STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K025	A. BUILDING _____ B. WING _____	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL SUPPORT HOME HEALTH AGENCY	956 BEECHWOOD AVENUE MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a federal recertification and state re-licensure survey, and an investigation of two (2) complaints. This was a fully extended survey per an agreed order. IN00347100 - Unsubstantiated IN00314538 - Unsubstantiated Survey Dates: April 19-23, 2021 Facility number: 011160 Provider number: 15K025 Current census: 171 Skilled: 40 HHA only: 131 These deficiencies reflects State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings.	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 registered nurse (RN) failed to ensure the comprehensive assessment contained all pertinent information regarding the patients' current health status for 2 of 8 active records reviewed (#1, 5). The findings included: 1. An agency policy dated 3/1/21 titled "comprehensive client assessment," stated	G 528		

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

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G 528	Continued From page 1 "...Purpose: To determine the appropriate care, treatment and services to meet client initial needs and his/her changing needs. ... The comprehensive assessment must accurately reflect the client's status, and must include at a minimum, the following information: The client's current health with a completed head to toe assessment, psychosocial, functional, and cognitive status ...." 2. The clinical record of patient #1 was reviewed on 4/19/21 and indicated a start of care date of 8/21/17. The record contained a plan of care for the certification period of 3/23/21-5/21/21 which stated "check INR [international normalized ratio-blood test that monitors the effectiveness of the anticoagulant medication warfarin (also known as coumadin)] every Monday and call results [to warfarin/coumadin clinic]...." The recertification comprehensive assessment completed on 3/18/21 failed to evidence a diagnosis or documentation for the rationale for INR blood tests to be done. 3. The clinical record of patient #5 was reviewed on 4/21 and 4/23/2021, and indicated a start of care date of 9-28-2018. The record contained a plan of care for the certification period of 3/16 to 5/14/2021, with orders for skilled nursing services. Review of an OASIS/comprehensive assessment, dated 3/12/2021, for patient #5, failed to evidence the patient's height and weight, as part of vital sign assessment, and as a basis for care planning. During an interview on 4/23/2021 at 12:30 PM, the administrator and nursing supervisor both reviewed the clinical record and verified patient	G 528		

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G 528	Continued From page 2 #5's height and weight should have been obtained and documented in the comprehensive assessment. 4. During an interview on 4/22/21 at 9:20 AM, the alternate administrator agreed the comprehensive assessment should contain all pertinent information regarding the health status of the patient.	G 528		
G 530	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This Element is not met as evidenced by: Based on record review and interview, the registered nurse (RN), failed to ensure the comprehensive assessment contained the patient's goals, and care preferences, as well as information to demonstrate progress toward achievement of goals identified by the patient and measurable outcomes identified by the agency for 2 of 8 active records reviewed (#1, 4). Findings include: 1. An agency policy dated 3/1/21 titled "comprehensive client assessment," stated "...The comprehensive assessment must accurately reflect ... The client's stregths, goals, and care preferences, including information that may be used to emonstrate the client's progress toward acheivement of the goals identified by the client abd measurable ouotcomes identified by the agency ...."	G 530		

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G 530	Continued From page 3 2. The clinical record of patient #1 was reviewed on 4/19/21 and indicated a start of care date of 8/21/17. The record contained a plan of care for the certification period of 3/23/21-5/21/21 which listed diagnoses (but not limited to) tramautic brain injury, quadriplegia, constipation, dysphagia, and history of urinary tract infection. A recertification comprehensive assessment dated 3/18/21 failed to evidence the patient's goals, and care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency. 3. The clinical record of patient #4 was reviewed on 4/20//2021, and indicated a start of care date of 7-12-2019. The clinical record contained a plan of care for the certification period of 3/3 to 5/142021, with orders for skilled nursing services. Review of an OASIS/comprehensive assessment, dated 3/2/2021, for patient #4, failed to evidence the patient's strengths, weakness, and care preferences had been documented as a basis for care planning. During an interview on 4/23/2021 at 12:30 PM, the administrator and nursing supervisor both reviewed the clinical record and verified patient #4's strengths, weaknesses, and care preferences were not documented on the OASIS/comprehensive assessment. Both indicated when adopting an electronic clinical record system at the end of 2020, they had not identified the electronic OASIS/comprehensive assessment failed to include a place to document patient strengths, weaknesses, and care preferences.	G 530		
G 536	A review of all current medications CFR(s): 484.55(c)(5)	G 536		

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G 536	Continued From page 4 A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This Element is not met as evidenced by: Based on record review and interview, the agency failed to ensure the plan of care documented all medications the patient was taking for 1 (Patient #5) of 8 active records reviewed. The findings included:: The clinical record of patient #5 was reviewed on 4/21 and 4/23/2021, and indicated a start of care date of 9-28-2018. The record contained a plan of care for the certification period of 3/16 to 5/14/2021, with orders for skilled nursing services. Review of documents obtained by fax, after request on 4/8/2021, from home health agency "Other identifier of A," which provided infusion therapy for patient #5, evidenced Cefepime, 1000 milligrams/10 mL, SWFI (sterile water for injection) every 12 hours for 6 weeks, date of order 3-29-2021 (end 6-9-2021.) Review of the medications on the plan of care, and review of the medication profile, failed to evidence Cefepime, an antibiotic, had been documented in an update to patient #5's medication list, to include name, dose, route, frequency, and duration of the intravenous antibiotic therapy. The clinical record failed to evidence Cefepime had been added to the medication profile for medication reconciliation to identify drug interactions, adverse affects, and	G 536		

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G 536	Continued From page 5 duplicative drug therapy. The agency's medication profile evidenced patient #5 was taking approximately 13 medications. On 4/23/2021 at 12:30 PM, the administrator and nursing supervisor both reviewed the clinical record and indicated the Cefepime had not been added to the medication profile, plan of care, or been checked for drug interactions with patient #5's other multiple medications.	G 536		
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; (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	G 574		

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G 574	Continued From page 6 (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 agency failed to ensure the plan of care (POC) included all medications the patient was taking and all durable medical equipment (DME) and supplies for 2 of 8 records reviewed for 2 of 8 active records reviewed (#1, 5). Findings include: 1. An agency policy dated 3/1/21 titled "Plan of Care," Policy # C-580 stated, "...An individualized plan of care signed by a physician shall be required for each client ... The plan of care shall be completed in full to include: ... medications ... medical supplies and equipment required ...." 2. The clinical record of patient #1 was reviewed on 4/19/21 and indicated a start of care date of 8/21/17. The record contained a plan of care for the certification period of 3/23/21-5/21/21 which listed DME as (but not limited to), grab bars, hospital bed, hoyer lift, medical alert system, shower chair, wheelchair, and coag-meter. During a home visit observation on 4/20/21 at 8:00 AM with patient #1, home health aide (HHA) E was observed providing personal care. During the visit, a bedside table, humidifier, TED hose, and a foam overlay for the bed were observed. The observed items failed to be listed on the plan of care. During an interview on 4/22/21 at 4:02 PM, the alternate clinical manager stated all DME should be listed on the plan of care. 3. The clinical record of patient #5 was reviewed	G 574		

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G 574	Continued From page 7 on 4/21 and 4/23/2021, and indicated a start of care date of 9-28-2018. The record contained a plan of care for the certification period of 3/16 to 5/14/2021, with orders for skilled nursing services. Review of documents obtained by fax, after request on 4/8/2021, from home health agency "Other identifier of A," which provided infusion therapy for patient #5, evidenced Cefepime, 1000 milligrams/10 mL (milliliter), SWFI (sterile water for injection) every 12 hours for 6 weeks, date of order 3-29-2021 (end 6-9-2021.) Review of the plan of care failed to evidence antibiotic for infusion, Cefepime, had been documented on the plan of care to update patient #5's medication list. On 4/23/2021 at 12:30 PM, the administrator and nursing supervisor both reviewed the clinical record and verified the Cefepime had not been added to the plan of care, as it should have been, for patient #5. 17-13-1(a)(1)(D)(ix)	G 574		
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 and interview, the agency failed to ensure all staff followed standard precautions and infection control policies for 1 of 2 home health aide (HHA) observations (#1).	G 682		

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G 682	Continued From page 8 Findings include: During a home visit observation on 4/20/21 at 8:00 AM with patient #1 (start of care 8/21/17), HHA E was observed providing personal care. HHA E washed hands throughout the visit at different times for 5 seconds, 8 seconds, 3 seconds, and 5 seconds. Additionally, hand sanitizer was utilized at least once during the visit. After hand sanitizer was applied to hands, HHA E rubbed hands together briefly and then shook hands to dry prior to donning gloves. HHA E failed to wash hands for 20 seconds or rub hands vigorously together until the hands were dry. During an interview on 4/22/21 at 9:20 AM, the alternate administrator stated staff should wash hands for a minimum of 20 seconds.	G 682		