STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	R-C 06/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS This was a post condition revisit (PCR) for the Federal and State home health recertification survey originally completed on February 23, 2021. Survey Dates: June 16, 17, 18, 21; 2021 Facility Number: 014255 Provider Number: 15K162 Unduplicated Admissions for Last 12 Months: 1 Active Census: 25 Skilled Patients Only: 6 Home Health Aide Only Patients: 11 Personal Service Only Patients: 0 During this survey, 3 condition level deficiences were found corrected, 16 standard level deficiencies were found corrected, and 8 standard level deficiencies were re-cited. These deficiencies reflects State Findings cited in accordance with 410 IAC 17.	{G 000}		
{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 record review and interview, the home health agency failed to ensure the comprehensive assessment contained a complete and thorough psychosocial status for 1 of 3 active records reviewed (#2), in a total sample of 6 records. Findings include: An agency policy number 10008, titled "Assessment - Nursing" and revised 1/15/18,	{G 528}		

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

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{G 528}	Continued From page 1 stated "Purpose ... To ensure that the patient's current needs and/or problems are continuously evaluated and the care, treatment and/or services provided are adjusted accordingly. Policy: ... The patient shall be assessed and reassessed during each skilled visit ... Procedure: ... the Comprehensive Assessment will be completed by the RN [Registered Nurse] ... Includes the following information ... The patient's psychosocial status, including emotional/psychological barriers to treatment, cognitive limitations, memory ...." An undated agency job description titled "Registered Nurse" stated " ... Essential Functions: ... Performs comprehensive subjective and objective ... ongoing assessment of client status that includes physical, psychosocial, and environmental parameters ...." An agency document titled "Right at Home Case Conference Agenda," dated 3/5/21, stated " ... The Comprehensive Assessment will include patient health, psychosocial ... Thorough assessment of patient mental health status ...." The clinical record of Patient #2 was reviewed on 6/16/21 - 6/17/21, and indicated a start of care date of 10/25/18, with patient diagnoses including but not limited to: Diabetes Type II, essential hypertension (high blood pressure with no known cause), atrial fibrillation (irregular heart rhythm), congestive heart failure, fall risk, and BPH (benign prostate hyperplasia, an enlargement of the prostate gland). The record contained a comprehensive "addendum" assessment, completed on 5/11/21 by Registered Nurse (RN) #2, for the recertification plan of care 4/12/21 - 6/10/21. The assessment included a section titled "Assessment and Observation Signs /	{G 528}		

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{G 528}	Continued From page 2 Symptoms," which stated " ... Mental Status: No change. Oriented ... Forgetful at times day/night ...." The comprehensive assessment also included a section titled "Strengths, Goals, and Care Preferences," which stated " ... Limitations that may interfere with the delivery of home health services: ... anxiety episodes ...." The comprehensive assessment failed to evidence a thorough assessment of the patient's anxiety episodes (frequency and duration of episodes, symptoms exhibited, triggers, relieving factors). An interview was conducted on 6/21/21 at 12:23 PM with the Administrator, Clinical Manager, and RN #1. During the interview, the Clinical Manager indicated Patient #2 did not have a diagnosis of anxiety or anxiety episodes, however the patient had recently been experiencing anxiety episodes after the passing of a loved one. The Clinical Manager also indicated the comprehensive assessment should include a complete and thorough psychosocial assessment. 17-14-1(a)(1)(B)	{G 528}		
{G 574}	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted;	{G 574}		

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{G 574}	Continued From page 3 (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the plan of care (POC) included the patient's psychosocial status, duration of services, patient-specific and measurable goals, and vital sign parameters which adhered to the physician orders, for 2 of 3 active records reviewed (#2, 3), in a total sample of 6 records. 1. An agency policy titled "Care Plan Implementation," numbered #10020 and revised 2/26/21, stated " ... Policy: ... Right at Home will include the following elements in the patient's individualized comprehensive assessment and plan of care ... The patient's mental, psychosocial, and cognitive status ... The frequency and duration of visits to be made ... measurable outcomes and goals identified by the [agency] and the patient ... Any additional items the [agency] or physician or allowed practitioner may choose to include ...." 2. An agency document titled "Right at Home	{G 574}		

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{G 574}	Continued From page 4 Case Conference Agenda," dated 3/5/21, stated " ... Care Planning. The plan of care will include the following ... (2) The patient's mental, psychosocial, and cognitive status ... (4) The frequency and duration of visits to be made ... (14) ... Measurable outcomes and goals identified by the [home health agency] and the patient ...." 3. The clinical record of Patient #2 was reviewed on 6/16/21 - 6/17/21, and indicated a start of care date of 10/25/18, with patient diagnoses including but not limited to: Diabetes Type II, essential hypertension (high blood pressure with no known cause), atrial fibrillation (irregular heart rhythm), congestive heart failure, fall risk, and BPH (benign prostate hyperplasia, an enlargement of the prostate gland). The record contained a plan of care for the recertification period 4/12/21 - 6/10/21. The POC included a section titled "Recertification 60 Day Comprehensive Assessment Summary" which stated " ... Mental Health / Cognitive Status: Alert and oriented to person, placed and time. PHQ-2 Scale depression Screening Score [method of assessing for depression presence and/or severity, rating is from 0 (no signs of depression) to 8 (severe depression)]: 0 for Little interest in doing things. 0 for falling down, depression or hopeless. No problems with memory deficit noted during this visit ...." The clinical record also included a comprehensive "addendum" assessment completed on 5/11/21 by Registered Nurse (RN) #2. The assessment included a section titled "Assessment and Observation Signs / Symptoms," which stated " ... Mental Status: No change. Oriented ... Forgetful at times day/night ...." The comprehensive assessment also included a section titled "Strengths, Goals, and Care Preferences," which stated " ... Limitations	{G 574}		

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{G 574}	Continued From page 5 that may interfere with the delivery of home health services: ... anxiety episodes ...." The POC failed to evidence a complete and thorough psychosocial status as it failed to evidence the patient's "anxiety episodes." The POC included a section titled "Recertification 60 Day Comprehensive Assessment Summary," which stated " ... Patient specific short term goals and long term goals developed with patient. Short term goal: Patient would like for respiratory status to improve to increase his endurance ...." The POC also included a section titled "Goals/Rehabilitation Potential/Discharge Plans," which stated " ... Goals: Demonstrate compliance with medication by 30 days. Demonstrate competence in following medical regime by 60 days ... Enhance personal care/hygiene with assist of [home health aide] by 60 days ...." The POC failed to evidence all goals were patient-specific and measurable. 4. The clinical record of Patient #3 was reviewed on 6/18/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: cerebral palsy, neurologic neglect, Development Disability Syndrome, GERD (Gastro-Esophageal Reflux Disease), microcephaly, and convulsions. The record contained a plan of care for the for the recertification period 6/4/21 - 8/2/21. The POC included the service orders for Skilled Nursing visits 4 - 8 hours per day, 4 - 5 days per week, and Respite Skilled Nursing visits "16 hours for Saturday/Sunday." The POC failed to evidence a clear description of the duration of respite skilled nursing services. The POC included a section titled "Recertification 60 Day Comprehensive Assessment," which	{G 574}		

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{G 574}	Continued From page 6 stated " ... Patient specific short-term and long-term goals developed with patient's mother. Short-term goal: Free from respiratory distress by 30 days ... Progress towards existing goals: Short-term goal is ongoing. No recent occurrences of O2 SAT [oxygen saturation, a measurement of the percentage of red blood cells with oxygen attached] < 89%. No recent upper respiratory infection ...." The POC failed to evidence all goals were patient-specific and measurable. The clinical record included a physician order, recorded by Former Employee #1 on 4/14/21 and signed by the patient's primary care provider on 4/20/21, which stated " ... Addendum to Plan of Care: Call for Pulse > 120 ...." The clinical record included a second physician order recorded by RN #2 on 6/2/21 and not yet signed by the patient's primary care provider, which stated " ... Additional orders: Physician's Call Parameters ... Pulse > 100 ... Systolic B/P [Systolic Blood Pressure, first value obtained during blood pressure reading, measures the pressure of the heart during contraction] > 180 or < 90 ...." The clinical record included a comprehensive assessment completed on 6/2/21 by RN #2. The comprehensive assessment contained a "Medication Profile," reviewed and signed by RN #2 on 4/2/21, which included the order " ... 4/2/21 ... Physician's Call Parameters: Notify MD for any of the following: ... Pulse > 110 ... Systolic B/P > 180 or < 80 ...." The POC included a section titled "Medications," which stated " ... Physician's Call Parameters: Notify MD for any of the following: ... Pulse > 110 ... Systolic B/P > 180 or < 60 ...." The POC also	{G 574}		

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{G 574}	Continued From page 7 included a section titled "Recertification 60 Day Comprehensive Assessment Summary," which stated " ... MD Call Parameters: Notify MD for Any of the Following: ... Pulse ... > 100 ... Systolic B/P < 90 or > 180 ...." The POC failed to evidence clear and up-to-date call parameters for the patient's heart rate and systolic blood pressure. 5. An interview was conducted on 6/21/21 at 12:23 PM with the Administrator, Clinical Manager, and RN #1. During the interview, the Clinical Manager indicated the plan of care should include the patient's psychosocial status, service orders should include duration, orders on the plan of care should match the most recent physician orders, and all goals should be patient-specific and measurable. 17-13-1(a)(1)(C)(i, iii, xiii)	{G 574}		
{G 590}	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This Element is not met as evidenced by: Based on record review and interview, the Registered Nurse (RN) failed to ensure the patient's medical provider was notified of a blood pressure reading, heart rate reading, or wound measurement within provider call parameters for 1 of 1 active records with vital sign and wound measurements within provider call parameters (#3), in a total sample of 6 records. Findings include:	{G 590}		

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{G 590}	Continued From page 8 An undated agency policy titled "Wound Documentation and Measurements," policy number G-261, stated " ... Procedure: 1. Wounds are to be measured either weekly or bi-weekly per [Skilled Nurse] visit order ... 4. All significant changes will be reported to the MD the same day as noted on visit ...." An agency document titled "Right at Home Case Conference Agenda," dated 3/5/21, stated " ... Coordination of Patient Services. MD Call Parameters Process: SN [Skilled Nurse] will notify MD of any changes in patient condition or vital signs outside of MD established parameters ... SN will measure wounds weekly or bi-weekly per visit order. All significant changes will be reported to MD by SN the same day as noted on the visit ...." The clinical record of Patient #3 was reviewed on 6/18/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: cerebral palsy, neurologic neglect, Development Disability Syndrome, GERD (Gastro-Esophageal Reflux Disease), microcephaly, and convulsions. The record contained a plan of care (POC) for the recertification period 4/5/21 - 6/3/21. The POC included service orders for skilled nursing visits 8 hours per day, 5 days per week, and respite skilled nursing visits up to 60 hours per month. The POC also included the physician call parameters of " ... Notify MD for any of the following: ... Pulse > 110 ...." The clinical record included a "Nursing Visit Note" documented on 4/6/21 by LPN #2. The visit documentation indicated Patient #3's heart rate was "115" beats per minutes (bpm). The record failed to evidence nurse notified the patient's	{G 590}		

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{G 590}	Continued From page 9 provider of the elevated heart rate. The clinical record included a "Nursing Visit Note" documented on 4/8/21 by LPN #2. The visit documentation indicated Patient #3's heart rate was "114" bpm. The record failed to evidence the nurse notified the patient's provider of the elevated heart rate. The clinical record included a POC for the recertification period 6/4/21 - 8/2/21. The POC included service orders for skilled nursing visits 4-8 hours per day, 4-5 days per week, and respite skilled nursing visits "16 hours for Saturday/Sunday." The POC included the nursing interventions " ... Measure Wound Weekly per [Skilled Nurse], Notify MD if wound increased > 1.0 cm in [length, width, depth] or tunneling ...." The POC also included vital sign call parameters of " ... Notify MD for any of the following: ... Systolic B/P [P [Blood Pressure, first value obtained during blood pressure reading, measures the pressure of the heart during contraction]] > 180 or < 60. Diastolic B/P [second value obtained during blood pressure reading, measures the pressure of the heart during relaxation] > 90 or <60 ...." The record included a "Nursing Visit Note" documented on 6/3/21 by LPN #2, which indicated the patient's wound was measured with a length of "0.6 cm." The record also included a "Nursing Visit Note" documented on 6/11/21 by LPN #2 which indicated the patient's wound was measured with a length of "1.7 cm." The clinical record failed to evidence the patients' provider was notified of the increase in the wound's length of 1.1 cm. The clinical record included a "Nursing Visit Note" documented on 6/7/21 by LPN #1. The visit documentation indicated Patient #3's blood	{G 590}		

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{G 590}	Continued From page 10 pressure was "77/55." The record failed to evidence the nurse notified the patient's physician of the low blood pressure. An interview was conducted on 6/21/21 at 12:23 PM with the Administrator, Clinical Manager, and RN #1. During the interview, the Clinical Manager indicated the nurse should notify the patient's provider of any vital signs or wound measurements outside of provider call parameters. 17-13-1(a)(2)	{G 590}		
{G 642}	Program scope CFR(s): 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. This Standard is not met as evidenced by: Based on record review and interview, the home health agency failed to evidence its quality assurance and performance improvement (QAPI) program documented and clearly evidenced which quality indicators it would track with an emphasis of infection control due to the public health emergency related to COVID-19. Findings include: An agency policy titled "Performance	{G 642}		

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{G 642}	Continued From page 11 Management," policy number #9002 and dated 7/24/17, stated "Policy: ... Performance measures are selected by QI [the agency's QAPI committee] based on their impact on patient care, services offered, clinical practice, fiscal accountability and cost effectiveness ... The [Home Health Agency] shall also collect data on evaluation and improvement of conditions in the environment, infection prevention and control, and the medication management system. Procedure: ... Data is collected to measure performance of each of the following: Significant medication errors. Significant adverse drug reactions. Patient perception of the safety and quality of care, treatment, or services delivered by the [Home Health Agency]. Patient satisfaction with and complaints about products and services. The timeliness of response to patient questions, problems, and concerns. The impact of the organization's business practices on the adequacy of patient access to equipment, items, services, and information. Adverse events involving patients due to inadequate or malfunctioning equipment, supplies, or services, i.e., injuries, accidents, signs and symptoms of infection, hospitalizations. Staff opinions and needs. Staff perceptions of risk to individuals. Staff suggestions for improving patient safety. Staff willingness to report adverse events (conditions in the organization or patient environment that are related to care, treatment or services) ...." An agency document dated 2/25/21, titled "Helping Angels, Inc. dba [doing business as] Right at Home, Inc. Emergency Board of Directors Meeting following the Indiana State Department of Health 2/23/2021 Survey Condition Level Findings," stated " ... Since the Agency Governing Body takes regulatory compliance	{G 642}		

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{G 642}	Continued From page 12 seriously, they met in an emergency meeting to review the condition level findings ... On discussion of 'Performance Management,' the Governing Body agreed that the agency update the board agenda to include quality indicators methods, frequency of tracking, and frequency and method of analyzing. Going forward, the Board meetings will include the Governing Body agreed upon plans for specific quarterly indicators, frequency, methods of tracking, and frequency and methods of analyzing. The Governing Body has instructed the administrator and alternate administrator that the following areas must be tracked on an ongoing basis: a. Complaint Investigations. b. Patient falls. c. Infections. d. Incidents. e. Daily Update Reports to the Clinical Manager from the RN [Registered Nurse] Case Managers. f. Medical Plans of Care. g. Assessment Documentation. h. Clinical Record Reviews ... This is to ensure all pertinent indicators are tracked, measured, and analyzed and the Governing Body is involved and has input into the process ... The QAPI committee will report the following types of performance measures to the Governing Body on a quarterly basis: a. Agency complaint summary logs. b. Agency Incident tracking logs. c. Agency POC [plan of care] audit results d. Agency hospitalization/emergency department utilization tracking log. e. Agency Physician Verbal Order compliance f. Patient Fall Tracking Log. g. Patient Infection Tracking Log. h. Medical Record Audit Results ...." The Governing Body minutes failed to evidence the specific indicators to be tracked with "Daily Update Reports to the Clinical Manager from the RN Case Manager ... Medical Plans of Care ... Assessment Documentation ... Clinical Record Reviews ...." An agency document titled "Right at Home.	{G 642}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 642}	Continued From page 13 Quality Improvement Quarterly Meeting for First Quarter 2021," dated 4/29/21, indicated the quality indicators tracked and analyzed by the QAPI committee were " ... Human Resources: Number of Employees ... Number of New Hire Employees and Position ... Number of HHA [Home Health Aide] Class Participants ... Number of Participants from HHA Class that are still working ... Turnover Report ... % [Percentage] of Employee Competency Evaluations Completed Timely ... % of Annual Employee Competency Evaluations Completed Timely ... % of HHA 12 Hour Inservice Completed ... % of HHA 12 Hour mandated Inservice completed ... % of Employee Evaluations Completed ... % of TB [tuberculosis] Skin Tests Completed Timely ... % of Personnel File Audits that show compliance with content ... Workplace Safety / OHSA: Workmen Compensation Claims ... Needle or Sharps Injury ... Medical Device Issues ... Number of Employee Infections ... Reportable Events ... Sentinel Events ... Disaster Drills ... Scheduling Coordinator: Number of Scheduled Visit Hours for SN [Skilled Nurse] and HHA ... Number of Completed Visit Hours for SN and HHA ... Number of Missed Visits ... Satisfaction Survey Reports. Net Promoter Scores ... Patient Satisfaction ... Employee Satisfaction ... Employee Suggestions ... Clinical/Nursing: Number of Patient Admissions and Diagnosis ... Number of Patients Admitted within 48 hours of Referral or MD Order for Start of Care ... Number of Patient Census ... Number of Patients Admitted to Hospital and Reason/Diagnosis ... Number of Patient Discharges with Reasons ... % of Patients Assessed for Pain ... Number of Nutritional Risk Assessments Completed ... Number of Wound Care Patients ... Types of Wound and Note of Healing Process ... Number	{G 642}		

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{G 642}	Continued From page 14 of Patients Recertified ... Number of Medication Profiles Completed ... Number and Type of Patient Infections Acquired Following Admission ... Number of Patient Incidents / Falls and Type ... Number of Medication Errors ... Number of Medication Adverse Reactions ... % of MD Plans of Care and or Verbal Orders Signed and Returned to HHA Office within 30 days of Receipt of Order ... VA [Veterans Administration] Patient Orders are Tracked Weekly with report to VA ... % of Supervisory Visits Completed Within Appropriate Time Frame ... Number of Patient Complaints ... Number of Complaints Resolved ... Clinical Audits: Nurses Notes (Findings) ... Home Health Aide Notes (Findings) ...." An undated agency document titled "Right at Home, Inc. Quarter 1 2021: QAPI Analysis and Trends" stated "Quality Indicators ... Clinical Record Audit: Admissions ... Discharges ... Recert ... Complaint ... Falls ... Hospitalization ... Incident ... MD signed orders ... Medical Records Audit ... POC Auditing ... Verbal Orders ... Wound Measurement Tracking changes in demension [sic] ... (SA [Surface area of wound] initial [minus] SA current [divided by] SA initial [multiplied by] 100 [equals] (% SA Reduction) ...." An interview was conducted on 6/21/21 at 3:25 PM with the Clinical Manager and RN #1. During the interview, the Clinical Manager indicated the QAPI team tracked "any changes with the patient ... infections, falls, changes in medication ..." within the "Daily Update Reports to Clinical Manager from RN Case Managers quality indicator, the team tracked "any changes to the plan of care" under the quality indicator "Medical Plans of Care," and the team tracked the "Comprehensive Assessment and OASIS [completion]" for the quality indicator	{G 642}		

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{G 642}	Continued From page 15 "Assessment Documentation." The Clinical Manager also indicated all quality indicators determined by the governing body should be detailed and clearly evidence which indicator(s) it was tracking. 17-12-2(a)	{G 642}		
{G 682}	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This Standard is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure all employees followed agency infection control policies and procedures and standard precautions for 2 of 2 home visit observations (#1, 2). Findings include: 1. An agency policy titled "Hand Washing," policy number C-130 and dated 7/24/17, stated " ... Policy: All staff will use the hand-hygiene techniques, as set forth in the following procedure ... Procedure ... Using an alcohol-based hand rub: apply the manufacturer's recommended amount of alcohol-based hand rub to palm of one (1) hand. Rub hands together, covering all areas of the hands and fingers, until hands are dry, per manufacturer's recommendations ...." 2. An agency policy titled "Standard Precautions," policy number 5010 and dated 7/24/17, stated " ... Policy: Standard Precautions are designed for care of all patients in facilities,	{G 682}		

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{G 682}	Continued From page 16 regardless of diagnosis or presumed infection status, to reduce the risk of transmission from both recognized and unrecognized sources of infection ... Standard Precautions include: ... Personal Protective Equipment: Personal Protective Equipment (PPE) is used to protect staff from contact with infectious agents, and to prevent staff from carrying these infectious agents from patient to patient. Gloves: To be worm when touching blood, body fluids, secretions, excretions, mucous membranes, non-intact skin and other contaminated items, i.e., equipment ... Gloves should be changed between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms ...." 3. Centers for Disease Control and Prevention (CDC). Revised 8/19/2020. "Using PPE." Retrieved 6/22/21 from www.cdc.gov. " ... How to Put On (Don) PPE Gear ... 6. Put on gloves. Gloves should cover the ... wrist ...." 4. A home visit observation was conducted on 6/17/21 at 10:50 AM with Patient #1 (start of care 10/18/19) and Home Health Aide (HHA) #1. During the home visit, HHA #1 was observed assisting Patient #1 with a shower. After the patient had finished her shower, the aide assisted the patient to walk to her room to finish getting ready and get dressed. HHA #1 laid a clean towel on the patient's bedside commode for her to sit on then applied alcohol-based hand sanitizer (ABHS) to her hands, rubbed her hands together, and waved her hands in air to finish drying. The aide started to put on her gloves, but the first glove broke while donning, so the aide removed the broken glove, waved her hands in the air to allow them to dry more, then donned	{G 682}		

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{G 682}	Continued From page 17 new gloves. HHA #1 continued the process of applying ABHS, rubbing her hands together, and then waving them in the air to finish drying a total of 3 more times. The HHA failed to follow agency policy by rubbing her hands until the ABHS dried rather than rubbing then waving her hands in the air to dry. 5. A home visit observation was conducted on 6/17/21 at 1:00 PM with Patient #2 (start of care 10/25/18) and Registered Nurse (RN) #2. During the visit, RN #2 was observed completing a medication set up for the patient. After the nurse had completed the medication set up, she removed her gloves, performed hand hygiene with ABHS, and applied new gloves, however the glove on her left hand was only applied halfway down the back of her hand, not fully to her wrist. RN #2 obtained Patient #2's vital signs and began to perform a physical assessment of the patient. During the assessment, RN #2 removed her gloves, performed hand hygiene using ABHS, and donned new gloves, however each glove was rolled up on her posterior hand. The nurse continued her physical assessment of the patient. The nurse failed to follow agency policy and standard precautions by wearing her gloves incorrectly. 6. An interview was conducted on 6/17/21 at 3:35 PM with the Administrator, Clinical Manager, and RN #1. During the interview, the Clinical Manager indicated when using ABHS hands should be rubbing completely to dry. The Clinical Manager also indicated gloves should be worn down to the wrist. 17-12-1(m)	{G 682}		
{G 706}	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1)	{G 706}		

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{G 706}	Continued From page 18 Ongoing interdisciplinary assessment of the patient; This Element is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct a complete and thorough assessment of the patient per professional and agency standards for 1 of 1 skilled nurse visit observations (#2) and 1 of 3 active records reviewed (#3), in a total sample of 6 records reviewed. 1. An agency policy titled "Assessment - Nursing," policy number #10008 and revised 1/15/18, stated " ... Policy: ... The patient shall be assessed and reassessed during each skilled visit ... The Comprehensive Assessment ... includes the following information ... Pertinent physical findings ...." 2. An undated agency job description titled "Licensed Practical Nurse [LPN]," stated "Job Summary: Performs nursing care to patient in accordance with an established plan of care ...." 3. An undated agency job description titled "Registered Nurse [RN]," stated " ... Essential Functions: ... Performs comprehensive subjective and objective ... ongoing assessment of client status that includes physical ... parameters ...." 4. The clinical record of Patient #2 was reviewed on 6/16/21 - 6/17/21, and indicated a start of care date of 10/25/18, with patient diagnoses including but not limited to: Diabetes Type II, atrial fibrillation (irregular heart rhythm), and congestive heart failure (CHF). The clinical record included a plan of care for the certification period 4/12/21 -	{G 706}		

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{G 706}	Continued From page 19 6/10/21, which included the order " ... Oxygen 2 - 4 L/min [liters per minute, how oxygen is dosed] via NC [nasal cannula] continuous ...." A home visit observation was conducted on 6/17/21 at 1:00 PM with Patient #2 and RN #2. During the visit, the patient reported to the nurse he had "gained weight," but did not specify the amount of weight gained or the period of time the weight was gained. Patient #2 also reported shortness of breath with exertion, and that he had recently increased his oxygen to 5 L/min during an episode of shortness of breath. When reviewing the patient's medication list, RN #2 verified with the patient that he had recently changed his diuretic from furosemide to spironolactone (both medications given to reduce excess fluid in the body), which the patient indicated was correct. Later during the visit, RN #2 asked the patient what his blood sugar reading was that day. Patient #2 reported he had not checked his blood sugar, as his glucometer (machine used to check blood sugar) was not working. The nurse failed to assess the patient's weight, failed to assess the patient for further symptoms of CHF exacerbation (cough with frothy sputum, fatigue, palpitations, etc) and failed to assess the patient for signs and symptoms of hypo or hyperglycemia (low and high blood sugar; dizziness, sweating, confusion, etc for hypoglycemia, nausea and vomiting, dry mouth, abdominal pain, etc for hyperglycemia). An interview was conducted on 6/18/21 at 2:00 PM with Patient #2. During the interview, Patient #2 indicated he had gained 20 pounds over the last month. Patient #2 also indicated he had a scale in his home and weighed himself approximately once a week.	{G 706}		

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{G 706}	Continued From page 20	{G 706}		

5. The clinical record of Patient #3 was reviewed on 6/18/21, and indicated a start of care date of 2/15/19, with patient diagnoses including but not limited to: cerebral palsy, neurologic neglect, Development Disability Syndrome, GERD (Gastro-Esophageal Reflux Disease), microcephaly, and convulsions. The clinical record included a plan of care for the certification period 4/5/21 - 6/3/21, which included the medication " ... Acetaminophen [Tylenol, over-the-counter medication given for pain and/or fever] 500 mg / 15 ml [milliliter], Take 15 - 30 ml ... every 4 - 6 hours as needed for pain and/or temp > 101 [degrees Fahrenheit] ...."

The clinical record included a "Medication Administration Record (MAR)" for the months of April 2021 and May 2021, which indicated the medications administered by the agency staff. The MAR indicated the Patient #3 received a dose of Tylenol on 5/2/21 by LPN #1 and on 4/5/21, 4/12/21, 4/15/21, 4/16/21, 4/22/21, 4/24/21, 4/27/21, 5/11/21, 5/12/21, 5/13/21, and 5/25/21 by LPN #2. The "Nursing Note Visit" documentation failed to evidence the patient exhibited a fever, pain, or other reason for why the Tylenol was administered by the nurse.

6. An interview was conducted on 6/17/21 at 3:35 PM with the Administrator, Clinical Manager, and RN #1. During the interview, the Clinical Manager indicated the nurse should assess the patient's weight, either by patient report or observation (if the patient had orders for daily weight checks), during each skilled visit. The Clinical Manager also indicated the nurse should assess a diabetic patient for signs and symptoms of hypo or hyperglycemia.

7. An interview was conducted on 6/21/21 at

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{G 706}	Continued From page 21 12:23 PM with the Administrator, Clinical Manager, and RN #1. During the interview, the Clinical Manager indicated the nurse's clinical documentation should reflect why a PRN (as needed) medication was administered, such as Tylenol for pain or fever. 17-12-2(g)	{G 706}		
{G 768}	Competency evaluation CFR(s): 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. This Standard is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure 4 of 4 home health	{G 768}		

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{G 768}	Continued From page 22 aides (HHA) (#2, 3, 4, 5, 6) were competency checked on patient-specific Hoyer lifts via manufacturer's instructions prior to use in 1 of 1 active patients with Hoyer lift and HHA services (#5). Findings include: 1. An agency policy titled "Certified Home Health Aide Competency Evaluation Program" dated 7/24/17 and policy number # 4050, stated " ... Policy: In order to comply with state and federal regulations, which mandate that individuals providing home health aide services must have completed a training and competency and evaluation program before furnishing home health aide services, the following steps will be taken: ... Procedure: ... The Home Health Aide's competency will be demonstrated in each task to be performed before the Home Health Aide provides the specific care independently ... A Home Health Aide will not perform tasks in which he/she has not demonstrated competency ...." 2. An undated agency job description titled "Home Health Aide" stated " ... Essential Functions: ... Performs other assigned activities that are taught by a nurse for a specific patient. These include but not 5. [sic] limited to: ... c. Assisting with the use of devices for aid to daily living ... lift device ...." 3. An agency document titled "Right at Home Case Conference Agenda. Survey Plan of Correction In-Service Meeting," dated 2/25/21, stated " ... Coordination of Patient Services: ... All agency home health aides who provide care for patients with transfer equipment will be in-serviced according to the manufacturer's instructions for the patient's specific equipment	{G 768}		

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{G 768}	Continued From page 23 ...." 4. An undated agency document titled "Master Client Report" was received from the Clinical Manager on 6/16/21, who indicated the report was the agency's active patient list. The list included the patients' name, start of care, services received, and indicated if the patient had specialty care and/or equipment, including a Hoyer lift. The active patient list was reviewed on 6/16/21 and indicated Patients #3 (start of care 2/15/19) and Patient #5 (start of care 4/10/18) had Hoyer lifts in the home. The document indicated Patient #3 received skilled nursing services, and the Hoyer lift was "used by LPNs [licensed practical nurse] only." The document also indicated Patient #5 received HHA services 4 - 7 hours per day, 5 -7 days per week. The patient list failed to evidence any further patients had a Hoyer lift in the home. 5. An untitled and undated document was received from the Clinical Manager on 6/16/21, who indicated the document was Patient #5's visit schedule for the week of 6/13/21 - 6/19/21. The visit schedule indicated HHAs #2, 3, 4, 5, and 6 were scheduled for HHA visit(s) with Patient #5 during the designated week. 6. An agency document titled "In-Service: DRIVE Patient Lift Manufacturer's Instruction Manual Quiz," (type of Hoyer lift used by Patient #5), dated 2/26/21, indicated HHAs #2, 3, 4, and 5, as well as other agency HHAs, completed an in-service on the Drive Hoyer. The in-service documentation included a written quiz and a copy of the Drive Hoyer's manufacturer's instructions. The in-service documentation failed to evidence the HHAs were competency checked on use of Patient #5's Hoyer in the patient's home.	{G 768}		

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{G 768}	Continued From page 24 7. The personnel file of HHA #2 was reviewed on 6/21/21. The personnel file failed to evidence the employee was competency checked by a nurse on Patient #5's Hoyer lift prior to providing care to the patient. 8. The personnel file of HHA #3 was reviewed on 6/21/21. The personnel file failed to evidence the employee was competency checked by a nurse on Patient #5's Hoyer lift prior to providing care to the patient. 9. The personnel file of HHA #4 was reviewed on 6/21/21. The personnel file failed to evidence the employee was competency checked by a nurse on Patient #5's Hoyer lift prior to providing care to the patient. An interview was conducted on 6/21/21 at 3:58 PM with HHA #4. During the interview, the HHA indicated she currently provided aide services to one patient (#5) with a Hoyer lift. The aide reported during HHA orientation she was competency checked on use of a Hoyer lift by Former Alternate Clinical Manager #1 via direct observation of transferring a pseudo-patient with a Hoyer lift. HHA #4 also indicated she was not competency checked by a nurse on the use of Patient #5's Hoyer in Patient #5's home prior to transferring the patient with the Hoyer. 10. The personnel file of HHA #5 was reviewed on 6/21/21. The personnel file failed to evidence the employee was competency checked by a nurse on Patient #5's Hoyer lift prior to providing care to the patient. 11. The personnel file of HHA #6 was reviewed on 6/21/21. The personnel file failed to evidence	{G 768}		

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{G 768}	Continued From page 25 the employee was competency checked by a nurse on Patient #5's Hoyer lift prior to providing care to the patient. 12. An interview was conducted on 6/21/21 at 3:25 PM with the Clinical Manager and RN #1. During the interview, the Clinical Manager indicated all new hire HHAs were competency checked on Hoyer transfers via direct observation during aide orientation by Agency Consultant RN #1. The Clinical Manager also indicated the agency did not conduct HHA competency checks of the aide conducting transfers of patients in the home using the patient-specific Hoyer prior to the aide's use of the Hoyer. 17-14-1(l)(A)	{G 768}		
{G 798}	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This Standard is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed to develop a home health aide (HHA) care plan which was specific to the patient's needs for 2 of 2 active records reviewed of patients with HHA services (#1, 2), in a total sample of 5 records. Findings include:	{G 798}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K162	A. BUILDING _____ B. WING _____	R-C 06/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 798}	Continued From page 26	{G 798}		

1. An undated agency job description titled "Registered Nurse" stated " ... Essential Functions: 4. Coordinates delivery of care along health care continuum ... 6. Demonstrates teamwork and effective communication to accomplish patient and agency goals / outcomes ... 7. Uses professional nursing judgement to delegate selected nursing tasks when determined safe and appropriate ... Retains responsibility and authority for determining appropriateness of plan and implements corrective actions when necessary ...."

2. An undated agency job description titled "Home Health Aide," stated " ... Essential Functions: ... 2. Performs work under the supervision of the Nursing Supervisor. 3. Performs personal care activities contained in a written assignment by the Nursing Supervisor ...."

3. The clinical record of Patient #1 was reviewed on 6/16/21 - 6/17/21, and indicated a start of care date of 10/18/19, with patient diagnoses including but not limited to: cervicalgia (neck pain), fibromyalgia, chronic pain, congestive heart failure, and seborrhea capitis (skin condition of the scalp which causes patches of reddened, dry, and flaky skin). The record contained a plan of care for the recertification period of 4/10/21 - 6/8/21, which included service orders for HHA visits 2-4 hours per day, 5-7 days per week. The plan of care indicated HHA tasks were to include "Every visit give shower ... hair care ... medication reminder ... assist with ambulation wheelchair/walker, mobility assist with chair/bed/dangle/commode/shower/tub .... Shampoo hair 1-2 x [times] weekly using medicated shampoo ...." The plan of care also indicated the patient's "Activities Permitted" were

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{G 798}	Continued From page 27 " ... Up as Tolerated ... Wheelchair. Walker ...," and the patient's medications included " ... Ketoconazole 2% shampoo [used to treat fungal infections of the scalp], apply topically two times weekly ...." A home visit observation was conducted on 6/17/21 at 10:50 AM with Patient #1 (start of care 10/18/19) and Home Health Aide (HHA) #1. During the visit, HHA #1 was observed assisting the patient with a shower, which included shampooing the patient's hair with non-medicated shampoo. HHA #1 also assisted the patient with walking from the bathroom to the bedroom, and later the bedroom to her recliner chair, with the assist of a rollator walker. Patient #1 was observed to have a bedside commode in her bedroom. An interview was conducted on 6/17/21 at 11:45 AM with Patient #1 and HHA #1. During the interview, the patient indicated she had not used her medicated shampoo "in a while," and the aide indicated the medicated shampoo was used "when [the patient] has build-up [due to seborrhea capitis]." The clinical record included an "Aide Care Plan," reviewed and signed by the Clinical Manager on 4/9/21. The aide care plan stated " ... Assignment ... Shampoo. 1-2 x weekly. Use medicated shampoo ... Medication Reminder. Daily ... Mobility Assist: Chair / Bed. Dangle / Commode. Shower / Tub. Daily ...." The aide care plan failed to include up-to-date instructions on the frequency the patient's hair was to be shampooed and which shampoo to use; failed to evidence detailed instructions on when medication reminder(s) were to be performed (does the patient need a reminder with a certain meal(s) or time(s) of day), and failed to evidence patient-specific mobility assistance instructions.	{G 798}		

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{G 798}	Continued From page 28 4. The clinical record of Patient #2 was reviewed on 6/16/21 - 6/17/21, and indicated a start of care date of 10/25/18, with patient diagnoses including but not limited to: Diabetes Type II, essential hypertension (high blood pressure with no known cause), atrial fibrillation (irregular heart rhythm), congestive heart failure, fall risk, and BPH (benign prostate hyperplasia, an enlargement of the prostate gland). The record contained a plan of care for the recertification plan of care 4/12/21 - 6/10/21, which included service orders for HHA visits 1-2 hours per day, 2-4 days per week. The plan of care indicated HHA tasks were to include "Every visit ... assist ambulation with cane ... meal prep per patient request ... equipment care/check O2 [oxygen]." The plan of care also included orders for "Oxygen 2-4 L/min [liters per minute, how oxygen is dosed] via NC [nasal cannula] ...," and indicated Patient #2's "Nutritional Requirements" were "Regular Diet with NAS [no added salt] and NCS [no concentrated sweets]." A home visit observation was conducted on 6/17/21 at 1:00 PM with Patient #2 (start of care 10/25/18) and Registered Nurse (RN) #2. During the visit, Patient #2 was observed with a rollator walker (walker with wheels on all four legs and a brake). No cane was observed in the home. Patient #2 reported he was currently using 2 L/min of oxygen, and RN #2 indicated the patient could titrate his oxygen between 2-4 L/min. An interview was conducted with Patient #2 on 6/18/21 at 2:00 PM. During the interview, the patient indicated he had been using the rollator walker for ambulation assistance for approximately 8 months. The patient also reported he no longer used a cane for	{G 798}		

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{G 798}	Continued From page 29 ambulation. The clinical record included an "Aide Care Plan," reviewed and signed by RN #2 on 4/11/21. The aide care plan stated " ... Precautionary and Other Pertinent Information ... Diabetic [not checked] ... Diet [left blank] ... Other (specify): O2 at 6 L/NC [liters per minute through a nasal cannula] ... Assignment: ... Assist with Ambulation ... Cane ...." The aide care plan failed to evidence the patient's dietary requirements, failed to indicate the patient was diabetic, failed to evidence the correct amount of oxygen the patient was to receive, and failed to evidence the correct assistance device the patient used for ambulation. 5. An interview was conducted on 6/21/21 at 12:23 PM with the Administrator, Clinical Manager, and RN #1. During the interview, the Clinical Manager indicated the aide care plan should be detailed and patient-specific. The Clinical Manager stated after the previous survey (exit date of 2/23/21), the agency had begun indicating which precautions the HHA was to follow on the backside of the weekly HHA visit note sheets, and Patient #2 had "Diabetic Precautions" indicated on his HHA visit note sheets. The Clinical Manager also indicated Patient #2's aide care plan did not indicate the patient was diabetic, only the weekly visit note sheets. 17-13-2(a)	{G 798}		