DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K094	A. BUILDING 00 B. WING	02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SCOTT'S HOME HEALTHCARE LLC	1817 DOGWOOD CT KOKOMO, IN 46902

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G 0000 Bldg. 00	This was a federal recertification home health survey with three (3) complaints. This survey was announced as fully extended on February 2/19/19 at 4:00 PM. Complaints: IN00175656; substantiated with findings IN00212618; substantiated with findings IN00277902; substantiated with findings Facility #: 012928 Provider #: 15K094 Medicaid #: 201091400 Survey dates: February 15, 18, 19, 20, 21, 22, 25, 26; 2019 Skilled Services: 2 Home Health Aide only: 78 Unduplicated Census: 128 Record reviews with home visit: 3 Record review without home visits: 14 Discharged record reviews: 6 Focused record reviews: 10 Total clinical records reviewed: 17 Scott's Home Healthcare, LLC is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning February 26, 2019 to February 26, 2021 for being found out of compliance with the Conditions of Participation 484.55 Comprehensive	G 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Assessment of Patients, and 484.60 Careplanning, coordination, quality of care.			
G 0372 Bldg. 00	Based on record review and interview, the agency failed to submit OASIS (outcome and assessment information set) within 30 days of assessment completion for 3 of 3 skilled records requiring OASIS submissions (#2, 8, 9). Findings include: 1. An agency policy dated 1/14/19, titled "Completing the Comprehensive assessment," stated "Once OASIS assessment is completed accurately and reflect the patient's status at time of assessment, the CM [case manager] will turn in completed form to the assistant clinical manager (ACM) for review. After review and approval is complete ACM will deliver completed OASIS to the administrative billing specialist to encode and electronically transmit to CMS [centers for medicare and medicaid] within 30 days of completion of the patient assessment ...." 2. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record failed to evidence that OASIS submissions occured within 30 days of competion as evidenced by: An agency OASIS recertification was completed on 3/29/18. The OASIS submission was not completed until 7/27/18. An agency OASIS recertification was completed on 5/24/18. The OASIS submission was not	G 0372	Agency CM will complete the patient OASIS assessment and submit to the Assistant Clinical Manager (ACM) for review. After the ACM has approved the completed OASIS, the ACM will submit the OASIS to the CMS and print the verification report. The report will be kept in the OASIS report binder in the ACM office. The ACM will ensure the OASIS is submitted within 30 days of completing the assessment of the beneficiary. The Administrator will ensure the completion and submission of OASIS per the agency policy by reviewing the OASIS report binder weekly and verifying the completion and submission of OASIS was done in the appropriate timeline.	03/28/2019

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completed until 7/25/18.

An agency OASIS recertification was completed on 9/20/18. The OASIS submission was not completed until 2/20/19.

An agency OASIS recertification was completed on 11/20/18. The OASIS submission was not completed until 1/3/19.

3. The clinical record of patient #8 was reviewed 2/22/19 and indicated a start of care date of 3/9/18. The record failed to evidence that OASIS submissions occured within 30 days of competion as evidenced by:

An agency OASIS start of care was completed on 3/22/18. The OASIS submission was not completed until 7/25/18.

An agency OASIS recertification was completed on 5/14/18. The OASIS submission was not completed until 7/25/18.

4. The clinical record of patient #9 was reviewed 2/20/19 and indicated a start of care date of 9/2/18.

An agency OASIS start of care was completed on 9/19/18. The OASIS submission was not completed until 2/20/19.

An agency OASIS recertification was completed on 11/8/18. The OASIS submission was not completed until 1/3/19.

5. During an interview on 2/26/19 at 1:56 PM, employee B, billing specialist, stated that the agency should be submitting OASIS data within 30 days of the registered nurse completing the assessment.

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G 0438 Bldg. 00	Based on observation, record review and interview, the agency administrator failed to ensure a confidential clinical record was maintained for 1 of 1 home visits observed utilizing electronic documentation (#1). Findings include: An agency policy dated 1/10/19, titled "HIPAA [health insurance portability and accountability act] Administrative Policies and Procedures." Policy # 113.00 stated "...Purpose: To ensure compliance with HIPAA regulations and guidelines and to provide protection for protected patient information ...." During an observation on 2/18/19 at 8:00 AM, employee D, home health aide (HHA), was observed assisting with personal care with patient #1. After completion of care employee D swiped the screen on her cell phone (no lock on her cell phone) and went into the agency's software program to begin charting and the visit note was observed. A username and password was required to get into the agency's software program. Employee D went in and out of the agency's software program three times. Each time employee D would go back into the app, the app did not have her re-enter the username and password, but rather took her back to the same screen that it had been left on. The agency failed to ensure staff protected the electronic clinical record against unauthorized use by documenting on unlocked personal cell phones and the system did not require username and passwords to be re-entered when leaving the agency software	G 0438	The agency will ensure all patient clinical records are kept confidential. For field employees specifically, the agency will enforce the policy titled "Computer Terminals/Workstations/Hand Held Devices," specifically #3 of said policy stating "A user may not leave his/her workstation, terminal or hand held device unattended for periods of time (e.g breaks, lunch, meetings, etc) unless the terminal or device screen is cleared and the user is logged off." #4 A user must clear the terminal and device screen if the workstation or terminal is left unattended. All field staff will be in serviced by 3/28/19 on confidential clinical records. The agency's field staff will be required to lock their hand held device per the above mentioned policy and specifically #8 Hand held devices must have a security pass code/word, screen lock or finger print lock enabled on the lock screen. The field staff is to lock their screen any time their device is not actively in use by the field staff. The field staff will complete the home health aide note by marking the completed tasks, receive the patients signature for verification of tasks and depart from the electronic home health aide note. The field staff will only	03/28/2019

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	program. During an interview on 2/18/19 at 9:00 AM, employee D was asked if she realized that anyone could pick her phone up and get into the patient's clinical record and she stated, "That's not good, I didn't know it did that." During an interview on 2/18/19 at 1:59 PM, the administrator stated that she would have to call main agency software program company about this as the system is supposed to have staff re-login after leaving the screen.		be on their hand held device during this time and will lock their device when they are not actively completing their home health aide note. The in service record will be kept in the employees file to ensure completion. The Administrator will ensure all field staff were in serviced by nursing staff by reviewing the completed in service log. All new field employees will be trained on proper HIPAA procedures and sign the above mentioned policy prior to FPC. The agency will not rely on the clinical software system to ensure employee electronic device is secured and will utilize this process to guarantee patient medical information is kept confidential. The case manager will monitor compliance by checking aide phone and if it is locked when not in use at supervisory visit. CM will also educate about hand held devices as needed and at supervisory visit concerning locking screen and HIPAA. This will be added as part of the supervisory visit form. Supervisory visits will be audited by ACM or other RN delegate for compliance.	
G 0480 Bldg. 00	Based on record review and interview, the agency administrator failed to investigate and document	G 0480	The Client/Grievance Incident form recreated to show the details of the grievance process from	03/28/2019

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	complete complaint investigations for 2 of 2 complaint investigations reviewed (#9, 12). Findings include: 1. An agency policy dated 1/10/18, titled Client Grievance / Incident Process," stated "... Client / Family Grievance / Incident Policy for receiving, reviewing and resolving complaints and / or concerns is based on the premises of the patient's rights and responsibilities ...." The policy failed to evidence that the complaint would be investigated. 2. The clinical record of patient #9 was reviewed on 02/20/19 and indicated a start of care date of 9/12/18. An agency document titled, "Grievance / Incident Form" dated 10/19/16 indicated an employee report of bed bugs in the patient home. The "Resolution / Counseling" for the incident on 10/20/16 indicated the patient was to be removed from the employee schedule and "RN notified of possible bed bugs in patient home. RN to follow up with patient" The grievance failed to evidence a thorough investigation as no patient follow up was performed. 3. The clinical record of patient #12 was reviewed 2/25/19 and indicated a start date of 10/4/16. An agency document titled "Grievance / Incident Form" dated 6/18/18 indicated an employee phoned in a concern for patient #12 that regarded another HHA signed patient #12's signature after a visit. The "Resolution / Counseling" of the incident dated 6/19/18 indicated "HR [human resources employee W] counseled aide to never sign for a client. If can't sign to call the office. Immediately! Aide understood...." The grievance / incident failed to evidence a through investigation as no patient follow up in regards to		initiation to resolution. The format will be as follows: Date Grievance/Incident received, Grievance Filed by, Individual complaint pertains to, Details of grievance, Employee(s) investigating complaint, Details of investigation, Time frame of investigation, patient notification of resolution and follow up to ensure resolution was completed. The Administrator to review all complaints and delegate resolution. The Administrator to review completed complaint form in its entirety to ensure resolution is acceptable and all sections correctly completed and resolved. The Administrative Billing Specialist to keep all completed Grievance/Incident forms in a log in the Administrative Billing office. All agency staff will be in serviced by 3/28/19 to educate on the updated Client/Grievance Incident form process.	

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	incident. 4. During an interview on 2/25/19 at 2:22 PM, the administrator stated that the "resolution /counseling" area of the complaint was the investigation and stated it "could be more detailed, I suppose."			
G 0510 Bldg. 00	Based on record review and interview, the Registered Nurse (RN) failed to complete the inital assessment within 48 hours of referral (see tag G514); failed to ensure contents of the comprehensive assessment was accurate (see tag G526); failed to ensure patient goals were identified in the comprehensive assessment (see tag G530); failed to ensure all drug to drug interactions were identified and failed to specify indications for PRN (as needed medication) (see tag G536); failed to ensure all current information was updated and included in the comprehensive assessment (see tag G544) and failed to ensure a Resumption of Care assessment (ROC) was performed after hospitalization (see tag G548). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients.	G 0510	The agency will ensure the initial assessment is completed within 48 hours of the referral date and the comprehensive assessment completed within 5 days of the referral. The ACM will receive the patient referral, assign the CM and ensure the patient was contacted and the initial assessment is set up and completed within 48 hours. The CM will document on the clinical note the date and time the patient was contacted and the date and time the initial assessment meeting is scheduled. The ACM reviews all documentation by the CM an will review the clinical note and utilize this system as a tracking resource and timeline for the referral to admission process. The CM will receive an order from the MD if the patient is appropriate for services and the Comprehensive Assessment will be completed within 5 days of the referral. The ACM will ensure the timeline is executed and oversee the process. The Administrator will	03/28/2019

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			meet daily with the ACM to review the status of referrals to ensure the initial assessment and admission of patients is completed in the regulated time frame. All clinical staff to be retrained on patient referral timelines by 3/28/19. Once the comprehensive assessment is completed upon admission, the ACM will review for content and accuracy. The CM will review the medical diagnosis of the patient and create goals for the medical diagnosis to support the assessment findings. The CM will also ensure the patient participates in creating a goal(s) that they want to achieve. The CM will run drug to drug interactions on all patient identified medications. The CM will use drugs.com to ensure the interactions are properly identified. Any interactions will be reported to the MD with follow up instructions requested. All instructions to be documented in the clinical chart and medications updated per MD order if applicable. The patient education will be documented in the nurse assessment and any follow up education and or instructions to be documented in a clinical note in the medical chart. The ACM to review all assessments including the medication interactions and ensure interactions are reported with MD orders received and	

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			patient education conducted. The ACM will utilize the admission and recertification audit checklist to ensure all mandatory requirements are completed by CM. All PRN medications will be reviewed and must have documented indications for use in patient understood verbiage. The CM to review all findings from the current certification period in the clinical chart and address each item that occurred in the comprehensive assessment along with the resolution. A patient that has been hospitalized for 24 hours will be placed on hold per MD order. The CM will complete a resumption of care assessment on the patient before resuming agency services. The ACM will meet daily with the clinical staff and review the status of each patient in order to ensure proper procedures are followed regarding resumption of care.	
G 0514 Bldg. 00	Based on record review and interview, the Registered Nurse (RN) failed to complete the initial admission assessment within 48 hours of referral for 1 of 7 records reviewed (#1). Findings include: An agency policy dated 1/13/18, titled "Admission Policy and Procedure," stated "... The	G 0514	The agency will ensure the initial assessment is completed within 48 hours of the referral date and the comprehensive assessment completed within 5 days of the referral. The ACM will receive the patient referral, assign the CM and ensure the patient was contacted and the initial assessment is set up and completed within 48	03/28/2019

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	case manager is assigned to ... complete initial assessment within 48 hours in order to evaluate ...." The clinical record of patient #1 was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The agency referral / intake form was completed on 3/7/18 by an unknown employee. The agency "initial assessment," was completed on 3/21/18 by an RN. The RN failed to complete the initial assessment within 48 hours of referral. During an interview on 2/25/19 at 1:26 PM, the administrator stated the agency would set up the admission within 48 hours, but the RN had 5 days to admit a patient and they would complete the initial and the comprehensive assessments on the same day.		hours. The CM will document on the clinical note the date and time the patient was contacted and the date and time the initial assessment meeting is scheduled. The ACM reviews all documentation by the CM an will review the clinical note and utilize this system as a tracking resource and timeline for the referral to admission process. The CM will receive an order from the MD if the patient is appropriate for services and the Comprehensive Assessment will be completed within 5 days of the referral. The ACM will ensure the timeline is executed and oversee the process. The Administrator will meet daily with the ACM to review the status of referrals to ensure the initial assessment and admission of patients is completed in the regulated time frame. All clinical staff to be retrained on patient referral timelines by 3/28/19. Once the comprehensive assessment is completed upon admission, the ACM will review for content and accuracy. The CM will review the medical diagnosis of the patient and create goals for the medical diagnosis to support the assessment findings. The CM will also ensure the patient participates in creating a goal(s) that they want to achieve. The CM will run drug to drug interactions on all patient identified	

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			medications. The CM will use drugs.com to ensure the interactions are properly identified. Any interactions will be reported to the MD with follow up instructions requested. All instructions to be documented in the clinical chart and medications updated per MD order if applicable. The patient education will be documented in the nurse assessment and any follow up education and or instructions to be documented in a clinical note in the medical chart. The ACM to review all assessments including the medication interactions and ensure interactions are reported with MD orders received and patient education conducted. The ACM will utilize the admission and recertification audit checklist to ensure all mandatory requirements are completed by CM. All PRN medications will be reviewed and must have documented indications for use in patient understood verbiage. The CM to review all findings from the current certification period in the clinical chart and address each item that occurred in the comprehensive assessment along with the resolution. A patient that has been hospitalized for 24 hours will be placed on hold per MD order. The CM will complete a resumption of care assessment on the patient before resuming agency services. The ACM will	

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			meet daily with the clinical staff and review the status of each patient in order to ensure proper procedures are followed regarding resumption of care.	
G 0526 Bldg. 00	Based on observation, record review and interview, the Registered Nurse (RN) failed to ensure contents of the comprehensive assessment was accurate for 1 of 7 full records reviewed in a sample of 17 (#3). Findings include: An agency policy dated 1/14/19, titled "... Completing the Comprehensive assessment" stated "Once OASIS assessment is completed accurately and reflect the patient's status .... " The clinical record of patient #3 was reviewed on 02/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care (POC) for the certification period of 2/14/19-4/14/19, which indicated a medication "Nitoruranton" [sic] (an antibiotic used to treat urinary tract infections) 100 milligrams 1 tablet by mouth three times daily for 3 days that began 2/11/19 and a diagnosis of Type 2 diabetes. The record failed to evidence information regarding an infection or the use of an antibiotic, and accurate information about the patient's ability to independently reach feet to apply socks and shoes as evidenced by: During a home visit observation on 2/18/19 at 12:00 PM, at patient #3's home, employee E, a	G 0526	The CM will provide a comprehensive assessment that accurately reflects the patient status. The agency will ensure consistency of this regulation by requiring all CM to follow and complete an approved checklist form of tasks at each comprehensive assessment visit titled comprehensive assessment checklist. This form includes review of all medications, their use and indication, any education regarding initial diagnosis requiring prescribed medication need and systems review including skin assessment to address all medical diagnosis in plan of care. Care plan items will be reviewed with patient at each nurse visit to ensure no changes in patient have occurred during current certification period. Care plan to be customized and updated if patient status change occurs to reflect patients current needs. ACM to ensure all checklist items for patient visit have been completed by nurse by reviewing all visit documentation for accuracy. The ACM will utilize	03/28/2019

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	home health aide (HHA), was observed providing personal care. After the patient's shower was complete, the HHA applied lotion on the patient's legs and feet. The patient then lifted the right leg and placed it over the left knee. The patient pointed out a thick, beige, callused area below the right great toe. The patient stated the callus had been present for "a long time" and recently the patient had pulled part of the callus of the foot. The patient then pulled on the sock to the right foot and repeated this process on the left foot. The patient bent over in her recliner to put both on shoes independently. A Recertification comprehensive assessment dated 2/12/19 indicated "... No diabetes complications... [patient] is diabetic and requires HHA to perform diabetic foot care at each visit as she is unable to reach her feet ...." The assessment failed to evidence the presence of a calloused, build-up to the soles of the feet, failed to evidenced genitourinary problems, and failed to evidence the patient's recent infection that required antibiotic use.During an interview on 2/25/19 at 2:27 PM, the administrator stated that the comprehensive assessment should have reflected accurate information.		the CM checklist in auditing the skilled nurse documentation. Clinical staff will be in serviced and re educated on comprehensive assessment procedure by 3/28/19. The Administrator or her delegate will audit at least 10% of all comprehensive assessment visits to ensure this regulation is upheld.	
G 0530 Bldg. 00	Based on record review and interview, the Registered Nurse (RN) failed to ensure patient goals were identified in the comprehensive assessment for 7 of 7 full record reviews in a sample of 17 (#1, 2, 3, 4, 5, 9, 15). Findings include: 1. The clinical record of patient #3 was reviewed	G 0530	Every admitted patient to have patient centered goals in their comprehensive assessment completed by the RN at the patient visit. The RN will inquire what goals the patient has for themselves then write specific patient centered goals in the assessment. These goals to be	03/28/2019

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	on 02/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care (POC) for the certification period of 2/14/19-4/14/19. The recertification comprehensive assessment dated 2/12/19 failed to evidence patient-specific goals. 2. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC for the certification period of 10/2/18 -11/30/18. The recertification comprehensive assessment dated 10/2/18 failed to evidence patient-specific goals. 3. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date 9/12/18. The record contained a POC for the certification period of 1/10/19-3/10/19. The recertification comprehensive assessment dated 1/10/19 failed to evidence patient-specific goals. 4. The clinical record of patient #15 was reviewed on 02/21/19 and indicated a start of care date of 05/24/13. The record contained a plan of care for the certification period of 01/23/19 - 03/23/19. The recertification comprehensive assessment dated 01/21/19 failed to evidence patient-specific goals. 5. The clinical record of patient #1 was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The record contained a plan of care for the certification period of 1/15/19-3/15/19.		reviewed at each assessment visit, along with all diagnosis centered goals, and updated with the current status of goals, specifically documented in narrative section of goal. RN to educate patient at every assessment visit on how goals can be met. ACM to review all patient documentation for accuracy and to ensure RN is documenting updated status of goal and any education given to patient regarding goals. Administrator to ensure requirement is completed by auditing 10% of assessment documentation monthly. Non compliance with this regulation will result in disciplinary action per agency policy.	

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	A recertification assessment dated 1/10/19 failed to evidence patient-specific goals. 6. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19. A recertification assessment dated 1/21/19 failed to evidence patient-driven goals. 7. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18, A recertification assessment dated, 6/27/18 failed to evidence patient-specific goals. 8. During an interview on 2/25/19 at 1:47 PM, the administrator stated that the plan of care should contain goals that the patient has made for themselves.			
G 0536 Bldg. 00				
	Based on record review and interview, the Registered Nurse (RN) failed to ensure all drug to drug interactions were identified in the drug regimen review and failed to specify indications for as needed (PRN) medications for 7 of 7 full records reviewed (#1, 2, 3, 4, 5, 9, 15), in a sample of 17. Findings include: 1. An agency policy, dated 1/14/19 titled "Medication Reconciliation," stated "Purpose: To	G 0536	Nursing staff to review all patient medications patient is using to identify any potential adverse effects and drug interactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and non compliance with drug therapy. The RN will utilize the comprehensive assessment checklist to ensure each step is completed. The RN will write all medications in layman's terms	03/28/2019

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	ensure medication reconciliation is up to date and accurate in the patient's medical chart and in the home ...." 2. The clinical record of patient #3 was reviewed on 2/18/19 and indicated a start date of 8/28/17. The record contained a plan of care for the certification period of 12/16/18-2/13/19. The record contained a current Medication profile effective 2/14/19 with the following medications: "ASA 1 PO QD...Cetirizine 1 PO QHS PRN Allergy...Cyclobenzaprine 1 PO BID am, evening...Eliquis 2 tabs PO QD...Gabapentin 1 PO TID...Jardiance 1 PO QD...Levothyroxine 1 PO QD...Lisinopril 1 PO QD...Metformin 1 PO BID...Nitoruranton [sic]1 PO TID X 3 Days...Norco 1 PO Q8H PRN...Tradjenta 1 PO QD...Tramadol 1 PO BID am, evening...Tylenol 1 PO Q8H PRN...Vitamin D 2 2 on SUN and WED...Vitamin D3 1 PO QD." The record failed to evidence a medication review that had identified medications put into layman's terms that were easy for the patient to understand, failed to evidence that an accurate medication interaction check was completed and was sent to the physician as evidenced by: On 02/19/19 an agency Drug to Drug interaction was run from the agency's software program. The agency software program failed to identify a drug to drug interactions. The record failed to evidence that drug to drug interactions were run as there was no documentation or tracking within the system to show that it was completed. On 02/20/19 the following medications were checked on Drugs.com for interactions: Major interactions with Cyclobenzaprine and Tramadol;		that is easy for patient to understand and document review was completed with patient, the acknowledgment that patient understands medications, side effects, interactions, duplicate therapy and risks associated with non compliance. The nurse will utilize drugs.com to run drug interactions and note that interactions were reviewed with patient. The MD will be notified of any interactions and follow up orders to be received from MD. RN to implement requested changes, update medication profile and educate patient on changes. ACM to review all documentation and run drug interactions on patient medication profile to ensure compliance and review documentation for changes, applicable MD orders, and documented education performed with patient. ACM will utilize comprehensive assessment checklist created by Administrator to ensure consistency of audit. Administrator to audit 10% of visit documentation per month to ensure requirements are completed.	

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Major interactions with Aspirin and Eliquis; Major interactions with Cyclobenzaprine and Norco; Major interactions with Vitamin D 2 and Vitamin D3 and Major interactions with Norco and Tramadol. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

3. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date of 10/2/18. The record contained a plan of care for the certification period of 10/2/18-11/30/18.

The record contained a current Medication profile effective 10/2/18 with the following medications; "Allopurinol 1 PO QD...Buspirone 1 PO BID...Dicyclomine 1 PO QID...Levothyroxine 1 PO QD...Lexapro 1 PO QD...Miltivitanin [sic] 1 PO QD, Mirapex 1 PO BID...Norco 1 PO Q6H PRN...Topiramate 1 PO BID...Trazodone 1 PO QHS...Vitamin B 12 1 PO QD...Vitamin D3 1 PO QD..."

The record failed to evidence a medication review that identified medications in layman's terms, that was easy for the patient to understand, had an accurate medication interaction check completed, and was sent to the physician as evidenced by:

On 02/20/19, an agency Drug to Drug interaction was run from the agency's software program. The agency software program failed to identify a drug to drug interactions. The record failed to evidence that drug to drug interactions was ran as there was no documentation or tracking within the system to show that it was completed.

On 02/20/19 the following medications were checked on Drugs.com for interactions: Major

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	interactions with Trazodone and Lexapro; Major interactions with Dicyclomine and Topiramate; Major interactions with Buspirone and Lexapro; Major interactions with Buspirone and Norco and Major interactions with Buspirone and Trazodone. The Drugs. com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit." 4. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date of 9/12/18. The record contained a plan of care for the certification period of 01/10/19-03/10/19. The record contained a current Medication profile effective 2/20/2019 with the following medications: "... Advair Diskus 1 puff QD...Aspirin 1 PO QD... Baclofen 1 PO BID... Benadryl PO PRN...Belsomra 1 PO QHS (bedtime)...Benadryl 1-2 tabs PO PRN...Cetirizine 1 PO QD...Clopidogrel 1 PO QD...Colace 1 PO BID...Combivent Respimat 1 Puff QID (four times daily) PRN...COQ 10 1 PO Q QHS (at bedtime)...Cranberry 1 PO QD PRN...D3 2 Caps PO BID...Ezetimibe 1 PO QD...Fenofibrate 1 PO QD...Flonase 1 Spray each Nostril BID...Glucose 1 tab PRN S/S (signs / symptoms) hypoglycemia...Hydralazine 1 PO TID (three times daily)...Ibuprofen 3 tabs PO Q 6 hrs PRN...Januvia 1 PO QD...Lyrica 200 mg (milligrams) 1 PO Q AM (morning)...Lyrica 300 mg 1 PO Q QHS...Maxalt 1 PO Q 2 HRS(hours) PRN...Metoprolol Succinate ER (extended release) 1 PO QD...Miralax 17 GM (grams) PO QD...Norco 1 PO Q 6 HRS...Pepcid 1 PO Q PM...Pramipexole 1 PO QHS...Spiriva 2 Puffs QD...Tramadol 1 PO Q 12 HRS...Venlafaxine 1 PO QD...Xopenex 3 ML (milliliters) Q 6 HRS PRN." The record failed to evidence a medication review that identified medications in layman's terms, that			

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was easy for the patient to understand, had an accurate medication interaction check completed, and was sent to the physician as evidenced by:

On 02/20/19, an agency Drug to Drug interaction was run from the agency's software program. The agency software program identified the following interactions: Major interactions with Atorvastatin and Fenofibrate; Major interactions with Venlafaxine and Maxalt; Major interactions with Ibuprofen and Aspirin and major interactions with Baclofen and Norco.

On 02/20/19, the following medications were checked on Drugs.com for interactions: Tramadol, Belsomra, Venlafaxine, Maxalt, Norco, Baclofen, Atorvastatin, Fenofibrate, Ibuprofen, and Aspirin. Major interactions with Venlafaxine and Maxalt; Major interactions with Venlafaxine and Tramadol; Major interactions with Tramadol and Maxalt; Major interactions with Norco and Belsomra; Major interactions with Baclofen and Norco; Major interactions with Hydrocodone and Tramadol; Major interactions with Atorvastatin and Fenofibrate; Major interactions with Ibuprofen and Aspirin; Major interactions with Baclofen and Tramadol. The Drugs. com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

5. The clinical record of patient #15 was reviewed on 2/21/19 and indicated a start of care date of 5/24/13.

The record contained a plan of care for the certification period of 01/23/19-03/23/19. The record contained a current Medication profile effective 2/20/2019 with the following medications: "... Aspirin 1 PO QD...Brilinta 1 PO

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	BID...Esomeprazole 1 PO QD...Furosemide 40 mg (milligrams) PO daily...Glipizide 1 PO QD...Januvia 100 mg PO daily...Lipitor 1 PO Q IHS...Metformin 500 mg PO BID with meals...Metoprolol 25 mg ER 1 PO QD...Nexium 40 mg QD before breakfast..." The record failed to evidence a medication review that identified medications in layman's terms, that was easy for the patient to understand, had an accurate medication interaction check completed, and was sent to the physician as evidenced by: On 02/20/19, an agency Drug to Drug interaction was run from the agency's software program. The agency software program identified the following interactions: Moderate interactions between Furosemide and Metformin; Moderate interactions between Furosemide and Januvia. On 02/20/19, the following medications were checked on Drugs.com for interactions: Major interactions with Potassium Chloride and Ramipril. The current medication profile evidenced duplicative medications of Esomeprazole 40 mg (milligrams) 1 PO (by mouth) QD (every day) start date of 08/16/17 and Nexium 40 mg 1 PO QD before breakfast start date 02/08/17. The Medication profile evidenced both medications were entered on POC (plan of care) on 1/23/19. The clinical record failed to evidence if the physician had been notified of duplicative Esomeprazole and Nexium. 6. During an interview on 2/15/19, at 9:28 AM, the Administrator stated, during a drug regimen review the nurse reviewed all medications with the patient. If discrepancies were found, an order should be sent to the physician and the agency's software program would do an interaction check.7.			

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	The clinical record of patient #1 was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The record contained a plan of care for the certification period of 1/15/19-3/15/19. The record contained a current Medication Profile effective 2/19/2019 with the following medications: "... amlodipine 1 PO (by mouth) QD (daily) ... atorvastatin 1 PO QPM [every evening] ... benicar 1 PO QD ... Buspar 1 PO TID [3 times per day] ... clopidogrel 1 PO QD ... colace 1 PO QD PRN [as needed] ... divalproex 2 PO QPM ... ferrous sulfate 1 PO QD ... flonase 2 sprays each nostril QD ... gabapentin 1 PO TID ... glucagon IM [intramuscular] PRN hypoglycemia ... Levemir 24 units subQ [subcutaneous] BID [2 times per day] ... levothyroxine 1 PO QAM [every morning] ... Maalox PO Q 8 hr [hour] ... metoprolol tartrate 1 PO BID ... milk of magnesia PO QD PRN ... montelukast 1 PO QPM ... myrbetriq 1 PO QD ... Novolog 14 units subQ QID [4 times per day] ... nuedexta 1 PO QD ... pepcid 1 PO QPM ... probiotic 1 PO QD ... protonix 1 PO QD ... quetiapine 1 PO QPM ... triamcinolone to RLE [right lower extremity] BID ... tylenol 2 tabs PO Q [every] 6 hours PRN ... voltaren gel ... zofran 1 PO Q 6 hr PRN ...." The record failed to evidence a medication review that identified medications in layman's terms, that was easy for the patient to understand, had an accurate medication interaction check completed, and was sent to the physician as evidenced by: On 2/21/19 an agency drug to drug interaction was run from the agency's software system and indicated 3 moderate drug to drug interactions and 2 minor drug to drug interactions. The record failed to evidence that drug to drug interactions were run as there was no documentation or			

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tracking within the system to show that it was completed.

On 2/21/19, the following medications were checked on Drugs.com for interactions: amlodipine, atorvastatin,
Benicar, Buspar, clopidogrel, colace, divalproex sodium, ferrous sulfate, Flonase, gabapentin, glucagon, Levemir, levothyroxine, Maalox, Metoprolol Tartrate, montelukast, Myrbetriq, Novolog, Nuedexta, Pepcid, Acidophilus Probiotic Blend, Protonix, quetiapine, triamcinolone, Tylenol, Voltaren, and Zofran. The Drugs.com list identified the following reactions: Major interactions with Buspar and Zofran; Major interactions with Nuedexta and Zofran; and Major interactions with Nuedexta and quetiapine. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

8. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19.

The record contained a current Medication Profile effective 2/18/2019 with the following medications: "... advair diskus 1 puff inhale BID ... albuterol 1 vial TID PRN ... baclofen 1 PO BID PRN ... benadry [sic] (Benadryl) 1-2 tabs PO Q 4-6 hr PRN ... buspirone 1 tab PO QD ... calcium 1 tab PO TID ... cephalexin 2 tabs PO TID ... doxycycline 1 PO BID ... eliquis 1 tab PO BID ... ibuprofen 3 PO QD PRN ... ipratropium 2 sprays to nares Q 4 hr PRN ... januvia 1 tab PO QD ... levaquin 1 PO QD ... lidocaine apply patch to back for 8 hrs QD PRN ... lyrica 1 tab PO BID ... meloxicam 1 tab PO QD ... metoprolol 1 tab PO BID ... montelukast 1 tab PO

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QD ... myrbetriq 1 tab PO Q HS [bedtime] ... nitrofurantoin 1 PO BID ... Norco 1-2 tabs QD PRN ... omeprazole 1 tab PO QD ... oxygen ... paroxetine 1 tab PO QD ... pravastatin 1 tab PO QD ... prednisone 3 PO QD ... pyridium 1 PO BID PRN ... tessalon perle [sic] 1 PO BID PRN ... tudorza inhale 1 puff QD until gone ... vitamin D3 1 tab PO QD ...."

The record failed to evidence a medication review that identified medications in layman's terms, that was easy for the patient to understand, had an accurate medication interaction check completed, and was sent to the physician as evidenced by:

On 2/19/19 an agency drug to drug interaction was run from the agency's software system that indicated no drug to drug interactions. The record failed to evidence that drug to drug interactions were run as there was no documentation or tracking within the system to show that it was completed and sent to the physician.

On 2/19/19, the following medications were checked on Drugs.com for interactions: Benadryl, cephalexin, lidocaine, lyrica, montelukast, myrbetriq, paroxetine, pravastatin, prednisone, pyridium, tessalon, tudorza, vitamin D3, Advair, albuterol, baclofen, buspirone, calcium, doxycycline, eliquis, ibuprofen, ipratropium, Januvia, meloxicam, metoprolol, nitrofurantoin, Norco, and omeprazole. The Drugs.com list identified the following reactions: Major interactions with meloxicam and eliquis; Major interactions with Nuedexta and Zofran; and Major interactions with buspirone and hydrocodone; Major interactions with calcium and vitamin D3; Major interactions with buspirone and paroxetine; Major interactions with baclofen and

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hydrocodone; Major interactions with ibuprofen and eliquis. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."

9. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18.

The record contained a current Medication Profile effective 2/18/2019 with the following medications: "... amitriptyline 1 PO QD ... baclofen 1 PO TID PRN ... buproprion 1 PO QD ... clonazepam 1/2 tab PO Q AM at [and] noon, 1 tab PO QHS ... divalproex 3 tabs PO QPM ... flomax 1 PO QD ... gabapentin 1 PO QHS ... lisinopril 1 PO QD ... Miralax QD PRN ... percocett 2 tabs po q 4 hrs PRN ... protonix 1 PO BID ... tramadol 1 PO Q 6 hr PRN ... trintellix 1 PO QD ...."

The record failed to evidence a medication review that identified medications in layman's terms, that was easy for the patient to understand, had an accurate medication interaction check completed, and was sent to the physician as evidenced by:

On 2/21/19 an agency drug to drug interaction was run from the agency's software system that indicated no drug to drug interactions. The record failed to evidence that drug to drug interactions were run as there was no documentation or tracking within the system to show that it was completed and sent to the physician.

On 2/21/19, the following medications were checked on Drugs.com for interactions: amitriptyline, baclofen, bupropion, clonazepam,

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	divalproex, flomax, gabapentin, lisinopril, miralax, percocet, protonix, tramadol, and trintellix. The Drugs.com list identified the following reactions: Major interactions with bupropion and tramadol; Major interactions with bupropion and trintellix; and Major interactions with clonazepam and percocet; Major interactions with tramadol and trintellix; Major interactions with clonazepam and tramadol; Major interactions with baclofen and percocet; Major interactions with percocet and tramadol; Major interactions with baclofen and tramadol; Major interactions with bupropion and percocet; Major interactions with amitriptyline and tramadol; Major interactions with amitriptyline and trintellix. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit." 10. During an interview on 2/19/19 at 12:27 PM, employee K, registered nurse, stated that when inputting new medications into the software system, if a medication interaction was present, the agency would only notify the physician if the agency could not manage potential adverse effects of the medication such as monitoring labs.			
G 0548 Bldg. 00	Based on record review and interview, the Registered Nurse (RN) failed to ensure a Resumption of Care assessment (ROC) was performed after hospitalization for 1 of 1 patient who required a ROC in a sample of 17 (#2). Findings include: The clinical record of patient #2 was reviewed	G 0548	All patients that are admitted to the hospital for 24 hours or more will receive a resumption of care assessment by the RN. This will be evidenced by a resumption of care assessment document in the patient clinical chart. The ACM will ensure all documentation is reviewed and that the RN received a resumption order prior to	03/28/2019

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	2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19. An agency care coordination note completed by the registered nurse (RN) on 1/14/19 at 1:13 PM stated the patient was going to the emergency room. Hospital documentation indicated that the patient had a hospital inpatient stay from 1/14/19-1/18/19. The agency RN completed recertification on 1/21/19. The RN failed to complete a resumption of care after the patient was released from the hospital within 48 hours. During an interview on 2/25/19 at 1:46 PM, the administrator stated that a resumption of care should be completed within 48 hours of discharge from the hospital.		resuming services. The nurse will be notified by the patient/caregiver of the hospital DC. The nurse will inform scheduling and the ACM of the impending resumption. The nurse will get a resumption order from the MD prior to the resumption of care visit. Once the ACM is notified of the impending resumption, they will track the status of the patient to ensure the order was received from the MD and that the resumption of care assessment was completed. The ACM will meet daily at the start of each work day with clinical staff to review current status of each patient and to ensure resumption of care is performed on all patients DC from hospital. The Administrator will ensure all proper documentation is completed on patients resumed by meeting with ACM daily to review status of patients and documentation required for each patient. The Administrator will review 10% of visit documentation monthly to ensure this process is upheld.	
G 0570 Bldg. 00	Based on observation, record review and interview the Registered Nurse (RN) failed to ensure a complete and individualized plan of care was developed (see tag G574); failed to ensure a written visit schedule was provided to the patients (see tag G614) and failed to ensure that a	G 0570	The RN will compose a complete and individualized care plan for the patient upon admission and will review the patient care plan with the patient at each nurse visit. The RN will do so by utilizing the electronic patient system and	03/28/2019

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	medication list was provided to the patient (see tag G616). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care Planning, coordination, quality of care.		creating individual tasks for each patient. Each task will be specific as to when (day and/or time of day) the task should be completed during the visit and the degree of involvement the aide will have in helping the patient complete the task. The Administrator will in service all nursing staff on the care plan requirements by 3/28/19. The ACM will review all visit documentation for thoroughness and to ensure care plan is specific to patient needs. Administrator to ensure procedure is followed by auditing 10% of all charts monthly for accuracy. Scheduling to mail patient visit schedules one time monthly to patients per agency policy. Scheduling to notify Administrator the last week of each month to report schedules were mailed. Schedule to be kept in patient folder. Schedule to show date, time and scheduled aide. The RN to put copy of completed patient medication list in patient folder in patient home. RN to update as applicable. RN to check patient folder at each nurse visit to ensure patient schedule and medication profile is present in patient folder and replace if missing. ACM to perform nurse supervisory visits monthly and inspect patient folder for all mandatory items including patient schedule and medication profile. Administrator to review all completed nurse supervisory visits	

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			during daily meetings with ACM.	
G 0574 Bldg. 00	Based on observation, record review and interview, the Registered Nurse (RN) failed to accurately complete the plan of care to include all pertinent diagnoses for 6 of 7 records reviewed (#2, 3, 4, 5, 9, 15), ensure the goals were present for all identified needs for 7 of 7 records reviewed (#1, 2, 3, 4, 5, 9, 15), included all patient-specific frequency and duration for 1 of 7 records reviewed (#2) and contained all durable medical equipment (DME) in the patient's home for 2 of 7 records reviewed (#2, 15) in a sample of 17. Findings include: 1. An agency policy dated 1/14/19, titled, "Patient Plan of care," Policy# N0533 stated "... The nursing care-plan will contain the following:..4. Services to be provided. 5. Frequency and duration of visits 6. Medications including time of administration and route 8. Signed and dated clinical notes from all personnel providing services...11. 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...." 2. The clinical record of patient #3 was reviewed on 02/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care (POC) for the certification period of 2/14/19-4/14/19 which indicated diagnoses of "... Type 2 diabetes mellitus without complications... essential ... hypertension..." The plan of care	G 0574	The RN will utilize the comprehensive assessment checklist at each nursing visit to ensure all required tasks are completed. All diagnosis to be listed in plan of care. All medications listed to have an appropriate diagnoses to support the patient medication prescribed. ACM to audit all documentation for accuracy after each nurse visit and to ensure all assessment findings have a listed diagnosis to support findings. Patient specific frequency and duration to be reviewed and verified with the MD order. RN to ask patient at each nurse visit to state all DME in the home and list on the plan of care in DME specific section. ACM to ensure all DME reported in assessment is listed in DME section of plan of care. ACM to ensure process is followed by performing nursing supervisory visit and reviewing DME observed and reported in the patient home and reviewing each medical diagnoses with patient to ensure all diagnoses are listed on plan of care. ACM to educate nurse on any deficiencies found. Nurse to correct deficiencies within 48 hours and deliver updated patient information to patient folder in	03/28/2019

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	failed to evidence goals related to the type 2 diabetes, hypothyroidism, and failed to evidence the patient's allergies (if any) or NKA (no known allergies). The agency comprehensive recertification assessment dated 2/12/19, indicated the patient was taking Cetirizine (antihistamine), Eliquis (blood thinner) and Levothyroxine (hypothyroidism). The plan of care failed to evidence pertinent diagnoses and goals related to use ceterizine, eliquis, and levothyroxine. 3. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC for the certification period of 10/2/18 -11/30/18 that indicated diagnoses of: chronic obstructive pulmonary disease (COPD)...Chronic congestive heart failure (CHF). The plan of care failed to evidence patient specific goals related to COPD and CHF. The agency comprehensive recertification assessment dated 10/2/18 indicated the patient was experiencing dyspnea and edema and a diagnosis of Hypertension. The POC failed to evidence a pertinent diagnosis of hypertension and goals related to dyspnea and edema. 4. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date 9/12/18. The record contained a POC for the certification period of 1/10/19-3/10/19 which indicated, but not limited to diagnoses of Type 2 diabetes mellitus without complication. The plan of care failed to evidence goals related to Type 2 diabetes. The agency comprehensive recertification		home if applicable and patient medical chart. Administrator to meet with ACM daily and review all nursing supervisory visits. Administrator to review supervisory visit forms to ensure ACM completed form and addressed all deficiencies with nurse. Administrator to ensure nurse has corrected any deficiencies and documented updated information was delivered to patient within given time frame.	

assessment dated 1/17/19 indicated the patient was taking Atorvastatin (hypercholestrol), Belsomra (insomnia), Colace (constipation), Miralax (constipation), Pepcid (gastroesophageal reflux), Maxalt (migraines), Venlafaxine (antidepressant), and Clopidogrel (blood thinner). The plan of care failed to evidence pertinent diagnoses and goals related to use of the medications identified in the comprehensive assessment.

5. The clinical record of patient #15 was reviewed on 02/21/19 and indicated a start of care date of 05/24/13. The record contained a plan of care for the certification period of 01/23/19 - 03/23/19 that indicated diagnoses but not limited to..."Type 2 diabetes mellitus without complications and unspecified osteoarthritis... DME [durable medical equipment] ... glucometer, test strips, lancets, alcohol pads, urinary drainage bag, urinary leg bag...SN (skilled nurse) to RN will educate patient on measure to decrease edema....." The plan of care failed to evidence patient specific goals related to diabetes and osteoarthritis and failed to evidence a diagnosis related to edema.

The agency comprehensive recertification assessment dated 01/21/19 identified the patient had an indwelling foley catheter and hypertention and edema. The plan of care failed to evidence pertainent diagnosis and goals related to the patients indwelling foley catheter,and hypertension (due to the use of metoprolol), failed to evidence foley catheter size, infection control measures and emergency plans related to the catheter based on needs of the patient.6. The clinical record of patient #1 was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The record contained a plan of care for the certification period of 1/15/19-3/15/19. The plan of care failed

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	to evidence goals related to edema, constipation, pain, and diabetes based on the identified needs of the patient on the comprehensive assessment as evidenced by: The agency's comprehensive recertification dated 1/10/19 identified the patient had edema, constipation, pain and was a diabetic. 7. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19 that indicated a frequency of 70 hours a month waiver attendant hours. The plan of care failed to evidence patient-specific goals related to urinary incontinence, type II diabetes, asthma and chronic obstructive pulmonary disease (COPD), failed to evidence a diagnosis related to the use of antihypertensive medication and failed to have specific frequency and duration for the patient's attendant care needs. During a home visit observation on 2/18/19 at 10:00 AM, with patient #2, employee C, licensed practical nurse (LPN), was observed providing skilled care. DME in the home observed was a grabber, nebulizer, hospital bed, and an emergency alert bracelet. The plan of care failed to evidence the equipment identified in the home. The agency's comprehensive recertification dated 6/1/17 identified the patient had edema, incontinence, and shortness of breath with oxygen use. The plan of care failed to evidence goals related to edema, incontinence, and shortness of breath and/ or oxygen use based on the needs of the patient. 8. The clinical record of patient #5 was reviewed			

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	2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18 that indicated "Incision will cont [continue] to heal with no s / sx infection throughout certification period ...." The plan of care failed to evidence patient-specific goals related to urinary incontinence, intermittent asthma, and hypertension failed to evidence diagnoses related to the incision goal and anti-anxiety medication use. The agency's comprehensive recertification dated 6/27/18 identified the patient had edema, constipation, and urinary incontinence. The plan of care failed to evidence goals related to edema, constipation, and urinary incontinence based on needs. During an interview on 2/25/19 at 1:46 PM, the administrator stated that the plan of care should contain all DME in the home, all pertinent diagnoses related to the patient's medications, and goals for all identified needs.			
G 0614 Bldg. 00	Based on observation, record review and interview, the agency failed to ensure a written visit schedule was provided for review for 3 of 3 home visits observed and failed to follow the agency scheduling policy (#1, 2, 3) in a sample of 17. Findings include: 1. A policy dated 1/14/19 titled "Patient Care Scheduling #258.00" stated, "...9. Patient's	G 0614	The agency will provide paper visit schedules to the patient monthly. The agency policy will reflect this change and states the patient schedules are to be mailed by the scheduling department the last week of the month. Nursing to verify at the monthly supervisory visit to see if patient received schedule. Nurse to encourage patient to keep schedule in patient folder and refer to as needed.	03/28/2019

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	individual two-week schedule to be completed in entirety every other Tuesday and mailed to patient home by Thursday of that week unless other arrangements have been made ...." 2. During a home visit observation with employee D, home health aide (HHA), on 2/18/19 at 8:00 AM, at patient #1's home (start of care 3/21/18), the patient's home health folder was observed and it failed to evidence a visit schedule provided by the agency. 3. During a home visit observation with employee C, licensed practical nurse (LPN), on 2/18/19 at 10:00 AM, at patient #2's home (start of care 5/26/17), the patient's home health folder was observed and it failed to evidence a visit schedule provided by the agency. 4. During a home visit observation with employee E, HHA, on 2/18/19 at 12:00 PM, at patient #3's home (start of care 8/23/17), the patient's home health folder was observed and it failed to evidence a visit schedule provided by the agency.5. During an interview on 2/18/19 at 1:55 PM, the administrator stated written schedules used to be mailed to the patient's every week but it was confusing the patients. The administrator stated about a month ago, the agency implemented a new procedure where the HHA's pull up the schedule for the patients every Wednesday and review it with the patient for the following week. The patients could request a hard copy if they wanted, but it was not automatically sent.		Scheduling department to report to Administrator on the last week of the month once schedules have been mailed to ensure this process is upheld. Nursing to verify patient received paper visit schedule each month at the supervisory visit. Nurse to document patient received schedule and schedule is present in patient folder unless otherwise noted (Ex: patient prefers to keep visit schedule on refrigerator.) ACM to ensure patient received paper copy of patient schedule when nurse supervisory visit is performed. If paper schedules are not mailed the last week of the month, scheduling will be disciplined per agency discipline process. Scheduling to notify Administrator prior to required mailing date if there is an issue that will prohibit scheduler from mailing patient schedules at appropriate time. Administrator will ensure paper schedules are mailed the last week of the month by scheduling report given. Administrator or her delegate will mail paper patient schedules if scheduling department states they are unable to do so by required date.	
G 0616 Bldg. 00		G 0616	The nurse will review all patient	03/28/2019

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	Based on observation and interview, the agency failed to ensure that a medication list was provided to the patient for 1 of 3 home visits observed (#3). Findings include: During a home visit observation with employee E, home health aide (HHA), on 2/18/19 at 12:00 PM, at patient #3's home (start of care 8/23/17), the patient's home health folder was observed and it failed to evidence a medication list provided by the agency. During an interview on 2/19/19 at 3:30 PM, the director of nursing stated a current medication list should be in the patient's home folder.		medications at each nurse visit, update medications if appropriate, request order from MD to ensure medication changes are accurate and verify medication schedule is present in patient home folder. RN to replace medication schedule at nurse visit if missing or inaccurate. The ACM will ensure nursing completes this task by utilizing the updated supervisory visit form which prompts the nurse to check the medication profile in the patient folder. The ACM will also utilize the visit check list which also requires the nurse check the patient folder to ensure the current medication list is present. The ACM will also check the patient folder for the medication profile list at the nursing supervisory visit performed. Utilizing these three processes will ensure the medication list is present in the patient folder. The Administrator will ensure this process is followed by reviewing the nursing supervisory visit documentation performed by the ACM or her delegate. The Administrator will meet with the ACM daily to review current patient status and review all nurse supervisory visit forms completed. The nurse supervisory visits to be filed in nurse employee file for verification of completion.	

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G 0682 Bldg. 00	Based on observation and interview, the agency failed to ensure all staff followed infection control policies and standard precautions for 3 of 3 home visits observed (#1, 2, 3). Findings include: 1. The centers for disease control (CDC) website stated that the handwashing procedure was the following: "Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds." 2. An agency policy dated 1/10/18 titled "Infection Control," Policy # 259.00 stated "... If staff must use antibacterial soap, they will wash their hands with soap and warm water, scrubbing all surfaces of the hands, for at least 10 seconds ...." The agency policy failed to follow the CDC guidelines for professional standards. 3. During a home visit observation on 2/18/19 at 8:00 AM, with patient #1, employee D, home health aide (HHA), was observed providing personal care. Employee D started the visit with a 19-second hand wash and applied gloves. After the patient finished with shower employee D applied lotion to the patient back and bilateral feet removed gloves and completed a 12-second hand wash. After completion of the visit, employee D completed a 12-second hand wash. Employee D failed to perform hand hygiene per CDC [centers	G 0682	The agency handwashing policy to state employee must scrub all surfaces of hands for 20 seconds. All clinical staff to be reeducated and checked off on handwashing by nursing staff before 3/28/19. Nursing staff to be checked off by Administrator before 3/28/19. Copy of check off to be filed in employee file as proof of compliance. Administrator to ensure all field staff was compliant before 3/28/19 by reviewing employee handwashing checkoff report showing completion of employee check off. Case manager nurse to supervise proper handwashing technique at each supervisory visit. This will be a line item on the supervisory visit form. CM will educate aide as needed and document on Supervisory visit. Supervisory visit will be audited by ACM or delegated RN for compliance. All new employees to receive employee handbook including handwashing policy.	03/28/2019

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	for disease control] recommendation of at least 20 seconds. 4. During a home visit observation on 2/18/19 at 10:00 AM, with patient #2, employee C, licensed practical nurse (LPN), was observed providing skilled care. Employee C started the visit with a 13-second hand wash. Employee C failed to perform hand hygiene per CDC recommendation of at least 20 seconds. 5. During a home visit observation on 2/18/19 at 12:00 PM, with patient #3, employee E, HHA, was observed providing personal care. Employee E started the visit with an 11-second hand wash. During the course of the visit employee E completed a 5 second and an additional 11-second hand wash. Employee E failed to perform hand hygiene per CDC recommendation of at least 20 seconds. 6. During an interview on 2/18/19 at 1:43 PM, the administrator stated that staff should be washing their hands for 20 seconds.			
G 0710 Bldg. 00	Based on record review and interview, the skilled nurse (SN) failed to conduct visits in accordance with the plan of care for 1 of 2 records reviewed with skilled nurse services (#2) in a sample of 17. Findings include: The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19 that	G 0710	The agency will indicate a frequency for the skilled nurse visit by documenting the visit per week and not hours per week the patient is seen for an MD ordered skill. The frequency and order for skilled nurse visits will be on the patient plan of care. The ACM will educate the nursing staff, at the daily nurse meeting, on this process and implement the change by 3/28/19. The ACM will	03/28/2019

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	indicated a frequency for the skilled nurse (SN) of 1 hour per week to fill the pillbox. The SN failed to follow the plan of care by not meeting the frequency as evidenced by: On week 1 the SN visit was completed on 1/22/19 for 30 minutes. On week 2 the SN visit was completed on 1/28/19 for 45 minutes. On week 2 the SN visit was completed on 2/4/19 for 30 minutes. On week 2 the SN visit was completed on 2/12/19 for 45 minutes. On week 2 the SN visit was completed on 2/18/19 for 45 minutes. During an interview on 2/25/19 at 1:47 PM, the administrator stated that staff should be following ordered frequencies.		ensure this process is upheld by reviewing all clinical documentation completed by the nurse and utilizing the comprehensive assessment checklist when auditing all clinical documentation, specifically the patient plan of care. The Administrator will ensure this process is upheld by reviewing 10% of all nursing visits monthly.	
G 0716 Bldg. 00	Based on record review and interview, the skilled nurse (SN) failed to prepare clinical notes completely and accurately for 1 of 2 patients receiving skilled nursing services in a sample of 17 (#4). Findings include: The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC for the certification period of 10/2/18 -11/30/18 that indicated	G 0716	The ACM will review all clinical documentation after the nurse completes the applicable visit in the electronic medical chart. The ACM will utilize the comprehensive assessment visit check list to verify accuracy of documentation. ACM to check patient pain level that was documented by nurse and if above baseline was reported to MD with follow up instructions received and patient education performed and	03/28/2019

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	diagnoses of Chronic Obstructive Pulmonary Disease, Unspecified abnormalities of gait, other chronic pain, Chronic congestive heart failure..." The agency comprehensive recertification assessment dated 10/2/18 indicated the patient had a diagnosis of Hypertension and was experiencing dyspnea and edema. The document evidenced a pain 0-10 pain scale and indicated, "perceived pain level during the day of assessment: 0... Perceived pain level AFTER pain relief measures: 7 ... CaseManager and/or Physician notified of the elevated pain level: No... COPD: No ... Chronic obstructive pulmonary disease YES ... dyspnea NO...." The document evidenced conflicting documentation in relation to pain, respiratory status, and diagnoses.During an interview on 2/25/19 at 1:48 PM, the administrator stated that nursing documentation should not be conflicting.		resolution documented. ACM to check diagnosis documentation to ensure consistency between plan of care and assessment in clinical software. The visit check list will prompt the ACM to review each diagnosis listed in the plan of care and assessment against the nurse documentation in the clinical chart assessment visit. The ACM will instruct the nurse to correct any inconsistencies and review the corrected documentation before locking in the clinical chart. The Administrator to ensure the process is upheld and will audit 10% of monthly visit documentation.	
G 0750 Bldg. 00	Based on record review and interview, the agency administrator, failed to ensure that all perspective home health aide employees performed all tasks required in their entirety as required for placement on the home health aide registry (see tag G768; failed to ensure that an aide careplan was completed for each shift and failed to ensure that the aide care plan was individualized with specific tasks timeframe's to be completed (see tag G798); and the home health aide (HHA) failed to follow the plan of care (see tag G800). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.80	G 0750	The agency will obtain a contract RN to observe perspective home health aide employees perform all tasks in their entirety required for placement on the registry. This RN will meet the required state standards and qualifications by the state. The RN will have a contract on file with the agency. The RN will observe perspective HHAs performing tasks required on a live patient, in the patient's home, in it's entirety. The RN will observe the aide performing any task that can be demonstrated in a laboratory setting in its entirety.	03/28/2019

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	Home Health Aide Services.		The completed check off will be signed by the perspective employee and contract RN and be filed in the employee file. The contract RN will register the employee with the state department of health if the contract RN documents the completion of all required tasks by the employee. Any employee that does not successfully complete the check off will not be registered with the state and the employee will repeat the check off portion of orientation before being appropriate for licensing. The case manager will customize the patient care plan for each patient visit. The RN will specify on each task which visit the task is to be completed if multiple visits are ordered. The CM will ensure the care plan is followed daily by observing the aide providing care at the supervisory visit. The note auditing specialist will review every home health aide note for completion and accuracy. The note auditing specialist will document all non compliant employees and list the deficiency on the report. Every aide that is non compliant with following the patient care plan will be counseled by HR per the agency disciplinary policy. The deficiency will be reviewed and the aide will be educated on how to correct the action to ensure the incorrect action is not repeated. The	

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			counseling documentation will be in the electronic employee file. The Administrator will ensure compliance with this process by reviewing the counseling report weekly prepared by the note auditing specialist and verifying the counseling was performed and documented in the employee file.	
G 0768 Bldg. 00	Based on record review and interview, the agency administrator, failed to ensure that all prospective home health aide (HHA) employees performed all tasks required, in their entirety with a patient and not simulated, as required to show competence for placement on the home health aide registry for 1 of 1 agency. Findings include: 1. A policy dated 1/14/19, titled "Home Health Aide Supervision, Training and Education" stated, "...Training: [agency] provides a competency and certification program for home health aides. The program utilizes the Medicaid required guidelines...." 2. During an interview on 2/19/19 at 9:00 AM the Nurse Practioner (NP) indicated she developed the HHA (home health aide) training program after going through the Indiana State test for HHA competency. The NP indicated the training is 8 hours on Fridays with her after the orientation training with the Administrator. The NP reported every aide performed all tasks required to be placed on the State registry independently. She	G 0768	The agency will obtain a contract RN to observe perspective home health aide employees perform all tasks in their entirety required for placement on the registry. This RN will meet the required state standards and qualifications by the state. The RN will have a contract on file with the agency. The RN will observe perspective HHAs performing tasks required on a live patient, in the patient's home, in it's entirety, specifically (b)(3)(1), (iii), (ix), (x), and (xi). These areas will be observed being performed on a live patient. The RN will observe the aide performing any task that can be demonstrated in a laboratory setting in its entirety. The completed check off will be signed by the perspective employee and contract RN and be filed in the employee file. The contract RN will register the employee with the state department of health if the contract RN documents the	03/28/2019

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	indicated patient #9 had allowed 9 prospective HHA's to perform a complete tub bath and shampoo during one visit. The NP indicated all the HHA's in the program were trained by the Administrator and herself and stated, "If I feel they did a good job in the field, I sign the registry." When asked if there was any instance in which the prospective HHA would not be placed on the State registry, the NP stated, "If I felt they didn't do cath care properly or Hoyer properly or foot care properly." 3. During an interview on 2/19/19 at 10:51 AM, employee I (date of hire 11/29/18) indicated she received 2 days of training before being placed on the State registry. Employee I indicated during the training, she did not perform a bed or tub bath and while performing a shower, each prospective HHA rotated tasks. "Nobody did a start to finish." 4. During an interview on 2/19/19 at 11:16 AM, employee H (date of hire 12/27/18) indicated she did 2 partial days of patient training and was assigned a schedule the subsequent Saturday. 5. During an interview on 2/19/19 at 12:35 PM, employee G (date of hire 7/27/16) indicated she had "4 hours training one day, period." Employee G indicated she "already knew that [how to wrap a limb with an ace wrap], but I went through the training." 6. During an interview on 2/25/19 at 1:50 PM, the Alternate Administrator stated, "We have a competency check off. We train, but we don't do the 75 hours the state requires. We don't have the money to do the 2 week program. We don't have enough money to pay high-quality aides."		successful completion of all required tasks by the employee. Any employee that does not successfully complete the check off will not be registered with the state and the employee will be required to repeat the check off portion of orientation successfully before being appropriate for licensing. The Administrator will review all completed paperwork by the contract RN to ensure the employee has successfully completed the competency check off. The Administrator will contact the patient(s) utilized for the live check off to verify each perspective employee completed the required tasks in their entirety on the patient. Once verification is obtained from the patient, the Administrator will initial the competency check off as documentation of completion. At this time the contract RN will be notified and approved to register the incoming employee.	

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	7. During an interview on 2/25/19 at 2:00 PM the Administrator indicated each HHA should complete all required tasks prior to being placed on the State registry. The Administrator indicated if more than one prospective HHA was in the field for competency training it was acceptable for each trainee to perform parts of the bath or task, taking turns on one patient to verify competency and that the NP was training the HHA to assess the patients in their care. 8. During an interview on 2/25/19 at 2:18 PM, the Administrator indicated the agency had a home health aide training program with a competency "out in the field ... Other agencies send their staff here to train them."9. An agency competency assessment form titled "Skills evaluated on Live Patient,"... indicated the skills that needed demonstrated on a live patient was: bed bath, sponge bath, tub bath, shower, sink shampoo, tub shampoo, bed shampoo, fracture pan placement, urinal, bathroom and tilting assistance, catheter care, perineal care, nail care, skin care, oral hygiene and gum care, denture care, bedside commode, offering bedpan/ placement, proper use of gait belt, transfer from bed to chair, transfer from chair to toilet/ bedside commode, transfer to wheelchair, assisting with ambulation, assist ambulating with cane, assist ambulating with a walker, assist with wheelchair to/ from, demonstrates passive ROM [range of motion], upper and lower body, demonstrates active ROM, upper and lower body, demonstrates proper bedding position, demonstrates proper chair positioning, demonstrates ability to provide pertinent report/ information to patients, representatives, caregivers, and agency staff, demonstrates ability to follow patient assignment sheet, temperature, pulses, respirations, blood pressure (optional) based on agency policy,			

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	reading, writing ...." 10. An agency competency assessment form titled "Skills evaluated through simulation by demonstration, written /case scenarios, or oral training," indicated the skills that needed demonstrated but did not have to be completed on a live patient was "assist with a medical lift, knowledge of signs and symptoms of dehydration, edema, and importance of hydration, knowledge of normal dietary requirements, knowledge of special diets, knowledge of normal skin, risk factors for skin problems, s / s [signs and symptoms] of skin breakdown, knowledge of importance of changing positions frequently, helping a patient dress, proper body mechanics, using a safety razor, using an electronic razor, elastic/ compression stocking application, use of hoyer lift, back rub, working with a patient who has an infusion line, if patient had telehealth unit in place, reminds them to do checks, knowledge of normal body functions, knowledge of information that must be reported to supervisor, identifies safety hazards/ issues in the home, basic cleaning methods, making occupied bed, making unoccupied bed, knowledge of food safety, cleaning equipment, recognizes emergency situations, knowledge of what to do in an emergency, incident report, recognizes and reporting of suspect abuse/ neglect, is familiar with individual patient emergency preparedness plan, demonstrates understanding of the need to respect privacy, knowledge of patient rights, demonstrates knowledge of confidentiality and information covered under HIPAA [health insurance portability and accountability act], knowledge of professional boundaries, understanding of the patient complaint process, knowledge of working with patients served by the agency, understanding the different types of			

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baths, demonstrates knowledge of general patient observations, identifies changes in a patient's condition or appearance that should be reported, demonstrates ability to report patient changes to appropriate person (s), demonstrates ability to accurately document tasks, care or observations, document in the clinical record id accurate and effective, handwashing, use of sanitizer versus handwashing, disposal of waste, standard precautions, recognized signs of potential infections, understands methods to decrease risk for infection ...."

11. During an interview on 2/18/19 at 8:00 AM, employee D (date of hire 11/5/15), HHA stated the agency put her on the aide registry. Employee D stated she only did a shower in someone's home to be checked off.

12. During an interview on 2/19/19 at 12:01 PM, former employee J (date of hire 9/27/18), HHA, stated she had gone to a patient's home one day for check offs, washing someone's hair while with other people being checked off and was on the schedule the next day.

13. During an interview on 2/20/19 at 11:39 AM, patient # 9 stated that he/ she would let the agency do tub bath check offs in their home. The patient stated every Friday, a group of new aides would come to his / her home accompanied by the administrator or the nurse practitioner (NP). The patient reported on average 3-4 aides trained at a time, sometimes more or less. The patient was asked while the aides were in the home if he/ she would multiple tub baths from each aide present, in which the patient stated: "no, never." The patient stated, "If I got multiple baths per day my skin would be so raw." The patient explained the aides would do a "round robin," approach where

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	someone washed the hair, one washed the area, one rinsed the area, they would all do different areas. The patient stated the "odd man out would do pericare." The patient stated they would not be okay with a full bath being completed by every aide. 14. During an interview on 2/20/19 at 11:57 AM, patient #15 stated he/ she would allow agency aides to do bed baths on Fridays. The patient stated that a group of 2-3 people would come together and take turns washing different areas of the body.			
G 0798 Bldg. 00	Based on record review and interview, the registered nurse (RN) failed to ensure that an aide care plans were completed for each shift and failed to ensure that the aide care plan was individualized with specific tasks timeframe's to be completed for 7 of 7 patients receiving HHA (home health aide) services (#1, 2, 3, 4, 5, 9, 15). Findings include: 1. The clinical record of patient #3 was reviewed on 02/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care (POC) for the certification period of 2/14/19-4/14/19 which indicated a HHA frequency of 1-3 hours per day 1-3 days per week to assist with diabetic foot care and with all ADL's (activities of daily living) and IADL's (instrumental activities of daily living) per the HHA care plan. The Recertification comprehensive assessment	G 0798	The RN will compose a complete and individualized care plan for the patient per the agency policy. The RN will do so by utilizing the electronic patient system and creating individual tasks for each patient. Each task will be specific as to when the task should be completed during the visit and the degree of involvement the aide will have in helping the patient complete the task. The ACM will review all visit documentation for thoroughness and to ensure care plan is specifics to patient needs. The ACM will utilize the comprehensive assessment checklist to specifically prompt the ACM to check the care plan for specific tasks, specific time/days tasks are to be performed and ensure the care plan is current for the patient	03/28/2019

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	dated 2/12/19 indicated, "...Aide Care Plan - Effective on 11/29/17: The agency aide/ homemaker care plan had the tasks to be completed as follows: Assist with shower, assist with sponge bath, clean bathroom, dusting...foot care, spray with alcohol before and after visit, standard precautions, up as tolerated, up with assistance - walker, clean kitchen, dishes, laundry, take out trash..." The HHA care plan failed to be updated and identify the timeframe (every visit or once a week for example) the tasks that were to be completed. 2. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC for the certification period of 10/2/18 -11/30/18 indicated a HHA frequency of 2-4 hours a day, 5-7 days a week to assist with ADL's and IADL's per the HHA care plan. The agency document titled "Aide/ Homemaker Care Plan" indicated, "...Patient goal: [blank]...Current Aide Plan (Effective Date 10/4/2018)... Assist with Shower Utilizing Shower Chair - AM... Clean Bathroom, Comb Hair, Complete Bed Bath - AM visit, Encourage [sic] patient to do as much as possible...Have patient stand up to change pull-up...Hoyer lift - May use after pt has attempted to transfer, Incontinent care...Peri Care, Put 2 pull-ups at each visit...Up with Assistance - Wheelchair ...." The HHA care plan failed to identify the timeframe (every visit or once a week for example) the tasks that were to be completed. 3. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date 9/12/18. The record contained a POC for the certification period of 1/10/19-3/10/19 indicated a		needs based on the visit assessment performed by the nurse. Administrator to meet with ACM daily to review patient status on all agency's patients. ACM will also review care plan at nursing supervisory visits.Administrator to ensure procedure is followed by meeting with ACM daily to review all nursing supervisory documentation. Administrator to ensure compliance with process by auditing 10% of all charts monthly for accuracy.	

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	HHA frequency of 2-3 hours a day 5-7 days per week to assist with ADL's and IADL's. The agency document titled, "Aide/ Homemaker Care Plan" indicated "...Patient goal: [blank]...Current Aide Plan (Effective Date: 9/12/2018)...Assist with Ambulation, Assist with Dressing, Assist with Shower Utilizing Shower Chair, Assist with Sponge bath, Assist with Transfer, Assist with Tub Bath...Clean Bathroom, Clean Dentures, Clean Kitchen, Clean up after service dog, Comb Hair, Dishes, Foot Care...Incontinent Care, Make bed, Peri Care, Prepare Meal...Shampoo Hair, Sweeping, Take out Trash, Up as Tolerated, Up with Assistance - Walker...." The HHA care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. 4. The clinical record of Patient # 15 with a start of care date of 05/24/13 and certification periods of 01/23/19 - 03/23/19 was reviewed on 02/21/19 indicated a HHA frequency of 4 hours a day 7 days a week to assist with ADL's and IADL's. The agency document titled, "Aide/Homemaker Care Plan" indicated "... Patient goal: [blank]...Current Aide Plan (Effective Date: 11/30/2017)...Assignment instructions included:...Assist with shower utilizing shower chair...Assist with sponge bath...Assist with transfer...Catheter care...Change linens...Dusting, Footcare...Peri care...Remind patient to take blood sugar...Shampoo hair, Spray with Alcohol before and after visit ...." The HHA care plan failed to identify patient-specific tasks for the aide to complete during each visit. The HHA care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. 5. The clinical record of patient #1			

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	was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The record contained a plan of care for the certification period of 1/15/19-3/15/19 that indicated a home health aide (HHA) frequency of 1 hour, 3-5 days per week. The agency aide/ homemaker care plan had the tasks to be completed as follows: Apply non-medicated lotion to the skin, assist with ambulation, assist with showering utilizing shower chair, assist with transfer, clean bathroom, clean dentures, comb hair, foot care ... Incontinent Care, Make Bed, Oral care, Peri Care, remind patient to put in / assist with hearing aid, remind patient to put on glasses. The aide care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. During a home visit observation on 2/18/19 at 8:00 AM, with patient #1, employee D, home health aide (HHA), was observed providing personal care. Employee D stood outside the shower while the patient showered self. The patient requested employee D wash the back. The aide applied lotion to the back per patient request. All other care the patient provided to self. Employee D failed to clean dentures, complete oral care, peri care or remind the patient to put in hearing aide. Employee D failed to follow the aide care plan. 6. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19 that indicated a HHA frequency of 3-5 hours per day, 4-6 days per week. The agency aide/ homemaker care plan had the tasks to be completed as follows: assist with ambulation, assist with dressing, assist with			

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	showering utilizing shower chair, assist with a sponge bath, blood sugar reminder, clean bathroom, clean kitchen, comb hair, dishes ... Incontinent- bladder, Incontinent ... laundry ... peri care ... prepare meal ... shampoo hair ... take out trash, Make Bed, Oral care, Peri Care. The aide care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. 7. The clinical record of patient #3 was reviewed 2/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care for the certification period of 12/16/18-2/13/19. The aide careplan indicated the aide was to complete: assist with shower, assist with sponge bath, clean bathroom, dusting (Wednesday), foot care, up with assistance (walker). During a home visit observation on 2/18/19 at 12:00 PM, with patient #3, employee E, HHA, was observed providing personal care. Employee E stood outside of the shower while the patient showered self. Employee E washed the back of the patient's legs and back. After the patient got out of the shower, employee E dried the patient's legs and feet. The patient dressed self, brushed teeth and ambulated to the chair. Employee E rubbed lotion on the patient's feet, and the patient put own socks and shoes on. Employee E failed to follow the aide care plan. 8. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18 4-6 hours per day, 5-7 days per week. The agency aide/ homemaker care plan had the tasks to be completed as follows: Apply			

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	non-medicated lotion to skin, assist with ambulation, assist with dressing, assist with feeding patient, assist with shower utilizing shower chair, assist with sponge bath, assist with transfer, clean linens, clean bathroom, clean kitchen, comb hair, Make Bed, medication reminders, Oral care, Peri Care. The aide care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. 9. During an interview on 2/25/19 at 1:33 PM, the administrator stated that the aide care plan is specific to the patient and that the Elvis system (aide documenting system) only allows the agency to have one aide care plan for all shifts and payer types.			
G 0800 Bldg. 00	Based on record review and interview, the home health aide (HHA) failed to follow the plan of care for 3 of 7 full records reviewed (#4, 5, 9) in a total sample of 17. Findings include: 1. An agency job description dated 1/10/18, titled "Home health aide," Policy # 606.00 stated "... Performance Responsibilities ... Follows a written plan of care ...." 2. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC (plan of care) for the certification period of 10/2/18 -11/30/18, which indicated a frequency of 2-4 hours per day, 5-7 days per week. The agency	G 0800	The agency will provide home health services based on the MD approved order. Any time the agency falls below the hours or days of the approved order the MD will be notified. The process will be as follows: The note auditing specialist will review all completed visits utilizing the note verifier in the medical software system. If a completed visit falls below the ordered hours or the patient was not seen for the ordered minimum days, the note auditing specialist will write a communication to the case manager. The case manager will notify the MD that the patient was not seen for the minimum hours or days per the	03/28/2019

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	visit schedule indicated a HHA visit was completed on 10/25/18 and was 1 hour 30 minutes in duration. The HHA failed to follow the frequency parameters on the plan of care (2-4 hours). 3. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date 9/12/18. The record contained a POC for the certification period of 1/10/19-3/10/19, which indicated a frequency of 2-3 hours per day, 5-7 days per week. The agency visit schedule indicated the HHA visits on 1/17/19 and 2/16/19 were only 1 hour in length.4. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18 that indicated a frequency of 4-6 hours per day, 5-7 days per week. The agency visit schedule indicated HHA visits completed on: 2/2/18 that was 2 hours in duration, 7/4/18 was 3.5 hours in duration, and 7/17/18 was 3 hours in duration. The HHA failed to follow the frequency parameters on the plan of care (4-6 hours). 5. During an interview on 2/25/19 at 1:47 PM, the administrator stated that staff should be following ordered frequencies.		MD order. The case manager will inform the MD who provided care for the patient and the status of the patient during the time not seen by the agency. The ACM will be copied on the notification by the note auditing specialist in order to track and ensure that the case manager notified the MD and documented appropriately. The ACM will review all documentation by the case manager in order to verify notification to the MD is completed in a timely manner. The Administrator will ensure this policy is upheld by meeting with the ACM daily to review the status of each patient and any and all follow up needed and completed. The Administrator will audit 10% of all clinical documentation monthly to ensure nursing is following the process appropriately. Home health aides to be educated on 3/26/19 by letter with paycheck explaining order frequency and duration and discussing this with clinical Manager or delegate who will ensure understanding through question and answer with each aide by phone or face to face. All new employees will be trained about frequency and duration in same manner upon hire.	
G 0984 Bldg. 00	Based on observation, record review, and	G 0984	The agency will utilize the comprehensive assessment	03/28/2019

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	interview, the Clinical Manager failed to ensure the skilled nurse (SN) performed a complete physical assessment per professional standards for 1 of 1 skilled nurse home visits observed (#2). Findings include: An agency policy titled, "Nurse Care Visit Note" dated 1/14/19, stated: "Policy: Nurse Care Visit Note completed by CM (case manager) Nurse to show accurate assessment and documentation of patient visit. Procedure: 1. CM Nurse to address every item on Nurse Care Visit Note while completing the physical assessment ...." Constantine, L., MSN, RN, C-FNP. (2004, June 15). Overview of Nursing Health Assessment. Retrieved February 26, 2019, from rn.com, indicated, "Skin assessment can be performed throughout physical examination. ... When assessing the skin, EXAMINE the following: General pigmentation and texture, Edema, Bruising, Lesions, Hair, Nails. Remember that skin breakdown is a common problem with the ill and hospitalized patients. Skin assessment is vital to identify areas of vulnerability in the prevention of pressure ulcers. ... Cardiovascular Assessment: When assessing the cardiovascular system, examine the following ... Auscultate hear sounds ... Listen for any extra heart sounds ...Palate peripheral pulses, Inspect extremities (color, capillary refill, edema, ulcerations) ... PULMONARY ASSESSMENT: When examining the pulmonary system ... Inspect the thoracic cage, palpate the thoracic cage, Auscultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth, Auscultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any		checklist for every skilled nurse visit. The nurse will complete the checklist in its entirety. The checklist will review each system for a complete head to toe assessment. The assessment will include vital signs, cardiovascular assessment including auscultation, listen and note any abnormal sounds, palpate peripheral pulses, inspecting extremities for color, capillary refill, edema, ulcerations, pulmonary assessment, including inspecting the thoracic cage, palpate the thoracic cage, auscultate the anterior and posterior chest, counting respirations for one minute, auscultate between each rib, assessing the abdomen/gastrointestinal system, investigate any abdominal pain, any change in bowel habits, auscultate for bowel sounds and bruits, dividing the abdomen into 4 quadrants and auscultating each quadrant. Heart rate x 1 min, skin assessment including general pigmentation and texture, edema, bruising, lesions, hair, and nails, genitourinary assessment including any pain or discomfort and incontinent status if applicable. The ACM will review all nursing documentation for thoroughness after each skilled nurse visit utilizing the comprehensive assessment checklist to ensure all sections	

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	adventitious breath sounds. ... Assessing the Abdomen/Gastrointestinal System: When examining the abdomen/gastrointestinal system, ASK about the following ... Any abdominal pain, Any change in bowel habits ... Auscultate for bowel sounds and bruits. Begin by dividing the abdomen into 4 quadrants, by drawing an imaginary line vertically and horizontally across the abdomen to intersect the umbilicus. Right, Upper Quadrant, Left Upper Quadrant, Right Lower Quadrant, Left Lower Quadrant. Auscultation should begin in the right lower quadrant. If bowel sounds are not heard, in order to determine if bowel sounds are truly absent, listen for a total of five minutes." During a home visit observation on 2/18/19 at 10:00 AM, with patient #2, employee C, licensed practical nurse (LPN), was observed providing skilled care. Employee C took patient vital signs of oxygen saturation and pulse via pulse oximeter and blood pressure via wrist cuff. Employee C auscultated posterior lungs in 4 areas and the apical heart sounds. Employee C failed to complete a skin assessment, full lung assessment, bowel assessment, cardiac assessment, or endocrine assessment. During an interview on 2/18/19 at 1:50 PM, the administrator stated that during a skilled nurse visit, the nurse should complete a head to toe physical assessment, perform any skill the patient required, perform vital signs, and review all medications.		are completed. Each SN will be checked off by the Clinical Manager for completing a comprehensive assessment, and will be supervised at a patient's home 1 time monthly by Clinical Manager or Assistant Clinical Manager or delegate RN. The Administrator will ensure the process is upheld by auditing 10% of all clinical documentation monthly and meeting with the ACM daily to review current patient status and all follow up and outstanding documentation needed by clinical staff.	
G 1022 Bldg. 00	Based on record review and interview, the agency	G 1022	The agency case manager will send a completed discharge	03/28/2019

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	failed to ensure that a transfer summary was completed and sent to the admitting inpatient facility for 2 of 2 patients hospitalized (#2, 8) in a sample of 17. Findings include: 1. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19. An agency care coordination note completed by the registered nurse (RN) on 1/14/19 at 1:13 PM stated the patient was going to the emergency room. Hospital documentation indicated the patient had a hospital inpatient stay from 1/14/19-1/18/19. The agency failed to complete and send a transfer summary to the hospital when the patient was admitted. 2. The clinical record of patient #8 was reviewed 2/25/19 and indicated a start of care date of 3/9/18. The record contained a plan of care for the certification period of 1/3/19-3/3/19. An agency skilled nurse visit was completed by employee T, a registered nurse on 2/220/19. The note indicated the patient was transported to the local hospital's emergency department per ambulance at 11:35 AM. The agency failed to complete a transfer summary to send to the hospital when the patient was admitted. 3. During an interview on 2/25/19 at 2:52 PM, that administrator stated a transfer should be completed when a patient goes into the hospital for skilled patients.		summary per the admission, discharge, and transfer policy, to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA within 5 business days of the patient discharge. If the patient will be transferred to a health care facility a transfer summary will be sent to the facility within 2 business days of the planned transfer. A completed transfer summary will be sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. The case manager will inquire what facility the patient will be transferred to and the contact information of the facility. The case manager will contact the facility to give report on patient status. The case manager will also fax the current plan of care, including medication profile, to the facility for coordination of care. The case manager will document all communication and coordination of care with the facility in the patient medical chart. If the patient is discharged from the agency, the case manager will complete the discharge summary in the clinical chart and send to the health care professional within 5 days. The	

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			ACM will track the status of all patients in the agency and meet daily with the clinical staff to review the status of each patient and any outstanding documentation needed. The ACM will ensure all transfer documentation and discharge summaries are sent to the appropriate provider within the regulated time frame. The ACM will review all documentation provided by the case manager prior to sending to the medical provider. The Administrator will meet daily with the ACM to review patient status and ensure all documentation has been sent to the appropriate provider in the regulated time frame required. The Administrator will also review 10% of all documentation monthly to ensure the documentation was sent in the regulated time frame for all patients transferred or discharged from the agency.	
G 1024 Bldg. 00	Based on record review and interview, the agency failed to authenticate visit documentation for 3 of 7 full records reviewed. (#2, 4, 5) Findings include: 1. A policy dated 1/14/19, titled "Clinical Records-Purpose and Content #252.00" stated, "...7. Signed and dated clinical notes for each contact	G 1024	The ACM will review all clinical documentation composed by the nursing staff for accuracy. The nursing staff will complete visit documentation in the electronic medical chart and select "complete" at the conclusion of their documentation. Once complete, the ACM will receive the electronic documentation and	03/28/2019

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	which are written the day of service and incorporated into the patient's clinical record at least weekly ...." 2. The clinical record of patient #4 was reviewed on 2/20/19. An agency discharge comprehensive assessment was completed on 11/2/18. The record failed to evidence a date, time, or a signature for the Skilled Nurse (Employee T) who completed the document. 3. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19. An agency care coordination note completed by the registered nurse (RN) on 1/14/19 at 1:13 PM stated that the patient was going to the emergency room. Hospital documentation indicated that the patient had a chest X-ray completed at the hospital on 1/14/19 at 3:23 PM and had a hospital inpatient stay from 1/14/19-1/18/19. A visit note completed by employee S, home health aide (HHA), was documented on 1/14/19 from 3:40 PM-5:02 PM. The agency failed to authenticate the visit for employee S, home health aide, from 1/14/19 as the patient was in the emergency room at the time the visit was completed. During an interview 2/25/19 at 3:49 PM, the administrator stated the scheduler should have notified the aide to leave after taking the patient to the hospital, they are not sure what happened but believe the aide stayed at the hospital with the patient until the shift ended.		review each document for completion. The ACM will review for content, date and signature by the nurse. The ACM will utilize the comprehensive assessment checklist to audit all visit documentation. The ACM will lock the document once the visit documentation is complete. All nursing staff will be in serviced and re educated on the documentation process by 3/28/19. Field staff will notify the agency at any time the visit can not be completed in the patient home due to a changed condition in the patient medical status. The field staff will contact the agency and request to speak with the case manager. If the case manager is not present the field staff will request to speak to a member of the nursing staff present at the agency at the time of the call. Nursing staff will instruct the field staff on how to proceed with the patient visit and instruct the field staff to end the patient visit if the patient is taken to the hospital and the aide can not complete the visit as scheduled. Nursing will document in the phone log of the patient the instructions given and verbal understanding of the instructions. Nursing will inform scheduling department and note auditing specialist of visit status. All field staff will be in serviced by 3/28/19 on reporting patient status instructions to agency when visit	

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	4. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. An agency DC comprehensive assessment was completed on 11/2/18. The record failed to evidence a date, time, or a signature for the skilled nurse who completed the document. 5. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. An agency discharge (DC) comprehensive assessment was completed on 8/2/18. The record failed to evidence a date, time, or a signature for the skilled nurse who completed the document. 6. During an interview on 2/26/19 at 10:40 AM, the administrator, and alternate administrator was notified of the findings and had nothing further to submit for review.		can not be completed in patient home in its entirety. All office staff will be in serviced on authenticating visit documentation by 3/28/19. The Administrator will ensure this procedure is upheld by reviewing all phone log reports daily by end of each business day. Administrator to meet with ACM daily to review patient status and utilize this information to ensure all documentation is completed in the patient phone log of patient chart.	
N 0000 Bldg. 00	This was a state re-licensure home health survey with three (3) complaints. Complaints: IN00175656; substantiated with findings IN00212618; substantiated with findings IN00277902; substantiated with findings Facility #: 012928 Provider #: 15K094 Medicaid #: 201091400 Survey dates: February 15, 18, 19, 20, 21, 22, 25, 26; 2019	N 0000		

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	Skilled Services: 2 Home Health Aide only: 78 Unduplicated Census: 128 Record reviews with home visit: 3 Record review without home visits: 14 Discharged record reviews: 6 Focused record reviews: 10 Total clinical records reviewed: 17			
N 0470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation and interview, the agency failed to ensure all staff followed infection control policies and standard precautions for 3 of 3 home visits observed (#1, 2, 3). Findings include: 1. The centers for disease control (CDC) website stated that the handwashing procedure was the following: "Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds." 2. An agency policy dated 1/10/18 titled "Infection Control," Policy # 259.00 stated "... If staff must use antibacterial soap, they will wash	N 0470	The agency handwashing policy to state employee must scrub all surfaces of hands for a minimum of 20 seconds. All clinical staff to be reeducated and checked off on handwashing by nursing staff before 3/28/19. Nursing staff to be checked off by Administrator before 3/28/19. Copy of check off to be filed in employee file as proof of compliance. Administrator to ensure all field staff was compliant before 3/28/19 by reviewing employee handwashing checkoff report showing completion of employee check off. Case manager nurse to supervise proper handwashing technique at each supervisory visit. This will be a line item on the supervisory visit form. CM will educate aide as needed	03/28/2019

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	their hands with soap and warm water, scrubbing all surfaces of the hands, for at least 10 seconds ...." The agency policy failed to follow the CDC guidelines for professional standards. 3. During a home visit observation on 2/18/19 at 8:00 AM, with patient #1, employee D, home health aide (HHA), was observed providing personal care. Employee D started the visit with a 19-second hand wash and applied gloves. After the patient finished with shower employee D applied lotion to the patient back and bilateral feet removed gloves and completed a 12-second hand wash. After completion of the visit, employee D completed a 12-second hand wash. Employee D failed to perform hand hygiene per CDC [centers for disease control] recommendation of at least 20 seconds. 4. During a home visit observation on 2/18/19 at 10:00 AM, with patient #2, employee C, licensed practical nurse (LPN), was observed providing skilled care. Employee C started the visit with a 13-second hand wash. Employee C failed to perform hand hygiene per CDC recommendation of at least 20 seconds. 5. During a home visit observation on 2/18/19 at 12:00 PM, with patient #3, employee E, HHA, was observed providing personal care. Employee E started the visit with an 11-second hand wash. During the course of the visit employee E completed a 5 second and an additional 11-second hand wash. Employee E failed to perform hand hygiene per CDC recommendation of at least 20 seconds. 6. During an interview on 2/18/19 at 1:43 PM, the administrator stated that staff should be washing their hands for 20 seconds.		and document on Supervisory visit. Supervisory visit will be audited by ACM or delegated RN for compliance All new employees to receive employee handbook including handwashing policy. The agency field staff to have annual infection control review at the HHA Blitz that is conducted at the agency by the nursing staff and reviews all requirements of the field staff while performing patient visits. The Administrator to oversee the annual skill review and ensure every employee has infection control education annually.	

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N 0508 Bldg. 00	410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records.			
	Based on observation, record review and interview, the agency administrator failed to ensure a confidential clinical record was maintained for 1 of 1 home visits observed utilizing electronic documentation (#1). Findings include: An agency policy dated 1/10/19, titled "HIPAA [health insurance portability and accountability act] Administrative Policies and Procedures." Policy # 113.00 stated "...Purpose: To ensure compliance with HIPAA regulations and guidelines and to provide protection for protected patient information ...." During an observation on 2/18/19 at 8:00 AM, employee D, home health aide (HHA), was observed assisting with personal care with patient #1. After completion of care employee D swiped the screen on her cell phone (no lock on her cell phone) and went into the agency's software program to begin charting and the visit note was observed. A username and password was required to get into the agency's software program. Employee D went in and out of the	N 0508	The agency will ensure all patient clinical records are kept confidential. For field employees specifically, the agency will enforce the policy titled "Computer Terminals/Workstations/Hand Held Devices," specifically #3 of said policy stating "A user may not leave his/her workstation, terminal or hand held device unattended for periods of time (e.g breaks, lunch, meetings, etc) unless the terminal or device screen is cleared and the user is logged off." #4 A user must clear the terminal and device screen if the workstation or terminal is left unattended. All field staff will be in serviced by 3/28/19 on confidential clinical records. The agency's field staff will be required to lock their hand held device per the above mentioned policy and specifically #8 Hand held devices must have a security pass code/word, screen lock or finger print lock enabled on the lock	03/28/2019

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	agency's software program three times. Each time employee D would go back into the app, the app did not have her re-enter the username and password, but rather took her back to the same screen that it had been left on. The agency failed to ensure staff protected the electronic clinical record against unauthorized use by documenting on unlocked personal cell phones and the system did not require username and passwords to be re-entered when leaving the agency software program. During an interview on 2/18/19 at 9:00 AM, employee D was asked if she realized that anyone could pick her phone up and get into the patient's clinical record and she stated, "That's not good, I didn't know it did that." During an interview on 2/18/19 at 1:59 PM, the administrator stated that she would have to call main agency software program company about this as the system is supposed to have staff re-login after leaving the screen.		screen. The field staff is to lock their screen any time their device is not actively in use by the field staff. The field staff will complete the home health aide note by marking the completed tasks, receive the patients signature for verification of tasks and depart from the electronic home health aide note. The field staff will only be on their hand held device during this time and will lock their device when they are not actively completing their home health aide note. The in service record will be kept in the employees file to ensure completion. The Administrator will ensure all field staff were in serviced by nursing staff by reviewing the completed in service log. All new field employees will be trained on proper HIPAA procedures and sign the above mentioned policy prior to FPC. The agency will not rely on the clinical software system to ensure employee electronic device is secured and will utilize this process to guarantee patient medical information is kept confidential. The case manager will monitor compliance by checking aide phone and if it is locked when not in use at supervisory visit. CM will also educate about hand held devices as needed and at supervisory visit concerning locking screen and HIPAA. This will be added as part of the supervisory visit form.	

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			Supervisory visits will be audited by ACM or other RN delegate for compliance.	
N 0514 Bldg. 00	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the agency administrator failed to investigate and document complete complaint investigations for 2 of 2 complaint investigations reviewed (#9, 12). Findings include: 1. An agency policy dated 1/10/18, titled Client Grievance / Incident Process," stated "... Client / Family Grievance / Incident Policy for receiving, reviewing and resolving complaints and / or concerns is based on the premises of the patient's rights and responsibilities ...." The policy failed to evidence that the complaint would be investigated. 2. The clinical record of patient #9 was reviewed on 02/20/19 and indicated a start of care date of 9/12/18. An agency document titled, "Grievance /	N 0514	The Client/Grievance Incident form recreated to show the details of the grievance process from initiation to resolution. The format will be as follows: Date Grievance/Incident received, Grievance Filed by, Individual complaint pertains to, Details of grievance, Employee(s) investigating complaint, Details of investigation, Time frame of investigation, patient notification of resolution and follow up to ensure resolution was completed. The Administrator to review all complaints and delegate resolution. The Administrator to review completed complaint form in its entirety to ensure resolution is acceptable and all sections	03/28/2019

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	Incident Form" dated 10/19/16 indicated an employee report of bed bugs in the patient home. The "Resolution / Counseling" for the incident on 10/20/16 indicated the patient was to be removed from the employee schedule and "RN notified of possible bed bugs in patient home. RN to follow up with patient" The grievance failed to evidence a thorough investigation as no patient follow up was performed. 3. The clinical record of patient #12 was reviewed 2/25/19 and indicated a start date of 10/4/16. An agency document titled "Grievance / Incident Form" dated 6/18/18 indicated an employee phoned in a concern for patient #12 that regarded another HHA signed patient #12's signature after a visit. The "Resolution / Counseling" of the incident dated 6/19/18 indicated "HR [human resources employee W] counseled aide to never sign for a client. If can't sign to call the office. Immediately! Aide understood...." The grievance / incident failed to evidence a through investigation as no patient follow up in regards to incident. 4. During an interview on 2/25/19 at 2:22 PM, the administrator stated that the "resolution /counseling" area of the complaint was the investigation and stated it "could be more detailed, I suppose."		correctly completed and resolved. The Administrative Billing Specialist to keep all completed Grievance/Incident forms in a log in the Administrative Billing office. All agency staff will be in serviced by 3/28/19 to educate on the updated Client/Grievance Incident form process.	
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:			
	Based on record review and interview, the home	N 0522	The agency will provide home health services based on the MD	03/28/2019

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	health aide (HHA) failed to follow the plan of care for 3 of 7 full records reviewed (#4, 5, 9) in a total sample of 17. Findings include: 1. An agency job description dated 1/10/18, titled "Home health aide," Policy # 606.00 stated "... Performance Responsibilities ... Follows a written plan of care ...." 2. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC (plan of care) for the certification period of 10/2/18 -11/30/18, which indicated a frequency of 2-4 hours per day, 5-7 days per week. The agency visit schedule indicated a HHA visit was completed on 10/25/18 and was 1 hour 30 minutes in duration. The HHA failed to follow the frequency parameters on the plan of care (2-4 hours). 3. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date 9/12/18. The record contained a POC for the certification period of 1/10/19-3/10/19, which indicated a frequency of 2-3 hours per day, 5-7 days per week. The agency visit schedule indicated the HHA visits on 1/17/19 and 2/16/19 were only 1 hour in length.4. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18 that indicated a frequency of 4-6 hours per day, 5-7 days per week. The agency visit schedule indicated HHA visits completed on: 2/2/18 that was 2 hours in duration, 7/4/18 was 3.5 hours in duration, and 7/17/18 was 3 hours in duration. The HHA failed to follow the frequency		approved order. Any time the agency falls below the hours or days of the approved order the MD will be notified. The process will be as follows: The note auditing specialist will review all completed visits utilizing the note verifier in the medical software system. If a completed visit falls below the ordered hours or the patient was not seen for the ordered minimum days, the note auditing specialist will write a communication to the case manager. The case manager will notify the MD that the patient was not seen for the minimum hours or days per the MD order. The case manager will inform the MD who provided care for the patient and the status of the patient during the time not seen by the agency. The ACM will be copied on the notification by the note auditing specialist in order to track and ensure that the case manager notified the MD and documented appropriately. The ACM will review all documentation by the case manager in order to verify notification to the MD is completed in a timely manner. The Administrator will ensure this policy is upheld by meeting with the ACM daily to review the status of each patient and any and all follow up needed and completed. The Administrator will audit 10% of all clinical documentation monthly to ensure nursing is following the process appropriately. Home	

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	parameters on the plan of care (4-6 hours). 5. During an interview on 2/25/19 at 1:47 PM, the administrator stated that staff should be following ordered frequencies		health aides to be educated on 3/26/19 by letter with paycheck explaining order frequency and duration and discussing this with clinical Manager or delegate who will ensure understanding through question and answer with each aide by phone or face to face. All new employees will be trained about frequency and duration in same manner upon hire.	
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.	N 0524	The RN will utilize the	03/28/2019

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	Based on observation, record review and interview, the Registered Nurse (RN) failed to accurately complete the plan of care to include all pertinent diagnoses for 6 of 7 records reviewed (#2, 3, 4, 5, 9, 15), ensure the goals were present for all identified needs for 7 of 7 records reviewed (#1, 2, 3, 4, 5, 9, 15), included all patient-specific frequency and duration for 1 of 7 records reviewed (#2) and contained all durable medical equipment (DME) in the patient's home for 2 of 7 records reviewed (#2, 15) in a sample of 17. Findings include: 1. An agency policy dated 1/14/19, titled, "Patient Plan of care," Policy# N0533 stated "... The nursing care-plan will contain the following:..4. Services to be provided. 5. Frequency and duration of visits 6. Medications including time of administration and route 8. Signed and dated clinical notes from all personnel providing services...11. 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...." 2. The clinical record of patient #3 was reviewed on 02/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care (POC) for the certification period of 2/14/19-4/14/19 which indicated diagnoses of "... Type 2 diabetes mellitus without complications... essential ... hypertension..." The plan of care failed to evidence goals related to the type 2 diabetes, hypothyroidism, and failed to evidence the patient's allergies (if any) or NKA (no known allergies). The agency comprehensive recertification		comprehensive assessment checklist at each nursing visit to ensure all required tasks are completed. All diagnosis to be listed in plan of care. All medications listed to have an appropriate diagnoses to support the patient medication prescribed. ACM to audit all documentation for accuracy after each nurse visit and to ensure all assessment findings have a listed diagnosis to support findings. Patient specific frequency and duration to be reviewed and verified with the MD order. RN to ask patient at each nurse visit to state all DME in the home and list on the plan of care in DME specific section. ACM to ensure all DME reported in assessment is listed in DME section of plan of care. ACM to ensure process is followed by performing nursing supervisory visit and reviewing DME observed and reported in the patient home and reviewing each medical diagnoses with patient to ensure all diagnoses are listed on plan of care. ACM to educate nurse on any deficiencies found. Nurse to correct deficiencies within 48 hours and deliver updated patient information to patient folder in home if applicable and patient medical chart. Administrator to meet with ACM daily and review all nursing supervisory visits. Administrator to review supervisory visit forms to ensure ACM	

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	assessment dated 2/12/19, indicated the patient was taking Cetirizine (antihistamine), Eliquis (blood thinner) and Levothyroxine (hypothyroidism). The plan of care failed to evidence pertinent diagnoses and goals related to use ceterizine, eliquis, and levothyroxine. 3. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC for the certification period of 10/2/18 -11/30/18 that indicated diagnoses of: chronic obstructive pulmonary disease (COPD)...Chronic congestive heart failure (CHF). The plan of care failed to evidence patient specific goals related to COPD and CHF. The agency comprehensive recertification assessment dated 10/2/18 indicated the patient was experiencing dyspnea and edema and a diagnosis of Hypertension. The POC failed to evidence a pertinent diagnosis of hypertension and goals related to dyspnea and edema. 4. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date 9/12/18. The record contained a POC for the certification period of 1/10/19-3/10/19 which indicated, but not limited to diagnoses of Type 2 diabetes mellitus without complication. The plan of care failed to evidence goals related to Type 2 diabetes. The agency comprehensive recertification assessment dated 1/17/19 indicated the patient was taking Atorvastatin (hypercholestrol), Belsomra (insomnia), Colace (constipation), Miralax (constipation), Pepcid (gastroesophageal reflux), Maxalt (migraines), Venlafaxine (antidepressant), and Clopidogrel (blood thinner).		completed form and addressed all deficiencies with nurse. Administrator to ensure nurse has corrected any deficiencies and documented updated information was delivered to patient within given time frame.	

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The plan of care failed to evidence pertinent diagnoses and goals related to use of the medications identified in the comprehensive assessment.

5. The clinical record of patient #15 was reviewed on 02/21/19 and indicated a start of care date of 05/24/13. The record contained a plan of care for the certification period of 01/23/19 - 03/23/19 that indicated diagnoses but not limited to..."Type 2 diabetes mellitus without complications and unspecified osteoarthritis... DME [durable medical equipment] ... glucometer, test strips, lancets, alcohol pads, urinary drainage bag, urinary leg bag...SN (skilled nurse) to RN will educate patient on measure to decrease edema....." The plan of care failed to evidence patient specific goals related to diabetes and osteoarthritis and failed to evidence a diagnosis related to edema.

The agency comprehensive recertification assessment dated 01/21/19 identified the patient had an indwelling foley catheter and hypertention and edema. The plan of care failed to evidence pertainent diagnosis and goals related to the patients indwelling foley catheter,and hypertension (due to the use of metoprolol), failed to evidence foley catheter size, infection control measures and emergency plans related to the catheter based on needs of the patient.6. The clinical record of patient #1 was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The record contained a plan of care for the certification period of 1/15/19-3/15/19. The plan of care failed to evidence goals related to edema, constipation, pain, and diabetes based on the identified needs of the patient on the comprehensive assessment as evidenced by:

The agency's comprehensive recertification dated

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1/10/19 identified the patient had edema, constipation, pain and was a diabetic.

7. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19 that indicated a frequency of 70 hours a month waiver attendant hours. The plan of care failed to evidence patient-specific goals related to urinary incontinence, type II diabetes, asthma and chronic obstructive pulmonary disease (COPD), failed to evidence a diagnosis related to the use of antihypertensive medication and failed to have specific frequency and duration for the patient's attendant care needs.

During a home visit observation on 2/18/19 at 10:00 AM, with patient #2, employee C, licensed practical nurse (LPN), was observed providing skilled care. DME in the home observed was a grabber, nebulizer, hospital bed, and an emergency alert bracelet. The plan of care failed to evidence the equipment identified in the home.

The agency's comprehensive recertification dated 6/1/17 identified the patient had edema, incontinence, and shortness of breath with oxygen use. The plan of care failed to evidence goals related to edema, incontinence, and shortness of breath and/ or oxygen use based on the needs of the patient.

8. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18 that indicated "Incision will cont [continue] to heal with no s / sx infection throughout certification period ...." The plan of care failed to evidence

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	patient-specific goals related to urinary incontinence, intermittent asthma, and hypertension failed to evidence diagnoses related to the incision goal and anti-anxiety medication use. The agency's comprehensive recertification dated 6/27/18 identified the patient had edema, constipation, and urinary incontinence. The plan of care failed to evidence goals related to edema, constipation, and urinary incontinence based on needs. During an interview on 2/25/19 at 1:46 PM, the administrator stated that the plan of care should contain all DME in the home, all pertinent diagnoses related to the patient's medications, and goals for all identified needs.			
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits.			

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	(8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. Based on record review and interview, the registered nurse (RN) failed to ensure that an aide care plans were completed for each shift and failed to ensure that the aide care plan was individualized with specific tasks timeframe's to be completed for 7 of 7 patients receiving HHA (home health aide) services (#1, 2, 3, 4, 5, 9, 15). Findings include: 1. The clinical record of patient #3 was reviewed on 02/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care (POC) for the certification period of 2/14/19-4/14/19 which indicated a HHA frequency of 1-3 hours per day 1-3 days per week to assist with diabetic foot care and with all ADL's (activities of daily living) and IADL's (instrumental activities of daily living) per the HHA care plan. The Recertification comprehensive assessment dated 2/12/19 indicated, "...Aide Care Plan - Effective on 11/29/17: The agency aide/ homemaker care plan had the tasks to be completed as follows: Assist with shower, assist with sponge bath, clean bathroom, dusting...foot care, spray with alcohol before and after visit, standard precautions, up as tolerated, up with assistance - walker, clean kitchen, dishes, laundry, take out trash..." The HHA care plan failed to be updated and identify the timeframe (every visit or once a week for example) the tasks that were to be completed.	N 0533	The RN will compose a complete and individualized care plan for the patient upon admission and will review the patient care plan with the patient at each nurse visit. The RN will do so by utilizing the electronic patient system and creating individual tasks for each patient. Each task will be specific as to when (day and/or time of day) the task should be completed during the visit and the degree of involvement the aide will have in helping the patient complete the task. The Administrator will in service all nursing staff on the care plan requirements by 3/28/19. The ACM will review all visit documentation for thoroughness and to ensure care plan is specific to patient needs. Administrator to ensure procedure is followed by auditing 10% of all charts monthly for accuracy. Scheduling to mail patient visit schedules one time monthly to patients per agency policy. Scheduling to notify Administrator the last week of each month to report schedules were mailed. Schedule to be kept in patient folder. Schedule to show date, time and scheduled aide. The RN to put copy of completed patient medication list in patient folder in patient home. RN to update as applicable. RN to	03/28/2019

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	2. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC for the certification period of 10/2/18 -11/30/18 indicated a HHA frequency of 2-4 hours a day, 5-7 days a week to assist with ADL's and IADL's per the HHA care plan. The agency document titled "Aide/ Homemaker Care Plan" indicated, "...Patient goal: [blank]...Current Aide Plan (Effective Date 10/4/2018)... Assist with Shower Utilizing Shower Chair - AM... Clean Bathroom, Comb Hair, Complete Bed Bath - AM visit, Encourage [sic] patient to do as much as possible...Have patient stand up to change pull-up...Hoyer lift - May use after pt has attempted to transfer, Incontinent care...Peri Care, Put 2 pull-ups at each visit...Up with Assistance - Wheelchair ...." The HHA care plan failed to identify the timeframe (every visit or once a week for example) the tasks that were to be completed. 3. The clinical record of patient #9 was reviewed on 2/20/19 and indicated a start of care date 9/12/18. The record contained a POC for the certification period of 1/10/19-3/10/19 indicated a HHA frequency of 2-3 hours a day 5-7 days per week to assist with ADL's and IADL's. The agency document titled, "Aide/ Homemaker Care Plan" indicated "...Patient goal: [blank]...Current Aide Plan (Effective Date: 9/12/2018)...Assist with Ambulation, Assist with Dressing, Assist with Shower Utilizing Shower Chair, Assist with Sponge bath, Assist with Transfer, Assist with Tub Bath...Clean Bathroom, Clean Dentures, Clean Kitchen, Clean up after service dog, Comb Hair, Dishes, Foot Care...Incontinent Care, Make bed, Peri Care,		check patient folder at each nurse visit to ensure patient schedule and medication profile is present in patient folder and replace if missing. ACM to perform nurse supervisory visits monthly and inspect patient folder for all mandatory items including patient schedule and medication profile. Administrator to review all completed nurse supervisory visits during daily meetings with ACM.	

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	Prepare Meal...Shampoo Hair, Sweeping, Take out Trash, Up as Tolerated, Up with Assistance - Walker...." The HHA care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. 4. The clinical record of Patient # 15 with a start of care date of 05/24/13 and certification periods of 01/23/19 - 03/23/19 was reviewed on 02/21/19 indicated a HHA frequency of 4 hours a day 7 days a week to assist with ADL's and IADL's. The agency document titled, "Aide/Homemaker Care Plan" indicated "... Patient goal: [blank]...Current Aide Plan (Effective Date: 11/30/2017)...Assignment instructions included:...Assist with shower utilizing shower chair...Assist with sponge bath...Assist with transfer...Catheter care...Change linens...Dusting, Footcare...Peri care...Remind patient to take blood sugar...Shampoo hair, Spray with Alcohol before and after visit ...." The HHA care plan failed to identify patient-specific tasks for the aide to complete during each visit. The HHA care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed.5. The clinical record of patient #1 was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The record contained a plan of care for the certification period of 1/15/19-3/15/19 that indicated a home health aide (HHA) frequency of 1 hour, 3-5 days per week. The agency aide/ homemaker care plan had the tasks to be completed as follows: Apply non-medicated lotion to the skin, assist with ambulation, assist with showering utilizing shower chair, assist with transfer, clean bathroom, clean dentures, comb hair, foot care ... Incontinent Care, Make Bed, Oral care, Peri Care, remind patient to			

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	put in / assist with hearing aid, remind patient to put on glasses. The aide care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. During a home visit observation on 2/18/19 at 8:00 AM, with patient #1, employee D, home health aide (HHA), was observed providing personal care. Employee D stood outside the shower while the patient showered self. The patient requested employee D wash the back. The aide applied lotion to the back per patient request. All other care the patient provided to self. Employee D failed to clean dentures, complete oral care, peri care or remind the patient to put in hearing aide. Employee D failed to follow the aide care plan. 6. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19 that indicated a HHA frequency of 3-5 hours per day, 4-6 days per week. The agency aide/ homemaker care plan had the tasks to be completed as follows: assist with ambulation, assist with dressing, assist with showering utilizing shower chair, assist with a sponge bath, blood sugar reminder, clean bathroom, clean kitchen, comb hair, dishes ... Incontinent- bladder, Incontinent ... laundry ... peri care ... prepare meal ... shampoo hair ... take out trash, Make Bed, Oral care, Peri Care. The aide care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. 7. The clinical record of patient #3 was reviewed 2/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care for			

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the certification period of 12/16/18-2/13/19. The aide careplan indicated the aide was to complete: assist with shower, assist with sponge bath, clean bathroom, dusting (Wednesday), foot care, up with assistance (walker).

During a home visit observation on 2/18/19 at 12:00 PM, with patient #3, employee E, HHA, was observed providing personal care. Employee E stood outside of the shower while the patient showered self. Employee E washed the back of the patient's legs and back. After the patient got out of the shower, employee E dried the patient's legs and feet. The patient dressed self, brushed teeth and ambulated to the chair. Employee E rubbed lotion on the patient's feet, and the patient put own socks and shoes on. Employee E failed to follow the aide care plan.

8. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. The record contained a plan of care for the certification period of 6/30/18-8/28/18 4-6 hours per day, 5-7 days per week.

The agency aide/ homemaker care plan had the tasks to be completed as follows: Apply non-medicated lotion to skin, assist with ambulation, assist with dressing, assist with feeding patient, assist with shower utilizing shower chair, assist with sponge bath, assist with transfer, clean linens, clean bathroom, clean kitchen, comb hair, Make Bed, medication reminders, Oral care, Peri Care. The aide care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed.

9. During an interview on 2/25/19 at 1:33 PM, the administrator stated that the aide care plan is

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	specific to the patient and that the Elvis system (aide documenting system) only allows the agency to have one aide care plan for all shifts and payer types.			
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on record review and interview, the skilled nurse (SN) failed to conduct visits in accordance with the plan of care for 1 of 2 records reviewed with skilled nurse services (#2) in a sample of 17. Findings include: The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained a plan of care for the certification period of 1/22/19-3/22/19 that indicated a frequency for the skilled nurse (SN) of 1 hour per week to fill the pillbox. The SN failed to follow the plan of care by not meeting the frequency as evidenced by: On week 1 the SN visit was completed on 1/22/19 for 30 minutes. On week 2 the SN visit was completed on 1/28/19 for 45 minutes. On week 2 the SN visit was completed on 2/4/19 for 30 minutes. On week 2 the SN visit was completed on 2/12/19 for 45 minutes.	N 0537	The agency will indicate a frequency for the skilled nurse visit by documenting the visit per week and not hours per week the patient is seen for an MD ordered skill. The frequency and order for skilled nurse visits will be on the patient plan of care. The ACM will educate the nursing staff, at the daily nurse meeting, on this process and implement the change by 3/28/19. The ACM will ensure this process is upheld by reviewing all clinical documentation completed by the nurse and utilizing the comprehensive assessment checklist when auditing all clinical documentation, specifically the patient plan of care. The Administrator will ensure this process is upheld by reviewing 10% of all nursing visits monthly.	03/28/2019

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	On week 2 the SN visit was completed on 2/18/19 for 45 minutes. During an interview on 2/25/19 at 1:47 PM, the administrator stated that staff should be following ordered frequencies.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, record review and interview, the Registered Nurse (RN) failed to ensure contents of the comprehensive assessment was accurate for 1 of 7 full records reviewed in a sample of 17 (#3). Findings include: An agency policy dated 1/14/19, titled "... Completing the Comprehensive assessment" stated "Once OASIS assessment is completed accurately and reflect the patient's status .... " The clinical record of patient #3 was reviewed on 02/18/19 and indicated a start of care date of 8/23/17. The record contained a plan of care (POC) for the certification period of 2/14/19-4/14/19, which indicated a medication "Nitoruranton" [sic] (an antibiotic used to treat urinary tract infections) 100 milligrams 1 tablet by mouth three times daily for 3 days that began 2/11/19 and a diagnosis of Type 2 diabetes. The	N 0541	The CM will provide a comprehensive assessment that accurately reflects the patient status. The agency will ensure consistency of this regulation by requiring all CM to follow and complete an approved checklist form of tasks at each comprehensive assessment visit titled comprehensive assessment checklist. This form includes review of all medications, their use and indication, any education regarding initial diagnosis requiring prescribed medication need and systems review including skin assessment to address all medical diagnosis in plan of care. Care plan items will be reviewed with patient at each nurse visit to ensure no changes in patient have occurred during current certification period. Care plan to	03/28/2019

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	record failed to evidence information regarding an infection or the use of an antibiotic, and accurate information about the patient's ability to independently reach feet to apply socks and shoes as evidenced by: During a home visit observation on 2/18/19 at 12:00 PM, at patient #3's home, employee E, a home health aide (HHA), was observed providing personal care. After the patient's shower was complete, the HHA applied lotion on the patient's legs and feet. The patient then lifted the right leg and placed it over the left knee. The patient pointed out a thick, beige, callused area below the right great toe. The patient stated the callus had been present for "a long time" and recently the patient had pulled part of the callus of the foot. The patient then pulled on the sock to the right foot and repeated this process on the left foot. The patient bent over in her recliner to put both on shoes independently. A Recertification comprehensive assessment dated 2/12/19 indicated "... No diabetes complications... [patient] is diabetic and requires HHA to perform diabetic foot care at each visit as she is unable to reach her feet ...." The assessment failed to evidence the presence of a calloused, build-up to the soles of the feet, failed to evidenced genitourinary problems, and failed to evidence the patient's recent infection that required antibiotic use.During an interview on 2/25/19 at 2:27 PM, the administrator stated that the comprehensive assessment should have reflected accurate information.		be customized and updated if patient status change occurs to reflect patients current needs. ACM to ensure all checklist items for patient visit have been completed by nurse by reviewing all visit documentation for accuracy. The ACM will utilize the CM checklist in auditing the skilled nurse documentation. Clinical staff will be in serviced and re educated on comprehensive assessment procedure by 3/28/19. The Administrator or her delegate will audit at least 10% of all comprehensive assessment visits to ensure this regulation is upheld.	
N 0544 Bldg. 00	410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for			

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	purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interview, the skilled nurse (SN) failed to prepare clinical notes completely and accurately for 1 of 2 patients receiving skilled nursing services in a sample of 17 (#4). Findings include: The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. The record contained a POC for the certification period of 10/2/18 -11/30/18 that indicated diagnoses of Chronic Obstructive Pulmonary Disease, Unspecified abnormalities of gait, other chronic pain, Chronic congestive heart failure..." The agency comprehensive recertification assessment dated 10/2/18 indicated the patient had a diagnosis of Hypertension and was experiencing dyspnea and edema. The document evidenced a pain 0-10 pain scale and indicated, "perceived pain level during the day of assessment: 0... Perceived pain level AFTER pain relief measures: 7 ... CaseManager and/or Physician notified of the elevated pain level: No... COPD: No ... Chronic obstructive pulmonary disease YES ... dyspnea NO...." The document evidenced conflicting documentation in relation to pain, respiratory status, and diagnoses.During an interview on 2/25/19 at 1:48 PM, the administrator stated that nursing documentation should not be conflicting.	N 0544	The ACM will review all clinical documentation after the nurse completes the applicable visit in the electronic medical chart. The ACM will utilize the comprehensive assessment visit check list to verify accuracy of documentation. ACM to check patient pain level that was documented by nurse and if above baseline was reported to MD with follow up instructions received and patient education performed and resolution documented. ACM to check diagnosis documentation to ensure consistency between plan of care and assessment in clinical software. The visit check list will prompt the ACM to review each diagnosis listed in the plan of care and assessment against the nurse documentation in the clinical chart assessment visit. The ACM will instruct the nurse to correct any inconsistencies and review the corrected documentation before locking in the clinical chart. The Administrator to ensure the process is upheld and will audit 10% of monthly visit documentation.	03/28/2019
N 0596	410 IAC 17-14-1(l)(A) Scope of Services			

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Bldg. 00	Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and			
	Based on record review and interview, the agency administrator, failed to ensure that all prospective home health aide (HHA) employees performed all tasks required, in their entirety with a patient and not simulated, as required to show competence for placement on the home health aide registry for 1 of 1 agency. Findings include: 1. A policy dated 1/14/19, titled "Home Health Aide Supervision, Training and Education" stated, "...Training: [agency] provides a competency and certification program for home health aides. The program utilizes the Medicaid required guidelines...." 2. During an interview on 2/19/19 at 9:00 AM the Nurse Practioner (NP) indicated she developed the HHA (home health aide) training program after going through the Indiana State test for HHA competency. The NP indicated the training is 8 hours on Fridays with her after the orientation training with the Administrator. The NP reported every aide performed all tasks required to be placed on the State registry independently. She indicated patient #9 had allowed 9 prospective HHA's to perform a complete tub bath and shampoo during one visit. The NP indicated all	N 0596	The agency will obtain a contract RN to observe perspective home health aide employees perform all tasks in their entirety required for placement on the registry. This RN will meet the required state standards and qualifications by the state. The RN will have a contract on file with the agency. The RN will observe perspective HHAs performing tasks required on a live patient, in the patient's home, in it's entirety, specifically (b)(3)(1), (iii), (ix), (x), and (xi). These areas will be observed being performed on a live patient. The RN will observe the aide performing any task that can be demonstrated in a laboratory setting in its entirety. The completed check off will be signed by the perspective employee and contract RN and be filed in the employee file. The contract RN will register the employee with the state department of health if the contract RN documents the successful completion of all required tasks by the employee. Any employee that does not	03/28/2019

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	the HHA's in the program were trained by the Administrator and herself and stated, "If I feel they did a good job in the field, I sign the registry." When asked if there was any instance in which the prospective HHA would not be placed on the State registry, the NP stated, "If I felt they didn't do cath care properly or Hoyer properly or foot care properly." 3. During an interview on 2/19/19 at 10:51 AM, employee I (date of hire 11/29/18) indicated she received 2 days of training before being placed on the State registry. Employee I indicated during the training, she did not perform a bed or tub bath and while performing a shower, each prospective HHA rotated tasks. "Nobody did a start to finish." 4. During an interview on 2/19/19 at 11:16 AM, employee H (date of hire 12/27/18) indicated she did 2 partial days of patient training and was assigned a schedule the subsequent Saturday. 5. During an interview on 2/19/19 at 12:35 PM, employee G (date of hire 7/27/16) indicated she had "4 hours training one day, period." Employee G indicated she "already knew that [how to wrap a limb with an ace wrap], but I went through the training." 6. During an interview on 2/25/19 at 1:50 PM, the Alternate Administrator stated, "We have a competency check off. We train, but we don't do the 75 hours the state requires. We don't have the money to do the 2 week program. We don't have enough money to pay high-quality aides." 7. During an interview on 2/25/19 at 2:00 PM the Administrator indicated each HHA should complete all required tasks prior to being placed		successfully complete the check off will not be registered with the state and the employee will be required to repeat the check off portion of orientation successfully before being appropriate for licensing. The Administrator will review all completed paperwork by the contract RN to ensure the employee has successfully completed the competency check off. The Administrator will contact the patient(s) utilized for the live check off to verify each perspective employee completed the required tasks in their entirety on the patient. Once verification is obtained from the patient, the Administrator will initial the competency check off as documentation of completion. At this time the contract RN will be notified and approved to register the incoming employee.	

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	on the State registry. The Administrator indicated if more than one prospective HHA was in the field for competency training it was acceptable for each trainee to perform parts of the bath or task, taking turns on one patient to verify competency and that the NP was training the HHA to assess the patients in their care. 8. During an interview on 2/25/19 at 2:18 PM, the Administrator indicated the agency had a home health aide training program with a competency "out in the field ... Other agencies send their staff here to train them."9. An agency competency assessment form titled "Skills evaluated on Live Patient,"... indicated the skills that needed demonstrated on a live patient was: bed bath, sponge bath, tub bath, shower, sink shampoo, tub shampoo, bed shampoo, fracture pan placement, urinal, bathroom and tilting assistance, catheter care, perineal care, nail care, skin care, oral hygiene and gum care, denture care, bedside commode, offering bedpan/ placement, proper use of gait belt, transfer from bed to chair, transfer from chair to toilet/ bedside commode, transfer to wheelchair, assisting with ambulation, assist ambulating with cane, assist ambulating with a walker, assist with wheelchair to/ from, demonstrates passive ROM [range of motion], upper and lower body, demonstrates active ROM, upper and lower body, demonstrates proper bedding position, demonstrates proper chair positioning, demonstrates ability to provide pertinent report/ information to patients, representatives, caregivers, and agency staff, demonstrates ability to follow patient assignment sheet, temperature, pulses, respirations, blood pressure (optional) based on agency policy, reading, writing ...." 10. An agency competency assessment form			

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	titled "Skills evaluated through simulation by demonstration, written /case scenarios, or oral training," indicated the skills that needed demonstrated but did not have to be completed on a live patient was "assist with a medical lift, knowledge of signs and symptoms of dehydration, edema, and importance of hydration, knowledge of normal dietary requirements, knowledge of special diets, knowledge of normal skin, risk factors for skin problems, s / s [signs and symptoms] of skin breakdown, knowledge of importance of changing positions frequently, helping a patient dress, proper body mechanics, using a safety razor, using an electronic razor, elastic/ compression stocking application, use of hoyer lift, back rub, working with a patient who has an infusion line, if patient had telehealth unit in place, reminds them to do checks, knowledge of normal body functions, knowledge of information that must be reported to supervisor, identifies safety hazards/ issues in the home, basic cleaning methods, making occupied bed, making unoccupied bed, knowledge of food safety, cleaning equipment, recognizes emergency situations, knowledge of what to do in an emergency, incident report, recognizes and reporting of suspect abuse/ neglect, is familiar with individual patient emergency preparedness plan, demonstrates understanding of the need to respect privacy, knowledge of patient rights, demonstrates knowledge of confidentiality and information covered under HIPAA [health insurance portability and accountability act], knowledge of professional boundaries, understanding of the patient complaint process, knowledge of working with patients served by the agency, understanding the different types of baths, demonstrates knowledge of general patient observations, identifies changes in a patient's condition or appearance that should be reported,			

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demonstrates ability to report patient changes to appropriate person (s), demonstrates ability to accurately document tasks, care or observations, document in the clinical record id accurate and effective, handwashing, use of sanitizer versus handwashing, disposal of waste, standard precautions, recognized signs of potential infections, understands methods to decrease risk for infection ...."

11. During an interview on 2/18/19 at 8:00 AM, employee D (date of hire 11/5/15), HHA stated the agency put her on the aide registry. Employee D stated she only did a shower in someone's home to be checked off.

12. During an interview on 2/19/19 at 12:01 PM, former employee J (date of hire 9/27/18), HHA, stated she had gone to a patient's home one day for check offs, washing someone's hair while with other people being checked off and was on the schedule the next day.

13. During an interview on 2/20/19 at 11:39 AM, patient # 9 stated that he/ she would let the agency do tub bath check offs in their home. The patient stated every Friday, a group of new aides would come to his / her home accompanied by the administrator or the nurse practitioner (NP). The patient reported on average 3-4 aides trained at a time, sometimes more or less. The patient was asked while the aides were in the home if he/ she would multiple tub baths from each aide present, in which the patient stated: "no, never." The patient stated, "If I got multiple baths per day my skin would be so raw." The patient explained the aides would do a "round robin," approach where someone washed the hair, one washed the area, one rinsed the area, they would all do different areas. The patient stated the "odd man out

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	would do pericare." The patient stated they would not be okay with a full bath being completed by every aide. 14. During an interview on 2/20/19 at 11:57 AM, patient #15 stated he/ she would allow agency aides to do bed baths on Fridays. The patient stated that a group of 2-3 people would come together and take turns washing different areas of the body.			
N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry.			
	Based on record review and interview, the agency failed to authenticate visit documentation for 3 of 7 full records reviewed. (#2, 4, 5) Findings include: 1. A policy dated 1/14/19, titled "Clinical Records-Purpose and Content #252.00" stated, "...7. Signed and dated clinical notes for each contact which are written the day of service and incorporated into the patient's clinical record at least weekly ...." 2. The clinical record of patient #4 was reviewed on 2/20/19. An agency discharge comprehensive assessment was completed on 11/2/18. The record failed to evidence a date, time, or a signature for the Skilled Nurse (Employee T) who completed the document3. The clinical record of patient #2 was reviewed 2/19/19 and indicated a start of care date of 5/26/17. The record contained	N 0610	The ACM will review all clinical documentation composed by the nursing staff for accuracy. The nursing staff will complete visit documentation in the electronic medical chart and select "complete" at the conclusion of their documentation. Once complete, the ACM will receive the electronic documentation and review each document for completion. The ACM will review for content, date and signature by the nurse. The ACM will utilize the comprehensive assessment checklist to audit all visit documentation. The ACM will lock the document once the visit documentation is complete. All nursing staff will be in serviced and re educated on the documentation process by 3/28/19. Field staff will	03/28/2019

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	a plan of care for the certification period of 1/22/19-3/22/19. An agency care coordination note completed by the registered nurse (RN) on 1/14/19 at 1:13 PM stated that the patient was going to the emergency room. Hospital documentation indicated that the patient had a chest X-ray completed at the hospital on 1/14/19 at 3:23 PM and had a hospital inpatient stay from 1/14/19-1/18/19. A visit note completed by employee S, home health aide (HHA), was documented on 1/14/19 from 3:40 PM-5:02 PM. The agency failed to authenticate the visit for employee S, home health aide, from 1/14/19 as the patient was in the emergency room at the time the visit was completed. During an interview 2/25/19 at 3:49 PM, the administrator stated the scheduler should have notified the aide to leave after taking the patient to the hospital, they are not sure what happened but believe the aide stayed at the hospital with the patient until the shift ended. 4. The clinical record of patient #4 was reviewed on 2/20/19 and indicated a start of care date 10/2/18. An agency DC comprehensive assessment was completed on 11/2/18. The record failed to evidence a date, time, or a signature for the skilled nurse who completed the document. 5. The clinical record of patient #5 was reviewed 2/21/19 and indicated a start of care date of 3/2/18. An agency discharge (DC) comprehensive assessment was completed on 8/2/18. The record		notify the agency at any time the visit can not be completed in the patient home due to a changed condition in the patient medical status. The field staff will contact the agency and request to speak with the case manager. If the case manager is not present the field staff will request to speak to a member of the nursing staff present at the agency at the time of the call. Nursing staff will instruct the field staff on how to proceed with the patient visit and instruct the field staff to end the patient visit if the patient is taken to the hospital and the aide can not complete the visit as scheduled. Nursing will document in the phone log of the patient the instructions given and verbal understanding of the instructions. Nursing will inform scheduling department and note auditing specialist of visit status. All field staff will be in serviced by 3/28/19 on reporting patient status instructions to agency when visit can not be completed in patient home in its entirety. All office staff will be in serviced on authenticating visit documentation by 3/28/19. The Administrator will ensure this procedure is upheld by reviewing all phone log reports daily by end of each business day. Administrator to meet with ACM daily to review patient status and utilize this information to ensure	

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	failed to evidence a date, time, or a signature for the skilled nurse who completed the document. 6. During an interview on 2/26/19 at 10:40 AM, the administrator, and alternate administrator was notified of the findings and had nothing further to submit for review.		all documentation is completed in the patient phone log of patient chart.	