, ,,	al record failed to evide	nce				
		e obtained to confirm the					
	medication changes.	c obtained to commit ti	1030				
	modication changes.						
	The clinical record in	cluded a plan of care fo	or the				
		1/8/21 - 3/8/21, which	1110				
	· ·	ation orders " Novolo	a				
		g insulin used to decrea	·				
	blood sugar in diabet		130				
	_	ted directly underneath	the				
	-	•					
		e - Glucometer check u	-				
		ree times daily in the A					
		- 120 = 2 units, 121 - 13					
		inits, 181 - 240 = 8 unit					
		lucose [sugar] 1 tablet					
		d for blood sugar of less					
	80 Call MD if follow	un Blood Sugar readin	n etill				1

Printed: 03/26/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/ 2021
	OVIDER OR SUPPLIER			RESS, CITY, STA	,	•	
RIGHT AT	HOME, INC			SOADWAY S	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL REI DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 580	[less than] 80" A "Nursing Visit Note completed on 2/5/21 Licensed Practical N patient's glucometer The nurse document 64 No s/s [signs of [Patient #1] eating gl dinner in 5 minutes evidence the patient' rechecked 15 minutes glucose tablet accord. A "Nursing Visit Note completed on 1/29/2 by LPN #1 indicated blood sugar check w units of Novolog (insphysician order). LP correct dose of insuli physician's orders. A "Nursing Visit Note completed on 1/25/2 by LPN #1 indicated blood sugar reading units of NovoLog (insphysician order). LP correct dose of insuli physician order). LP correct dose of insuli physician order). LP correct dose of insuli physician's orders. A "Nursing Visit Note completed on 1/13/2 LPN #1 indicated the sugar reading was 24 Novolog (instead of corder). LPN #1 failed order). LPN #1 failed	"for the skilled nurse vi from 5:20 PM - 6:20 PM urse (LPN) #1 indicated blood sugar check was ed " BS [Blood Sugar or symptoms] any distresucose tablet - will be ea" The nurse failed to s blood sugar was after administration of ding to the physician or of the skilled nurse vi 1 from 11:30 AM -12:30 the patient's glucometer as 225 and he received tead of 8 units per the N #1 failed to administer according to the patient's glucometer as 240 and he received the skilled nurse vi 1 from 11:30 AM - 12:30 the patient's glucometer was 240 and he received stead of 8 units per the N #1 failed to administer and stead of 8 units per the N #1 failed to administer the N #1 failed to administ	If by the 64. [7] = 65. [7] ting for the first ph. 10 for the form of the form	G 580			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		15K162		B. WING		02/2	C 3/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	RRECTIVE ACTION SHOULD BE CONTROL CONT	
G 580	Continued From pag	e 49		G 580			
	Notes" for the skilled LPN #2 on 2/4/21 froi sugar was 77), 1/21/2 (blood sugar was 75) (blood sugar was 77) 9:10 AM (blood sugar LPN #2 failed to adm the patient's blood su according to the physical transport of the skilled LPN #1 on 2/1/21 froi sugar was 78), 1/26/2 PM (blood sugar was 6:20 PM (blood sugar was 6:20 PM (blood sugar 11:30 AM - 12:30 PM 1/9/21 from 11:30 AM 79), 1/9/21 from 5:20 was 62). During the vadminister a glucose sugar readings less the physician orders.	ontained "Nursing Visit nurse visits completed m 5:20 PM - 6:20 PM (b21 from 11:30 AM - 12:36 70), 1/26/21 from 5:20 r was 75), 1/21/21 from (blood sugar was 77), 1 - 12:30 (blood sugar w PM - 6:20 PM (blood susits, LPN #1 failed to tablet for the patient's behan 80 according to the ontained "Nursing Visit"	blood AM 0 AM 0 AM - isits, for 80 by blood 30 PM -				
	LPN #3 on 1/31/21 fr (blood sugar was 69) 12:45 PM (blood sugar visits, LPN #3 failed t	nurse visits completed om 11:45 AM - 12:45 P , 1/17/21 from 11:45 AN ar was 70). During the o administer a glucose d sugar readings less the	M vl - tablet				
	5. The clinical record on 2/12/21 and indica 4/10/18, with patient limited to: transverse	I of Patient #2 was revieus as the date of care date diagnoses including but myelitis (inflammation of the diagnoses)	of t not of the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K162		B. WING		02/:	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BR	ESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	(EACH CORRECTIVE ACTION	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	
G 580	lower portion of the binfections (UTI, an insystem), and asthma comprehensive asses 1/21/21 by Former RI period 1/24/21 - 3/24, assessment included which indicated the p C, Vitamin E, and Tyl discontinued, and Ibutablet by mouth twice patient's medication I record failed to evide obtained by the nurse changes. 6. The clinical record on 2/16/21 and 2/18/2 care of 5/22/19, with CVA (Cerebrovascula flow to the brain) with to one side of the bod neuropathy (series of by damage to the out blood pressure. The care for the recertifica 2/7/2021, which inclu Health Aide (HHA) visting the services from 9 provided HHA services from 9 provided HHA services from 9 provided HHA services from 9 provided in physician services for more that per day on the above	ody), history of urinary fection of the urinary. The record contained asment, completed on N I, for the recertificatio (21. The comprehensive a section titled "Medicationt's medications Viterial Extra-Strength we uprofen 200 milligram (research and a day, was added to the section of the endication	n ve ation" camin re mg), 1 me leved tof ding: ad kness used m of leved for 2 ded vided 3 or a cal gency rs	G 580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/23/202	21
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, STA	TE, ZIP CODE	"	
RIGHT AT	HOME, INC		1125 BF	ROADWAY S	TREET SUITE B		
			ANDER	SON, IN 460	012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	CTION SHOULD BE DAD THE APPROPRIATE	
G 580	Continued From page	e 51		G 580			
0 000	. •	21, and indicated a star	t of	0 000			
		with patient diagnoses					
	including but not limited to: Cerebral Palsy (group						
	<u> </u>	rs which result from bra	• •				
	damage prior to birth						
	• .	nability for patient to se	nse				
	or move one side of t	he body), and Bowel					
	Incontinence (inability						
	-	cord contained a plan o					
		ation 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						
		to 1L to keep O2 SAT					
		also expressed as SpO	2 a				
		ures the percentage of					
	_	oxygen] > 93%. Notify					
		< 11 per min [minute],					
		ns or symptoms of dys					
	and if HR > 110, SBP	[systolic blood pressur	e, the				
	first of two numbers in	n a blood pressure read	ding]				
		Skilled Nurse] 60 Hours					
		ent's family member] to	I				
		cal Wound on Back 2 ti	mes				
	a Week or as Needed	· ·	N 4: -J				
		ssing (Cleanse Wound al Saline], Cover with A					
	· ·	ound dressing] and Sec	I				
		medical adhesive] / Tap					
		rd indicated the patient					
		ed nursing services for 8	I				
	=	urs on 1/3/21, 12 hours					
		10/21, 8 hours on 1/16/					
		hours on 1/23/21, 8 ho					
	on 1/24/21, 8 hours o	n 1/30/21, and 8 hours	on				
		88 hours from 1/1/21 -					
	1/31/21. The record to						
		obtained to provide resp	I				
	nursing services for n	nore than the ordered 6	50				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	
15K162 B. WING C 02/23/20	
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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) ID 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 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, 12/11/20, 12/15/20, 12/9/20, 12/16/20, 12/17/20, 12/18/20, 12/19/20, 12/23/20, 12/30/20, 12/30/20, 12/30/20, 12/23/20, 11/20/21, 11/2	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		15K162		B. WING		02/	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 580	obtained to increase to L/min. A "Nursing Visit Note, LPN #4, indicated the administered at "3" L/ The visit note summa a] rough night. Labor the patient's blood preshift was "77/63." The evidence an order wapatient's oxygen to 3 the nurse notified the systolic blood pressur (SBP < 90). A "Nursing Visit Note, LPN #4, indicated the administered at "3" L/ The nursing note faile obtained to increase to L/min. A "Nursing Visit Note, LPN #3, indicated the administered at "3" L/ rate was "120,", and the LPN #3 documented all lung lobes and dysnote failed to evidence increase the patient's nurse notified the patinate and systolic blood parameters. A "Nursing Visit Note, LPN #3, indicated the administered at "3" L/ SpO2 was "99%," and spo2	the patient's oxygen to a documented on 2/1/2 patient's oxygen was a min and SpO2 was "97 any stated " [Patient # red breathing," and indicessure prior to end of the nursing note failed to as obtained to increase L/min and failed to evide patient's physician of the below the call parameter below the patient's oxygen was a min, SpO2 was 96%, holood pressure was "84 the patient had "crackle spnea at rest. The nursie an order was obtaine oxygen to 3 L/min and ient's physician of the had pressure above the call parameter below the call para	1 by "%." 5 had cated ne the lence he eters 21 by "%." was 3 21 by leart /53." les" to sing d to the leart all 21 by	G 580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02	C 2/ 23/2021
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ESS, CITY, STA	ΓΕ, ZIP CODE	•	
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 580	obtained to increase L/min and administer and failed to evidence patient's physician of the call parameters. A "Nursing Visit Note LPN #3, indicated the administered at "2.5" heart rate was "115," "83/45." LPN #3 doc "crackles" to all lung heard during auscultare sulting from infection dyspnea at rest. The evidence an order was patient's oxygen to 2. evidence the nurse most the heart rate and above the call paramed habove the call pa	the patient's oxygen to through a nasal cannule the nurse notified the the heart rate reading." "documented on 1/28, a patient's oxygen was L/min, SpO2 was "97% and blood pressure was umented the patient had been about the lungs, normal and/or inflammation) and/or inflammation and/or inflammation and/or inflammation and/or inflammation and/or inflammation and failed to discontified the patient's phyblood pressure reading eters. "documented on 1/27, a patient's oxygen was L/min via nasal cannul spiratory rate was "22," LPN #3 documented the to both lower lung lob. The nursing note failed as obtained to increase a sobtained to increase to L/min and administer ula, and failed to evide patient's physician of the call parameters." "documented on 1/26, a patient's oxygen was /min, SpO2 was "97%," '23," heart rate was "12	la, above /21 by /6," as d ally and the sician /21 by a, and ne es, d to the nce he s. /21 by	G 580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		` '	E CONSTRUCTION	COMPLETED	
		15K162		B. WING		02	C 2/23/2021
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	E, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY ST SON, IN 460	REET SUITE B 12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 580	lower lung lobe, the the right lower lung to this area), and do note summary indicadministered at "2. failed to evidence a increase the patient failed to evidence to physician of the hereading above the reading	ere were no breath sound lobe (meaning no air get yspnea at rest. The nursicated the patient's oxyger 5" L/min. The nursing no an order was obtained to it's oxygen to 2-2.5 L/min he nurse notified the patient rate and blood pressurcall parameters. Ite," documented on 1/25 and the patient's oxygen was 5" L/min, SpO2 was "95-2". The nursing note summing of shift] Client O Air [no supplemental oxy Following routine meds on [treatment] [Patient on at] 2.5 [L/min] per [patient of the nurse documented of the nurse documented of the nurse documented the was 140, and at 4:30 PM the patient's heart rate was 140 increase the patient's physic patient's respiratory rate in and the patient's physic patient's respiratory rate in the spiratory rate in the patient's physic patient's respiratory rate.	itting ing ing in was ite and ent's re /21 by 96%," mary 2 sat //2en] and it] ent's ffic ed the is fic ed the //2 by //2en] and it] ent's ffic ed the //2 by //2en] //and	G 580			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		15K162		B. WING		02	C / 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BI	RESS, CITY, STATE ROADWAY S SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 580	stopped feeding in promiting in	ogress. Lift transfer to patient's follow up vital is SpO2 92%, respirator attent had "labored documented oxygen was ute not documented), a point vital sign check at 7 Piratory rate 20, blood at rate 125, and the patient's physician was experient's physician was experient's physician was experient's physician was experiented on 2/22/21 at rator, Alternate inical Supervisor. During a Supervisor indicated the numbration aphysician's ordication was changed if tion bottle within the hostrator stated the medical supervisor stated the medical stated in the medical stated in the hostrator stated the medical stated in the stated in th	sign y s nd M ent te s t rate, t 1:15 ng ed all ered vider. urse er the me.	G 580			
G 584	personnel authorized laws and regulations policies. (4) When services are physician or allowed personnel authorized laws and regulations are personnel authorized laws and regulations policies.	(4) st be accepted only by to do so by applicable and by the HHA's interr e provided on the basis practitioner's verbal ord dance with state licensu	of a ers, a	G 584			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED		ED				
		15K162		B. WING			C 3/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STAROADWAY SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 584	responsible for furnish ordered services, in a and the HHA's policie orders in the patient's date, and time the order authenticated and darallowed pracitioner in state laws and regular internal policies. This Element is not in Based on record revie health agency failed the were authenticated and provider for 1 of 1 act evidenced verbal order total sample of 11 recorders," dated 7/24/1 Home ensures the accorders Original and are transcribed onto a Prescription form a physician for signatur orders for medication Date and time of the conders A copy of Verbal Orders Form is medical record" An agency policy title Patient Information, "or "Purpose: To safely of and monitor Right at 1 To minimize the oppo	ning or supervising the accordance with state laws, must document the colinical record, and signers. Verbal orders must ded by the physician or accordance with applications, as well as the Hennet as evidenced by: we and interview, the hole of ensure all verbal order and dated by the ordering ive record reviewed where were received (#5), fords. d "Telephone / Verbal 7, stated " Policy: Riscuracy of telephone / verbal order / and mailed or faxed to the Procedure: All is shall include the followorder Name of preson who accepts the order: writing Signs and do for the Physician Telephone in the patient's de "Medication Manager"	ght at erbal ers the wing: criber attes one /	G 584			

		A. BUILDING		(X3) DATE SURVEY COMPLETED				
ı	15K162	B. WING		C 02/23/2021				
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE					
RIGHT AT HOME, INC		1125 BROADWAY STREET SUITE B ANDERSON, IN 46012						
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BE PREC TAG OR LSC IDENTIFYING	CEDED BY FULL REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION				
G 584 Continued From page 58		G 584						
are reviewed and assessed of visit. Any changes to the me conveyed to the ordering phy	dications are							
The clinical record of Patient 2/12/21 and 2/16/21, and ind date of 2/15/19, with patient obut not limited to: Cerebral Pamovement disorders which redamage prior to birth or early Neurologic Neglect (inability for move one side of the body Incontinence (inability to continence (inability to continence (inability to contine or are for the recertification per 2/3/2021, which included sentursing visits 8 hours per day The record included a "Nursing documented on 2/1/21 by LP [Patient #5 had a] rough nit breathing, client tearful Cunot effective enough. [Family member of Patient #5] put in Practitioner] to go to another order] received [for] Azithrom The record failed to evidence ordering provider and the verauthenticated and dated by the A "Nursing Visit Note," documented and dated by the record failed to evidence ordering provider, the date are was received, and the order of and dated by the ordering provider. A "Nursing Visit Note," documented by the ordering provider and the order of and dated by the ordering provider. A "Nursing Visit Note," documented by the ordering provider and the order of and dated by the ordering provider. The record failed to evidence ordering provider, and the order of and dated by the ordering provider. The record failed to evidence ordering provider, and the order of and dated by the ordering provider. The record failed to evidence ordering provider, and the order of and dated by the ordering provider.	diagnoses including alsy (group of esult from brain childhood), for patient to sense etc), and Bowel arol bowel attained a plan of a pla							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K162		B. WING	 	02/2	C 2 3/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 584	briefly for turning N.P waiting [for] retured call - portal" The record failed the ordering provide authenticated and d A "Nursing Visit Note LPN #3, stated " I since last visit Es Gastroesophageal F The record failed to ordering provider, the was received, and the and dated by the ordering Visit Note LPN #3, stated " I since last visit Trelieve pain]" The name of the orderime the order was reauthenticated and d An interview was co PM with the Administrator, and Cothe interview, the CI	[Family Member K] calle urn call 12 PM: N.F. ble CXR [chest X-ray] or the control of the extra and the verbal order wasted by the ordering provide." documented on 1/14/Medications. New or charactering providence the name of the date and time the order was authenticated and time the order was authenticated and time the order was authenticated and the evider or the record failed to evider the record failed to evider the and the order wasted by the ordering provider, the date are eceived, and the order wasted by the ordering provider and the order wasted by the ordering provider.	dered of as vider. 21 by anged eat" e er ed 21 by anged vider. 15	G 584			
G 590	Promptly alert relevance CFR(s): 484.60(c)(1) The HHA must promphysician(s) or allow changes in the paties suggest that outcome.	ant physician of changes) nptly alert the relevant yed practitioner(s) to any ent's condition or needs to nes are not being achieve of care should be altered	hat ed	G 590			

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		I	C 23/2021
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			1125 BI	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 590	This Element is not in Based on record revision health agency failed a provider was notified condition for 1 of 1 acchange in patient con of 11 records. Findings include: An agency policy titled Services," dated 7/24 Right at Home staff physician: When there patient's condition An undated agency poparameters Process greater than 101 [deg (BPM [beats per minuless than 12" An undated agency poparameters process greater than 101 and less than 12" An undated agency poparameters process greater than 101 in the staff physician in the service of the ser	net as evidenced by: ew and interview, the he ensure the patient's me of a change in the patie citive records with a note dition (#5), in a total sa d "Coordination of Patie /17, stated " Procedu f promptly contacts the e are changes in the " olicy titled "MD Call stated "1. Temperature grees Fahrenheit]. 2. Po ate]): greater than 100 ute): greater than 24 [o olicy titled "Wound Measurements," policy d " Procedure: 1. Wo ither weekly or bi-week rder 4. All significant ted to the MD the same Patient #5 was reviewe and indicated a start of patient diagnoses include ebral Palsy (group of which result from brain or early childhood), hability for patient to se the body), and Bowel	dical ent's ed mple ent ure: e: ulse 4. r] unds ly per e day ed on care ding	G 590			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
		15K162		B. WING			C 3/2021
	ROVIDER OR SUPPLIER			RESS, CITY, STA			
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 590	movements). The recare for the recertifica 2/3/2021, which inclu Skilled Nursing 8 hou and Respite Skilled Nper month. The plan included orders which L/min [liters per minurhow oxygen administ PRN [as needed]. MO2 SAT [Oxygen Sat SpO2, a vital sign which percentage of blood view of two numbers in a brain minute], or if pat symptoms of dyspneating HR > 110, SBP [system of two numbers in a brain minute]. Measure [spinal sum of two numbers in a brain minute] was motified outside the call paramare required more oxygen A "Nursing Visit Note LPN #3, indicated the administered at "3" Late of the clinical record failed to the clinical r	cord contained a plan of ation period 12/6/2020 - ded service orders for a particle particle plants of the patient's heart rate was defined and the patient's heart rate meters and the patient or 2/2/2 e patient's oxygen was /min and SpO2 was "95 illed to evidence the meters and the patient required moters of the patient	week, rs 0.5 PM, sk keep as and if first < 80" 1 by s and he was 1 by s and he 1 by	G 590			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		15K162		B. WING			C 3/2021
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 590	The visit note summa a] rough night. Labor ATB [antibiotic] not ef call to N.P [Nurse Pra ATB [Order] receiv" and indicated the prior to end of the shi record failed to evided was notified the patie the blood pressure was parameters, and requirement order. A "Nursing Visit Note, LPN #4, indicated the administered at "3" L/The clinical record fail provider was notified oxygen than the current oxygen than the current administered at "3" L/Tate was "120,", and the administered at "3"	ary stated " [Patient # red breathing Currer fective enough. Mom patientioner] to go to another fective enough. Mom patient's blood pressur ft was "77/63." The clirince if the medical provint had labored breathing as outside the call sired more oxygen than " documented on 1/31/2 patient's oxygen was min and SpO2 was "98 led to evidence the methe patient required more the patient required more the patient was "84 the patient had "crackle ord during auscultation or ing from infection and/ong lobes and dyspneator failed to evidence the notified the patient's heare were outside of call and had abnormal breather that the current order. " documented on 1/29/2 patient's oxygen was " documented on 1/29/2 patient's ox	at but in her TB re hical der hig, the 21 by dical bre 21 by heart 1/53." he bor at he he heart his her her his her her her his her her his	G 590			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			1, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02	C 2/ 23/2021
NAME OF PR	OF PROVIDER OR SUPPLIER			RESS, CITY, STAT	E, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S' SON, IN 460	TREET SUITE B 112		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENCY M OR LSC		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 590	notified the medica rate was outside of required more oxygon the patient was recidifferent route than A "Nursing Visit No LPN #3, indicated to administered at "2.5 heart rate was "115" "83/45." LPN #3 do "crackles" to all lung The clinical recordinotified the medica rate and blood presparameters, the parameters, the parameters, the parameters, the parameters and dyspnerequired more oxygon A "Nursing Visit No LPN #3, indicated to administered at "2.5 SpO2 was "98%," routside of call parameters abnormal lung sour patient required more order, and the patient required more order.	I provider of the patient's call parameters, the patient than the current order eiving oxygen through a ordered. Ite," documented on 1/28/he patient's oxygen was 5" L/min, SpO2 was "97%, and blood pressure was commented the patient hat globes and dyspnea at refailed to evidence the nurly provider the patient's he sure were outside of call tient had abnormal lung as at rest, and the patient ein than the current order the," documented on 1/27/he patient's oxygen was 5" L/min via nasal cannul respiratory rate was "22," B." LPN #3 documented thes" to both lower lung lob to the clinical record faile notified the medical province and heart rate was receiving oxygen than the current was receiving oxygen eint was receiving oxygen.	ent r, and /21 by 6, " as d est. se eart /21 by a, and ne es ed to rider vere the nt /21 by	G 590			

ICZT11

			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/2	C 3/2021	
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 590	lower lung lobe, there the right lower lung lobe, there the right lower lung lo to this area), and dys note summary indicat administered at "2.5" failed to evidence the provider the patient's and blood pressure w parameters, the patie sounds and dyspnea required more oxyger A "Nursing Visit Note, LPN #4, indicated the administered at "2.5" heart rate was "122." stated "9 AM [beginni was 88% on Room Ai briefly for turning F nebulizer, percussion currently on [oxygen a family member]" time not documented patient's respiratory raminute and heart rate oxygen was titrated d L/min. At 4 PM, the repatient's heart rate wanurse documented the 136. Later during the documented), the patiented to be "102.3 [declinical record failed to notified the medical prespiratory rate, heart temperature were out the patient required morder.	were no breath soundable (meaning no air get pnea at rest. The nursing ed the patient's oxygen L/min. The clinical reconstruction are notified the med respiratory rate, heart refer outside of call in thad abnormal lung at rest, and the patient in than the current order. "documented on 1/25/epatient's oxygen was L/min, SpO2 was "95-9 The nursing note suming of shift] Client O2 or [no supplemental oxystements] [Patient at] 2.5 [L/min] per [p	ting ng ng nwas ord ical ical ate 21 by 16%," nary 2 sat gen] and lent's fic d the s fic d the as	G 590				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		l ` ′	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		15K162		B. WING			C 3/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 590	LPN #4, indicated du time documented) the was 24 breaths per mand SpO2 was 92 - 9 stated " 5:45 PM: [stopped feeding in pr," and indicated the check at 6:30 PM warate of 24, and the pabreathing." LPN #4 cstarted at 1 L/min (routhe patient's follow upwas SpO2 97%, resppressure 88/56, hear was exhibiting no "disfailed to evidence the provider the patient's rate were outside of cpatient had labored by LPN #3, indicated wound was measured 1.9 centimeters (cm). documented on 12/23 the patient's spinal su 2.3 cm, an increase of measurement. A "Nu documented on 1/15/patient's spinal surgic cm. A "Nursing Visit 1/22/21 by LPN #3, in surgical wound's dep of 0.4 cm from the las wound's measurement of 1.5 cm at both 12 cm. "Nursing Visit Note," LPN #3, indicated the wound's tunneling was sure was sure wound's tunneling was sure was sure was sure wound's tunneling was sure was	ring the visit (no specific patient's respiratory raninute, heart rate was 1 44%. The nursing summer Patient's family member ogress. Lift transfer to patient's follow up vital is SpO2 92%, respirator attent had "labored documented oxygen was ute not documented), a povital sign check at 7 Prinatory rate 20, blood to rate 125, and the patiestress." The clinical receivation of the patient of the medical parameters and the call parameters and the call parameters and the patient's spinal summer dand the wound's depthor of 0.4 cm from the previous of 0.4 cm from	ate 40, nary er] bed I sign ry s nd M ent cord dical dical dical diart 8/21 gical h was " ed vas ous d the 1.6 binal diase ling A I by al and	G 590			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		C 02/23/2021	
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLET	TION
G 590	cm respectively from A "Nursing Visit Note. LPN #3, indicated the wound's tunneling waincrease of 0.6 cm owneasurements. The evidence the patient's notified of the increase An interview was con PM with the Administrator, and CI the interview, the Clir nurse should notify the for any change in patients.	the previous measurent," documented on 2/5/2 patient's spinal surgicals 2.1 cm at 6 o'clock, aver the past two wound clinical record failed to see in wound measurement of the patient's medical Supervisor. During patient's medical provider was been wound measurement of the patient's medical provider patient's medical provider on a "Nurse's Note" of the Alternate of Patient #5's spinal	1 by al an ents. 15 ng ed the vider	G 590			
G 592	toward the measurab identified by the HHA care. This Element is not r Based on record revie health agency failed t care (POC) contained towards their goals for	patient's updated ssment, and contain ag the patient's progress le outcomes and goals and patient in the plan	of ome an of	G 592			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/2	C 23/2021	
	NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 592	7/24/17, stated " I care is reviewed, up Each member of the plan of care to even the plan of care to even the plan and the pat" 2. An undated ager "Registered Nurse" Functions: Modifictor reflect progress to 3. The clinical record on 2/16/21 and 2/17 care date of 9/16/19 including but not lim (both sides of the boand Chronic Obstruction (COPD, a respirator included a plan of caperiod 1/8/21 - 3/8/2 evidence the patient goals. 4. The clinical record on 2/12/21 and indiction (UTI, an insystem), and asthmosphane for the infections (UTI, an insystem), and asthmosphane for care for the insystem), and asthmosphane for the progress towards the care in the progress towards the care in the progress towards the care in the plan of care for the progress towards the care in the plan of care for the progress towards the care in the plan of care for the progress towards the care in the plan of care for the progress towards the care in the plan of care for the progress towards the care in the plan of care for the progress towards the plan of care for the p	r titled "Care Planning," of Procedure The plan of dated and/or modified the healthcare team review valuate the appropriate receiption titled stated " Essential es and updates plan of cowards outcomes" and of Patient #1 was review valuate the appropriate receiption titled stated " Essential es and updates plan of cowards outcomes" and of Patient #1 was review valuate to: diabetes, bilaterated are for the recertification the record are for the recertification but the body), history of urinary infection of the urinary and the recertification period 1/24 failed to evidence the patient goals.	of rs the ess of coals are ewed t of al pain, e r ewed t of t not of the e tract l a 4/21 - tient's	G 592				
		rd of Patient #3 was revid 18/21, and indicated a s						

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/ 2021
NAME OF PR	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
RIGHT AT HOME, INC				ROADWAY S SON, IN 460	TREET SUITE B 012		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 592	care date of 7/17/19, including: low back padepression, and anxie plan of care for the re 3/9/21. The POC faile progress towards their 6. The clinical record on 2/16/21 and 2/18/2 care of 5/22/19, with pCVA (Cerebrovascula flow to the brain) with to one side of the bod neuropathy (series of by damage to the out blood pressure. The plan of care for the re 3/11/21. The POC faile progress towards their 7. The clinical record on 2/12/21 and 2/16/2 care date of 2/15/19, including but not limite of movement disorder damage prior to birth Neurologic Neglect (in or move one side of the Incontinence (inability movements). The record for the recertification 2/3/2021. The POC patient's progress towards the PM with the Administrator, and Clinthe interview, the Clinthe interview is a constant.	with patient diagnoses ain, COPD, fibromyalgia aty. The record contain certification period 1/9/ed to evidence the patier goals. of Patient #4 was review at a patient diagnoses includer Accident, loss of blood left hemiparesis (weak by), Type 2 Diabetes, medical conditions cautying nerves), and high clinical record contained certification period 1/11 alled to evidence the pater goals. of Patient #5 was review at a patient diagnoses and indicated a star with patient diagnoses and to: Cerebral Palsy (gress which result from braison early childhood), anability for patient to see the body), and Bowel at the control bowel cord contained a plan of the patient diagnoses are to control bowel at the patient diagnoses are alled to evidence the patient diagnoses.	eed a 21 - ent's ewed t of ding: d aness used d a 1/21 - cient's ewed t of group ain nse f t 1:15	G 592			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		CLIA (LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/	C 23/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 608	Coordinate care delive CFR(s): 484.60(d)(4) Coordinate care delive needs, and involve the anylow and caregiver (secondination of care at This Element is not a Based on observation interview, the home hensure care was cooknome care agencies reviewed of patients multiple home care a sample of 11 records Findings include: An agency policy title Services," dated 7/27 ensure effective and continuity of care, tree Policy: When the treatment and/or services and the organizations/provide that the responsibilitied Agency] and the other collaborative and examintained between regarding changes in services or care to be impact the overall cal" An undated agency ju "Registered Nurse" services or care to be impact the overall cal"	very to meet the patient' ne patient, representatives), as appropriate, in the activities. met as evidenced by: n, record review, and nealth agency failed to rdinated with shared patient of 4 active records who received care from agencies (#2), in a total street. ded "Coordination of Patient, and the activities of the patient is receiving care vices from other ers, Right at Home ensures of the [Home Health er organizations/provide clusive. Communication those provided or goals that re, treatment and/or services ob description titled	e (if tient o n and rs are n is s	G 608 G 608				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
		15K162		B. WING			C 3/2021
RIGHT AT HOME, INC 1125					TREET SUITE B		
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 608	effectively Relays to physician and other The survey's Entrance conducted on 2/10/21 Administrator, Alternated Clinical Manager. Due Conference, the Clinical Manager. Due Conference of 2/12/21 and indicated 4/10/18, with patient of limited to: transverse spinal cord), parapleg lower portion of the binfections (UTI, an infections (UT	significant changes in some members of the team at 10:57 AM with the ate Administrator, and uring the Entrance cal Manager indicated that are with shared patient ading the patient's POC ency and communication with the other agency. Patient #2 was reviewed a start of care date of diagnoses including but myelitis (inflammation of the urinary ection of the urinary ection of the urinary ection of the urinary ection of the urinary experience" note, signed but the con 1/21/21, which state that Skilled Nursing [provided by J], primary care provided between Right at Horest end of the transport of the condition of the urinary experience was coordinated by J], primary care provided between Right at Horest end that the state of the condition of the urinary experience.	the to ng ed on the tof the ettract or the ettract	G 608			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES (DENTIFICATION NUMBER OF CORRECTION (X1) PROVIDER/SUPPLIES (X1) PROV				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/23/	
	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 608	fungal infections or of Coloplast Hydroph medicated cream whi healing]" The clinical record als for the patient's morn HHA visits, signed as on 1/21/21. The aide Assignment: Inspective [Frequency:] Every victommay apply tape or ne coccyx [tailbone] when the coccyx [tailbone] when the Health Entity J #2's was reviewed or start of care of 8/13/1 plan of care for the realized for the realized for the prevent infection [given to improve airf disorders] B 100 supplement] Baclo spasms] Co-Q-10 supplement which can conditions] Diflucation fections] Diflucation treat various conditions [given to improve conditions] Diflucation treat various conditions [given to treat various conditions] cought supplement [given to treat pain] Ironto treat various conditions [given to treat pain] given to treat pain] given to treat pain]	ther conditions of the slilic Wound Cream [a ich assisted with wound ich assist with a care plans stated " ich assist ich ich ich assist ich	plans	G 608			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE S COMPLE	ETED
		15K162		B. WING		02	C / 23/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 608	Treatments" which st for Wound #11 Lo Type: Pressure Ulcer prolonged pressure, Appropriate Skilled C [Normal Saline], pat of Duoderm paste [med assists with wound he Aide, service provide apply daily Wound Buttox, Type: Pressu Skilled Caregiver to C apply thin layer of Duapply daily Wound [group of muscles whouttocks and upper th Appropriate Skille NS, pat dry, apply thin areas on glutes. HHA A home visit observa 2/11/21 at 9:15 AM whome visit, Patient #2 redness to her sacruidirectly above the costage 2 pressure ulcithree (surveyor unab wounds due to area of medicated cream) Stileft buttocks, and one skin fold between the posterior thigh. The were "shearing" wound buttock wounds were (type of gauze dressi to the right posterior or topical cream note wound care was mar J, and HHA #1 indica	ated " Wound Treatmostation: Rt Upper Buttox [wound caused by staged from 1 to 4] aregiver to Cleanse with dry, apply thin layer of licated topical cream whealing]. HHA [Home Hed by Right at Home] mad #12, Location: Rt Low re Ulcer Appropriate Cleanse with NS, pat dry toderm paste. HHA mad #7, Location: Left Glunich are located in the high], Type: Pressure Uld Caregiver to Cleanse in layer of Duoderm paste. A may apply daily" Ition was conducted on with Patient #2. During to was observed to have my (lowest area of the specyx) and both buttock, the to distinguish number to the right buttock, the to distinguish number age 2 pressure ulcers the Stage 2 pressure ulcers the Stage 2 pressure ulcers the stage 2 pressure ulcers the covered with a dry AB mg) and tape, and the vothigh did not have a dread. Patient #2 indicated thaged by Home Health aged by Home Health	c [sic]. ch NS nich ealth ealth eay er e y, y te clicer with ste to che che che che che che che che che ch	G 608			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K162		B. WING		02/	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BI	RESS, CITY, STA ROADWAY S RSON, IN 460	TREET SUITE B	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 73			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 608	wounds on the patient HHA #1 also stated so the patient's sacrum and any with the patient's dressing or ointments patient's right thigh. Home Health Entity Jevidence the orders for Nystatin, Riley Butt Control Hydrophilic Wound Included J's POC. The medication list wound the wound in Hydrophilic Wound Included Hydrophilic Wound Control Hydrophilic Wound Included J's POC. The medication list wound the wound care to be covered by a drawhich wound care oir the wound, what was care, etc).	at's sacrum and buttock the changed the dressing and bilateral buttocks enter bath, and did not apply to the wound on the state of Tizanidine, Ibuprofer ream, and Coloplast ream included within Refer at Home POC fates for Acidophylis, Albuttomplex, Baclofen, Co-Con-180, Miralax, Mucine and within Home Health I ation lists from the two lained conflicting type and tration for Nystatin ("portness a day per Right at stand "cream" to be aphome Health Entity J's clinical records of Patient of the care was coordinated.	ng to very very very very very very very very	G 608			
G 614	CFR(s): 484.60(e)(1) Visit schedule, includ	ing frequency of visits be	•	G 614			
		personnel acting on beh	•				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		15K162		B. WING		02/2	C 23/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	TE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 614	This Element is not in Based on observation interview, the home in provide the patient whome visit observation. Findings include: 1. An agency policy Implementation," dature in a dature in patient is care, treatmed in the patient's care, treatmed in the patient's care, treatmed in the patient's care, treatmed in the days and at the patient in family" 2. The clinical record on 2/16/21 and 2/17/2 care of 9/16/19. The care for the recertificate which indicated the polynomial in the patient i	met as evidenced by: n, record review and nealth agency failed to ith a visit schedule for 3 ons performed (#1, 2, 3)	pose: ment, blicy: d/or ncy e and the ewed t of of 8/21, killed day and rs per d also ation I #1 s for day, day er nday urday de	G 614			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K162		B. WING		02/2	C 2 3/2021
RIGHT AT HOME, INC			1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 614	visits every Sunday a every other Saturday form also indicated H services 8 AM - 1 PM every other Saturday #5) and HHA #5 was AM - 1 PM every other (opposite HHA #4). A home visit observation faile Form or visit schedule or home health binder 3. The clinical record on 2/12/21 and indicated the patient 4 - 7 hours per day, 5 review of the HHA visindicated the daily Hithree shifts (AM, After record included a "Soc certification period 1/2 the Clinical Manager indicated HHA #1 was for the AM visit Mond shift on Wednesdays; HHA services for the and Thursdays; HHA services for the after Wednesdays, and Friprovide HHA services except Wednesdays; Sundays; and the after and Sundays were "compared to the state of the services and Sundays were "compared to the services and Sundays and Sundays and Sundays were "compared to the services and Sundays and Su	and AM and afternoon vince (opposite LPN #1). The IHA #4 was to provide HI, Monday thru Friday and Sunday (opposite to provide HHA service er Saturday and Sunday tion was conducted on Month With Patient #1. The Hid to evidence a Schedule within the patient's holer. If of Patient #2 was reviewed a start of care date contained a plan of care ind 1/24/21 - 3/24/21, where is a few for the certification plan hours were divided in the contained and PM). The contained in the contained in the certification plan hours were divided in the contained in the certification plan hours were divided in the contained in the con	ne HHA nd HHA ss 8 y nome uling me ewed of e for vhich rvices period nto linical by ces ne PM m /s A /s	G 614			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE S COMPLE	ETED
		15K162		B. WING		02	C 23/2021
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE	•	
RIGHT AT HOME, INC				ROADWAY ST SON, IN 460	REET SUITE B 12		
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 614	2/11/21 at 9:15 AM w visit observation faile. Form or visit schedulor home health binde #2 indicated she had agency staff and did from the agency. 4. The clinical record on 2/12/2021 and 2/1 care date of 7/17/19. plan of care for the ready and a services 1 - 2 howeek. The clinical reform for the certification of the certification of the certification of the certification of the paservices 9 AM - 12 Pand 9 AM - 11 AM on indicated HHA #9 was failed to evidence if Patient's services, or scheduled with the patient's services, or sc	ith Patient #2. The hold to evidence a Schedule within the patient's hold to evidence a Schedule within the patient's hold to evidence a visit, Patient a set schedule with sannot receive a visit schedule with receive a visit schedule with a set schedule with sannot receive a visit schedule with a set schedule with patient was to receive patient was to receive patient was to receive HMM Tuesdays and Thurse Saturdays. The form a set the "Primary HHA," but had allowed the patient #3. The hold to evidence a Schedule within the patient #3. The hold to evidence a Schedule within the patient #3. During the interview, Panot receive a visit schedule with Patient #3.	alling ome ent me dule ewed eart of a '21 - ceive s per duling //21, ne I/A days also ut all the e me alling ome on atient dule tt 1:40 ical	G 614			

Printed: 03/26/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE S COMPLE	ETED	
		15K162		B. WING		02	C / 23/2021	
	ROVIDER OR SUPPLIER HOME, INC		1125 BI	RESS, CITY, STAT ROADWAY S' SON, IN 460	TREET SUITE B	EET SUITE B		
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G 614	received a "schedul visits were to be pro ranges" the visits w Manager also indica provide patients wit specific employee a	age 77 le" of the days of the weed ovided as well as the "ho ere to last. The Clinical ated the agency did not h a visit schedule with the assigned to each visit, an were not provided to the	ur e	G 614				
G 618	·		ne tions sfer	G 618				
	Services," dated 7/2 ensure effective and continuity of care, tree Procedure: The individual be available to all a Coordination of serving the patient's home shall contain up-to-ordination of the services that an responsibilities of ensure ensurements.	y titled "Coordination of F 24/17, stated "Purpose: 1 d appropriate coordination reatment and/or services ividualized plan of care se ppropriate staff vice activities is document e care record. Each recordate information regarding the being provided. The pack service / discipline.	To In and In and Hould Inted Ord Ing:					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		, ,	LE CONSTRUCTION	COMPLET	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	STREET SUITE B 012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 78			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 618	Continued From pag	e 78		G 618				
	family response"							
	2. An undated job de Nurse" stated " Est Implements teaching needs Plans, teac counsels patient and care 4. Coordinate health care continuum equipment in a respo achieved desired outout 3. A complete list of alifts in the home was Manager on 2/11/21 a indicated three active Hoyer lifts in their hor 4. The clinical record on 2/16/21 and 2/17/2 care of 9/16/19. The care (POC) for the re 3/8/21, which indicated Skilled Nursing service per day (AM, Afternoweek, and Home Heat 5 hours per day, 5 - 7	family regarding physices delivery of care along m Utilizes supplies insible manner to comes" active patients with Hoyprovided by the Clinical at 1:00 pm. The list expatients (#2, 4, 5) had mes. If of Patient #1 was reviewed and indicated a start record included a plan incertification period 1/8/2 and the patient was to reces 1 hour per visit, 3 vion, and PM), 7 days pealth Aide (HHA) services	ent's cal g and /er l ewed of of 21 - ceive sits r s 4 -					
	on 2/12/21 and indica 4/10/18. The record the recertification per indicated the patient 4 - 7 hours per day, 5	d of Patient #2 was revieted a start of care date contained a plan of carriod 1/24/21 - 3/24/21, was to receive HHA ser 5 - 7 days per week. The patient's "Activities	of e for vhich vices					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1	E CONSTRUCTION	(X3) DATE S COMPL	ETED
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	ROVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STAT ROADWAY STATESON, IN 460	FREET SUITE B		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECORD LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 618	Permitted" included with a Hoyer lift (type equipment which aid non-ambulating patie. A home visit observa 2/11/21 at 9:15 AM wisit, HHA #1 was ob #2 from the bed to a Drive manual Hoyer was not provided a constructions for the For the home health a observation failed to within the patient's high 6. The clinical record on 2/12/2021 and 2/care date of 7/17/19 plan of care for the radio 3/9/21, which indicated HHA services 1 - 2 high week. A home visit observa 2/12/21 at 9:05 AM wisit observation failed within the patient's high record on 2/16/21 and 2/18, care of 5/22/19. The plan of care for the radio 3/11/21. The POC in "Activities Permitted" chair and stated the bedfast." The POC "DME [Durable Medical and patients of the poor of the poo	transfer from bed to chare of durable medical les in transferring lents). ation was conducted on with Patient #2. During to be served transferring Patimanual wheelchair using lift. Patient #2 reported copy of the manufacture loyer lift by the DME superior of the manufacture loyer lift by the DME superior. The home visit evidence a plan of care ome or home health bind of Patient #3 was reviolated and indicated a standard for the patient was to respect to the patient was reviolated to evidence a plan of the patient was reviolated to evidence a plan of the patient was reviolated to expect the patient was "primarily and indicated the patient's "were transfer from becapatient was "primarily also indicated the patient ical Equipment] And Hoyer lift. The clinical	the ient of ed a 1/21 -	G 618			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1 ' '	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC ID		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 618	manufacturer's instruction. An interview was con PM with the Clinical interview, the Clinical #4 did not use his Hoonly transfer out of be present. The Clinical report the specific bracelectric) of Hoyer lift. 8. The clinical record on 2/12/21 and 2/16/2016 care date of 2/15/19. plan of care for the refulzed in the refulzed in the manufacturer's "Activities P Tolerated in Transfel Lift." The clinical record the manufacturer's Hoyer lift. 9. An interview was PM with the Alternate Manager. During the Manager indicated the provided to the pahome, as all agency of the plans of care for manufacturer's instructions of care for manufacturer's instructions to any of lift. The Clinical Managency did not have	inducted on 2/11/2021 at Manager. During the I Manager indicated Palayer lift to transfer, and sed when his "friend" was I Manager was unable to and or type (manual or 21, and indicated a star The record contained exertification period. The POC indicated the remitted were "Up as a Bed [to] Chair with Hoord failed to evidence a sinstructions for the pate and conducted on 2/12/21 are Administrator and Clin interview, the Clinical secare plan did not need attent and maintained in nurses were provided cor patients they were seg services. The Clinical secare plan did not need attent and a Hoyer lift, a patient's home, and the dided the manufacturer's their patients with a Hotager also indicated the diager also indicated the	t 1:45 tient would s ewed t of a he yer copy ient's at 1:40 ical d to the popies I the he	G 618			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/	C 23/2021	
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B	•		
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G 622 G 622	CFR(s): 484.60(e)(5) Name and contact infimanager. This Element is not in Based on observation interview, the home hensure the patient's hup-to-date contact inficlinical supervisor for observations (#1, 2, 3) Findings include: 1. An undated agence "Administrator" stated 5. Ensures the accuramaterials" 2. A home visit obser 2/10/2021 at 4:07 PM care 9/16/19). During home binder was reviagency's clinical super Employee H. 3. A home visit obser 2/11/21 at 9:15 AM wid/10/18). During the home binder was reviagency's clinical super Employee H. 4. A home visit obser 2/12/21 at 9:05 AM wid/17/19). During the home binder was reviagency's clinical super Employee H.	formation of the HHA climet as evidenced by: In, record review and realth agency failed to some binder contained formation for the agency as of 3 home visit. By job description titled at " Essential Function acy of public information for the patient #1 (start of the patient #2 (start of the patient #3 (start of the	inical y's ns: n on of tient's e on care s e	G 622 G 622				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	≣D	
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G 622	reviewed on 2/23/21. Former Employee H's 6/15/2020. 6. An interview was on PM with the Alternate Manager. During the Manager indicated the should include up-to-	The personnel file indistermination date was conducted on 2/12/21 at Administrator and Clininterview, the Clinical e patient's home binder date and accurate continical Manager, including.	icated it 1:40 ical	G 622				
	showing measurable for which there is evic those indicators will in patient safety, and queries (2) The HHA must me quality indicators, included events, and other aspenable the HHA to aspenable the	at at least be capable of improvement in indicate dence that improvement myrovement myrove health outcome uality of care. Deasure, analyze, and traducting adverse patient beets of performance the sess processes of care perations. The met as evidenced by: The ew and interview, the house improvement (of the which quality indicators evidence the frequency lity indicators were to be and tracked, and failed its quality indicators, with control due to the publications.	ors t in ss, ack at c, ome QAPI) ss it r and el I to th an					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE SURY	:D
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC		1125 BR	OADWAY S	TREET SUITE B		
			ANDER	SON, IN 460	012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 642	Continued From page	e 83		G 642			
0 0 12	Findings include:			0 0 12			
	1. An agency policy to Management," dated Performance measure agency's QAPI common patient care, service fiscal accountability a The [Home Health Agon evaluation and impute environment, infer and the medication more performance of each medication errors. Si reactions. Patient performance of each medication errors. Si reactions. Patient performance of each medication errors. Si reactions. Patient performance of each medication errors and concert organization's business and concert organization's business adequacy of patient a services, and informational involving patients due malfunctioning equipmite, injuries, accidents infection, hospitalization needs. Staff perceptions Staff suggestions for Staff willingness to reconditions in the organizations. Multiple sources are organized home health services	7/24/17, stated "Policy es are selected by QI [to ittee] based on their improvement of conditions of the following: Significant adverse drug reption of the safety and particular products and services of the following: Significant adverse drug reption of the safety and products and services to patient questions. The impact of the services to equipment, its item. Adverse events a to inadequate or ment, supplies, or services, signs and symptoms ons. Staff opinions and ons of risk to individual improving patient safety port adverse events anization or patient related to care, treatment internal / external data data data monitor and asses for quality of healthcar	the inpact ctice, is data is in ontrol, cant indirect by ion vices. ons, ems, of diss. y.				
	to, the following: Patie accident / incident rep	include, but are not liment clinical records. Paperts. Medication error	tient				
	reports, including repo	orts of near misses.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER HOME, INC		1125 BF	DDRESS, CITY, STATE, ZIP CODE BROADWAY STREET SUITE B ERSON, IN 46012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 642	Infection prevention a perception of care / s Patient letters and/or services. Staff comprediction, in-services records Other data to patient care. Exter but are not limited to, organizations. Regul 2. An agency docum Board of Directors Me 12/18/2020, stated " will be completed after scheduled [1/21/21] 3. The agency's QAF 2/23/21. The binder i "Right at Home Quali Meeting for Fourth Quali Meeting for Fourth Quali Meeting for Fourth Quali Meeting held on 1/21 present included the Administrator, Clinica Director #1. The meeting held on 1/21 present included the Administrator, Satisface Employee Suggestion Clinical Audits. The "indicators included: "I Number of New Hire HHA [Home Health A Number of Participan still working Turno Employee Competen Timely % of Annual forms and the sum of the	and control reports. Pata atisfaction questionnain comments regarding etency assessments ement activity form. State and continuing educate a relating directly / indirectly and continuing educate a relating directly / indirectly agencies" The state of the following: Professional data sources include the following: Professional data yagencies" The state of the distribution of the final QAPI meeting directly and the final QAPI meeting" PI binder was reviewed included a document title try Improvement Quarte uarter 2020," which included a document title fity Improvement Quarte uarter 2020, which includes for the agency's Collect at 11:00 AM. State Administrator, Alternate all Manager, LPN #4, and the divided into eight luded: Human Resource SHA, Scheduling the divided into eight luded: Human Resources of the provided in the graph of the graph of the provided in the graph of the provided in the graph of the graph o	es. aff ion ectly le, onal e tion g on led rly uded QAPI aff e d HR the es, of of are ted cy	G 642				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC				TREET SUITE B		
			ANDER	SON, IN 460	012		
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G 642	Continued From page	e 85		G 642			
0 0		% of Annual Inservi	ce	0 0			
		IHA 12 Hour mandated					
	Inservice Completed						
	-	ed % of TB [Tubercu	ılosis]				
		d Timely % of Perso					
	-	compliance with conte					
		Safety / OSHA" quality					
		Vorkmen Compensatio					
	Claims Needle or Sharp Injury Medical						
	Device Issues Number of Employee Infections						
	Reportable Events Sentinel Events						
	Disaster Drills" The "Scheduling Coordinator"						
	•	uded "Number of Sche					
		killed Nursing] and HH					
	•	d Visit Hours for SN an	d				
	HHA Number of M						
	•	Reports" quality indicat					
		er Scores: Staff Net					
		tient (Question asked: I					
	•	mmend services from the					
		Satisfaction Employ- nunication from provide					
		ee Complaints Empl					
		" The "Employee	Oyee				
	•	indicator included only					
		ons." The "Clinical / Nu	rsina"				
		uded "Number of Patie					
		nosis Number of Pa					
	_	ours of Referral or MD (
	for Start of Care N	umber of Patient Cens	us				
	Number of Patients A	dmitted to Hospital and	ı				
	Reason / Diagnosis .	Number of Patient					
	Discharges with Reas	sons % of Patients					
	· ·	dmission, ROC [Resun					
		on, SN visit, etc) Nu					
		sessments Completed					
	=	Wound Care Patients v	vith				
	Healing Process N						
		er of Medication Profile	s				
	Completed Number	er and Type of Patient					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
RIGHT AT	HOME, INC		1125 BF	ROADWAY S	TREET SUITE B		
	•		ANDER	SON, IN 460	012		
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G 642	Infections Acquired For Number of Patient Incomment of Medication Medication Adverse For Care and or Verbal Returned to [Home H 30 days of Receipt of VA] Patient Orders and report to VA % of Strain Completed within App The "Clinical Audits" of "Home Health Aide Notes (Findings)" stated " New Busin infections for employed Process for tracking COVID immunizations	collowing Admission cidents / Falls and Type in Errors Number of Reactions % of MD Forders Signed and ealth Agency] Office with Order [Veteran Affate Tracked Weekly with Supervisory Visits propriate Time Frame quality indicators included to (Findings) Nurse The meeting minutes eas: Process of trackets and patients review COVID exposure and store employees and	Plans thin irs," ed es	G 642			
	COVID and or a posit" The QAPI meeting an analysis was condindicators, including in COVID-19 infections agency's QAPI document a governing-body agroup specific quality indicators, and frequency and method indicators, and frequency analyzing the quality in the Administrator, and Clinterview, the Alternation she was responsible to program. The Alternation agency's QAPI quality in the indicators" within the second control of the program.	nts with signs / symptor rive COVID test reviewed grainutes failed to eviduated of the quality monitoring and assessing and risk factors. The mentation failed to evide eed upon plan for the tors to be tracked, the dof tracking quality ency and method of indicators.	ed lence ing for ence it 3:46 it the ed it did it did it				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		, ,	CONSTRUCTION	COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY STE SON, IN 4601:			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 642	meeting. The Alter quality indicators w present "talking about Alternate Administr agency's Governing the QAPI program approving the qualimethod used to tra	reate Administrator stated yere analyzed by the staff out" each indicator. The rator also indicated the g Body reviewed and app annually, and this include ity indicators tracked and ck each indicator.	proved ed	G 642			
G 656	CFR(s): 484.65(c)(The HHA must take performance impro implementing those measure its successensure that improve that improve the successensure that improve the left agency faile assurance and perprogram measured improvement projects ustained improver Findings include: 1. An agency policity Performance Improstated "Purpose: and resolve areas of status of identified assure improvement."	e actions aimed at vement, and, after e actions, the HHA must as and track performance ements are sustained. It met as evidenced by: eview and interview, the hid to ensure its quality formance improvement (I and analyzed its performances (PIP) for success and ments. Experience of concern with the problems is monitored to vement entire of concern with the problems is monitored to the proble	OME QAPI) nance 4/17, ove The	G 656			
	assess and improv related to patient co organization Do	ized to plan, design, mea e functions and processe are and safety throughou : Data is collected to er design specifications fo	t the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ĒD
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	<u> </u>	
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	STREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 656	processes were met correct identified prote performance. Evalua actions taken and docare Reporting Fooutcomes of performa will be reported to Improvement Commit designated" 2. The agency's QAF 2/23/21. The binder idocument titled "PDS Change," which was Performance Improved documentation. The Fundamental Questic What are we trying to Plans for HHA [Home [and] reflective of patiknow that a change is notes will be accurate 100% of audited note will receive care necelifie and meet needs 4/1/2020 Do: Describe and meet needs 4/1/2020 Do: Describe how the me observations companimprovements noted notes of care given. (e.g., modify the idea idea test a new idea weekly audits of HHA. Eone teaching, follow to endought of the completed correctly weducation of HHA. Eone teaching, follow to endought of the completed correctly weducation of HHA. Eone teaching, follow to endought of the completed correctly weducation of HHA. Eone teaching, follow to endought of the completed correctly weducation of HHA. Eone teaching, follow to endought of the completed correctly weducation of HHA. Eone teaching, follow to endought of the completed correctly weducation of HHA. Eone teaching, follow to endought of the completed correctly weducation of HHA. Eone teaching, follow to endought of the correctly weducation of HHA.	Act: Take actions to blem areas or improve the the effectiveness of cument the improvement active the Performance the on a quarterly basistee on a	ont in vities s as on g aff as on g aff as on enter the content of the content on g e on urn	G 656			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 656	each individual patier days and updated as documentation failed was enacted, the per notes found during of the documentation as the success of the PI completed. The agency's QAPI be titled "Right at Home Quarterly Meeting for (January, February a at 1:30 PM. The QAI the Administrator, Alt Manager, HR Director Former Employee H meeting. The meeting Health Aide Notes (F note corrections has aides not following the [Alternate Clinical Macreate notes for each allows the HHA to maclient's care plan. The implemented and we the amount of note comeeting minutes failed measurement and are (was the PIP continuous the PIP continuous the III agency's QAPI be titled "Quality Improves Second Quarter of 20 10:00 AM. The docu Administrator, Alternate Manager, HR Director were present for the minutes stated " Head of the minu	ant reviewed [every] of the needs change." The Pote to evidence the date the centage of accurate Historia audits (indicated with the near audits (indicated with the needs of the method of measure P), and the date the Pleasing minutes included a docum Quality Improvement of First Quarter of 2020 and March)," dated 4/22 Pleasing minutes indivernate Administrator, Confully and the present for the lang minutes stated " Historia minutes indiversed due to recently increased due to eclient's care plan. In anager] / HR has helped in individual client that or ark tasks that follow that has been recently hope it will solve and literations "The QAI and to evidence specific halysis of the agency's lead, modified, or complete the properties of the document quarterly Meeting 200," dated 7/17/2020 and individual of the properties of the agency's lead, modified, or complete the properties of the agency's lead, modified, or complete the properties of the agency's lead, modified, or complete the properties of the agency's lead, modified, or complete the properties of the agency's lead, modified, or complete the properties of the agency's lead, modified, or complete the properties of the agency's lead to evidence agency	PIP ne PIP HA ithin ring P was nent /2020 icated clinical and ome of HHA to d hly t mit PI PIP eted). nent ng for at cal #1	G 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
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G 656	minutes failed to evid and analysis of the agancy of the meeting. The Home Health Aide Not blank]" The QAP evidence if the agancy and if so, failed to evisustained improvement accuracy. 3. An interview was of PM with the Administrator, and Clinterview, the Alternative agancy of the programment of the agancy of the ag	otes. More accurate" The QAPI meeting ence specific measurer gency's PIP. inder included a documement Quarterly Meetin 0," dated 10/23/2020 at ment indicated the ate Administrator, Clinic r #1, Scheduling QI Assistant #1 were promeeting minutes stated otes (Findings): [Section I meeting minutes failed by PIP had been completed ent in HHA documentation conducted on 2/23/21 at rator, Alternate inical Manager. During the Administrator indicate I the success of its PIPs these were discussed terly meetings. The or also indicated the ng HHA documentation ined as completed and	eent g for al essent d " o d to eted, ed in on t 3:46 the	G 656			
G 682	Infection Prevention CFR(s): 484.70(a)			G 682			
	practice, including the	accepted standards of					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	E CONSTRUCTION	(X3) DATE S COMPL	ETED
	15K162		B. WING		02	C 2/23/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE	-	
RIGHT AT HOME, INC			OADWAY ST SON, IN 460	REET SUITE B 12		
PRÉFIX (EACH DEFICIENCY MUST E	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE ITIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 682 Continued From page infections and commun This Standard is not m Based on observation, interview, the home here ensure all employees for control policies and proprecautions for 3 of 3 h (#1, 2, 3). Findings include: 1. An undated agency Washing," policy number Center for Disease Corroutinely washing hand situations: After carring Procedure: 9. Wet he hand, lathering thorough using plenty of lather and 15 seconds 13. Rinst thoroughly" 2. An undated agency "Handwashing: at Home About," indicated as wrom what is the right way Scrub all surfaces of your scrubbing for at least 2. 3. An undated agency policy number N-120, so inside of the bag and its clean. Therefore: Hand before entering the bag removed from the bag are turning to the bag	icable diseases. et as evidenced by: record review and alth agency failed to ollowed agency infect cedures and standar ome visit observation policy titled "Hand er C-130, stated " antrol (CDC) recomme s in the following ng for a client ands 10. Apply so hly. 11. Wash hands and friction for at least se hands and wrists document titled e, at Play, and Out an itten by the CDC, star to wash your hands our hands Keep 0 seconds" policy titled "Nursing tated " Guidelines: s contents are consid d washing must occur of or any reason. All i	The nds ap to 10 t	G 682			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING			C 3/ 2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 682	recommends using and and control practices pandemic, along with recommended as par delivery to all patients intended to apply to a suspected or confirme Implement Universal Equipment [PPE] I should use PPE as defollow Standard Precafollowing should be we control and for proencounters: A well selection of a facema of a cloth mask over the conform to the wearest conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conform to the wearest selection of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a facema of a cloth mask over the conformation of a fac	dditional infection prever during the COVID-19 standard practices to froutine healthcare to These practices are all patients, not just those d SARS-CoV-2 infections of Personal Protections of Personal Protection of Personal Protections of Personal Protections of Personal Protection of Personal Protections of Personal Prot	se on stive riders] hould are use sto nes a new slp anest nat ean on of (LPN) nds, od ing ssure	G 682			

			(X3) DATE SUR'	ED .				
		15K162		B. WING			C 8/ 2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
RIGHT AT	HOME, INC		1125 BR	BROADWAY STREET SUITE B				
			ANDER	SON, IN 460	012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRIOR OF THE	JLD BE	(X5) COMPLETION DATE	
G 682	Continued From page	e 93		G 682				
		within her nursing bag	. The					
		thermometer and SpO						
	(oxygen saturation, m	•						
	percentage of blood v							
		ed hands, obtained the						
	0 0	emperature, wiped the						
	monitor and thermom							
		placed them with gloved	ı					
		to the plastic bag withir						
	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 glov	ed hands into the plast	ic					
	bag within the nursing	g bag. The nurse then						
	reached into her pock	et with gloved hands, t	ook					
	out her phone, observ	ved the patient's respira	atory					
	rate (number of breat	hs per minute), wiped t	he					
	phone with an alcoho	l cleansing wipe, and						
	immediately placed th	ne phone with gloved ha	ands					
	into her pocket. Later							
		ing bag with the same						
	_	ed her stethoscope fror						
	•	sing bag, auscultated P						
		cleaned the stethoscop						
		sing wipe, and immedia	•					
		aced the stethoscope ba						
		ithin her nursing bag. A						
	· ·	was observed removing	,					
		nursing bag, and leavi	ng the					
	· ·	LPN failed to allow the	_					
	_	vital sign equipment an						
		lacing them into her nu						
		e nursing bag or pocke						
		ash or use hand sanitiz						
		the alcohol to dry on he	1					
	-	ng it to her pocked, and	a bor					
	=	d hygiene after removin	y ner					
	gloves.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING COMPLETED C B. WING O1/223/2021 NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC (X3) DATE SURVEY COMPLETED C 02/23/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES B. WING B. WING B. WING B. WING B. WING COMPLET STREET ADDRESS, CITY, STATE, ZIP CODE 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETED COMPLETED (X5) COMPLETED COMPLETED	
RIGHT AT HOME, INC 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	2021
RIGHT AT HOME, INC 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
(A4) ID COMPLET	
	(X5) COMPLETION DATE
G 682 Continued From page 94 G 682	
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 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's back, she removed her gloves, placed a towel behind the patient's back, and handed the patient a bottle of lotton. 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. 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 alconol-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	

	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE (X3) DATE SURVE (X4) MULTIPLE CONSTRUCTION (X5) DATE SURVE (X6) DATE SURVE (X6) DATE SURVE (X6) DATE SURVE (X7) DATE SURVE (X7) DATE SURVE (X8) DATE S		ΓED				
		15K162		B. WING		02/2	C 3/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDF	RESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	STREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 682	Continued From pag	e 95		G 682			
G 682	seconds (total scrubb and then dried her hat the patient's bedside, phone out of the way removed her gloves, new gloves. The HHA items on the bedside performed hand hygic applying soap, scrubb water for 21 seconds, then donned new gloves then donned new gloves. One glove browning. HHA #1 remoned a new one. The patient #2 with her battle HHA assisted Patiside. The patient had linens from an episod (inability to control bowiped the stool from the exposed buttocks using her gloves, performed and water, donned new dressing which covern (both sides of body) barea. Patient #1 was pressure ulcer wound and pelvic area. The washcloth to clean the used to clean the stool HHA #1 completed the	ing time 20 seconds), rinds. HHA #1 returned moved the patient's ce of the bath supplies, and immediately donned set up the patient's batable, removed her glovene with soap and water bed her hands under rustring the bash bathing water, removed her pants, and donned toke while the HHA was moved the broken glovene HHA continued to as ath. Later during the batient #2 to turn on her led stool on her rectum and the patient's rectum and a washcloth, removed the patient's rectum and a washcloth, removed the patient's bilatera buttocks and posterior proted to have multiple as to her bilateral buttocks.	to II d th ves, r by nning ands, ath, ved new and ssist tth, at d ed cap d a I l edvoap d a I lelvic ks was tum. the	G 682			
	Range of Motion (RO compression stocking removed her gloves, using ABHS and soan new gloves. The HH.		e ed gin to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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RIGHT AT	HOME, INC			SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR' OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 682	pocked, retrieved he removed her gloves, patient's tablet, pulle performed hand hyginew gloves. The Hipatient to transfer frousing the Hoyer lift. to roll onto the Hoyer applied ABHS to her hands together, adju hands, then complet together until the AB. The HHA failed to we Protective Equipment hand washing per aghand hygiene immediand in between glove clean washcloth to wand failed to perform according to agency. An interview was corn AM with HHA #1. Duindicated she wore consurgical masks durin personal preference. 8. A home visit observed as A home visit observed as the hower, dried herself the HHA performed and water, donned gipatient's bath when repatient #3 completed shower, dried herself HHA #10 removed herose and abdomen, dressing, brushed heroself herself hersel	r phone, turned off the a adjusted the settings of d up her hands, then iene with ABHS and dor A then began to assist om the bed to her wheele HHA #1 assisted the par sling, removed her glothands, began to rub he ested her mask with her ed rubbing her hands HS and her hands were ear appropriate Personant (PPE), failed to perfor gency policy, failed to perfor gency policy, failed to use vash the patient's wound hand hygiene using AB policy. Inducted on 2/11/21 at 17 uring the interview, the beloth masks instead of ghome visits due to	n the nned the chair tient ves, or dry. Il m erform oves a Is, BHS 1:20 HHA on care A #10 ower. ap	G 682			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C DEPLAY OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02	C / 23/2021
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			1125 BF	RESS, CITY, STATE ROADWAY SESON, IN 460	TREET SUITE B	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
G 682	leaving the home was remained in the home of the completed). HHA is hygiene after removed. An interview was PM with Alternate of Manager. During the Manager indicated after cleaning with returning the nursing gloves and perform obtaining items from should perform har removing gloves. Indicated staff should perform har removing gloves indicated staff should between glove chas ame washcloth us rectum on another performing hand his soap and water, stim with soap for "at le running water and	ygiene prior to the survey visit observation (the HHA me, as the visit was not #10 failed to perform hand	d at 1:40 ed before ve taff fter o in e the with ds of	G 682			
G 684	` ,	(1)(2)		G 684			
	agency-wide progridentification, preveninvestigation of infediseases that is an quality assessmen	ectious and communicable integral part of the HHA's t and performance PI) program. The infection	5				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURV		
15K16 NAME OF PROVIDER OR SUPPLIER			B. WING		02/23	C // 2021		
NAME OF DR	OV/IDED OD SLIDDLIED		STREET ADDE					
				DDRESS, CITY, STATE, ZIP CODE BROADWAY STREET SUITE B				
RIGHT AT HOME, INC				SON, IN 460				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
G 684	Continued From page	e 98		G 684				
	expected to result in i prevention. This Standard is not Based on observation interview, the home hensure an agency-wid was maintained for the prevention, control, and staff infections for entries of patients with COVID-19 (#1, 5, 8, 1 infection control log esymptoms but a diagrinfection" (#12), 3 of 1 entries of employees COVID-19 (HHAs #11 of 1 active records repatient developed syrand 1 of 3 home visit had the potential to effection.	reproblems; and ropriate actions that are mprovement and disea met as evidenced by: n, record review and ealth agency failed to de infection control prog e surveillance, identificand investigation of patie r 7 of 7 infection contro h documented symptom 13, 14, 15, 16), 1 of 1 ntries for patients with i	gram ation, ent I log ns of no cted e L), ed the #5), ch					
	employees. Findings include:							
	Virus (2019-nCoV)," onumber 5001-A, state policy is to follow the CDC [Centers for Disc Prevention] by supple existing policies and prevention prevention a guidance on effective response to reports or		olicy his e o o iding					

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NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC STREET ADDRESS, CITY, STATE, ZIP CODE 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/C			(X3) DATE SURVEY COMPLETED				
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC XIMED SUMMARY STATEMENT OF DEFICIENCIES TAG	PLAN OF CORRECTION	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBE	:K:	A. BUILDING		COMPLE		
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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	and Assessment of Pac Clinicians should asset following: a. Does the symptoms of lower recough or shortness of report having these sycriteria of the clinical funder Investigation] is surgical mask Staf also follow standard precautions, and airbot 2. An agency policy thand Control Program, number 5001, stated Infection Prevention at ensures that this organization wide [sic] control and investigatic communicable diseas Prevention and Control Home incorporates the prevention and control the organization Every results Activities: In control activities include evaluation of key perfinfection prevention and manage communicable diseas Continuously collecting identify isolated incides outbreaks. Analyzing undesired trends. De organization acquired Examining data for collagency's] processes, could have resulted in		and Assessment of P Clinicians should assert following: a. Does the symptoms of lower recough or shortness of report having these striteria of the clinical of	ratients for [COVID-19] ess patients based on the patient have fever or espiratory infection, such foreath 4. Patients by ymptoms and meet the features for PUI [Personshould be asked to wear finolity of involved in the care so precautions, contract forme precautions" titled "Infection Prevention," dated 7/24/17 and por " Policy: Right at Holand Control Program anization develops maintains an active, program for the prevention of infection and sees The Infection for Program at Right at the following Surveillation of infections throughous the following and monitoring formance aspects of and control surveillance and control surveillance and control surveillance and and/or screening date ents or potential infection of the problems or etermining if infections and and for community acquired of the problems or etermining if infections and the community acquired of the problems or etermining if infections and the community acquired of the problems or potential infections and the problems or po	the thas who n ur a hould ion dicy me's ntion, ance, out ng d e, at to ous are do to the that	G 684				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ORDER IDENTIFICATION NUMB			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	TED	
	15K162			B. WING		02/	C 23/2021
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			1125 BF	RESS, CITY, STAR ROADWAY S SON, IN 460	TREET SUITE B		
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G 684	3. CDC (Updated 2/2 Prevention and Control Healthcare Personned Disease 2019 (COVII 3/9/21 from www.cdc using additional infect practices during the Coving additional infect practices during the Coving additional infect practices during the Coving additional infect practices are inpatients, not just those confirmed [COVID-19 develop policies and recommendations are their setting (e.g., Re-evaluate admit symptoms of COVID-symptoms should alse assessments of all act and symptoms consist admitted patients should and evaluated) Croto [COVID-19] Expose Care Personnel] and should establish a in a healthcare facility managed and how coperformed. The plant following: Who is responded. The plant following: Who is responded and notifications and foll those who were exponded. CDC (Updated 2/2 Coronavirus." Retrievent for the properties of the prop	to assure correct andard Precautions	in ery) in ery) in ery) in ery) ind rand daily ers enong ed	G 684			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SUF COMPLET	ED	
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RIGHT AT I	HOME, INC			ROADWAY S SON, IN 460	STREET SUITE B 012		
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	People with these syr COVID-19: Fever or or breath or difficulty breath or body achest taste or smell. Sore to nose. Nausea or von emergency warning strouble breathing 5. Centers for Medica (Revised 4/23/2020). Control and Preventic Disease 2019 (COVID Agencies Retriev www.cdc.org. " Petriage, and isolation opatients are essential exposures among par When making a hoask patients about the travel within the last 1 sustained community symptoms of a respiratever, cough, and should ast 14 days, has had or under investigation with respiratory illness community where wich transmission of COVI should [Home Health home visits for health develop signs and sy infection while on-the [home health agency] information on individing locations the person of the survey's Entra	symptoms reported mptoms may have chills. Cough. Shortne eathing. Fatigue [tiredness. Headache. New losthroat. Congestion or miting. Diarrhea Lootigns for COVID-19 New confusion" are & Medicaid Service "Guidance for Infection on Concerning Coronavor D-19) in Home Health and 3/9/21 from er CDC, prompt detection potentially infectious to prevent unnecessartients, healthcare personavor in the statement of potentially infectious to prevent unnecessartients, healthcare personavor in the statement of the statement o	ess]. s of unny k for s n virus on, y onnel ld onal h ns or a ln the with is ill ased ow estrict ff that y the	G 684			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			1` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K162 B. WING C 02/23/202					
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC				RESS, CITY, STA			
RIGHT AT HOME, INC				SON, IN 460	STREET SUITE B 012		
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G 684	she oversaw the track and employees. The indicated prior to each shift, the aide would of screening of themselv screening was perform (Electronic Visit Verificater to the agency if the positive screening. To stated the agency number of the visit. The Clinic patient was diagnose agency would complete and the agency had be exposed to patients with the visit. The Clinic patient was diagnose agency would complete and the agency had be exposed to patients with the visit. It patient for COVID-19 guidelines (see Finding 8. The agency's Infect 1/1/2020 - 2/10/2021 The binder contained "Patient Infection Corlinfection Log." The alang included an unsite 12/1/2020, which indic COVID-19 symptoms stated," the employee negative COVID-19 to failed to evidence the	ate Administrator, and uring the Entrance mate Administrator indicking of infections for para Alternate Administrator in Home Health Aide (Honduct a COVID-19 wes and the patient. The med using the agency's cation), and would send the HHA or patient had he Alternate Administrators as did not conduct a geening as they were COVID-19] signs and an urse assessment pot cal Manager indicated in dwith COVID-19, the set a "14-day tracking fooly had two employees with suspected COVID-19 was reviewed on 2/23/2 agency documents title agency documents title agency is "Employee Infection Control binder from was reviewed on 2/23/2 agency documents title agency is "Employee Infection Control binder from was reviewed on 2/23/2 agency documents title atrol Log," and "Employ gency's "Employee Infection Control binder from was reviewed on 2/23/2 agency documents title atrol Log," and "Employ gency's "Employee Infection Control binder from was reviewed on 2/23/2 agency documents title atrol Log," and "Employ gency's "Employee Infection Control binder from was reviewed and had a control by	tients (HA) (HE) (HE)	G 684			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
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G 684	to the employee two symptoms and/or whi experiencing symptoms resolved, a returned to work. The "Patient Infection entry by LPN #4, date indicated Patient #5 (developed a "URI [Upand was noted to have [degrees Fahrenheit]. logged. The log entry notified and the patien "Azithromycin [an antinfections]." The infeevidence if the patient COVID-19 symptoms breath, chills, etc), fait time, and employee we failed to evidence if the COVID-19 or the phytest, failed to evidence were exposed to the symptoms, and failed of the infection (did pand if so, what was the symptoms are the symptoms and head condicated the patient's patient was prescribed infection was "resolved to evidence if the patient's patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infection was "resolved to evidence if the patient was prescribed infec	days prior to the onset alle the employee was ms, the date the employend the date the date (SOC) 2/1 oper Respiratory Infective a temperature of "10 other symptoms with indicated the physician of the date of the da	yee's yee an 5/19) on]," 3 were n was cterial o er , an, or f a rees ution" live, 020, ad a nasal ry l, the e ailed dther date, an,	G 684			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER. AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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				ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
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G 684	COVID-19 or the phy test, failed to evidence were exposed to the symptoms, and failed "Resolution" of the in The agency's "Emplo an unsigned entry, daindicated HHA #12 hat the employee comple had a negative COVI evidence the date the started, if any patient employee two days p symptoms and/or white experiencing symptom employee quarantine symptoms resolved, it tested, the date the employee quarantine symptoms resolved, it tested, the date the employee quarantine symptoms resolved, it tested, the date the employee quarantine symptoms resolved, it tested, the date the employee quarantine symptoms resolved, it tested, the date the employee quarantine symptoms resolved, it tested, the date the employee quarantine symptoms resolved, it tested, the date the employee quarantine symptoms resolved, it tested the date the employee quarantine symptoms resolved, it tested the patient wand the infection was failed to evidence if the other COVID-19 symdate, time, and employed to the patient was failed to evidence if any age exposed to the patient	sician declined to order the if any agency employ patient and tracked for I to indicate the specific fection. Tyee Infection Log" inclu- ated 9/10/2020, which ad "suspected coronavi- eted a "self quarantine," D-19 test. The log faile e employee's symptoms is were exposed to the rior to the onset of ille the employee was ms, the number of days d, the date the employe the date the patient was est results were receive ployee returned to work. It Infection Control Log" LPN #4, dated 8/9/2020 ant #8 (discharge date ed "Pneumonia [an infe- ported symptoms of ands [to] all [lung] lobes. atient's physician was as admitted to the hosp is "resolved." The infection in e patient was screene ptoms, failed to indicate	rees ded rus," and doto the ee's sed, the bital, on log d for e the as failed toms,	G 684			

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		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S	TREET SUITE B 012		
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G 684	The agency's "Patient included an entry by I which indicated Patie developed a "Resp [F was "Asymptomatic [v indicated the patient's Xray during an office prescribed "Levofloxal infection was "resolve to evidence if the patic COVID-19 symptoms patient was tested for declined to order a teresults of the Chest X agency employees where and tracked for symptomes the specific "Resolution." The agency's "Emplorant unsigned entry, daindicated Former Employee's symptoms were exposed to the employee's symptoms were exposed to the employee quarant employee's symptoms was experiencing synthe employee quarant employee's symptoms patient was tested, the received, and the date work. The agency's "Patient included an entry by I which indicated Patie 8/1/2020) developed symptoms of "Altered	t Infection Control Log" LPN #4, dated 8/7/2020 Int #12 (SOC 6/9/2020) Respiratory]" infection b without symptoms]." The physician ordered a Covisit, the patient was used in [an antibiotic], and ad." The infection log fatent was screened for o grailed to evidence if the COVID-19 or the phys st, failed to evidence the ray, failed to evidence the ray, failed to evidence the ray, failed to indicated 7/23/2020, which blooded L had "suspected blooded L had "suspected blooded COVID-19 the completed a "se an egative COVID-19 the complete the date the se started, if any patients the mployee two days prices and/or while the emp inptoms, the number of tined, the date the se resolved, the date the se resolved, the date the se the employee returned the Infection Control Log" LPN #4, dated 6/8/2020 Int #13 (Discharge Date	ut ne log hest the illed ther e ician e if any ent cate ded d lf est. s or to loyee days evere d to	G 684			

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NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	E, ZIP CODE		
RIGHT AT	RIGHT AT HOME, INC			ROADWAY S' SON, IN 460	TREET SUITE B 112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
G 684	physician was notified to the hospital and trested for COVID-19 to evidence if any agexposed to the patier and failed to indicate the infection. The agency's "Patier included an entry by which indicated Patie 6/1/2020) developed symptoms of dyspnes welling to the lower gain. The log indicate was notified, the patient was screen symptoms, failed to expect the infection. The agency's "Patier included an entry by which indicated Patien developed a "Sinus I "facial flushing and disserting." The log physician was notified with Doxycycline (and bacterial infections), allergies), and Mucini	ge 106 ad, the patient was admirented, and the infection ection log failed to evide ened for other COVID-1 evidence if the patient was during hospitalization, gency employees were not and tracked for sympethe specific "Resolution the specific the patient was admitted to the specific the patient was admitted to evidence and the infection was stion log failed to evidence ened for other COVID-1 evidence if the patient was during hospitalization, gency employees were not and tracked for sympethe specific "Resolution the specific specific the patient was treat antibiotic given to	was ence if 9 //as failed toms, n'' of 20, h the hit an ce if 9 //as failed toms, n'' of	G 684			

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	15K162 B. WING		 				
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE		
RIGHT AT	RIGHT AT HOME, INC		1125 BROADWAY STREET SUITE B ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 684	failed to evidence if the other COVID-19 symmathe patient was tested to order a test, failed employees were expertacked for symptoms specific "Resolution" The agency's "Patient included an entry by which indicated Patient 10/7/2020) developed the symptom of a "preentry indicated the part indicated the part indicated the part indicated the part indicated the patient with infection was indicated infection log failed to screened for other Colevidence if the patier or if the physician deto evidence if any agree exposed to the patier and failed to indicate the infection. 9. The clinical record on 2/12/21 and 2/16/2 care date of 2/15/19, including but not limit of movement disorded damage prior to birth Neurologic Neglect (if or move one side of the Incontinence (inability movements). The recare for the recertifica 2/3/2021. The plant which stated " Oxymics or continuation of the patient of the recertifica 2/3/2021. The plant which stated " Oxymics or continuation of the patient of the recertifica 2/3/2021. The plant which stated " Oxymics or continuation of the patient of the recertifica 2/3/2021. The plant which stated " Oxymics or continuation of the patient of	the patient was screene ptoms, failed to evidence of or if the physician decto evidence if any agerosed to the patient and so, and failed to indicate of the infection. It Infection Control Log" LPN #4, dated 3/24/202 and #16 (Discharge Dated a respiratory infection oductive cough." The leatient's physician was was prescribed Cefdinire at bacterial infections), cated as "Resolved." The evidence if the patient OVID-19 symptoms, faint was tested for COVID clined to order the test, ency employees were not and tracked for symptoms and tracked for symptoms and tracked for symptoms and tracked for symptoms. The specific "Resolution of Patient #5 was revical, and indicated a start with patient diagnoses and to: Cerebral Palsy (grs which result from brain or early childhood), nability for patient to sethe body), and Bowel	ce if clined hery the 20, et with og and he was led to 0-19 failed toms, n' of ewed et of group ain ense	G 684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 684	administration is dose needed]. May titrate [Oxygen Saturation, a vital sign which meast blood which contains if Resp [respirations] patient is showing sig and if HR > 110, SBF first of two numbers i < 80" The plan of for Skilled Nurse (SN per day, 5 days a weup to 60 hours per modocumented on 2/3/2 patient's heart rate wadministered at "3" L. "96%." LPN #3 docur "Dyspnea [shortness nursing note failed to screened the patient evidence the nurse nand the agency's clin symptoms. A "Nursing Visit Note LPN #4, indicated the administered at "3" L. The visit note summa a] rough night. Labor the patient's blood pr shift was "77/63." LP family member contains the patient's "curre effective enough," and Azithromycin. The nuthe nurse screened the physician and the agent side of t	ed] via Mask PRN [as to 1L to keep O2 SAT also expressed as SpO sures the percentage of oxygen] > 93%. Notify < 11 per min [minute], gns or symptoms of dyso [systolic blood pressure read for care also included ord) services with visits 8 lek and Respite SN services with visits 8 le	or if cpnea re, the ding] ders hours vices lote," the bited The d to scician cient's 21 by 7%." 25 had cated he ent's cian ed on dence 9 and ent's	G 684			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUI			1 ' '		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02	C / 23/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 684	A "Nursing Visit Note LPN #3, indicated the administered at "3" L rate was "120,", and LPN #3 documented all lung lobes and dynote failed to evidence patient for COVID-19 nurse notified the patagency's clinical man symptoms. A "Nursing Visit Note LPN #3, indicated the administered at "2.5" heart rate was "115," "83/45." LPN #3 doc "crackles" to all lung heard during auscultare sulting from infection dyspnea at rest. The evidence the nurse s COVID-19 and failed notified the patient's clinical manager of the A "Nursing Visit Note LPN #3, indicated the administered at "2.5" SpO2 was "98%," resheart rate was "143." patient had "crackles and dyspnea at rest. the patient was startenursing note failed to screened the patient evidence the nurse in evidence the nurse in the control of the control of the patient was startenursing note failed to screened the patient evidence the nurse in the control of the control of the patient evidence the nurse in the control of the patient evidence the nurse in the control of the patient evidence the nurse in the control of the patient evidence the nurse in the control of the patient evidence the nurse in the patient	"," documented on 1/30, e patient's oxygen was /min, SpO2 was 96%, h blood pressure was "84 the patient had "crackle spnea at rest. The nurse the nurse screened to and failed to evidence itent's physician and the larger of the patient's "," documented on 1/28, e patient's oxygen was L/min, SpO2 was "97% and blood pressure was umented the patient had bobes (abnormal sound atton of the lungs, normal sound atton of the lungs, normal sound atton of the patient for to evidence the nurse physician and the agen he patient's oxygen was L/min via nasal cannul spiratory rate was "22," LPN #3 documented the to both lower lung lob The nurse also documed on Doxycycline. The evidence the nurse for COVID-19 and faile otified the patient's physical manager of	neart 1/53." es" to sing he the e /21 by s, " as d ally and cy's /21 by a, and ne es, ented e ed to sician	G 684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K162		B. WING		02	C / 23/2021
NAME OF PR	OF PROVIDER OR SUPPLIER STREE			ESS, CITY, STA	ΓE, ZIP CODE		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 684	A "Nursing Visit Note LPN #3, indicated the administered at "2" Larespiratory rate was "and blood pressure was documented the patie lower lung lobe, there the right lower lung lobe, and the right lower lung lobe, there the right lower lung lobe, there the right lower lung lobe, there the right lower lung lobe, and the right lower lung lobe, there the right lower lung lobe, and the right lower land agency's clinical man symptoms. A "Nursing Visit Note LPN #4, indicated the administered at "2.5" heart rate was "122." stated "9 AM [beginn was 88% on Room A briefly for turning" I contacted the Clinical inform her of the patie patient's family membrated the call (speand a Chest Xray was (specific time not documented the patient's oxygen was 1.5 L/min. At 4 PM, the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136. The nursing note that the patient's heart rate we nurse documented the 136.	"," documented on 1/26, e patient's oxygen was /min, SpO2 was "97%,' 1/23," heart rate was "12 was "83/59." LPN #3 ent had "crackles" to the were no breath sound obe (meaning no air get pnea at rest. The nursice the nurse screened to and failed to evidence ient's physician and the larger of the patient's", documented on 1/25, e patient's oxygen was L/min, SpO2 was "95-4." The nursing note sumiting of shift] Client O ir [no supplemental oxystollar] 2.5 [L/min] per [patient] 2.5 [L/min] per [patient] at] 2.5 [L/min] per [patient] was condition, and the per contacted the patient e patient's medical provincific time not documents ordered. Later in the	3," e left s to ting ng he the e (21 by 96%," mary 2 sat gen] and till ent's he wider ted) shift as 28 The urse to the l, the as	G 684			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES ND PLAN OF CORRECTION IDENTIFICATION NUM			1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/2	C 3/2021
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	CITY, STATE, ZIP CODE		
RIGHT AT HOME, INC				ROADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 684	failed to evidence the from the medical providested for COVID-19. A "Nursing Visit Note LPN #4, indicated duitime documented) the was 24 breaths permand SpO2 was 92 - 9 stated " 5:45 PM: [stopped feeding in pr," and indicated the check at 6:30 PM warate of 24, and the pabreathing." LPN #4 c started at 1 L/min (routhe patient's follow up was SpO2 97%, resp pressure 88/56, heard was exhibiting no "disfailed to evidence the for COVID-19 and fail notified the patient's pclinical manager of the The agency's infection evidence documental #5's infections, including prescribed an antibio 10. An interview was 3:46 PM with the Adn Administrator, Clinical #1. During the intervindicated if an agency symptoms of COVID-the patients and/or of exposed to the employif the employee tester.	e nurse requested an orvider for the patient be "" documented on 1/24/ ring the visit (no specifice patient's respiratory raninute, heart rate was 1/4%. The nursing summ Patient's family member ogress. Lift transfer to patient's follow up vital so spo2 92%, respiratory rate and the patient had "labored documented oxygen was used not documented), a point of the patient of the patient had "labored documented oxygen was the not documented), a point of the patient of the patient had "labored the patient had "labored had be not documented oxygen was the patient had "labored had be not documented oxygen was the patient had "labored he patient had "labored he patient had "labored he patient had "labored he patient had be p	21 by c ate 40, nary er] bed I sign ry s nd M ent ote atient se cy's ient at ector ent ally ated ontact	G 684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162 B. WING C 02/23/20						
	OVIDER OR SUPPLIER			ESS, CITY, STA				
RIGHT AT HOME, INC				SOADWAY S	TREET SUITE B 012			
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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)			G 706				
	patient; This Element is not in Based on observation interview, the Registe conduct and documer assessment per profestandards for 1 of 1 stobservations (#1) and patient's skin and word active patient records wound (#2), in a total Findings include: 1. An agency policy the Nursing, "revised 1/15/10008, stated " Pol assessed and reasse visit The Comprehincludes the following physical findings" 2. An undated agence "Licensed Practical Nound Summary: Performs in accordance with an example of client status that integrammeters"	n, record review, and ared Nurse (RN) failed to a complete and thore essional and agency killed nurse visit. If alied to assess the und condition for 1 of 2 with the presence of a sample of 11 records. It alied "Assessment - 5/18 and policy number icy: The patient sha ssed during each skille ensive Assessment information Pertine by job description titled urse [LPN]," stated "Johursing care to patient i stablished plan of care by job description titled N]," stated " Essentians comprehensive ive ongoing assessmit.	ough Il be d nt b n"					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/2	C 23/2021	
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
G 706	on 2/16/21 and 2/17/2 care date of 9/16/19, including but not limit included a plan of car period 1/8/21 - 3/8/21 Skilled Nurse (SN) vis per day, 7 days per w stated SN intervention Visit: Skilled Assessm Systems Diabetic or SN" A home visit observat 2/10/2021 at 4:07 PM #1. During the visit, L performing a nursing LPN #1 assisted Paties slippers, pressed on the patient's feet with the visit. The nurse frand thorough diabetic 5. The clinical record on 2/12/21 and indicated 4/10/18, with patient climited to: transverse spinal cord) and parallower portion of the bacomprehensive ass 1/21/21 by Former RI period 1/24/21 - 3/24/ assessment included Wound / Ostomy," whome visit observat 2/11/21 at 9:15 AM whome visit, Patient #2 wounds.	21 and indicated a start with patient diagnoses ed to: diabetes. The rece for the recertification, and included orders faits 1 hour per visit, 3 vicek. The plan of care as were to include "Evenent and Evaluation of a Foot Exam daily per Pation was conducted on I with Patient #1 and LF	cord or disits ery dall distinct PN ent. sion of distinct distinc	G 706				

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CENTERS	FOR MEDICARE & N	MEDICAID SERVICES				OMB NO	<u>J. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
		15K162		B. WING			C 3/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	TE. ZIP CODE		
	HOME, INC		1125 BI	ROADWAY S	TREET SUITE B		
			ANDER	SON, IN 460) 112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
G 706	spine, directly above buttocks, one Stage 2 caused by prolonged damage to the first la buttock, two or three distinguish number of covered with white m pressure ulcers to the Stage 2 pressure ulce posterior thigh. The pwere "shearing" wour buttock wounds were (type of gauze dressi to the right posterior to ropical cream note #1 indicated she wou Hydrophilic Wound C which assists with wo on the patient's sacrum and with the patient's sacrum and with the patient's bath dressing or ointments patient's right thigh. assessment failed to assessed the patient' wound, type of dressi 6. An interview was c PM with the Alternate Manager. During the Manager indicated th foot exam "every" vis and "cracks in bet bottom of the feet.	the coccyx) and both 2 pressure ulcer (wound pressure, resulting in pressure, resulting in the syers of the skin) to the (surveyor unable to f wounds due to area pedicated cream) Stage at left buttocks, and one er to a skin fold on the repatient reported the wornds. The left and right a covered with a dry ABI (and apply Coloplast cream (a medicated oint ound healing) to the worn and buttocks. HHA (and the did apply Coloplast cream (a medicated oint ound healing) to the worn and buttocks. HHA (and the did not apply any is to the wound on the The comprehensive evidence the nurse as wounds (location, typ)	right 2 right unds D pad vound essing HHA) tment unds #1 / day /	G 706			
G 768	17-12-2(g) Competency evaluati	ion		G 768			
	CFR(s): 484.80(c)(1)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K162			C 3/2021			
RIGHT AT HOME, INC 112				ROADWAY S	TREET SUITE B	•		
(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 CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 768	Standard: Competence An individual may furn on behalf of an HHA of successfully complete program as described (1) The competency of each of the subjects I this section. Subject paragraphs (b)(3)(i), (section must be evaluated through the competency of the tall pseudo-patient. The may be evaluated through the competency of the tall pseudo-patient as part (2) A home health aid program may be offer except as specified in section. (3) The competency of performed by a regist with other skilled prof This Standard is not Based on observation interview, the home he ensure home health a and competency chec Hoyer lifts for 1 of 1 he a patient with a Hoyer trained on patient-spe manufacturer's instruct patients with Hoyer lift had the potential to at	cy evaluation. Inish home health service only after that individually after that individually a competency evaluated a competency evaluated in this section. Evaluation must addressisted in paragraph (b)(3 areas specified under (iii), (ix), (x), and (xi) of (iii), (ix), (ix), and (iii), (ix), (ix), and (iii), and (iii), and (iii), and (iiii), and (iiiii), and (iiiiii), and (iiiiiii), and (iiiiiii), and (iiiiiiiii), and (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	I has ation s ation s B) of this aide's son, ome on , ted of rring e active	G 768				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K162		B. WING		02/	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 768	1. An agency policy of Aide Competency Ev 7/24/17, policy number In order to comply with regulations, which may providing home health copleted a training an evaluation program be health aide services, taken: A newly him receive a minimum of Procedure: Each in Aide will be determine being allowed to prove Home Health Aide's of demonstrated in each before the Home Health Aide in the specific care independent aide will not perform not demonstrated corrections.	citiled "Certified Home Haluation Program" date er 4050, stated " Polith state and federal andate that individuals haide services must haid competency and efore furnishing home the following steps will ed Home Health Aide wif 1 hours of orientation newly hired Home Health ed to be competent beforde care or services competency will be a task to be performed alth Aide provides the dently A Home Health atsks in which he/she had to the competency will be a task in which he/she had the state of the s	d licy: ave be vill th ore The	G 768			
	Hoyer / Hydraulic Lift stated " Procedure straps to holes in the jack enough for the minches and tighten the Determine if client is maintain head support. 3. An undated agence "Home Health Aide" so Functions: 4. Performance activities that are taughtent. These include Assisting with the use living lift device	"policy number M-140 : 8. Attach chains or sling 10 pump the nat to clear the bed about release valve. 11. fully supported and cannot" by job description titled stated " Essential forms other assigned with by a nurse for a specie but not limited to: to of devices for aid to design the state of the state	e ut 6 cific c.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		15K162		B. WING	····	02	C 2/ 23/2021	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	TREET SUITE B 112			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 768	Manual & Instruction www.drivemedical.c Thoroughly read Owner's Manual, obexperts perform the perform the entire li with proper supervis Wheelchair: 2. Thosition Wheelchair: 2. Thosition Wheelchair for the wheelchair for the locks are locked to the chair. 4. The phasear with their back 5. Begin to lower the control valve or by the counterclockwise 6 chair will pull back of sling to place the parameter. 5. California Depart Date). "How to Use 3/11/21 from www.c. The U-Sling is the intransferring [the patt U-Sling wraps around between the legs. Secure feel and preserved on 2/11/21 (start of care 4/10/15/22/19), and Patienhad Hoyer lifts. The clinical record of 2/12/21 and 2/16/21	ns." Retrieved 2/22/21 from. " Safety Summa the instructions in this perve a trained team of lifting procedures and the procedure several times ion Transferring to a the wheelchair is moved hair wheel locks must be pre lowering the patient in transport. 3. The rear who further prevent movement attent is positioned over against the back of the depatient either by opening	ry: nen es into in a nto eel nt of the chair. ng the the the chair (No ng: g for hese a iding was ent #2 are 19)	G 768				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLII ND PLAN OF CORRECTION IDENTIFICATION NU					(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02	C / 23/2021
	ROVIDER OR SUPPLIER			RESS, CITY, STAT			
RIGHT AT HOME, INC				SON, IN 460	TREET SUITE B 12		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENCY MUS OR LSC IE		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 768	Respite Skilled Nurse home health agency An interview was cor PM with the Clinical interview, the Clinical #4 did not use his Ho only transfer out of b present. 7. A home visit obse 2/11/21 at 9:15 AM w 4/10/18) and HHA #7 #1 was observed traibed to the wheelchaid Hoyer. The HHA #1 turning from side to sling underneath the the patient's bedside above the patient, ar hooks to the swivel b crank to lift the patient to back of the wheelchaid slightly forward, and Hoyer into the wheel the sling straps under when connecting the bar, failed to check the patient was slightly secure, and failed to wheelchair when low. An interview was cor AM with HHA #1. Duindicated she was rebeing hired by the agwhen she was hired.	de services only from the anducted on 2/11/2021 a Manager. During the all Manager indicated Paragrer lift to transfer, and and when his "friend" was ervation was conducted with Patient #2 (start of a 1. During the home visit insferring the patient from ir using a Drive manual assisted the patient with side, positioned the Hoy patient, moved the Hoy patient, moved the Hoy patient, moved the short out of the bed, moved the wheelchair, went to air, positioned the patient from the wheelchair, went to be the total the patient from the whole of the patient from the whole of the patient from the Hoyer straps when the Hoyer the patient into it. Inducted on 2/11/21 at 1 aring the interview, the ligistered as a HHA prior gency. The HHA indicated on the patient into it.	t 1:45 tient would is on care , HHA m the h err to par 6 Hoyer d the ont lechair in the cross is lechair were were were 1:20 HHA is to ted	G 768			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STA ROADWAY S SON, IN 460	TREET SUITE B	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 768	but she did not perfor demonstration of a Ho or pseudo-patient. Ho not have a nurse com #2's Drive manual Ho patient with the Hoyer 8. The personnel file 2/23/21. The personnel RN competency check #2's Hoyer lift was competency check Hoyer lift was competency check Hoyer lift, the serossed under the pashould not tilt a patient lowering the patient from the did hot how	the Registered Nurse (Firm an RN-observed over lift transfer of a part HA #1 also indicated shapetency check on Patinyer prior to transferring r. of HHA #1 was reviewed held file failed to evidence k of HHA #1 using Patinducted. conducted on 2/12/21 at Administrator and Clininterview, the Clinical hen connecting a Hoyer lift is leg straps should tient's thighs, and staff of the servation of a transfer of item and electric Hoyer lift is ervation of a transfer of item, and all HHAs who is patient with a Hoyer lift by an RN in the home, ecific Hoyer lift, prior to transfer. The Clinical in-home Hoyer compete	tient ne did ent the ed on ee an eent tt 1:40 ical r sling be when on ncy ft of a ft are	G 768			
G 798	Home health aide ass CFR(s): 484.80(g)(1)			G 798			
	Standard: Home hea	Ith aide assignments a	nd				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162		B. WING		C 02/23/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•
RIGHT AT HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012	
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION
patient by a registered skilled professional, winstructions for a home that registered nurse professional (that is, professional (that is	e assigned to a specific dinurse or other appropriate with written patient care to health aide prepared or other appropriate skelphysical therapist, hologist, or occupations met as evidenced by: In, record review and the aide (HHA) care plant the patient's needs for wed of patients with HI in a total sample of 11 The property of care also at the patient's personal property of care also and agency goals / outcome all nursing judgement to the aid agency goals / outcome all nursing judgement to the patient's metals when determined to the property of the property of the patient's property of the property of the patient's property of the property of	oriate by illed al on 4 of HA ong mined ty ss of n	G 798		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING A. BUILDING C B. WING NAME OF PROVIDER OR SUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED C 02/23/20			STATEMENT C
15K162 B. WING 02/23/20		, , , , , , , , , , , , , , , , , , , ,	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	15K1		
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RIGHT AT HOME, INC 1125 BROADWAY STREET SUITE B ANDERSON, IN 46012		AI HOME, INC	RIGHT AT
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG OR LSC IDENTIFYING INFORMATION) DEFICIENCY ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	RECEDED BY FUL	(EACH DEFICIENCY MUS	PRÉFIX
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 is low blood sugar] Assignment Assist with Elimination Assist with WC (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 myellits (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 asthram. The record included a plan	atient #1 was and indicated a solution diapotes, bilate e pain, low bulmonary Disease). The recording the recertificate plan of care or HHA visits 4 c. The record signed as revue aide care plan of care plan of care plan of care proglycemia [hype poglycemia is a commode, we aide care plan of sugar vas of hyperglyces to report, faite the patient to void in the basist: Chair / he aide care plan of sugar vas of hyperglyces to report, faite the patient to void in the basiste the patient to word in the basiste, and failed to eviden hyperglyces and failed to eviden hyperglyces to report, faite the patient to care of the patient to object	3. The clinical record on 2/16/21 and 2/17/2 care date of 9/16/19, including but not limit (both sides of the bod and Chronic Obstruct (COPD, a respiratory included a plan of car period 1/8/21 - 3/8/21 contained service ord per day, 5-7 days per included a HHA care 1/7/21 by Former RN " Precautions and 0 Watch for hyper / h is elevated blood sugablood sugar] Assigt Elimination Assist Walker / Cane Mo Dangle / Commode . failed to evidence speand/or signs and symhypoglycemia the HH evidence specific ass with elimination (did pwith the use of a beds incontinence briefs, edetailed directions on device the patient was evidence detailed ass HHA to assist the patient of 2/12/21 and indicated 4/10/18, with patient of limited to: transverse spinal cord), parapleg lower portion of the brinfections (UTI, an informatical records).	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SI COMPLE	TED
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G 798	of care for the recert 3/24/21, which contavisits 4 - 7 hours per The record also inclutitled "AM Care Plan" "PM Care Plan," all s 1/21/21 by Former R included the task "As "PM Care Plan" also Precautions." The a evidence specific as with elimination, and evidence detailed insprecautions the HHA patient's increased rirazors, report any bloom between the second 2/12/2021 and 2/care date of 7/17/19, including: low back procession, and anxiplan of care for the ready of the second also in signed as reviewed a aide care plan including ambulation Walke Assist." The care pla ambulation assistant patient. 6. The clinical record on 2/16/21 and 2/18/care of 5/22/19, with CVA (Cerebrovasculflow to the brain) with to one side of the boom to the procession of the boom to the procession of the boom to the brain) with the cone side of the boom to the procession of the boom to the procession of the boom to the brain) with the procession of the boom to the procession of	ification period 1/24/21 inded service orders for day, 5 - 7 days per week aded three HHA care play; "Afternoon Care Plany; "Afternoon Care Plany; "Afternoon Care Plany; included as reviewed on the care plans failed to sistance the patient neek the night care plan failed structions regarding which was to perform for the lisk of bleeding (avoid us	HHA ek. ans, "and s The ded ded to ch se of ewed start of a, ned a /21 - HA The n e with ed the	G 798			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/2	C 2 3/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	STREET SUITE B 012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 798	by damage to the out blood pressure. The plan of care for the management of care plan signed as manager on 1/6/21, Precautionary and Owarch for hyper / hypercautions Assig / Complete. Complete [patient] refuses shower failed to evidence spand/or signs and synhypoglycemia the Hievidence detailed insprecautions the HHA patient's increased mediane when the promplete bed bath was to evidence specific needed with eliminate detailed assistance in assist the patient with the Administrator, and Owarch of the care and patient specific.	artlying nerves), and high a clinical record contained ecertification period 1/11 ded the service orders for 6 hours per day, up to ear. The plan of care were to include "Every vert] refuses shower give ed bath empty trash cord also included an HI reviewed on the Clinical which stated " other Pertinent Information poglycemia. Bleeding grament: Bed Bath - Forte or partial bed bath if wer Assist with ity Assist: Chair / Bed" The aide care plan pecific blood sugar value and the structions regarding which was to perform for the isk of bleeding, failed to patient was to receive a dersus partial bed bath, for assistance the patient cion, and failed to evider instructions for the HHA in mobility. Conducted on 2/22/21 attrator, Alternate clinical Manager. During all Manager indicated the replan should be detailed. The Clinical Manager are "trained to not do thin a clinical to not do thin a clinica	ed a 1/21 - 20 r 30 r risit as HA I Dn Partial s a and to ch ailed ace to t 1:15 the ed also	G 798			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			CONSTRUCTION	(X3) DATE S COMPL	
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RIGHT AT	HOME, INC			ROADWAY STR SON, IN 46012			
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G 798	competency check [within bleeding pro hyper/hypoglyceming 17-13-2(a)	ed to know what is includ ecautions and a monitoring]."	ed	G 798			
G 800	CFR(s): 484.80(g)(A home health aide (i) Ordered by the practitioner; (ii) Included in the (iii) Permitted to be and (iv) Consistent with This Element is not Based on record rehealth aide (HHA) included on the aid records reviewed of (#1, 2, 3, 4), and fawritten on the aide of their practice for of patients with HH sample of 11 records include: 1. An agency polic Implementation, "dinumber 10020, staprovides care, treat consistent with the and documented in Home provides care for each patient act professional standaregulations"	e provides services that an object of a physician or allowed plan of care; e performed under state land the home health aide tract met as evidenced by: eview and interview, the health did to complete all task le care plan for 4 of 4 action patients with HHA servicialled to complete only task care plan and within the services (#2, 3), in a tods.	ome s ve ces sscope ewed tal ome	G 800			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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G 800	"Home Health Aide," Functions: 2. Perf supervision of the Nu Performs personal cawritten assignment by 4. Performs other assignment by 5. Performs other assignment by 6. Performs other a	stated " Essential orms work under the orms work under the price of the price o	or e e e e e e e e e e e e e e e e e e	G 800			

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G 800	on the visit dates. The clinical record in "Aide Weekly Visit Re#5 provided HHA ser 1/24/21. The visit rectasks of "Meal Prepare Equipment Care" or declined by the pa The clinical record in "Aide Weekly Visit Re#5 provided HHA ser 1/23/21. The visit rectasks of "Wash Clothcompleted by the HH on this visit date. The clinical record in "Aide Weekly Visit Re#4 provided HHA ser 1/17/21, 1/18/21, 1/19/1/22/21. The visit rectasks of "Shower" on Clothes" on all dates Trash" on 1/17/21, 1/1 completed by the HH The clinical record in "Aide Weekly Visit Re#4 provided HHA ser 1/12/21, 1/13/21, 1/14 visit record failed to e "Shower" and "Empty dates and "Wash Cloexcept 1/12/21 were declined by the patient.	cluded a document title ecord," which indicated vices to Patient #1 on cord failed to evidence fration Wash clothes were completed by the tient on this visit date. cluded a document title ecord," which indicated vices to Patient #1 on cord failed to evidence from the ecord, which indicated vices Empty Trash A or declined by the patient #1 on ecord, which indicated vices to Patient #1 on ecord, which indicated vices to Patient #1 on ecord failed to evidence from the ecord, which indicated vices to Patient #1 on ecord failed to evidence from the ecord, which indicated vices to Patient #1 on ecord failed a document title ecord, which indicated vices to Patient #1 on ecord, which indicated wices to Patient #1 on ecord, which indicated wice	the HHA d HHA the were tient d HHA the were tient d HHA the Vash mpty re tient. d HHA l/11/2, The e dates or	G 800			
	on 2/12/21 and indica	ated a start of care date	of				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
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G 800	4/10/18, with patient of limited to: transverse spinal cord), parapled lower portion of the binfections (UTI, an infinity system), and asthmatof care for the recertification of the recent also included the recent of the recent also included the recent of the rec	diagnoses including but myelitis (inflammation or gia (inability to move the ody), history of urinary fection of the urinary. The record included a fication period 1/24/21 - ned service orders for I day, 5 - 7 days per weed ded three HHA care play "Afternoon Care Plan, igned as reviewed on N.I. All three care plans Meal Preparation in thousekeeping," wo visit per the patient's are plans also included einforce Dressing. If d, may apply tape or not be to coccyx [tailbone] of the Care Plan" indicated Shampoo" were to be afternoon Care Plan Hair Care Shampoo to the e"PM Care Plan" indicated and the company in the end of the company in the	of the electract a plan	G 800			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE S COMPL	ETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE	•			
RIGHT AT	HOME, INC			1125 BROADWAY STREET SUITE B ANDERSON, IN 46012					
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G 800	Continued From pag	e 128		G 800					
G 800	The record included a Weekly Visit Record" provided HHA service shift on 1/25/21, 1/26 1/29/21, and 1/30/21 evidence the task "Wabove dates and "Haabove dates except at the HHA or declined The record included a Weekly Visit Record, provided HHA service shift on 1/24/21, 1/25 1/29/21, 1/30/21. The tasks "Bed Bath: Wash Clothes I completed by the HH on the above dates. The record included a Weekly Visit Record" provided HHA service afternoon shift on 1/2 The visit note failed to Bath: Partial Hair Care Wash Clothes	a document titled "Aide which indicated HHA # es to Patient #2 for the 1/21, 1/28/21, The visit note failed to ash Clothes" on all the ir Care Shampoo" o 1/28/21 were completed	AM n all l by #8 PM dence ation ' were tient #7 2/21. ded Skin by	G 800					
	Weekly Visit Record" provided HHA service afternoon shift on 1/2 note failed to evidence Partial Hair Care Wash Clothes" we	a document titled "Aide which indicated HHA # es to Patient #2 for the 26/21 and 1/28/21. The ce the tasks "Bed Bath Shampoo Skin Care completed by the HHnt on the above dates.	visit - are						

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G 800	The record included Weekly Visit Record provided HHA servi evening shift on 1/2 evidence the tasks Wash Clothes" v declined by the pati. The record included Weekly Visit Record provided HHA servi afternoon shift on 1 evidence the tasks Skin Care Wash by the HHA or decliabove date. A home visit observe 2/11/21 at 9:15 AM home visit, Patient redness to her sacrdirectly above the costage 2 pressure ul prolonged pressure first layers of the sk three (surveyor una wounds due to area medicated cream) Selft buttocks. The pwere "shearing" wo buttock wounds we (type of gauze dres indicated Home Herwound care, and Heapply Coloplast Hydrodicated ointment healing) to the would and buttocks and the every day with the providence in the provided that the provided Home Herwound care and Heapply Coloplast Hydrodicated ointment healing) to the would and buttocks and the every day with the provided Home Herwound care, and Herwound care and Hermound care and Herwound care and Hermound care and Her	age 129 d a document titled "Aide d" which indicated HHA # ces to Patient #2 for the 17/21. The visit note faile " Meal Preparation were completed by the H tent on the above dates. d a document titled "Aide d" which indicated HHA # ces to Patient #2 for the 1/30/21. The visit note fail " Hair Care Shamp Clothes " were completed by the patient on the 1/30/21. The visit note fail " Hair Care Shamp Clothes " were completed by the patient on the 1/30/21. The visit note fail " Hair Care Shamp Clothes " were completed by the patient on the 1/30/21 and both buttocks are and the specific wound caused by the patient #2. During the 1/30/21 and both buttocks are and the specific wound caused by the patient for the specific wound caused by the specific wound wo	the coine, so one the ds D pad to the day and dum pad	G 800			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 .	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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RIGHT AT	HOME, INC			SON, IN 460	TREET SUITE B 012		
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G 800	patient's dressing and daily by a nurse emp J (HHA #1 was unable) Home Health Entity J #2's was reviewed or start of care of 8/13/1 plan of care for the refulzed for the reful	d apply the Coloplast or loyed by Home Health I le to name the employed I's clinical record of Patin 2/17/21, and indicated 18. The record contained exertification period of nich included a section the eatment for Wound #11 suttox [sic]. Type: Press Skilled Caregiver to Cleinel, pat dry, apply thin I medicated topical cream bound healing]. HHA [see Home] may apply daily in: Rt Lower Buttox, Type propriate Skilled Caregiver to Cleinel, pat dry, apply thin layer Amay apply daily in: Rt Lower Buttox, Type propriate Skilled Caregiver to Cleinel, pat dry, apply thin layer Amay apply daily Woute [group of muscles we tooks and upper thigh], r Appropriate Skilled exito areas on glutes. In HHA #1 failed to perform on the aide care plan appractice. If of Patient #3 was revisitely. The record contained exitors are plan appropriate orders for HH lay, 2-4 days per week. Included a HHA care plan application appears and the plan appropriate orders for HH lay, 2-4 days per week. Included a HHA care plan appropriate and the plan appears and the plan a	Entity e). ent l a ed a itled h sure eanse ayer rvice e: iver of und hich HHA n nd ewed tart of a, hed a 21 - IA The	O08			

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	OVIDER OR SUPPLIER HOME, INC		1125 BR	ROADWAY S	TREET SUITE B		
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G 800	Record" which indical services to Patient #3 1/16/21. The aide vis performed the task "E each of the above visithe HHA performed of task" Nail Care and 1/16/21, and faile performed or the pati Wash Clothes" du The HHA care plan fa "Encourage Fluids" waide, and the visit not completed all tasks of care plan. The record included a which indicated HHA Patient #3 on 1/19/21 indicated HHA #9 per Fluids" during the visithe task " Assist with note failed to evidence tasks only as instructed. The clinical record on 2/16/21 and 2/18/2 care of 5/22/19, with CVA (Cerebrovascula flow to the brain) with to one side of the both neuropathy (series of by damage to the out blood pressure. The plan of care for the residual services and the services of the out blood pressure. The plan of care for the residual services and the services of the plan of care for the residual services and the services of the plan of care for the residual services and the services of the plan of care for the residual services and the services of the plan of care for the residual services and the services of the plan of care for the residual services and the services of the plan of care for the residual services and the services of the plan of care for the residual services and the services of the plan of care for the residual services and the services	an "Aide Weekly Visit ted HHA #9 provided H 3 on 1/12/21, 1/14/21, a sit note indicated HHA # Encourage Fluids" durin sit dates, failed to evider or the patient declined the "during the visits 1/12/2 ed to evidence the HHA ent declined the task " . I wring the visit on 1/12/21 ailed to evidence the task as to be performed by the failed to evidence the ently as instructed on the a "Aide Weekly Visit Re #9 provided HHA servical. The aide visit note rformed the task "Encourit, and failed to evidence ask or the patient declination or the HHA completed a ted on the aide care plant of Patient #4 was revical, and indicated a star patient diagnoses includar Accident, loss of bloom left hemiparesis (weak	nd #9 gg nce ne 21sk the HHA e aide cord" ces to urage e the led sit all n. ewed t of ding: d cness used d a 1/21 - or	G 800			
	plan of care for the re 3/11/21, which include	ecertification period 1/11 ed the service orders fo	1/21 - or				

FORM CMS-2567(02-99) Previous Versions Obsolete

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		C 02/23/2021	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
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G 800	Continued From page 132			G 800			
G 800	days per calendar year contained a HHA care aide was to assist the slide board transfer w " Shampoo Mob Commode / Shower every visit per the pat The clinical record incertain Record" which indicat HHA services to Patie The visit note failed to Shower Hair Care Slideboard Transfer HHA or the patient de The clinical record incertain Record which indicat HHA services to Patie 1/27/21, 1/28/21, and failed to evidence the Mobility Assist "we the patient declined the PM with the Alternate Manager. During the Manager indicated Hireplace" a wound dresser in the said of the sai	ar. The record also e plan which included the patient with showering ith every visit, and the sility Assist: Chair / Bed" were to be complete ient's request. Studed an "Aide Weekly ted HHA #2 provided resent #4 on 2/1/21 and 2/6 of evidence the tasks "" were performed by the clined the tasks. Cluded an "Aide Weekly ted HHA #2 provided resent #4 on 1/25/21, 1/26/1/29/21. The visit note tasks " Shower the tasks Conducted on 2/12/21 and Administrator and Clinical HAs were able to "secussing and the agency here!"	y and tasks ed / Visit espite 6/21 the / Visit espite //21, e HA or It 1:40 ical ire or inad	G 800			
	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		The				
			the ed tient per				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	E CONSTRUCTION	(X3) DATE S COMPLE	ETED
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	OVIDER OR SUPPLIER			RESS, CITY, STAT			
RIGHT AT	HOME, INC			ROADWAY ST SON, IN 460	TREET SUITE B 12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	(STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 800	agency did not valing patient if they would tasks to be perform to do this with ever	date if the HHAs asked the dike the "per patient requed as the aides were "tray patient during each visi	uest" iined"	G 800			
G 978	CFR(s): 484.105(e) An HHA must have another agency, wi individual when that services under arrapatients. The HHA responsibility for the arrangement, as weare furnished. The individual providing may not have been (i) Denied Medicare (ii) Been excluded health care program (iii) Had its Medical revoked; or (iv) Been debarred government program. This Element is not agreements were in services each ager active shared patie which had the pote identified as receiving other entity (#1, 2, 23, 24, 25, 26, 27). Findings include: 1. An agency police.	e a written agreement with the an organization, or with at entity or individual furnish angement to the HHA's a must maintain overall e services provided under ell as the manner in which agency, organization, or a services under arrangent or terminated from any fem or Medicaid; are or Medicaid billing priviting from participating in any and the as evidenced by: eview and interview, the had to ensure written an place which delineated ancy was to provide for 3 of ant records reviewed (#1, intial to affect 16 of 16 paing services from at least 4, 6, 15, 17, 18, 19, 20, 20, 20, titled "Coordination of Figure 19.	n an shes r h they hent deral leges ome the f 3 2, 4), tients one 1, 22,	G 978			
	Services," dated 7/	ey titled "Coordination of F 24/17, policy number 100 Care, treatment and/or se	21,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SURY	D
		15K162		B. WING			C 3/ 2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
RIGHT AT	HOME, INC			ROADWAY S SON, IN 460	STREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 978	are provided by Right interdisciplinary, collar clinical services provident and/or providers undowith Right at Home shanother and shall be Home to assure qualito promote positive propatient is receiving caservices from other or Right at Home ensure the [agency] and other are collaborative and is maintained betwee regarding services Procedure: Coordidocumented in the passach record shall corregarding: The services The responsibilities or Communication be conducted on 2/10/20 Administrator, Alternatical Manager. Du Conference, the Alternatical Manager. D	t at Home in an aborative manner The ded by Right at Home is a crontractual arrangemental complement one coordinated by Right at a coordinate and/or a coordinations / providers are treatment and/or a coordinations / providers are coordinations of service activition at a coordination of services and coordination of services activition at a coordination of services and coordination of services activition at a coordination of services activition at a coordination of services and coordination of services and coordination of services and coordination of	staff nent and the sand the s	G 978			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/23/202	1
	OVIDER OR SUPPLIER HOME, INC		1125 BR	ESS, CITY, STA COADWAY S SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COM	(X5) IPLETION DATE
G 978	#15 (2/20/21), #17 (S 11/19/2020), #19 (SC 5/6/2020), #21 (SOC 5/10/18), #23 (SOC 8 10/23/18). 4. A list of all active pentity other than PSA 2/10/21. The list indichome care services fine Patient #25 (SOC 6/1 services from PSA Er 5/16/19) received hor Health Entity R, and Preceived home care sentity S. 5. The clinical record on 2/16/21 and 2/17/2 comprehensive assess by Former Registered recertification period comprehensive assess received 75 hours peservices and 11 hours services. The clinical shared patient agreen the home health ager 6. The clinical record on 2/12/21 and indicated 1/10/18. The clinical Conference" note, sign Nurse (RN) I and Hor 1/21/21, which stated Skilled Nursing [providus]" The clinical record skilled Nursing [providus]" The clinical record skilled Nursing [providus]	OC 9/14/2020), #18 (SPC 4/9/19), #20 (SOC 10/18/19), #22 (SOC 10/18/19), #22 (SOC 16/19), and #24 (SOC 16/19), and #26 (SOC 16/19), and PSA Entity P. 1. If the second included a second included a second included a "Cas 16/19), and PSA Entity P. 2. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 3. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 4. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 5. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 6. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 6. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 6. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 6. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 6. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P. 6. If the patient #2 was reviewed a start of care date 16/19, and PSA Entity P.	other on ed y J, e care OC Home 19) alth ewed d a /7/21 nt are aker ace a /een ewed e of e ered #2 on : ntity a	G 978			

OLIVILIN	TON WEDICANE & I	IEDICAID SERVICES				OIVID I	<u>10. 0936-039 I</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K162		B. WING		02/	C 23/2021	
NAME OF DR	OVIDER OR SUPPLIER		STREET ADDE	RESS, CITY, STAT	E ZIP CODE			
					TREET SUITE B			
KIGHT AT	HOME, INC							
			ANDER	SON, IN 460	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 978	Continued From page	e 136		G 978				
	7. The clinical record on 2/16/21 and 2/18/2 care of 5/22/19, with p CVA (Cerebrovascular flow to the brain) with to one side of the body neuropathy (series of by damage to the out blood pressure. The evidence documentate home care services from to evidence a shared enacted between the PSA Entity P.	of Patient #4 was reviewed, and indicated a star patient diagnoses inclusive Accident, loss of blood left hemiparesis (weakly), Type 2 Diabetes, medical conditions caulying nerves), and high clinical record failed to ion the patient receiver om PSA Entity P, and patient agreement was home health agency a	t of ding: od kness used d failed					
G 980	CFR(s): 484.105(e)(3 The primary HHA is rule and must conduct and under arrangements, patients. This Element is not rule health agency failed to agreements were in pure agency was the primal shared patient record had the potential to addentified as receiving other entity (#1, 2, 4, 23, 24, 25, 26, 27). Findings include: 1. An agency policy to Services," dated 7/24	esponsible for patient of provide, either directly all services rendered to the as evidenced by: ew and interview, the hole of ensure written oblace which delineated any agency for 3 of 3 are serviewed (#1, 2, 4), we firect 16 of 16 patients a services from at least 6, 15, 17, 18, 19, 20, 2 will be a considered to the constraint of Firect 16 of the constraint of Firect	y or ome which stive which one 1, 22,	G 980				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SUF	ED
		15K162		B. WING			C 3/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STAROADWAY SON, IN 460	TREET SUITE B	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION SHOULD BE COMPLET O THE APPROPRIATE COMPLET DATE	
G 980	interdisciplinary, collar clinical services provired and/or providers undowith Right at Home shanother and shall be Home to assure qualito promote positive papatient is receiving caservices from other or Right at Home ensure the [agency] and other are collaborative and is maintained betwee regarding services Procedure: Coordidocumented in the pascach record shall corregarding: The service The responsibilities or Communication be conducted on 2/10/20 Administrator, Alternated Clinical Manager. Du Conference, the Alter the agency did not have agreements with agent home care services a shared with Personal "most PSA agencies a shared patient agreer agencies had "refuse agreement. 3. A list of all active patients #1 9/16/19), #2 (SOC 4/19)	aborative manner The ded by Right at Home is the contractual arrangement one coordinated by Right at the patient care/services attent outcomes. Where are, treatment and/or reganizations / providers that the responsibilitier organizations / providers exclusive. Communicate the providing services or care to be provided ination of service activitient's home care recontain up-to-date informates that are being provided that the services / disciplitive involved parties ance Conference was 221 at 10:57 AM with the Administrator, and uring the Entrance mate Administrator indicates who also provided in service Agencies (PSA don't know what to do" ments, and some of the dot osign" a shared patient patients shared with PSI on 2/10/21. The list	staff nent and a the es of lers ation ces tion ded. ine" e cated d were A), with ent A	G 980			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		15K162		B. WING		02/2	C 23/2021
	OVIDER OR SUPPLIER HOME, INC		1125 BF	RESS, CITY, STAROADWAY SON, IN 460	TREET SUITE B		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 980	11/19/2020), #19 (SO 5/6/2020), #21 (SOC 5/10/18), #23 (SOC 8 10/23/18). 4. A list of all active pentity other than PSA 2/10/21. The list indichome care services fr Patient #25 (SOC 6/1 services from PSA Er 5/16/19) received hor Health Entity R, and Freceived home care sentity S. 5. The clinical record on 2/16/21 and 2/17/2 comprehensive assess by Former Registered recertification period comprehensive assess received 75 hours perservices and 11 hours services. The clinical shared patient agreer primary agency was enealth agency and PS 6. The clinical record on 2/12/21 and indicated 1/10/18. The clinical Conference" note, signurse (RN) I and Hor 1/21/21, which stated Skilled Nursing [provided]" The clinical record shared patient agreer shared patient agreer	oc 4/9/19), #20 (SOC 10/18/19), #22 (SOC 10/18/19), #22 (SOC 10/18/19), and #24 (SOC 16/19), and #26 (SOC 16/19), and *26 (SOC 16/19),	on ed y J, e care DC Home 19) alth ewed d a y7/21 nt are aker ace a be eme ewed of e ered #2 on : ntity a be	G 980			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	E CONSTRUCTION	(X3) DATE SUR COMPLETI	
		15K162		B. WING			C 3/2021
	OVIDER OR SUPPLIER			RESS, CITY, STAT			
RIGHT AT	HOME, INC			ROADWAY S' RSON, IN 460	TREET SUITE B 112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
G 980	Continued From pag	e 139		G 980			
G1008	on 2/16/21 and 2/18/2 care of 5/22/19, with p CVA (Cerebrovascula flow to the brain) with to one side of the boomeuropathy (series of by damage to the out blood pressure. The evidence documentathome care services fit to evidence a shared indicated the primary between the home he P. 17-12-2(e)	medical conditions caulying nerves), and high clinical record failed to tion the patient received om PSA Entity P, and patient agreement which	t of ding: d :ness used d failed	G1008			
	Condition of participa The HHA must mainta containing past and o patient accepted by th health services. Infor clinical record must b current clinical record of practice, and be av allowed practitioner(s home health plan of o staff. This information electronically. This Condition is not Based on record revie health agency failed t one clinical record, in date, for 1 of 1 active	ain a clinical record surrent information for eight he HHA and receiving he mation contained in the eaccurate, adhere to documentation standar vailable to the physician of issuing orders for the eare, and appropriate Hamay be maintained met as evidenced by: we and interview, the he contained on ensure all patients had cluding one start of care patients with multiple tarts of care (#4), in a total contained to the contained of the care (#4), in a total care in the care of the care (#4), in a total care in the care of the care (#4), in a total care in the care of th	rds u(s) or HA ome				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SURV	D
		15K162		B. WING		02/23/	
	ROVIDER OR SUPPLIER			ESS, CITY, STA	•		
RIGHT AT	HOME, INC			OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G1008	Continued From pag	e 140		G1008			
	Findings include:						
	policy number 11010 Coordinator / Departr maintaining and retai in a manner consiste agency's] policies and laws, regulations and The clinical records of on 2/16/21 and 2/18/2 separate clinical record were separated by th (Veteran's Affairs (VA clinical record indicat was 5/22/19 and inclurecertification period of care indicated the VA, and the services and respite home hea clinical record indicat was 6/19/19 and inclurecertification period of care indicated the Medicaid, and the se health aide. Each cli separate initial and re assessments, verificat physician orders. An interview was con PM with the Administ Administrator, and Cl interview, the Administ had two separate clin two separate payer s	Records," dated 7/24/1, stated " Policy: Coment is responsible for ning patients' clinical rent with the [home health of procedures, and applestandards" If Patient #4 were reviewed. The agency held two for Patient #4, whice patient's payer source, and Medicaid). The fed the patient's start of uded a plan of care for 1/11/21 - 3/11/21. The patient's payer source wordered were skilled nualth aide. The second ed the patient's start of uded a plan of care for 12/10/20 - 2/7/21. The patient's payer source wordered was home inical record included exertification comprehentation of patient's rights, aducted on 2/22/21 at 15 and to the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights, aducted on 2/22/21 at 15 and the patient's rights.	cords n icable wed vo h e irst care the plan was urse care the plan was e nsive and				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE S COMPL	ETED
		15K162		B. WING	 	02	C / 23/2021
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ΓE, ZIP CODE		
RIGHT AT HOME, INC				OADWAY S SON, IN 460	TREET SUITE B 012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REG OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G1008	under the VA payer's respite home health a day of the patient recovers 5/22/19. The Adaptient had been recoveries from anothe the patient's family must he HHA services to I patient began receiving services from the age Administrator also increcord for Patient #4 began receiving hom the patient's payer so A follow up interview 10:50 AM with the Clinterview, the Clinical	ource for skilled nursing aide services and the file services and the file served care from the agridministrator indicated the eiving home health aide or home health agency to sember decided to trans Right at Home, and the ng home health aide ency on 6/19/19. The dicated a second clinical was started when the purce was different. was conducted on 2/23 inical Manager. During I Manger indicated Patinatient with more than o	rst ency e e e c until sfer al patient use 8/21 at the ent #4	G1008			