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
	15K141	A. BUILDING 00 B. WING	09/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOGETHER HOMECARE	555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143

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G 0000 Bldg. 00	This visit was for a complaint investigation survey of a Medicaid Home Health Agency. This was a full extended complaint investigation and the administrator was so notified on 9-9-2020, at 1:45 P.M. Complaint #: IN 00307172; substantiated with related and unrelated findings Survey Dates: 9-2, 9-3, 9-4, 9-7, 9-8, 9-9, 9-10, 9-11, 9-16, 9-17, and 9-18-2020 Facility #: 013867 CCN: 15K141 Facility Census: 160, combined for the Greenwood parent and the Columbus branch Clinical Records Reviewed: 6 (Clinical Record #6 was a limited review for content of Clinical Record only) Home visits: 1 An Immediate Jeopardy was identified and the administrator and clinical manager were notified on Friday, 9-11-2020, at 2:49 P.M. The Immediate Jeopardy began on Monday, 8-24-2020, time not documented, when an agency supervisory nurse, employee D, failed to perform a complete assessment, and the agency failed to document as a complaint, and conduct a thorough investigation, as required by agency policy, into a disabled minor patient's (#4) observed injury of unknown origin, a purple bruise on the upper right	G 0000	**Together Homecare ("Together") submits the following Plan of Correction as required by State and Federal law. Together's submission of this Plan of Correction should not be taken as an agreement with or admission of any of the findings contained therein. Together hereby expressly reserves the right to challenge the factual findings, legal conclusions, and allegations contained in the underlying reports.** **Compliance has been and will be achieved no later than the last completion date identified in the Plan of Correction. Together desires this Plan of Correction to be considered our Creditable Allegation of Compliance.**	

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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	thigh, alleged by the parent to have been perpetrated by an agency nurse (employee B); failed to document an adequate resolution to the observed injury of unknown origin alleged to have been perpetrated by agency nurse (employee B), to include reviewing the available videos; failed to document as a complaint or to document resolution to the allegation of verbal abuse by an unidentified person off camera, who may have been an agency nurse. The facility failed to implement its policy, "Patient/Family Complaints," which stated, " ... Purpose ... To establish a procedure for channeling complaints to the appropriate person for resolution, and to provide a response to the patient/family ... Complaints regarding treatment, services, or charges will be documented on the grievance form by the person receiving the complaint/grievance and forwarded as soon as possible to the appropriate director or to the management team for investigation action and trending ... All persons with a complaint will be notified of the steps taken to investigate the complaint, the result of the process and the date of completion ... " The agency failure to conduct a complete investigation, as required by policy, failure to document as a complaint with a responsive resolution, and failure to implement corrective measures to reduce the risk of abuse/neglect and protect all agency patients, posed a likely risk of serious harm, impairment, or death, to patient #4 as well as the home health agency's 22 other patients who received skilled care for chronic medical conditions, of a total of 160 agency patients. The immediate jeopardy which began on 8-24-2020, was removed on 9-18-2020, at 4:15 P.M., when the actions taken based on the agency's 3rd			

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	immediacy removal plan were determined to have removed the immediacy component of the immediate jeopardy. Based on the Condition-level deficiencies identified during the 9-18-2020, survey, your home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act, on 9-9-2020 at 1:45 P.M. Together Homecare was found to be out of compliance with Conditions of Participation 42 CFR 484.50 Patient Rights; 42 CFR 484.60 Care Planning, Coordination and Quality of Care; 42 CFR 484.65 Quality Assessment/ Performance Improvement; and Organization and Administration of Services, 42 CFR 484.105. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for two years beginning 9-18-2020, and continuing through 9-17-2022. These deficiencies reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed on 10/13/2020 by area 3			
G 0406 Bldg. 00	484.50 Patient rights Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. Based on record review and interview, the home health agency failed maintain compliance with the	G 0406	**Per ISDH instruction, a response is not recommended for this tag due to the absence**	10/21/2020

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	Condition of Participation of Patient Rights, 42 CFR 484.50, by having failed to respect a patient's dignity by failure to document an adequate resolution to a complaint of invasion of a patient's privacy, by a home health aide, when the HHA recorded video content in the patient's home, without consent, which showed the patient's home and patient's family members, and then posted the recorded video on You Tube (See G 428;) having failed to ensure a patient was free from verbal abuse, by having failed to obtain and review all video tapes recorded in the home during skilled nurse shift at issue; having failed to take actions to protect all agency patients from abusive language; and having failed to document a misappropriated handicap parking sticker had been returned to a patient (See G 430;) having failed to ensure patients received all the care visits ordered in the plan of care (See G 436;) having failed to document as a complaint, and having failed to document a responsive resolution to a complaint of physical and verbal abuse, to include an injury of unknown origin, for a minor patient, with extended hours of skilled nursing care for chronic medical conditions (See G 482;) and the agency failed to document complete and responsive resolutions to patient complaints (See G 484.) The cumulative effect of this systemic problem resulted in the agency's inability to ensure the provision of quality care in a safe environment for the Condition of Participation 42 CFR 484.50, Patient Rights. An immediate jeopardy related to patient rights under 42 CFR 484.50 (e)(1)(i)(B), began on 8-24-2020, and was identified on 9-11-2020. The administrator was notified on 9-11-2020 at 2:49 P.M. The agency's 3rd immediate jeopardy		**of any cited findings.**	

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	removal of immediacy plan and actions were determined to have removed the immediacy component of the immediate jeopardy on 9-18-2020, at 4:15 P.M.			
G 0428 Bldg. 00	484.50(c)(1) Property and person treated with respect Have his or her property and person treated with respect;			
	Based on record review and interview, the agency failed to respect a patient's dignity by having failed to document an adequate resolution to a complaint of invasion of privacy and stolen property (Patient #1), by home health aide (HHA), employee A, when the HHA recorded video content in patient #1's home showing patient #1's home and patient #1's family members, and then posted the recorded video on You Tube for 1 of 1 complaints of failure to respect a patient's dignity, of a total of 55 complaints in the complaint log for the year 2019. The findings included: Review of an undated start of care packet, with patients rights enumerated, "Rights and Responsibilities," evidenced, " ... Together Homecare must protect the exercise of these rights and maintain documentation showing that they have complied with the following rights: ... 3. To have your person and your property treated with respect ... 5. To ... voice grievances regarding the treatment or care that is (or fails to be) furnished, or regarding the lack of respect for you or your property by anyone who is furnishing services of behalf of the agency and must not be subjected to discrimination or reprisal for doing so. The agency must investigate complaints made regarding treatment or care that is (or fails to be)	G 0428	G 428 An Investigation Guidance form has been added to all complaint forms to assist in a thorough investigative process, including requesting copies of any video or audio recordings from the complainant. To further ensure that the Agency's investigative process is thorough and clear, the Agency's Patient Complaint Policy (C-381) has been updated to include more detailed instructions for components of the investigation, and the complaint form has been updated as well. All internal employees have been educated on the new complaint policy, the revised complaint form, and the Investigative Guidance document. Complaints will not be considered resolved until the Administrator and Director of Clinical Services have both agreed that the investigation is complete, and all evidence is clearly documented. The Administrator and Director of Clinical Services will audit 100% of complaints for 60 days to ensure they contain evidence of a	10/21/2020

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	furnished, or regarding the lack of respect for the patient or the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence and the resolution of the complaint ... " Review of a complaint dated 8-19-2019, at 4:07 P.M., evidenced patient #1 complained home health aide (HHA) employee A, had video recorded in patient #1's home, showing images of the home and family, and posted the video content on You Tube without consent, and alleged HHA, employee A, smoked marijuana in the patient's bathroom. Review of the complaint evidenced it was documented as resolved, and signed by the administrator, on 8-20-2019, at 4:24 P.M. During a telephone interview with patient #1 on 9-4-2020, at 10:53 A.M., patient #1 indicated having complained to the agency and also You Tube about the videos taken by HHA, employee A, without consent in patient #1's home. Patient #1 indicated being concerned about images and commentary in the posted videos which contained identifiable information about patient #1 and patient #1's family. Patient #1 stated You Tube had taken down the video posts. Patient #1 indicated having offered to send the videos to the administrator, but was not certain had done so. On 9-4-20, at 2:15 P.M., the administrator indicated having called employee A to come into the office to discuss the allegations in the above complaint and for drug testing. When employee A refused, the administrator indicated refusal served as a termination from employment for failure to cooperate with a complaint investigation. The office notes on the complaint form evidenced HHA, employee A, had taken patient #1's		thoroughly documented investigation process, as well as a clear resolution and documentation that the complainant was notified of the resolution. Once Agency has maintained 100% compliance for 60 days, Administrator and Director of Clinical Services will audit 20% of complaints quarterly to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur.	

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	handicap parking sticker, and the agency would ensure the parking sticker was returned. When queried whether the administrator had viewed the You Tube videos posted by employee A, which were recorded in patient #1's home, to determine the exact nature and scope of the invasion of patient #1's privacy, to include listening to the audio portion to determine if it contained identifying patient information, the administrator responded, "No." The administrator stated it was wrong of employee A to take patient #1's handicap parking sticker for any reason. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review. 410 IAC 17-12-3 (b)(2)(A) 410 IAC 17-12-3 (b)(4)(B)			
G 0430 Bldg. 00	484.50(c)(2) Be free from abuse Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; Based on record review and interview, the agency failed to ensure 1 (Patient #4) of 1 patient with guardian's allegation of verbal abuse of patient #4, was determined to be free from verbal abuse, by having failed to obtain and review all video tapes recorded in the home during skilled nurse shift at issue; having failed to take actions to protect all agency patients from abusive language; and having failed to document a misappropriated handicap parking sticker had been returned to a patient for 1 (Patient #1) of 1 patients who had filed a complaint with the agency in relation to	G 0430	G430 Investigations into the alleged verbal abuse and alleged neglect of patient #4 were re-opened as the Agency obtained additional information for its internal investigative process during the survey, including the review of video and audio recordings. All complaint investigations related to patient #1 have been completed, and the resolution has been communicated to the patient's	11/24/2020

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	misappropriation of property, in a sample of 6 patients whose clinical record was reviewed. The findings included: 1. Review of an undated start of care packet, with patients rights enumerated, "Rights and Responsibilities," evidenced, " ... Together Homecare must protect the exercise of these rights and maintain documentation showing that they have complied with the following rights: ... 3. To have your person and your property treated with respect. 4. To be free from verbal, mental, sexual, and physical abuse, including injuries of unknown origin, neglect, and misappropriation of property ... " 2. Review of the clinical record for patient #4, evidenced patient #4 was a minor child with diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; idiopathic sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes not intractable, without status epilepticus; obesity, unspecified; and gastrostomy [tube] status. Review of the plan of care for the certification period of 7-19-2020 to 9-8-2020, for patient #4 evidenced orders for skilled nursing under Medicaid Prior Authorization (PA) to allow the mother to work varied hours and attend school. In a phone interview with patient #4's mother on 9/8/2020 at 2:01 P.M., the mother of patient #4 stated patient #4 is unable to make needs known due to significant speech, cognitive, sensory, and developmental impairment. Review of a video recording taken in the home of		family. Since the survey, there have been no additional complaints or concerns from this family. The complaint investigation into the missing parking sticker was also re-opened to document a clearer resolution and follow-up. The patient has since obtained a new handicap parking permit and verbalizes satisfaction with her new full-time aide. The original complaint has been resolved, and the patient denies any additional complaints. The patient's full-time aide has been educated that the parking pass belongs to the patient and must be returned after each shift. All Together Homecare patients have been contacted to ensure there were no outstanding complaints, including concerns regarding verbal, physical, sexual, or mental abuse or neglect, misappropriation of property or injuries of unknown origin. No additional concerns regarding new or previously reported or unreported abuse (verbal/physical/emotional, sexual), neglect, misappropriation of property or injuries of unknown origin have been identified. The Administrator and Director of Clinical Services completed a 100% review of all patient complaints in 2020 regarding abuse, neglect or exploitation in 2020. Those complainants have been contacted by the Administrator and/or Director to	

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	patient #4, "I'm gonna crack you," could be heard from a person who was off camera. Review of a Client Logging Report, dated 8-24-2020, evidenced the agency had determined employee B, a registered nurse assigned to the care of patient #4, said to patient #4, "I'm gonna crack you." The nurse admission constituted verbal abuse. 3. Review of a complaint dated 8-19-2019, by patient #1, evidenced an agency home health aide, employee A, had taken, without permission, patient #1's handicap parking sticker, and not returned it. During a telephone interview with patient #1 on 9-4-2020, at 10:53 A.M., patient #1 indicated having complained to the agency that employee A, HHA, had taken handicap parking sticker without consent and not returned it. Review of a complaint dated 8-19-2019, at 4:07 P.M., evidenced patient #1 complained home health aide (HHA) employee A, had taken handicap parking sticker without consent. The complaint resolution evidenced would look to return the handicap sticker to patient #1. The resolution failed to document the misappropriated property had been retrieved from employee A, HHA, and returned to patient #1. 4. On 9-4-20, at 2:15 P.M., the administrator indicated it was wrong of employee A to take patient #1's handicap parking sticker for any reason, and this was a misappropriation of patient #1's property. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for		ensure they have no further concerns regarding the reported complaint, or any ongoing issues or concerns related to Patient Rights. The Administrator has verified that all complaints, including allegations of abuse or neglect have been thoroughly investigated and resolved, and no further actions are required to ensure patient safety. Additionally, all employees were re-educated on patient rights, including the right to be free from all abuse, injuries of unknown origin and misappropriation of property, as well as the right to voice grievances/complaints to the agency. The Administrator will be responsible for ensuring that any inactive employee receives all in-services distributed as part of the Agency's plan of correction, prior to being switched to "active" status and placed in the schedule. To ensure that the Agency's investigative process is thorough and clear, the Agency's Patient Complaint Policy (C-381) was modified to include more detailed instructions for obtaining and reviewing evidence in the investigative process, including requesting, reviewing, and documenting photographic, audio, or video submissions related to the complaint. An Investigation Guidance form was created to further facilitate a thorough investigative process and will be	

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	review. 410 IAC 17-12-3 (b)(4)(A)		utilized for each complaint to ensure a thorough and complete investigation with proper follow-up. The complaint form has also been updated to ensure that a detailed and responsive resolution is provided to the patient following the Agency's investigation. All internal employees were educated on the new complaint policy (C-381) and complaint forms. The Administrator and Director of Clinical Services are responsible for conducting and directing ALL complaint investigations to ensure patients are free from all abuse, injuries of unknown origin and misappropriation of property at all times. The Administrator and Director of Clinical Services will audit 100% of complaints for 60 days to ensure compliance with agency policy and state and federal requirements. All patients have been educated at the start of care on their patient rights, including the right to be free from all abuse, neglect or exploitation, as well as the right to voice a complaint and the options for doing so, including contacting the Agency and calling the ISDH complaint hotline. This information is present in all patient homes for easy access. The agency will continue to utilize supervisory visits and client satisfaction surveys as an additional outlet to receive patient complaints and to remind patients of their rights to	

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			bring complaints to the attention of the Agency. The Director of Clinical Services and Administrator are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	
G 0436 Bldg. 00	484.50(c)(5) Receive all services in plan of care Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure patients received all the care visits ordered in the plan of care for 1 (Patient #1) of 4 patients with home health aide only services, of 6 patients whose clinical records were reviewed. The findings included: Review of a policy, "Services on Hold," last revised/reviewed 8-21-19, evidenced the policy stated, "Services will be placed on hold when patients are unable to receive services in the home due to hospitalization, interruptions in therapy due to clinical response (infusion), or travel outside the agency service area. Services may be placed on hold for periods of time within a sixty (60) day episode but cannot be extended if the period is longer than the certification period ... When services are suspended the Director of Clinical Services/designee will place the services on hold with a reason identified ... The physician will be notified of the change in condition or circumstances precipitating the change. Physician orders will be obtained if there is a change in the care or treatments to be provided ... The agency will maintain regular contact to determine an estimated date for services to	G 0436	G436 All internal employees have been re-educated regarding the need to follow the ordered frequency and duration range outlined in the Plan of Care. The Administrator will be responsible for ensuring that any inactive employee receives all in-services distributed as part of the Agency's plan of correction, prior to being switched to "active" status and placed in the schedule. Any deviation from the ordered frequency and duration range will continue to be documented with a missed visit note or supplemental order and communicated to the Physician. The Agency will make every effort to make-up any missed visits within the work week. The Director of Clinical Services or designee will audit 100% of processed schedules for 60 days to ensure missed visit notes or supplemental orders are sent to the Physician for any schedules	11/11/2020

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	resume, if a pre-determined resumption date has not previously been established ... When it is anticipated that the patient services will not resume within the anticipated time, the Director of Clinical Services or designee will contact the patient/family and the appropriate staff members and initiate the discharge process. The physician will be notified of planned discharge." Review of an undated start of care packet, with patients rights enumerated, "Rights and Responsibilities," evidenced, " ... Together Homecare must protect the exercise of these rights and maintain documentation showing that they have complied with the following rights: ... To receive all services outlined in the plan of care ... " Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained a plan of care for the certification period of 7-5 to 9-2-2019, with orders for home health aide (HHA) "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week X [for] 9 weeks ... Medicaid PA [sic prior authorization] Program Hours: The patient has chosen to schedule PA hours as follows: 1-5 hours/day X 3-5 days/week, 2-6 hours a day X 1-2 days/week, 0.5- 4 hours/day X 1-3 days/week ... Medicaid Waiver Program Hours: The patient has chosen to schedule Waiver hours as follows: 3-7 hours/day X 3-5 days/week, 2-6 hours/day X 1-2 days/week, 4-8 hours/day X 1-3 days/week." The primary diagnosis was Multiple Myeloma. Functional limitations listed included "endurance." HHA prior authorization hour duties enumerated on the plan of care included: Housekeeping: Change bed linens: Weekly and PRN [as needed;] Take out trash; Clean bathroom(s): Weekly and PRN; Light Housekeeping: Every visit; Assist		falling outside of the ordered frequency and duration. Once 100% compliance has been maintained for 60 days, the Administrator or Director of Clinical Services will audit 10% of patients quarterly as part of the Agency’s QAPI program to ensure continued compliance. The Administrator and Director of Clinical Services are responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur.	

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	with Laundry, PRN; Assist with dishes: Every visit; Make bed PRN; Vacuum/Sweep weekly and PRN; Dust Weekly and PRN; Bathing: Shower chair/bench to be used during bathing; assist with Shower: PRN; Hygiene and Grooming: Assist with Shampoo PRN; Assist with Nail Care PRN; Assist with Dressing, PRN; Hair Care PRN; Peri Care PRN; notify Clinical Supervisor if no B.M. [bowel movement] in 3 days; document last B.M.date PRN; Assist to Commode PRN; Handling/Bringing meds [sic medications] to patient PRN; Verbal Medication Reminders PRN; Assist with wheelchair PRN; Assist with walker as needed for ambulation PRN; Assist with ambulation/transfers every visit; Assist with cane as needed for ambulation PRN; Encourage/Remind/Assist with Active Range of Motion Every visit; Prepare/Serve Meals Every visit; Encourage Fluids Every visit; May assist Patient with Pet Care Every visit; Bring in mail PRN. Review of patient #1 start of care comprehensive assessment, dated 7-5-2019, evidenced "Patient does not have a primary caregiver able to provide the hands on care he/she requires." Review of the HHA care plan dated 7-5-2019, evidenced "Visit Frequency/Duration: 1 visit /day X 6-7 days/week." The document evidenced the following schedule: "M [Monday]-Sat [Saturday] PA [prior authorization] = 9 AM to 12 P; W [Waiver] 12 PM to 5 PM ... Sun [Sunday] PA = 9 AM to 11 AM, W = 11 AM to 5 PM." Review of the HHA visit notes, for PA and Waiver, failed to evidence any care visits were made on Monday, 8-19 and Thursday, 8-22-2019. The plan of care frequency order of 6-7 visits per week was not met as only 5 care visits were			

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	provided. Review of the home health aide (HHA) visit notes, for PA and Waiver, failed to evidence any care visits were made on Monday, 8-26 and Tuesday, 8-27-2019. The plan of care frequency order of 6-7 visits per week was not met as only 5 care visits were provided. The clinical record failed to evidence how patient #1's needs for assistance with ADL's (activities of daily living) were met in the absence of the ordered care visits. On 9 -4-2020, at 2:15 P.M., the above findings were verified with the administrator and the DOCS. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.			
G 0482 Bldg. 00	484.50(e)(1)(i)(B) Mistreatment, neglect or abuse (i)(B) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA. Based on record review and interview, the home health agency failed to document as a complaint and therefore failed to document a responsive resolution to a complaint of physical and verbal abuse, to include an injury of unknown origin, for 1 of 1 (Patient #4) a minor patient, whose clinical record was reviewed and whose plan of care required extended hours skilled nursing care for chronic medical conditions, of a sample of 22 patients who received skilled nursing services for chronic medical conditions, in a current census of 160 patients for whom the agency provided care. The findings included:	G 0482	G 482 All internal staff members have received re-education regarding the proper process for complaint reporting and documentation as well as patient rights via a new in-service. This in-service included a review of the updated policies and forms, including C-381, C-540, and B-340, new complaint form and new Investigation Guidance form, as well as a review of the Patient Rights and Responsibilities document. All employees have been re-educated	11/24/2020

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	Review of an undated start of care packet, with patients rights enumerated, "Rights and Responsibilities," evidenced, " ... Together Homecare must protect the exercise of these rights and maintain documentation showing that they have complied with the following rights: ... To be free from verbal, mental, sexual, and physical abuse, including injuries of unknown origin, neglect, and misappropriation of property ... To ... voice grievances regarding the treatment or care that is (or fails to be) furnished, or regarding the lack of respect for you or your property by anyone who is furnishing services of behalf of the agency and must not be subjected to discrimination or reprisal for doing so. The agency must investigate complaints made regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient or the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence and the resolution of the complaint ... " Review of policy entitled "Patient/Family Complaint Policy," last reviewed/revised 8-21-2019, evidenced the policy stated," ... Purpose ... To establish a procedure for channeling complaints to the appropriate person for resolution, and to provide a response to the patient/family ... Complaints regarding treatment, services, or charges will be documented on the grievance form by the person receiving the complaint/grievance and forwarded as soon as possible to the appropriate director or to the management team for investigation action and trending ... All persons with a complaint will be notified of the steps taken to investigate the complaint, the result of the process and the date of completion ... "		about patient rights with emphasis on the patients' rights to be free from verbal, physical and emotional abuse and neglect. The Administrator will be responsible for ensuring that any inactive employee receives all in-services distributed as part of the Agency's plan of correction, prior to being switched to "active" status and placed in the schedule. All Together Homecare patients have been contacted to ensure there were no outstanding complaints, including concerns regarding verbal, physical, sexual, or mental abuse or neglect, misappropriation of property or injuries of unknown origin. No additional concerns regarding new or previously reported or unreported abuse (verbal/physical/emotional, sexual), neglect, misappropriation of property or injuries of unknown origin have been identified. Additionally, the Administrator and Director of Clinical Services contacted all individuals who filed complaints in 2020 regarding abuse or neglect to ensure there are no further concerns regarding the reported complaint, or any ongoing issues concerns related to Patient Rights. The Administrator and Director of Clinical Services are responsible for complaint investigations to ensure all complaints made are thoroughly investigated and documented and to ensure	

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	Review of policy entitled, "Identifying and Reporting Abuse/Neglect/Exploitation of Patients," last reviewed/revised 8-21-2019, evidenced the policy stated, "Patients have the right to be free from mental, physical, sexual, and verbal abuse, as well as neglect and exploitation ... Purpose ... To protect those persons who are, either by physical or mental disability or dependence on institutional services, particularly vulnerable to abuse or neglect ... The following are a list of common indicators for abuse/neglect in children and adults. The presence of these findings is an indication and should only be used as a guide: ... Unexplained or poorly explained physical injuries (bruises, burns) ... " Review of policy entitled, "Incident Reporting," last reviewed/revised 8-19-2019, evidenced the policy stated, "The reporting of incidents and the investigation are part of the agency's Performance Improvement Program ... Incident reports are reviewed by Administrator/Director of Clinical Services/designee, who will then determine what further action is needed ... After the report is reviewed by the Administrator/designee, he/she determines opportunities for performance improvement or whether to continue monitoring ... " Review of the clinical record for patient #4 evidenced a date of birth of 9-26-2002, a minor patient, and patient #4 had a parent as guardian. Patient #4 was diagnosed with Dravet Syndrome, was developmentally delayed with very few verbal expressions of words, had a gait abnormality, high seizure activity, fall precautions, stand-by assist, G-tube [gastrostomy] feedings, multiple medications (including seizure medications,) aspiration precautions, bleeding precautions,		patients are free from all abuse, injuries of unknown origin and misappropriation of property at all times. The Administrator and Director of Clinical Services will audit 100% of patient complaints for 60 days to ensure compliance with the Agency's complaint investigation process. After 60 days of 100% compliance, the Administrator and Director of Clinical Services will audit 20% of patient complaints each quarter, as part of the Agency's QAPI Program, to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	sleep apnea with a need for intermittent oxygen via a nasal cannula, temperature instability related to overheating, and cognitive impairment related to developmental delay. On 9-8-2020 at 2:01 P.M., during telephone interview with the parent guardian of patient #4, when queried about concerns related to scheduling/staffing issues, stated, "Which concerns? There have been so many." The parent indicated having contacted agency management on several occasions to request a visit from the supervisory nurse but the agency had failed to arrange a visit. The mother stated on or about 8-24-2020, patient #4 refused to go into the bathroom, which previously had not been an issue, and had started saying the word "belt", which was a word patient #4 had not normally use. The parent stated the bruise matched the shape and markings of the buckle on the gait belt and confirmed having taken photographs. The parent stated having found the gait belt in the living room, which was unusual because no one used it, and the gait belt was stored in a closet. The parent stated patient #4 is now frightened of the gait belt. The parent was unable to recall the exact date the bruise was identified; stated having a video(s) documenting the bruise, when patient #4, upon having been prompted, stated the nurse hit her. The parent also indicated having a video from the same day, parent alleged showed employee B, an agency registered nurse, having said "I'm going to crack you" to patient #4. Review of an untimed entry, dated 8-24-2020, into the Client Logging Report made by employee D, registered nurse case manager, evidenced employee D made a home visit at patient #4's parent request, to supervise, re-educate and train employee B, a registered nurse (RN,) and was			

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	shown patient #4's right upper thigh bruise. The entry evidenced the supervisory nurse arrived around 10 A.M. and patient #4's parent alleged the "full-time nurse may have hit the patient with her [patient #4's] gait belt." The home had cameras located everywhere except the bathrooms. The parent of patient #4 stated believing the incident may have occurred inside the bathroom, because there is no video camera in the bathroom, and the other home cameras failed to show patient #4 being hit. The RN Logging Report entry by RN, employee D, evidenced "called administration to inform them of the situation." The RN, employee D, requested the parent send the videos and pictures "to administration and further investigation will begin." The parent was informed "the patient's full-time nurse is not allowed inside of the home during this investigation." The agency failed to document this report as a complaint. Review of 2 videos with sound recordings provided by the mother of patient #4 evidenced the following: Video #1(img_8484.mp4) showed a view of the living room, a dining room table, the TV, and a hall with a Dutch door open to the steps. No people are visible at any time throughout the video. Audio was heard of an individual who stated, "Stop [first name of patient #4] ... Stop [first name of patient #4] ... I'm 'bout to crack you." Video #2 (img_8485.mov) evidenced patient #4 seated, possibly in the bathroom. Patient #4's legs were exposed and the parent was present on video. A purple bruise was visible on patient #4's upper right thigh. The parent asked, "What happened?" Patient #4 replied, "The nurse." The parent pointed at the bruise and asked again,			

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	"What happened? Did you say the nurse? The nurse, yes or no?" Patient #4 replied, "Bath." The parent was heard asking a version of "what happened" approximately 4 times and a version of "Did the nurse hurt you" approximately 10 times. The clinical manager indicated, on 9-10-2020, at 2 P.M., when queried about the abuse/neglect allegations related to patient #4, having known a little about patient #4, but not having known the care plan and other information well because "[name of patient #4] is not my patient." When queried concerning the absence of a complete investigation related to the observed injury of unknown origin; absence of physical assessment documentation by the supervisory nurse, to include measurements, assessment of the bruise, a pain assessment, and a full integumentary assessment to detect any further injuries of unknown origin, the clinical manager stated there was no physical assessment because "that's not what we were there for." On 9-11-2020, about 2:49 P.M., during a second query related to the failure to address allegations of abuse, the clinical manager asked, "What else did you want us to do?" When asked why a complete investigation was not conducted, as a means to resolve the complaint allegations of abuse/neglect, the clinical manager indicated the Incident Reporting Form and the Client Logging report documented all the actions the agency had taken. The administrator indicated, when queried on 9-10-2020, at approximately 2 P.M., having "made reports to all the appropriate agencies." Review of a document titled, "Incident Reporting Form," dated 8-24-2020, evidenced "Agency made all of the necessary reports for the allegation made earlier today. FSSA, CPS, MD and CICOA were all notified of the situation. CPS is currently			

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investigating, the agency will cooperate with any ongoing investigation and the caregiver [employee B, RN] remains suspended." When asked for a list of patients to whom the affected RNs had provided care, the administrator provided a list of 3 patient names. When queried if the administrator had contacted these families to identify any abuse/neglect concerns, the administrator stated, "No." When queried if the administrator had reviewed all the videos submitted by parent of patient #4, the administrator stated, "No."

Review of a document titled, "Incident Reporting Form", under Required Reporting To, the following items were marked:

1. DCS 8/24/2020 @ 1630 (Department of Child Services)
2. FSSA 8/24/2020 @ 1641 (Family and Social Services Administration)
3. Other: CICOA 8/24/2020 @ 1130 (Area Agency on Aging and Disability)
4. MD, 8/24/2020 @ 1600

The Incident reporting form failed to specify what comprised the "allegation made earlier today" and the agency actions taken to protect patient #4 and other similarly situated patients (22 who received extended hour skilled nursing services for chronic medical conditions, of a total of 160 patients for whom the agency provided care.) The incident report was documented as resolved the same day as reported, 8-24-2020.

During a query to the administrator, on 9-11-2020, at approximately 2 P.M., the administrator indicated having viewed videos #1 and #2, described above. The administrator indicated patient #4's guardian/mother did not notify the

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	agency of the bruise, or the allegation of verbal abuse, but the agency had received notification of allegations of the alleged abuse from the supervisory nurse, employee D, on 8-24-2020. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review. An immediate jeopardy related to patient rights under 42 CFR 484.50 (e)(1)(i)(B), began on 8-24-2020, and was identified on 9-11-2020. The administrator was notified on 9-11-2020 at 2:49 P.M. The agency's 3rd immediate jeopardy removal of immediacy plan and actions were determined to have removed the immediacy component of the immediate jeopardy on 9-18-2020, at 4:15 P.M. 410 IAC 17-12-3(c)(1) 410 IAC 17-12-3(c)(2)			
G 0484 Bldg. 00	484.50(e)(1)(ii) Document complaint and resolution (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to document completed and responsive resolutions to patient complaints for 12 of 16 complaints reviewed from 2019 and 2020. The findings included: 1. Review of an undated start of care packet, with patients' rights enumerated, "Rights and Responsibilities," evidenced, " ... Together Homecare must protect the exercise of these rights and maintain documentation showing that they	G 0484	G484 All internal employees have been re-educated on the Agency's complaint policy (B-341). All internal employees have also been educated on the requirement to conduct and document a thorough investigation, to include a complete and responsive resolution in the complaint write-up, and to report said	11/11/2020

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	have complied with the following rights: ... 5. To ... voice grievances regarding the treatment or care that is (or fails to be) furnished, or regarding the lack of respect for you or your property by anyone who is furnishing services of behalf of the agency and must not be subjected to discrimination or reprisal for doing so. The agency must investigate complaints made regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient or the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence and the resolution of the complaint ... " 2. Review of policy entitled "Patient/Family Complaint Policy," last reviewed/revised 8-21-2019, evidenced the policy stated," ... Purpose ... To establish a procedure for channeling complaints to the appropriate person for resolution, and to provide a response to the patient/family ... Complaints regarding treatment, services, or charges will be documented on the grievance form by the person receiving the complaint/grievance and forwarded as soon as possible to the appropriate director or to the management team for investigation action and trending ... All persons with a complaint will be notified of the steps taken to investigate the complaint, the result of the process and the date of completion ... " Review of the 2019 complaint log the following: 3. Review of a complaint from patient (Patient #7,) dated 5-15-19, related to dissatisfaction with plan of care home health aide (HHA) prior authorization (PA) and waiver hours. The documented actions to resolve the complaint were "scheduling team is working to restaff. The aide		resolution to the complainant. The complainant will be contacted by the Agency, in accordance with Agency policy (B-341) to report the results of the Agency's investigation and the resolution of the complaint. The Director of Clinical Services and Administrator are responsible for all complaint investigations and resolutions at all times. The Director of Clinical Services and Administrator will review 100% of complaints for 60 days to ensure each complaint includes documentation of a complete and responsive resolution befitting the complaint, as well as documentation that the resolution was communicated to the complainant. After 60 days of 100% compliance, the Administrator and Director of Clinical Services will audit 20% of complaints quarterly, as part of the Agency's QAPI Program, to ensure continued compliance. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	that [name of patient] wanted to come back FT [sic full time] has asked not to return d/t [sic due to] patient's heavy smoking ... CICOA [sic Central Indiana Council on Aging] notified to see if they can increase waiver hours at all. Clinical supervisor going out today for RCT, [sic recertification assessment] so if there's a change in condition noted on assessment, Agency will report to the MD and can try to request Pt [sic patient] increase [sic of ordered care hours per week] from MD." The complaint was documented as resolved on 5-15-2020. The complaint resolution failed to evidence the outcome of the recertification comprehensive assessment, whether the complainant was eligible for more care hours based on a change in condition, and whether the patient's physician had been contacted to coordinate ordered plan of care hours. The resolution documented was incomplete and did not document a responsive resolution to the patient's complaint. 4. Review of a patient (Patient #8) care complaint dated 6-28-2019, evidenced a complaint the agency nurse visit the day before was only 10 minutes. The complaint was documented resolved on 7-5-2019, based on an investigation. The complaint resolution failed to evidence if the sign in and sign out, and care provided by the nurse on 6-27-2019, were reviewed and were documented as per plan of care orders with all care orders completed. 5. Review of a patient (Patient #9) care complaint dated 7-17-19, evidenced a patient complaint alleging the nurse, employee DD, spent visit time on phone and not tending to patient's needs. Investigative findings evidenced the identified nurse had been asked by 2 other families not to return for skilled nursing care because the nurse			

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	had divulged too much of personal life rather than focus on care of pediatric patient. The resolution was documented as 7-17-2019, "schedulers and CSM [customer service manager] are trying to identify new nursing staff for when primary nurse is off ... " The documented resolution failed to evidence new nursing staff had been identified and the care visits for the patient in the complaint were being provided as ordered on the plan of care. The documented resolution was incomplete and did not resolve the allegations in the complaint in relation to failure to attend to the patient's needs, and a determination of nurse staffing in place. 6. Review of a patient (Patient #10) care complaint dated 8-2-2019, evidenced a patient complaint related to HHA not reporting to shift on time. Agency review of the complaint evidenced the HHA was late to the care visit and review of the schedule of visits gong back 3 months evidenced 5 days when care was not provided. "Actions Taken:" evidenced "Agency will contact CICOA to see about finding a different provider. Agency will continue to staff client until a new provider could be found or the family becomes satisfied with our services. Agency will also post an ad through Indeed to try to find additional staff in the area in which the patient resides." The complaint was documented as resolved on 8-5-2019. The documented resolution was not complete and responsive because the agency failed to address how the plan of care ordered care visits would be scheduled/staffed to meet the patient needs. 7. Review of a patient (Patient #10) care complaint dated 8-19-2019, evidenced a complaint the nurse who performed patient's bowel program was late for the scheduled visit. Review of the section,			

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	"Investigative Findings:" evidenced "In speaking with scheduling and looking at verified schedules, there have been some missed visits in [name of patient] schedule. The team is working diligently to find new nurses to assist in the bowel program. In speaking with scheduling, it was also determined that the patient's mother [name of mother] was upset about the lack of staff ... " Review of the section "Actions Taken:" evidenced " ... Administrator has reached out again , to [name of person] at CICOA about finding another provider that can better suit their needs ... As of right now, at 12:46, Agency has not heard back from CICOA ... " The complaint was documented as resolved on 8-20-2019. The documented resolution (Actions Taken) failed to evidence an outcome for the complaint allegations related to staffing--to include whether the agency had determined and assigned nurses to meet the plan of care orders, or whether the patient had chosen to select another provider. 8. Review of a patient (Patient #1) care complaint dated 8-19-2019, at 4:07 P.M., evidenced a patient #1 complained home health aide (HHA) employee A, had video recorded in patient #1's home, showing images of the home and family, and posted the video content on You Tube without consent, and alleged HHA, employee A, smoked marijuana in the patient's bathroom. Review of the complaint evidenced it was documented as resolved, and signed by the administrator, on 8-20-2019, at 4:24 P.M. The documented actions for resolution were "Caregiver [sic employee A] is no longer employed with the agency due to not following company protocol. Administrator has reached out to caregiver to get the parking pass back. Caregiver [sic employee A] stated that she would bring it back the following business day. We have temporarily re-staffed the client and are			

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	working to find a permanent solution." The documented resolution was not complete and responsive because there was no follow up to ensure patient #1's handicap parking pass was returned and the resolution failed to evidence the You Tube videos had been reviewed to determine the nature and scope of the violation of patient #1's privacy, e.g. whether or not a HIPAA (Health Insurance Portability and Accountability Act) violation also occurred. During a telephone interview with patient #1 on 9-4-2020, at 10:53 A.M., patient #1 indicated having complained to the agency and also You Tube about the videos taken by HHA, employee A, without consent in patient #1's home. Patient #1 indicated being concerned about images and commentary in the posted videos which contained identifiable information about patient #1 and patient #1's family. Patient #1 stated You Tube had taken down the video posts. 9. On 9-4-20, at 2:15 P.M., the administrator indicated having called employee A to come into the office to discuss the allegations in patient #1's above complaint and for drug testing. When employee A refused, the administrator indicated refusal served as a termination from employment for failure to cooperate with a complaint investigation. The office notes on the complaint form evidenced HHA, employee A, had taken patient #1's handicap parking sticker, and the agency would ensure the parking sticker was returned. When queried whether the administrator had viewed the You Tube videos posted by employee A, which were recorded in patient #1's home, to determine the exact nature and scope of the invasion of patient #1's privacy, to include listening to the audio portion to determine if it contained identifying patient			

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information, the administrator responded, "No." The administrator stated it was wrong of employee A to take patient #1's handicap parking sticker for any reason. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.

10. Review of a complaint (Patient #11) dated 8-26-2019, evidenced a patient care complaint related to staffing. Under "Investigative Findings" the document evidenced "The administrator went back through the schedule and found out there have been some missed shifts, primarily on the weekends. Dating back to June 1st, 2019, the agency has missed 7 total shifts ... Right now, Together Homecare does not have much staff that can be available last minute ... Update: I have spoken to [name of patient] and I let her know our plan to get the weekends taken care of ... " The documented resolution failed to evidence staffing needs for the patient, to include weekends, had identified staff assigned to meet the patient's care needs. The resolution was incomplete and non-responsive because a "plan to get weekends taken care of" is not a resolution of having identified the staff to meet the patient's care visits as ordered on the plan of care.

11. Review of a complaint dated 9-3-2019, evidenced a patient (Patient #12) care complaint related to staffing. Under "Actions Taken:" the agency documented "Just to reiterate, the previous aide has been removed from the schedule and we are currently providing staff with different aides until we can establish a permanent [sic HHA.] I also reiterated to [sic case manager] to be more concise when explaining our visit protocol to our clients/families. Agency will

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	identify a new aide and keep both the family and CICOA in the loop." The complaint was documented as resolved on 9-3-2019. The resolution failed to be responsive and complete to the allegations in the complaint. The agency had not documented care visits had been reviewed to ascertain if the agency had provided care visits (staffing) as ordered on the plan of care. The "Actions Taken" section was a plan to address the allegations, but failed to document a plan had been implemented and had resolved the patient's complaint. 12. Review of a patient (Patient #13) care complaint dated 10-7-2019, evidenced a patient complaint related to staffing. Under "Investigative Findings, Administrator reviewed the schedule and we did have 3 call offs in 4 days, however, we were able to identify staff for one of those shifts. Traditionally, we have had coverage, but we've had a tough time keeping aides out there, whether they do not want to go back, or [name of patient] does not want them back." The complaint was documented as resolved 10-8-2019, "We informed [name of patient] that we would be getting job postings up specific to their open needs. We apologized for the inconvenience and let him know we would do our best. It is communicated during every supervisory visit, that they [sic patients] have the right to choose their provider and at this time, they have decided to stay with Together Homecare." The documented resolution was not complete had was not responsive to the complaint. Future actions planned, which have not been documented as implemented to address the patient's complaint regarding staffing, were not a resolution. Review of the 2020 complaint log evidenced the following:			

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13. Review of a patient (Patient #14) care complaint dated 5-6-2020, alleged the HHA, employee JJ, had not been providing adequate care to patient # WWW and this HHA was sleeping on the job. "Investigative Findings" evidenced employee JJ admitted to having fallen asleep on the job, and was re-educated on providing care listed on the care plan. "Actions Taken" evidenced "Agency re-educated aide and gave [sic HHA] verbal warning about job performance and removed from patient schedule. Agency has remained in contact with the patient and [his/her] family about re-staffing [him/her] case with someone they approve of. The documented resolution failed to evidence the agency had implemented, not just planned, to provide the ordered care visits to meet the patient's needs.

14. Review of a patient (Patient #14) care complaint dated 6-12-2020, related to employee HH, home health aide, having brought child to assigned work shift, taking lunch breaks and not returning to duty for an hour, and using the telephone a lot while on duty (arguments with spouse.) The complaint was documented as resolved on 6-18-2020, with agency action of removing employee HH from assigned shifts. The resolution failed to document if the delivery of care and provision of HHA patient services had been negatively affected by the HHA's misconduct.

15. Review of a patient (Patient #15) care complaint dated 7-13-2020, evidenced a complaint the HHA had slept while on shift, had arrived late to assigned shift, and was taking lunch breaks of 30-45 minutes during assigned shift, and changed the incontinent bedbound patient's brief

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	incorrectly by lifting the patient's legs rather than log rolling patient while in bed to place the brief underneath patient. The complaint was documented as resolved on 7-13-2020, with the competency issue of changing briefs of a bedbound patient addressed by the DOCS by having provided verbal instruction to the HHA, employee GG. The resolution failed to evidence the agency had followed up to observe employee GG, HHA, while performing the task of changing the brief of an incontinent patient, for competency with the assigned task. 16. Review of a patient (Patient #16) care complaint dated 7-16-2020, related to staffing concerns for patient #4. "Investigative Findings" evidenced, "Staffing has been tough since [name of employee C, registered nurse] was removed from the schedule. The agency does not currently have the resources to staff but are actively recruiting." The complaint was documented as resolved on 7-17-2020, with "Actions Taken: Agency has informed the family of the staffing issues as well as CICOA [Central Indiana Council on Aging.] We spoke with [name of CICOA case manager] and she is aware, and the family has a pick list to identify an agency that can support their needs. If we find a nurse who can take the hours, we will continue to staff. In the meantime, we are taking it day by day to try and support the family the best we can." The documented resolution failed to evidence completed actions, but described a plan to proceed without meeting patient #4's care needs as ordered on the plan of care, or having documented the complainant was satisfied with the proposed resolution. 17. On 9-9-2020, at 2:10 P.M., the above concerns were discussed with the administrator and director of clinical services (DOCS,) who stated the			

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	complaint documentation was not complete and responsive. When queried for additional pertinent explanation, information, or documentation, the administrator and the DOCS stated having nothing further to present. 410 IAC 17-12-3 (c)(2)			
G 0526 Bldg. 00	484.55(c) Content of the comprehensive assessment Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: Based on record review and interview, the agency failed to ensure its registered nurses conducted and documented a complete comprehensive assessment as a basis for care planning for 1 (Patients #4) 2 patients who received skilled nursing care, of a total sample of 6 patients whose clinical records were reviewed. The findings included: Review of a policy, "Comprehensive Patient Assessment," evidenced the policy stated, "A thorough, well organized, comprehensive and accurate assessment, consistent with the patient's immediate needs will be completed for all patients ... Purpose To determine the appropriate care, treatment and services to meet patient initial and his/her changing needs ... To make care, treatment, or service decisions based on information developed about each patient's needs and the individual's response to care ... To increase clarity in measurement. To measure processes of care in the agency. To identify	G 0526	G526 All RN Clinical Supervisors have been re-educated on the importance of conducting and documenting a thorough comprehensive assessment at re-certification and not documenting “see POC” or “see med profile” with regard to DME settings, medication information or other details regarding patient status or care. The Director of Clinical Services reviewed patient #4’s plan of care to ensure it contained the detailed information related to her clinical status, including respiratory treatments, seizure precautions and DME settings. The record is 100% compliant. The Director of Clinical Services or RN designee will audit 100% of	11/11/2020

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	patient's medical, nursing, rehabilitative, social and discharge planning needs ... The Comprehensive Assessment will include a review of all medications the patient is using (prescription and nonprescription) ... Patient needs are assessed, and care guidelines established based on the assessment data." Review of the clinical record of patient #4 evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 5-12 to 7-10-2020, with orders for skilled nursing services for a minor patient with multiple chronic medical conditions. Review of the start of care comprehensive assessment, dated 5-12-2020, evidenced patient had multiple chronic health conditions, to include Dravet Syndrome [a seizure disorder characterized by frequent seizure, ataxia [impaired coordination], cognitive impairment, behavioral disorder, and motor deficits. Under the genitourinary assessment section, "History of UTIs [urinary tract infections] Mother reports patient may have a yeast infection ... " The comprehensive assessment failed to document observation of patient #4's urine for abnormal appearance or smell, the condition of patient #4's genitalia for redness, swelling, or exudate. Under neurological assessment "Patient Specific Seizure Plan: Included in POC [plan of care.]" The comprehensive assessment failed to document any portion of a seizure plan related to patient #4's seizure activity. Under "Additional Respiratory Requirements" evidenced "Apnea monitor settings: See POC [plan of care] Cough Assist Machine: Included in Plan of Care." The comprehensive assessment failed to document any data related to patient #4's apnea monitor, when it was used, settings, and whether the		comprehensive assessments conducted by RN Clinical Supervisors for a period of 30 days to ensure compliance with these requirements, and to ensure comments such as “see POC” or “See med profile” are not used in comprehensive assessment documentation. As of 11/10/2020, the review of all assessments has revealed 100% compliance. The Director of Clinical Services or RN designee will continue this 100% review for the remainder of the 30-day period. After 30 days of 100% compliance, the Director of Clinical Services or RN designee will review the comprehensive assessments during the QAPI quarterly 10% clinical record audit. The Director of Clinical Services is responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

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	settings were manual or programmed; and failed to document any data related to patient #4's cough machine, when it was used, settings, and whether the settings were manual or programmed. Review of patient #4's telehealth comprehensive assessment for recertification, dated 7-10-2020, evidenced under the "Pain Assessment" patient #4's guardian reported "complains of pain all the time." The comprehensive assessment failed to evidence the location(s) of patient #4's pain, and failed to evidence documentation of pain cues from patient #4. Under the genitourinary assessment section, "History of UTIs [urinary tract infections] Mother reports patient may have a yeast infection ... " The comprehensive assessment failed to document observation of patient #4's urine for abnormal appearance or smell, the condition of patient #4's genitalia for redness, swelling, or exudate. Under neurological assessment "Patient Specific Seizure Plan: Included in POC [plan of care.]" The comprehensive assessment failed to document any portion of a seizure plan related to patient #4's seizure activity. Under "Additional Respiratory Requirements" evidenced "Nebulizer treatments: See med[ication] profile" ... "Apnea monitor settings: See POC [plan of care] Cough Assist Machine: Included in Plan of Care." The comprehensive assessment failed to document any data related to patient #4's nebulizer type, medication(s) which required the nebulizer,when and how often it was to be used; failed to document and data related to patient #4's apnea monitor, when it was used, settings, and whether the settings were manual or programmed; and failed to document any data related to patient #4's cough machine, when it was used, settings, and whether the settings were manual or programmed.			

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	On 9-16-2020, at 12 noon, the above findings for patient #4 were reviewed with the administrator and the director of clinical services (DOCS) who verified the findings. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.			
G 0538 Bldg. 00	484.55(c)(6)(i,ii) Primary caregiver(s), if any The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules;			
	Based on record review and interview, the agency failed to ensure a patient had a competent caregiver in the home to provide care, as required by agency policy, for 1 (Patient 1) of 6 patients whose clinical record was reviewed. The findings included: Review of a policy, "Admission Policy," last reviewed/revised 8-21-2019, evidenced, " ... Criteria for Patient Admission ... 7. When determined necessary based on patient's condition, a competent caregiver and/or family member may assume responsibility for patient care with intermittent services provided by the agency ... " Review of the plan of care for patient #1, evidenced a start of care date of 7-5-2019, diagnosis of Multiple Myeloma, with a plan of care for the certification period of 7-5 to 9-2-2019. Review of the patient's comprehensive assessment dated 7-5-2019, evidenced "patient does not have a primary caregiver able to provide	G 0538	G538 Re-educated internal employees on Admission policy and proper documentation of patient's informal support system. All clinical records are currently 100% compliant with G 538 and Agency policy regarding documentation of a primary caregiver(s), if any, and other available supports. Director of Clinical Services or RN designee will audit 100% of new admissions for 60 days to ensure Agency continues to document the primary caregiver(s), if any, and other available supports, as part of each patient's comprehensive assessment. After 60 days of 100% compliance, Director of Clinical Services or RN designee will monitor continued compliance during the QAPI quarterly 10% clinical record audit.	11/11/2020

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	the hands-on care (sic) he/she requires." On 9-4-2020 at 2:15 P.M. the above findings were discussed with the administrator and the director of clinical services (DOCS.) The DOCS indicated based on patient #1's diagnosis and hours of care, should have had a qualified caregiver to assume responsibility for patient #1's care because the agency provided only intermittent home health aide services. The DOCS verified there was no qualified caregiver documented in the clinical record. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.		The Director of Clinical Services and Administrator are responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur.	
G 0570 Bldg. 00	484.60 Care planning, coordination, quality of care Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.			

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	Based on record review and interview, the agency failed to maintain compliance with the Condition of Participation of Care Planning, coordination of services, and quality of care, by having failed to ensure the plan of care visit hours for home health aide visits were individualized and based on meeting the patients identified needs; failed to ensure visits were provided as ordered in the plan of care; failed to include an established minimum number of baths/showers per week; and failed to ensure the nurse visit hours on the plan of care were individualized and based on the patient's needs (See G 572;) failed to ensure the plan of care included a measurable hygiene goal (See G 574;) failed to ensure the plan of care was evaluated and updated at the time of recertification (See G 586); and failed to ensure physicians who were responsible for aspects of a patient's care were contacted to coordinate care in relation to a patient's need for a seizure care and management plan, nutrition requirements and care of a gastrostomy feeding tube (See G 608.) The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of Care Planning, coordination of services, and quality of care, 42 CFR 484.60.	G 0570	G570 **Per ISDH instruction, a response is not recommended for this tag due to the absence of any cited findings.**	11/11/2020
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or			

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	her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.			
	Based on record review and interview, the agency failed to ensure the nurse visit hours on the plan of care were individualized and based on the patient's needs for 1 (Patient #4) of 2 patients who received skilled care, in a sample of 6 patients whose clinical records were reviewed; failed to ensure the plan of care visit hours for home health aide visits were individualized and based on meeting the patients' identified needs for 2 (Patients #1 and 6) of 4 patients who received home health aide only services, of a sample of 6 patients; failed to ensure visits were provided as ordered in the plan of care for 1 (Patient #1) of 4 patients who received home health aide only services; and failed to ensure the plan of care established a minimum number of baths/showers per week for 1 (Patient #1) of 4 patients who received home health aide only services, of a sample of 6 patients. The findings included: 1. Review of a policy, "Plan of Care," last reviewed/revised 8-21-2019, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and	G 0572	G572 All internal employees have been re-educated that each patient's individualized frequency and duration is developed in collaboration with the patient and/or family and will be approved by the managing Physician. The frequency and duration may evolve based on the patient condition or informal support status, Physician order, and patient/family request. Any such changes must be documented accordingly in the clinical record. Missed visit notes and/or supplemental orders will continue to be utilized to report any deviations from the ordered frequency and duration. Agency will make every effort to make up any missed visits within the work week. All clinical records have been reviewed to ensure that large ranges are not utilized, and that ranges are kept short/small, and do not vary by more than 1-2 days and/or 1-2 hours from the schedule that has been requested by the patient and approved by Medicaid. All clinical records are 100% compliant with this requirement. . The Director of Clinical Services or	11/24/2020

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	will be updated as necessary, but at least every sixty (60) days ... The Plan of Care shall be completed in full to include: ... Frequency and duration of visits to me made ... All medications and treatments ... Patient-specific interventions and education; measurable outcomes and goals ... " 2. Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 5-12 to 7-10-2020, with orders for skilled nursing services "Medicaid State Frequency and Duration 1 visit/day X [sic for] 4-6 days/week for 9 weeks; Medicaid PA [prior authorization] Program Hours (Skilled Nursing) The patient's mother has chosen to schedule these hours as follows 6.5 - 10.5 hours/day X 4-6 days/week Medicaid Respite Hours (Skilled Nursing) The patient is authorized for Respite hours that the patient's mother will schedule on an as-needed basis." The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Review of the skilled nursing visit notes evidenced the nurse visits were consistently 8 to 10 hours to provide the care ordered on the plan of care. The nurse visit hour range from 6.5 to 10.5 hours per visit was too wide of a variation for care orders and was not individualized to meet the patient's needs. On 9-8-2020 at 2:01 P.M., the parent guardian of minor patient #4, when queried about plan of care hours for the skilled nurse, stated the nurses had to stay 8-10 hours to provide all the care patient #4 required. When queried whether guardian had		RN designee will audit 100% of outgoing plans of care for 30 days to ensure that each patient's nursing or home health aide frequency and duration remains compliant with this requirement, and to ensure that no large ranges are utilized. Once 100% compliance has been maintained for 30 days, the Director of Clinical Services or RN designee will continue to include evaluation of the frequency and duration and adherence to the ordered frequency and duration as part of the Agency's quarterly 10% clinical record audit to ensure continued compliance. All HHAs and CNAs have been re-educated regarding properly documenting the reason for not completing a task during a visit. All RN Clinical Supervisors have been re-educated on the care planning process for home health aide tasks, including the establishment of a minimum weekly bath/shower schedule for patients with baths/showers on their aide care plan. The issue was immediately corrected when all Agency aide care plans were audited by the Director of Clinical Services to ensure the presence of a minimum weekly bathing threshold when applicable. All aide care plans are currently 100% compliant. In order to ensure a deficient practice does not occur, the	

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	chosen to schedule the skilled nursing care hours on a range of 6.5 to 10.5 hours, the guardian stated wanting all the hours patient #4 was allowed, to include respite care. The guardian of patient #4 stated the agency had never provided respite care hours due to lack of staffing. 3. Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained a plan of care for the certification period of 7-5 to 9-2-2019, with orders for home health aide (HHA) "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week for 9 weeks ... Medicaid PA [sic prior authorization] Program Hours: The patient has chosen to schedule PA hours as follows: 1-5 hours/day X 3-5 days/week, 2-6 hours a day X 1-2 days/week, 0.5- 4 hours/day X 1-3 days/week ... Medicaid Waiver Program Hours: The patient has chosen to schedule Waiver hours as follows: 3-7 hours/day X 3-5 days/week, 2-6 hours/day X 1-2 days/week, 4-8 hours/day X 1-3 days/week." The primary diagnosis was Multiple Myeloma. Functional limitations listed included "endurance." HHA prior authorization hour duties enumerated on the plan of care included: ... Bathing: Shower chair/bench to be used during bathing; assist with Shower: PRN; Hygiene and Grooming: Assist with Shampoo PRN; Assist with Nail Care PRN; Assist with Dressing, PRN; Hair Care PRN; Peri Care PRN. The care task of shower/bath was ordered PRN [as needed] with no minimum shower/bath per week established. Review of patient #1 start of care comprehensive assessment, dated 7-5-2019, evidenced "Patient does not have a primary caregiver able to provide the hands on care he/she requires." Height of 5' 9" and weight of 270 pounds was documented. Patient #1 reported anticipating right foot surgery		Director of Clinical Services will audit 100% of new Aide Care Plans for 30 days to ensure 100% compliance with establishing a minimum number of baths/showers per week to be provided to the patient by the home health aide for patients with baths/showers on their care plan. After 30 days of 100% compliance, the Director or RN designee will include review of Aide Care Plans during the 10% quarterly record audit to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring the corrective actions to ensure the deficiency will not recur.	

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on 7-16-2019. For gastrointestinal "will experience bowel incontinence if he/she is very sick .... and wears incontinence products PRN [as needed.] Durable medical equipment included assistive devices of cane [rarely used,] walker Knee walker-used post-op, Manual wheelchair, used post-op, right foot brace, bilateral wrist/hand braces to used as needed, and shower chair/bench. Patient Independence was "Moderate Assist with ADLs [activities of daily living.]

Review of the HHA care plan dated 7-5-2019, evidenced "Visit Frequency/Duration: 1 visit /day X 6-7 days/week."
The documented schedule was "M [Monday]-Sat [Saturday] PA [prior authorization] = 9 AM to 12 P; W [Waiver] 12 PM to 5 PM ... Sun [Sunday] PA = 9 AM to 11 AM, W = 11 AM to 5 PM." The 30 assigned HHA tasks on the HHA care plan did not vary at all by day of the week.

Review of the home health aide visit notes, for both PA and Waiver, evidenced documentation of shower/bath on 7-13-19, 8-5, 8-20, 8-21, 8-23, 8-24, 8-25, 8-28, 8-29, 8-30, and 8-31-2019. Patient #1 was documented to have received a shower/bath for 11 days out of a 60 day certification period. Review of the HHA visit notes failed to evidence documentation patient #1 had declined a shower or had taken shower without HHA assistance on the visits where no shower/bath had been documented.

Review of the HHA visit notes for Patient #1 failed to evidence the HHA had provided care visits on 8-19, 8-22, 8-26, 8-27, 9-1, and 9-2-2019.

Review of HHA visit notes with the clinical director on 9-8-2020, at 1:15 P.M., evidenced the

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	HHA visits were most often 3 hours for PA, and 4-5 hours for Waiver. The clinical director verified there were 4 weeks of the certification period for which zero shower/bath had been documented. When queried why the HHAs were in the home for patient #1, the clinical director said for hygiene and safety. When queried why no hygiene goal had been established individualized to include a minimum number of showers/baths per week, the clinical director stated believing "as needed" was adequate. When queried why the HHA visit orders had large ranges (PA of 1-5 hours/day ... 2-6 hours a day ... 0.5- 4 hours/day ... Waiver of 3-7 hours/day ... 2-6 hours/day ... 4-8 hours/day) the clinical manager stated it was for agency convenience in scheduling and to avoid having to contact physicians for any variances in care visits. When queried what the HHA could accomplish in a 0.5 hour visit, the clinical director indicated, "I don't know." When asked what justified the difference between a 1 hour and a 5 hour visit, a 2 hour and 6 hour visit, or a 0.5 hour visit and 4 hour visit, based on patient's #1 needs identified in the comprehensive assessment, the clinical director had no explanation. The clinical manager verified patient #1 did not have a qualified care giver in the home to assist with ADLs, and patient #1 had recent foot surgery which affected ambulation and mobility. The agency failed to ensure the HHA care visit orders were individualized to a narrow range of hours which would meet patient #1's needs as identified in the comprehensive assessment. 4. Review of the clinical record of patient #6 evidenced a start of care date of 8-17-2020, and contained a plan of care for the certification period of 8-17 to 10-15-2020, with orders for HHA care visits "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/ week X 9 weeks; Medicaid			

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	PA Program Hours (HHA) The patient and his wife have chosen to schedule his PA [prior authorization] hours as follows: 0.5 to 4 hours/day X 1-3 days/ week, and 5-9 hours/day X 4-6 days/ week Medicaid Waiver Program Hours (HHA) The patient and his wife have chosen to schedule his Waiver hours as follows: 0.5 - 4.5 hours/ day X 4-6 days/week." Patient #6 primary diagnosis was documented as Multiple Dystrophy, and evidenced wheelchair dependence and use of Hoyer lift for transfers. HHA care duties ordered for PA were Assist patient to keep DME [durable medical equipment]/ Assistive Devices clean, and notify Clinical Supervisor if any items are in disrepair or require attention ... assist with wheelchair every visit, assist with ambulation/transfers every visit, Hoyer lift must be used for ALL patient transfers [use Hoyer lift or Stander] ... Shower chair/bench to be used during bathing, assist with shower ... (Tuesday and Friday) .. Change bed linens weekly and PRN [as needed,] Light Housekeeping every visit, assist with laundry weekly ... assist with dishes every visit, vacuum/ sweep weekly and PRN, dust weekly and PRN ... Assist with Shampoo weekly and PRN, Assist with Dressing Every visit, Peri care Every visit ... Handling/ Bringing meds [sic medications] to patient (No administering,) Verbal Medication Reminders Every visit ... Prepare/ Serve Meals Every visit, Follow Aspiration Precautions, Assist with feeding, to include cut food into small bites PRN, Encourage Fluids Every visit ... Notify Clinical Supervisor if no BM in 3 days, Document last BM date PRN, Change brief/ peri pad PRN, Assist to Commode Every Visit. Patient #6 was identified as a high risk for falls. The plan of care evidenced patient #6's wife worked outside home full time and was unable to provide necessary care during working hours. The plan of care failed to individualize the HHA			

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	visit hours to a minimum of greater than 0.5 hours for a visit, and failed to individualize the HHA care plan orders to ranges of visits which were rationally related to patient #6's need for assistance with ADLs [activities of daily living] when wife was at full time job. 5. On 9-18-2020, at 4 P.M., the administrator and the director of clinical services (DOCS) verified the above findings, and stated the agency believed the ranges were proper because the attending physician had signed the plan of care orders. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS provided an email from June 17, 2019, from the director of an Indiana home and hospice care association which stated a range of 1-7 days for care visits per week, was too much of a variable, and relied on this email to justify hours of care per visit ranges having 3-4 hours of variation as permissible, without justification for the range based on availability of a caregiver, or other pertinent factors. 410 IAC 17-13-1 (a)			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations;			

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	(viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include.			
	Based on record review and interview, the agency failed to ensure the plan of care included a measurable hygiene goal for 1 (Patient #1) of 4 patients who received home health aide services only, out of a sample of 6 patients. The findings included: Review of a policy, "Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days ... The Plan of Care shall be completed in full to include: ... Frequency and duration of visits to me made ... All medications	G 0574	G574 All RN Clinical Supervisors have been re-educated on the care planning process for home health aide tasks and the establishment of patient goals that are specific and measurable, including the establishment of a minimum weekly bath/shower hygiene goal for patients for whom bathing is on the aide care plan. The issue was immediately corrected when all Agency aide care plans were immediately audited by the Director of Clinical Services to ensure the presence of a minimum weekly hygiene goal related to bathing when applicable. All aide care plans are currently 100% compliant. In order to ensure a deficient	11/11/2020

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	and treatments ... Patient-specific interventions and education; measurable outcomes and goals ... " Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained a plan of care for the certification period of 7-5 to 9-2-2019, with orders for home health aide (HHA) "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week for 9 weeks ... Medicaid PA [sic prior authorization] Program Hours: The patient has chosen to schedule PA hours as follows: 1-5 hours/day X 3-5 days/week, 2-6 hours a day X 1-2 days/week, 0.5- 4 hours/day X 1-3 days/week ... Medicaid Waiver Program Hours: The patient has chosen to schedule Waiver hours as follows: 3-7 hours/day X 3-5 days/week, 2-6 hours/day X 1-2 days/week, 4-8 hours/day X 1-3 days/week." The primary diagnosis was Multiple Myeloma. Functional limitations listed included "endurance." HHA prior authorization hour duties enumerated on the plan of care included: ... Bathing: Shower chair/bench to be used during bathing; assist with Shower: PRN; Hygiene and Grooming: Assist with Shampoo PRN; Assist with Nail Care PRN; Assist with Dressing, PRN; Hair Care PRN; Peri Care PRN. The care task of shower/bath was ordered PRN [as needed] with no minimum shower/bath per week established. The plan of care failed to evidence a goal in relation to hygiene for patient #1, who received HHA services only, ordered 5-7 days per week. Review of HHA visit notes for the certification period evidenced the HHA was in patient #1's home for care visits were 7 days/week, except for missed visits. On 9-8-2020, at 1:15 P.M., the above findings were		practice does not occur, the Director of Clinical Services or RN designee will audit 100% of new Aide Care Plans for 30 days to ensure 100% compliance with establishing a minimum/goal number of baths/showers per week to be provided to the patient by the home health aide for patients with baths/showers on their care plan. After 30 days of 100% compliance, the Director or RN designee will include review of Aide Care Plans during the 10% quarterly record audit to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring the corrective action to ensure the deficiency will not recur.	

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	verified by the administrator and the director of clinical services (DOCS.) When queried why no minimum number of showers per week or goal had been established for patient #1's hygiene, the DOCS had no explanation. When queried for further pertinent explanation, information, or documentation, the administrator and DOCS stated having nothing further to present for review. 410 IAC 17-13-1 (a)(1)(B) 410 IAC 17-13-1 (a)(1)(C) 410 IAC 17-13-1 (a)(1)(D)(i-xiii)			
G 0586 Bldg. 00	484.60(c) Review and revision of the plan of care Standard: Review and revision of the plan of care. Based on record review and interview, the registered nurse failed to ensure the plan of care was evaluated and updated at the time of recertification for 2 (Patients #1 and #4) of 4 patients on service more than 60 days. The findings included: 1. Review of a policy, "Plan of Care," last reviewed/revised 8-21-2019, evidenced the policy stated, "Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days ... The Plan of Care shall be	G 0586	G586 All internal employees have been re-educated that each patient's individualized frequency and duration is developed in collaboration with the patient and/or family and will be approved by the managing Physician. The frequency and duration may evolve based on the patient condition or informal support status, Physician order, and patient/family request. Any such changes must be documented accordingly in the clinical record. Missed visit notes and/or supplemental orders will continue to be utilized to report any deviations from the ordered frequency and duration. Agency will make every effort to make up any missed visits within the work	11/24/2020

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	completed in full to include: ... Frequency and duration of visits to me made ... All medications and treatments ... Patient-specific interventions and education; measurable outcomes and goals ... " 2. Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained a plan of care for the certification period of 9-3 to 11-1-2019, with orders for home health aide (HHA) "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week for 9 weeks ... Medicaid PA [sic prior authorization] Program Hours: The patient has chosen to schedule PA hours as follows: 1-5 hours/day X 3-5 days/week, 2-6 hours a day X 1-2 days/week, 0.5- 4 hours/day X 1-3 days/week ... Medicaid Waiver Program Hours: The patient has chosen to schedule Waiver hours as follows: 3-7 hours/day X 3-5 days/week, 2-6 hours/day X 1-2 days/week, 4-8 hours/day X 1-3 days/week." The primary diagnosis was Multiple Myeloma. Functional limitations documented included "endurance." HHA prior authorization hour duties enumerated on the plan of care included: ... Bathing: Shower chair/bench to be used during bathing; assist with Shower: PRN; Hygiene and Grooming: Assist with Shampoo PRN; Assist with Nail Care PRN; Assist with Dressing, PRN; Hair Care PRN; Peri Care PRN. The care task of shower/bath was ordered PRN [as needed] with no minimum shower/bath per week established. Review of the comprehensive assessment dated 8-28-19, evidenced patient #1 had a high fall risk; chronic pain; and occasional incontinence of bladder and bowel. Review of the 60 day summary of the plan of care for the certification period of 9-3 to 11-1-19, evidenced patient #1 had co-morbidities of chronic pain, asthma, difficulty walking,		week. All clinical records have been reviewed to ensure that large ranges are not utilized, and that ranges are kept short/small, and do not vary by more than 1-2 days and/or 1-2 hours from the schedule that has been requested by the patient and approved by Medicaid. All clinical records are 100% compliant with this requirement. The Director of Clinical Services or RN designee will audit 100% of outgoing plans of care for 30 days to ensure that each patient's nursing or home health aide frequency and duration remains compliant with the requirement, and to ensure that no large ranges are utilized. Once 100% compliance has been maintained for 30 days, the Director of Clinical Services or RN designee will continue to include evaluation of the frequency and duration and adherence to the ordered frequency and duration as part of the Agency's quarterly QAPI 10% clinical record audit to ensure continued compliance. All RN Clinical Supervisors have been re-educated on the re-certification process as a method for re-evaluating the care planning process for home health aide tasks that are specific to the patient's changing needs and abilities, as identified by the	

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	autoimmune hepatitis, systemic involvement of connective tissue, major depressive disorder, sleep disorder, fatigue, and hypothyroidism (low function of the thyroid gland) ... "continues to require significant assistance in her home with ADLs (activities of daily living)/ IADLs (instrumental activities of daily living) as well as assistance with transportation/errand on her Waiver hours ..." The registered nurse failed to evaluate the plan of care to ensure a minimum weekly order for shower/bath was care planned based on patient #1's assessed needs and functional limitations. 3. Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 7-11 to 9-8-2020, with orders for skilled nursing services "Medicaid State Frequency and Duration 1 visit/day X [sic for] 4-6 days/week for 9 weeks; Medicaid PA [prior authorization] Program Hours (Skilled Nursing) The patient's mother has chosen to schedule these hours as follows 6.5 - 10.5 hours/day X 4-6 days/week Medicaid Respite Hours (Skilled Nursing) The patient is authorized for Respite hours that the patient's mother will schedule on an as-needed basis." The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. The skilled nurse had orders to administer medications through the gastrostomy tube. Review of the non-OASIS (Outcome and Assessment Information Set) comprehensive assessment dated 7-10-2020, evidenced patient #4		patient and Agency. All aide care plans for active patients were immediately audited by the Director of Clinical Services to ensure the presence of a minimum weekly bathing threshold when applicable. All aide care plans are currently 100% compliant. All internal clinicians have been re-educated on ensuring that each patient's frequency and duration is individualized and must be re-evaluated regularly, including at the re-certification assessment. All clinical records were immediately reviewed to validate that the visit hours established on the plan of care for nurses and home health aides are individualized, based on meeting the identified needs of the patient. The Director of Clinical Services or RN designee will audit 100% of new Aide Care Plans and Plans of Care for 30 days to ensure continued 100% compliance with individualized frequency and duration and establishment of a minimum number of baths/showers per week for patients who have bathing on their care plans. The Director of Clinical Services or RN designee will audit 100% of start of careand re-certification assessments for 30 days to ensure the aide care plan continues to reflect the patient's current needs. After 30 days of 100% compliance, the Director or RN designee will include review of	

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	was a high fall risk; complained of "pain all the time;" had seizures; and was dependent on caregivers for bathing, dressing, and stand by assist for ambulation. Review of the nurse visit notes from the previous certification period evidenced the skilled nursing visits were 8-10 hours consistently to meet patient #4's care needs while parent guardian was at work. The nurse visit hour range from 6.5 to 10.5 hours per visit was too wide of a variation for care orders and was not individualized to meet the patient #4's needs because the agency had data from the visit notes evidencing care entailed visits of 8-10 hours per visit. 4. On 9-8-2020 at 2:01 P.M., the parent guardian of minor patient #4, when queried about plan of care hours for the skilled nurse, stated the nurses had to stay 8-10 hours to provide all the care patient #4 required. When queried whether guardian had chosen to schedule the skilled nursing care hours on a range of 6.5 to 10.5 hours, the guardian stated wanting all the hours patient #4 was allowed, to include respite care. The guardian of patient #4 stated the agency had never provided respite care hours due to lack of staffing. 5. On 9-18-2020, at 4 P.M., the administrator and the director of clinical services (DOCS) verified the above findings, and stated the agency believed the ranges were proper and did not need to be updated because the attending physicians had signed the plan of care orders. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS provided an email from June 17, 2019, from the director of IAHHC (Indiana Association for Home and Hospice Care) which stated a range of 1-7 days for care visits per week, was too much of a		frequency and duration and Aide Care Plans during the quarterly QAPI 10% clinical record audit to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring the corrective action to ensure the deficiency will not recur.	

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	variable, and relied on this email to justify hours of care per visit ranges having 3-4 hours of variation as permissible, without justification for the range based on availability of a caregiver, or other pertinent factors. 410 IAC 17-14-1 (a)(1)(C)			
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to ensure physicians who were responsible for aspects of a patient's care were contacted to coordinate care in relation to a patient's need for a seizure care and management plan, nutrition requirements and care of a gastrostomy feeding tube, for 1 (Patient #4) of 2 patients with skilled nursing care, out of a sample of 6 patients. The findings included: Review of a policy, "Plan of Care," last reviewed/revised 8-21-19, evidenced, "The Plan of Care is based on a comprehensive assessment and information provided by the patient/family and health team members ... The plan will be consistently reviewed to ensure that patient needs are met ... " Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 5-12 to 7-10-2020, with orders for skilled nursing services.	G 0608	G 608 Patient #4's seizure plan was updated in September with patient's re-certification. Director of Clinical Services audited current Plan of Care for 100% of Agency patients with seizure diagnosis to ensure patient-specific seizure plans were present, with additional orders sent to the Physician as required. All records are 100% compliant. All Agency RN Clinical Supervisors have been re-educated on the importance of coordinating care with other managing physicians when applicable, to ensure comprehensive oversight of the patient's care plan. Agency will continue to contact relevant physicians for specialty areas of patient care when so directed by the Physician signing the home health plan of care.	10/21/2020

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	Review of the start of care comprehensive assessment, dated 5-12-2020, evidenced patient had multiple chronic health conditions, to include Dravet Syndrome [a seizure disorder characterized by frequent seizure, ataxia [impaired coordination], cognitive impairment, behavioral disorder, and motor deficits. The comprehensive assessment documented patient #4 had a gastrostomy tube for tube feedings and water intake into the stomach. Under neurological assessment "Patient Specific Seizure Plan: Included in POC [plan of care.]" The comprehensive assessment failed to document a seizure plan related to the care and management of patient #4's seizure activity. Review of the plan of care failed to evidence a seizure care and management plan for patient #4. Review of the recertification comprehensive assessment dated 7-10-2020, evidenced under neurological assessment "Patient Specific Seizure Plan: Included in POC [plan of care.]" Review of the plan of care failed to evidence a plan for the care and management of patient #4's seizure activity. Review of the comprehensive assessment and the plan of care failed to evidence a seizure care and management plan for patient #4. Review of the clinical record, to include the plans of care, physician orders, and patient log entries, failed to evidence the agency had determined the name and contact information for patient #4's neurologist and gastroenterologist, to coordinate care in relation to a seizure care and management plan. On 9-14-2020 at 2:00 P.M., during telephone call with patient #4's attending physician's office (person CC) to review patient #4's plan of care, the nurse stated the attending physician did not manage patient #4's seizure medication or seizure		The Director of Clinical Services or RN designee will audit 100% of outgoing plans of care for 30 days to ensure plans of care are compliant. Following 30 days of 100% compliance, the Director of Clinical Services or RN designee will evaluate this component during the Agency's quarterly 10% clinical record audit to ensure continued compliance. The Director of Clinical Services is responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur. Completed 10/21/20 and ongoing	

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	plan and did not manage enteral feedings, care,maintenance, and changing of patient #4's gastrostomy tube, or the enteral and hydration feedings. On 9-18-2020 at 4:00 P.M., the above findings were verified by the administrator and the director of clinical services (DOCS.) When queried why the agency nurse and DOCS had not contacted the neurologist and gastroenterologist for patient #4, the DOCS indicated having dealt only with the attending physician. When queried for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review. 410 IAC 17-14-1 (a)(1)(F) 410 IAC 17-12-2 (g) 410 IAC 17-14-1 (a)(1)(G)			
G 0640 Bldg. 00	484.65 Quality assessment/performance improvement Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's			

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	performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.			
	Based on record review and interview, the agency failed to maintain compliance with the Condition of Participation of Quality Assurance and Performance Improvement. The agency failed to implement their policy by having failed to have identified measurable improvement for home health aide misconduct and missed care visits, both areas which would improve patient safety, outcomes, and quality of care (See G 642;) failed to implement its policy which required it to utilize measures derived from Outcome Assessment and Information Set in order to monitor the effectiveness and safety of services and quality of care in the design of the 2020 quality assessment and performance improvement program (see G 644;) failed to implement their policy which required the quality assurance performance improvement program to select performance improvement plans which focused on high-risk, high-volume, or problem-prone areas (See G 648;) failed to implement its policy which required the quality assessment and performance improvement program collect and analyze data for adverse event reports (See G 654;) and failed to ensure its quality assessment performance improvement program addressed the past performance of the home health agency's services and operation, by having failed to implement performance improvement projects designed to show measurable progress (See G 658.) The cumulative effect of these systemic problems	G 0640	**Per ISDH instruction, a response is not recommended for this tag due to the absence of any cited findings.**	11/11/2020

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	resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of			
G 0642 Bldg. 00	484.65(a)(1),(2) Program scope Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations.			
	Based on record review and interview, the agency failed to implement their policy by having failed to have identified measurable improvement for home health aide misconduct and missed care visits, both areas which would improve patient safety, outcomes, and quality of care, for 1 of 1 year reviewed, the 2020 quality assurance performance improvement performance improvement (QAPI) program. The findings included: Review of a policy, "Performance Improvement," undated, evidenced the policy stated, " ... Purpose To design processes, which through collaboration of all services and disciplines, will meet the needs of patients, staff and the community. To identify areas for improvement in the quality of care,	G 0642	G 642 The Administrator and Director of Clinical Services have been re-educated on the Agency's QAPI program, including review of the Agency's Performance Improvement Policy. The Director of Clinical Services completed HHQI's QAPI course, "Pave your Path," for additional QAPI education and guidance. Beginning with the Agency's 3rd quarter QAPI report, which details all findings from the Agency's QAPI review, including the clinical record audit results and measurement, analysis and tracking of data for falls, complaints, adverse events,	11/11/2020

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	treatment and services. To improve patient and agency outcomes through a coordinated collaborative approach to assessing and improving organizational performance. To evaluate all areas of concern and implement plans to resolve the issues ... " Review on 9-17 and 9-18-2020, of the QAPI log for 2020, evidenced 5 complaints of HHA misconduct and 4 complaints of missed care visits. On 9-18-2020, at 12 noon, the 2020 QAPI program data in the binder was reviewed with the administrator and the director of clinical services (DOCS) to include complaints in the 2020 complaint log related to the agency policy and complaints related to home health aide (HHA) misconduct and complaints of missed visits. The DOCS verified there was a pattern of complaints related to HHA misconduct and missed care visits, and indicated the QAPI program did not collect data on these 2 areas, had not captured a trend of HHA misconduct and missed care visits, and the QAPI program was unable to show measurable improvement in these areas or the implementation of any performance improvement plans. When queried if meeting the visits ordered on the plan of care and HHA misconduct were appropriate quality measures, the DOCS response was "Yes." When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review. 410 IAC 17-12-2 (a)		infections, hospitalizations / ER visits, as well as any required performance improvement plans, the Director of Clinical Services and Administrator will review the Agency's quarterly report against the Agency's Performance Improvement Policy to ensure the QAPI report contains the identification, implementation, and adherence to performance improvement plans. This validation of compliance will continue quarterly to ensure compliance is maintained. Conformance of the Agency's QAPI efforts to the Performance Improvement Policy will be reported to the Governing Body during quarterly QAPI reviews to ensure the deficiency does not recur. The Director of Clinical Services and Administrator are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur.	
G 0644 Bldg. 00	484.65(b)(1),(2),(3) Program data Standard: Program data.			

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	(1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body.			
	Based on record review and interview, the agency failed to implement its policy which required it to utilize measures derived from OASIS (Outcome Assessment and Information Set) in order to monitor the effectiveness and safety of services and quality of care in the design of 1 of 1 year reviewed, the 2020 quality assessment and performance improvement (QAPI) program. The findings included: Review of a policy, "Performance Improvement," undated, evidenced the policy stated, " ... The agency's performance improvement program consists of, but is not limited to, the following: Outcome based OBQI (Outcome Based Quality Improvement) and OBQM (Outcome Based Quality Monitoring) data from OASIS submission documents ... " On 9-17 and 9-18, 2020, the data in the 2020 QAPI binder was reviewed and failed to evidence indicators derived from OASIS. On 9-18-2020, at 12 noon, the QAPI data was reviewed with the administrator and the director of	G 0644	G 644 The Agency's Performance Improvement Policy, B-260, has been modified to reflect that OASIS data may be utilized as an evaluation tool for agency performance. The Agency will utilize quality indicator data, including measures derived from OASIS, where applicable, in its QAPI Program to monitor the effectiveness and safety of services and quality of care, and to identify opportunities for improvement, in accordance with the Medicaid regulation. Administrator and Director of Clinical Services have been educated on the Agency's Performance Improvement policy. The Administrator and Director of Clinical Services will validate each quarterly QAPI report to ensure that measures derived from OASIS, where applicable, are incorporated into the report to ensure ongoing compliance.	11/11/2020

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	clinical services (DOCS.) When queried if the agency had submitted OASIS data for skilled care patients, the DOCS replied "Yes." When queried if the QAPI program included any measures derived from OBQI and OBQM, the DOCS indicated not knowing what those terms meant after the names of the acronyms were provided. When queried if the QAPI program included any measures derived from OASIS reports, the DOCS replied "No." The administrator and the DOCS indicated not having implemented their policy as written. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.		The Director of Clinical Services and Administrator are responsible for monitoring the corrective action to ensure the deficiency is corrected and will not recur.	
G 0648 Bldg. 00	484.65(c)(1)(i) High risk, high volume, or problem-prone area (i) Focus on high risk, high volume, or problem-prone areas; Based on record review and interview, the agency failed to implement their policy which required the quality assurance performance improvement (QAPI) program select performance improvement plans (PIPs) which focused on high-risk, high-volume, or problem-prone areas for 1 of 1 year reviewed, the 2020 QAPI program. The findings included: Review of a policy, "Performance Improvement," undated, evidenced the policy stated, " ... Special Instructions ... Performance Improvement actions will focus on high-risk, high-volume, or problem-prone areas, and will consider incidence, prevalence, and severity of problems in those areas ... " On 9-17 and 9-18-2020, the QAPI program for 2020	G 0648	G 648 The Director and Administrator have been re-educated on the Agency's Performance Improvement Policy, including the requirement to implement performance improvement plans for high-risk, high-volume or problem-prone areas. The Director of Clinical Services completed the HHQI QAPI course, "Pave your Path," for additional QAPI education and training. Beginning with the Agency's 3rd quarter QAPI report, the Director of Clinical Services and Administrator will review the Agency's quarterly report against the Agency's Performance Improvement Policy to ensure the	11/11/2020

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	was reviewed and failed to evidence any performance improvement plans. Review of QAPI data and the complaint log evidenced high risk area of patients with falls, high volume area of patient with HHA misconduct and missed visit complaints, and problem prone area of missed care visits. On 9-18-2020, at 12 noon, the administrator and the director of clinical services (DOCS) verified the above findings and both indicated the agency had not identified or implemented any performance improvement plans based on high-risk, high-volume, or problem-prone areas. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.		QAPI report is compliant with Agency's policy, including the implementation of performance improvement plans for high-risk, high-volume or problem-prone areas. This validation will continue quarterly to ensure compliance is maintained. Conformance of the Agency's QAPI efforts to the Performance Improvement Policy will be reported to the Governing Body during quarterly QAPI reviews to ensure the deficiency does not recur. The Director of Clinical Services and Administrator are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur.	
G 0654 Bldg. 00	484.65(c)(2) Track adverse patient events Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the agency failed to implement its policy which required the quality assessment and performance improvement (QAPI) program collected and analyzed data for adverse event reports for 1 (2020) of 1 year of QAPI reviewed. The findings included: Review of a policy, "Performance Improvement,"undated, evidenced the policy stated, " ... The agency's performance improvement program consists of, but is not limited to, the following: ... Adverse events ...	G 0654	G 654 The Administrator and Director of Clinical Services have been re-educated on Agency's Performance Improvement Policy, including the tracking and analysis of adverse patient events to implement preventive actions. The Director of Clinical Services has also completed the HHQI University QAPI training, "Pave your Path," for additional QAPI education and guidance. Beginning with the Agency's 3rd quarter QAPI report, the Director	11/11/2020

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	Incident reports ... Data will be collected, measured, and analyzed to allow the agency to monitor its performance ... " Review of QAPI data from 2020 on 9-17 and 9-18-2020, failed to evidence collection of data, measurement, or analysis of adverse event reports or incident reports. On 9-18-2020, at 12 noon, the administrator and the director of clinical services (DOCS) reviewed the 2020 QAPI binder and were unable to provide evidence the QAPI program had collected, measured, and analyzed adverse event reports. The administrator and DOCS, when queried, indicated they considered an incident report and an adverse event report to be interchangeable terms. The administrator and DOCS verified the agency had not followed their own policy and there were reported adverse events in 2020. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.		of Clinical Services and Administrator will review the Agency's quarterly report against the Agency's Performance Improvement Policy to ensure the QAPI report is compliant with Agency's policy, including the analysis of adverse events and implementation of preventive measures. This validation will continue quarterly to ensure compliance is maintained. Conformance of the Agency's QAPI efforts to the Performance Improvement Policy will be reported to the Governing Body during quarterly QAPI reviews to ensure the deficiency does not recur. The Director of Clinical Services and Administrator are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur.	
G 0658 Bldg. 00	484.65(d)(1)(2) Performance improvement projects Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the			

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	reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the agency failed to ensure its quality assessment performance improvement (QAPI) program addressed the past performance of the home health agency's services and operation, by having failed to implement performance improvement projects designed to show measurable progress for 1 (2020) of 1 year reviewed. The findings included: Review of a policy, "Performance Improvement," undated, evidenced the policy stated, " ... Special Instructions ... Performance Improvement actions will focus on high-risk, high-volume, or problem-prone areas, and will consider incidence, prevalence, and severity of problems in those areas ... " On 9-17 and 9-18-2020, the QAPI program for 2020 was reviewed and failed to evidence any performance improvement plans. Review of QAPI data and the complaint log evidenced high risk area of patients with falls, high volume area of patient with HHA misconduct and missed visit complaints, and problem prone area of missed care visits. On 9-18-2020, at 12 noon, the administrator and the director of clinical services (DOCS) verified the above findings and both indicated the agency had not identified or implemented any performance improvement plans since 2016, based on high-risk, high-volume, or problem-prone areas. When further queried, the administrator and the DOCS could not identify any PIPS	G 0658	G 658 The Administrator and Director of Clinical Services have been re-educated on the implementation of an annual Performance Improvement Project as part of the Agency's QAPI program. The Director of Clinical Services and Administrator will propose and construct an annual performance improvement project for 2020 prior to the end of the calendar year. The performance improvement project will address the Agency's past performance and will be designed to measure the progress of the project's implementation. This plan will be included in the Agency's 4th quarter QAPI report. The Administrator and Director of Clinical Services will continue to ensure that at least one annual Performance Improvement Project is implemented for each calendar year. The presence and progress of any Performance Improvement Project(s) will be documented within the Agency's quarterly QAPI reports and reported to the Governing Body to ensure continued compliance. The Director of Clinical Services and Administrator are responsible for monitoring the corrective actions to ensure the deficiency is corrected and will not recur.	11/11/2020

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	undertaken by the agency to address identified deficiencies from their own data, OASIS reports, or from agency surveys. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.			
G 0708 Bldg. 00	484.75(b)(2) Development and evaluation of plan of care Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); Based on record review and interview the agency failed to ensure the evaluation of the plans of care for 2 (Patients #1 and 6) of 6 clinical records reviewed. The findings included: 1. Review of a policy, "Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days ... The Plan of Care shall be completed in full to include: ... Frequency and duration of visits to me made ... All medications and treatments ... Patient-specific interventions and education; measurable outcomes and goals ... " 2. Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained	G 0708	G 708 All RN Clinical Supervisors have been re-educated on the evaluation of the aide care plan, including the appropriateness of the care plan tasks in relation to each patient's wants and needs. All current aide care plans were immediately audited by the Director of Clinical Services to ensure the presence of a minimum weekly bathing threshold when applicable. The Director of Clinical Services or RN designee will audit 100% of new Aide Care Plans for 30 days to ensure continued 100% compliance with establishing a minimum number of baths/showers per week to be provided to the patient by the home health aide for patients with baths/showers on their care plan. After 30 days of 100% compliance, the Director or RN designee will include review of Aide Care Plans during the	11/11/2020

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	a plan of care for the certification period of 7-5 to 9-2-2019, with orders for home health aide care 5-7 days per week. The primary diagnosis was Multiple Myeloma. Functional limitations listed included "endurance." HHA prior authorization hour duties enumerated on the plan of care included: ... Bathing: Shower chair/bench to be used during bathing; assist with Shower: PRN; Hygiene and Grooming: Assist with Shampoo PRN; Assist with Nail Care PRN; Assist with Dressing, PRN; Hair Care PRN; Peri Care PRN. The registered nurse failed to evaluate the appropriateness of the medical plan of care in relation to ensuring shower/bath was ordered on a schedule minimum frequency rather than PRN [as needed.] 3. Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 5-12 to 7-10-2020, with orders for skilled nursing services. The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Review of the plan of care failed to evidence the nurse had evaluated the plan of care to ensure it was individualized to contain a seizure care and management plan. 4. On 9-18-2020, at 4 P.M., the administrator and the director of clinical services (DOCS) verified the above findings, and when asked for additional pertinent information, explanation, or documentation, the administrator and DOCS provided indicated having nothing further to present for review.		Agency's quarterly QAPI 10% clinical record audit to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring the corrective action to ensure the deficiency will not recur.	

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	410 IAC 17-14-1 (a)(1)(C)			
G 0714 Bldg. 00	484.75(b)(5) Patient and caregiver education Patient and caregiver education;			
	Based on record review and interview, the agency failed to ensure the nurses provided and documented education as ordered on the plan of care for 1 (Patient #4) of 2 patients who received skilled services, in a sample of 6 patients. The findings included: Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 5-12 to 7-10-2020, with orders for skilled nursing services. The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Review of the daily nurse visit notes from the certification period failed to evidence education was provided and documented as ordered on the plan of care in relation to non-verbal pain cues, seizure precautions, and fall precautions. Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 7-11 to 9-08-2020, with orders for skilled nursing services. The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related	G 0714	G 714 All nurses have been re-educated on the provision and documentation of education in accordance with the Plan of Care, including the description of the education provided. The Director of Clinical Services or designee will review 100% of nursing notes for 2 weeks to ensure 100% compliance. After 2 weeks of 100% compliance, the Director of Clinical Services will review the most recent 2 weeks of nursing notes during the Agency's quarterly QAPI 10% clinical record audit to ensure compliance with this requirement is maintained. The Director of Clinical Services is responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur. Completed 11/11/2020 and ongoing.	11/11/2020

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	non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Review of the daily nurse visit notes from the certification period failed to evidence education was provided and documented as ordered on the plan of care in relation to non-verbal pain cues, seizure precautions, and fall precautions. On 9-18-2020, at 4 P.M., the administrator and the director of clinical services (DOCS) verified the above findings, and when asked for additional pertinent information, explanation, or documentation, the administrator and DOCS provided indicated having nothing further to present for review.			
G 0716 Bldg. 00	484.75(b)(6) Preparing clinical notes Preparing clinical notes; Based on record review and interview, the registered nurses (employees B and C) failed to document in the clinical record accurate and complete visit notes for the care furnished for 1 (Patient #4) of 2 patients who received skilled nursing services, of a sample of 6 patients whose clinical records were reviewed. The findings included: Review of a policy, "Clinical Documentation," last reviewed/revised 8-21-19, evidenced the policy stated, " ... Purpose To ensure that there is an accurate record of the services provided, patient response, and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement ... "	G 0716	G 716 All nurses have been re-educated on the accuracy of clinical documentation in accordance with the Plan of Care orders, as well as consistency of documentation throughout a nursing note. All nurses have been re-educated to contact the office immediately if there is a discrepancy between the Plan of Care and a component of the patient's physical assessment so that the Physician can be contacted, and orders can be written as necessary. The Administrator will be responsible for ensuring that any inactive employee receives all in-services distributed as part of the Agency's plan of correction, prior to being	11/11/2020

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	Review of the clinical record of patient #4 evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 7-11 to 9-08-2020, with orders for skilled nursing services "Medicaid State Frequency and Duration 1 visit/day X [sic for] 4-6 days/week for 9 weeks; Medicaid PA [prior authorization] Program Hours (Skilled Nursing) The patient's mother has chosen to schedule these hours as follows 6.5 - 10.5 hours/day X 4-6 days/week Medicaid Respite Hours (Skilled Nursing) The patient is authorized for Respite hours that the patient's mother will schedule on an as-needed basis." The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Feedings were ordered as: Pediasure oral liquid 240 mL per gastrostomy tube, every 2 hours; at 0600-240 mL Pediasure +220 mL water; at 0800--240 mL Pediasure +220 mL water. If [patient #4] eats 50 % or less, get this water and Pediasure--12:00 240 mL Pediasure + 220 mL water OR 340 mL water. If [patient #4] eats greater than 50 % meal at 1600--240 mL Pediasure + 220 mL water OR 340 mL water if patient #4 eats greater than 50 % meal; at 2100-- 240 mL Pediasure Feedings. Review of a comprehensive assessment dated 7-10-2020, evidenced patient #4 had an 18 french, mini balloon (mini balloon was not defined] gastrostomy tube [feeding tube.] Review of a skilled nursing visit notes evidenced a visit note dated 8-5-2020, by employee B, a registered nurse, and evidenced documentation patient #4 had an 18 french feeding tube with a 5		switched to "active" status and placed in the schedule. The Director of Clinical Services or RN designee immediately audited all skilled nursing patients with gastrostomy status to ensure any discrepancies between the Plan of Care and nursing note were addressed with the Physician and clarified with an order as necessary. All clinical records are now 100% compliant. The Director of Clinical Services or designee will review 100% of nursing notes for patients with a gastrostomy for 2 weeks to ensure compliance with accurate and consistent documentation is maintained. After 2 weeks of 100% compliance, the Director of Clinical Services or RN designee will review nursing notes as part of the Agency's quarterly QAPI 10% clinical record audit to ensure compliance is maintained. The Director of Clinical Services is responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur.	

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	mL balloon. On the drawing of the integumentary system, the nurse documented the gastrostomy tube was 14 french with a 5.5 mL balloon. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed. Review of a skilled nursing visit notes evidenced a visit note dated 8-13-2020, by employee C, a registered nurse, and evidenced documentation patient #4's gastrostomy stoma was WNL [within normal limits] and elsewhere in the note documented the stoma site was red. This information was contradictory. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed. Review of a skilled nursing visit notes evidenced a visit note dated 8-17-2020, by employee B, a registered nurse, evidenced documentation patient #4 had a size 14 french gastrostomy tube with a 5.5 mL balloon. The visit note had documentation inconsistent with other nursing visit note entries, with no explanation if the tube had been changed, or reason for the 14 french feeding tube. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed. Review of a skilled nursing visit notes evidenced a visit note dated 8-18-2020, by employee B, a registered nurse, failed to evidenced documentation of patient #4's gastrostomy tube size and balloon size. The visit note failed to			

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	evidence as assessment of the gastrostomy feeding tube stoma site. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed. Review of a skilled nursing visit notes evidenced a visit note dated 8-19-2020, by employee B, a registered nurse, failed to evidence date of last known seizure and evidenced documentation patient #4 had a size 14 french gastrostomy tube with a 5.5 mL balloon. This documentation is inconsistent with the documentation from 8-18-2020. The visit note documented education had been provided related to fall safety. The visit note failed to document the content of the education provided and which fall safety measured were reviewed. On 9-18-2020, at 4 P.M., the administrator and the director of clinical services (DOCS) verified the above findings, and stated the registered nurse visit notes were not complete, accurate, and free of contradictory documentation. When queried for further pertinent information, explanation, or documentation, the administrator and the DOCS indicated having nothing further to present to be reviewed. 410 IAC 17-14-1 (a)(1)(E)			
G 0802 Bldg. 00	484.80(g)(3) Duties of a HH aide The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and			

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	(iv) Assistance in administering medications ordinarily self-administered. Based on record review and interview, the agency failed to ensure a home health aide (HHA) assigned care tasks included only the provision of hands on care, the performance of simple procedures as an extension of nursing services, assistance in ambulation or exercises, and assistance with administering medications which were ordinarily self-administered, to include having assigned home health aide duties of pet care for 1 (Patient #4) of 4 patients with home health aide only services, out of a sample of 6 patients. The findings included: Review of the home health aide plan of care for patient #1, evidenced pet care was an assigned task for prior authorization (PA) HHA care, and also for Waiver attendant care services. Review of visit notes identified as provided under PA hours by the HHA, evidenced the HHA had provided pet care on 7-10-19, 7-11-19, 7-12-19, and for each HHA care visit through 8-31-2019, during prior authorization care plan hours. Patient #1 had received care visits 7 days a week during the certification period of 7-5 to 9-2-2019, except for missed HHA visits on 8-19, 8-22, 8-26, 8-27, 9-1, and 9-2-2019. On 9-4-2020 at 2:15 P.M., when queried why the HHA on prior authorization care plan hours was assigned a task which was not the provision of direct patient care, the administrator and the director of clinical services presented a document dated 7-5-2010, from the Indiana Health Coverage Programs, which indicated home health agencies could assign the HHA on prior authorization	G 0802	G 802 All RN Clinical Supervisors have been educated on the requirement to ensure the aide care plan includes hands-on personal care, which requires the removal of pet care from PA care plans. All aide care plans have been reviewed and are compliant. The Director of Clinical Services will audit 100% of care plans for new patients for 30 days to ensure compliance is maintained. After 30 days of 100% compliance, the Director of Clinical Services or RN designee will include review of the aide care plan, including the omission of pet care from PA services, as part of the 10% quarterly clinical record audit to ensure compliance is maintained. The Administrator and Director of Clinical Services are responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur.	11/11/2020

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	hours "Any other task the home health agency may choose to have the home health aide provide." The requirements of 42 CFR 484. 80 (g) (3) were shared with the administrator and the director of clinical services (DOCS) which were: the provision of hands on personal care; the performance of simple procedures as an extension of therapy or nursing services; assistance in ambulation or exercises; and assistance with medication ordinarily self-administered. Both the administrator and the DOCS indicated believing the assigned task of "pet care" for PA services for the HHA was correct.			
G 0818 Bldg. 00	484.80(h)(4)(i-vi) HH aide supervision elements Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights.			
	Based on record review and interview, the agency failed to ensure supervisor visits of the home health aide were regularly reviewed for compliance with the home health aide care plan as required by agency policy for 1 (Patient #1) of 4 patients with	G 0818	G 818 All HHAs and CNAs have been re-educated regarding properly documenting the reason for not completing a task during a visit. All RN Clinical Supervisors have	10/21/2020

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	home health aide only services, of a total of 6 patients whose clinical records were reviewed. The findings included: Review of a policy, "Supervisory Visit of Patient/Staff," last reviewed/revised 8-21-2019, evidenced the policy stated, "All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice ... Purpose To ensure staff are demonstrating competence in the areas of communication, identifying and responding to patient needs, and performing procedures/techniques properly ... Documentation of supervisory visits will be reviewed regularly through the agency's Notes QA process, clinical record audits, and home visits ... " Review of the supervisory visit notes for patient #1, dated 8-2-19, evidenced the following: "Employee Present: Home Health Aide [no name documented] Employee following orders/Plan of Care: Yes ... Aide Care Plan Reviewed During Visit? Yes " Review of the home health aide (HHA) visit notes and HHA care plan dated 7-5-2019, for the certification period of 7-5 to 9-2-2019, evidenced assistance with shower/ bath was ordered once a week and PRN (as needed); there was no bath/ shower documented from 7-14 to 8-2-19, which represented 3 weeks with no documentation hygiene needs had been met. The supervising nurse, the director of clinical services (DOCS), failed to determine the HHA had not followed the HHA care plan in relation to provision/ assistance with patient #1's hygiene need of shower/bath for		been re-educated on the care planning process for home health aide tasks, as well as the need to review the appropriateness of the aide care plan based on patient condition and aide documentation at supervisory visits. The Director of Clinical Services or RN designee will audit 100% of supervisory visit forms and a sample of the related home health aide notes for 30 days to ensure the Agency maintains compliance with review of the aide care plan at supervisory visits. Once compliance has been maintained for 30 days, the Director of Clinical Services or RN designee will include supervisory visits as a component of the Agency's 10% quarterly clinical record audit. The Director of Clinical Services is responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur. Completed 10/21/20 and ongoing.	

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	3 weeks. On 9-4-2020, at 2:15 P.M., the above findings were verified with the administrator and the DOCS. When asked why patient #1 had HHA services, the DOCS stated it was for safety and to meet hygiene and ambulation/ transfer needs. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.			
G 0940 Bldg. 00	484.105 Organization and administration of services Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.			
	Based on record review and interview, the agency failed to maintain compliance with the Condition of Participation of Organization and Administration of Services. The administrator failed to be responsible for the day-to-day operations of the home health agency in relation to failure to provide the names and current addresses of members of the governing body; failure to ensure all complaints were recognized	G 0940	G 940 **Per ISDH instruction, a response is not recommended for this tag due to the absence of any cited findings.**	10/21/2020

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	and documented in the complaint log; failure to ensure all complaints had a responsive and complete resolution documented; failure to ensure allegations of abuse/neglect had documented follow-up actions to include a complete nursing assessment of an injury of unknown origin and interventions to protect all agency patients; failed to ensure the agency quality assurance and performance improvement (QAPI) program tracked adverse events and complaints, and conducted performance improvement plans (See G 948;) the director of clinical services failed to ensure a patient with an injury of unknown origin needs were continually assessed (See G 966;) and the director of clinical services (DOCS) failed to ensure patients' plans of care were evaluated and updated (See G 968.) The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of Organization and Administration of Services, 42 CFR 484.105.			
G 0948 Bldg. 00	484.105(b)(1)(ii) Responsible for all day-to-day operations (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to be responsible for the day-to-day operations of the home health agency in relation to failure to provide the names and current addresses of members of the governing body; failure to ensure all complaints were recognized and documented in the complaint log; failure to ensure all complaints had a responsive and complete resolution documented; failure to ensure allegations of abuse/neglect had	G 0948	G 948 Agency has created a document with names and addresses of Governing Body members and will provide upon request. All Together Homecare patients have been contacted to ensure there are no outstanding or unreported complaints, including those related to verbal, physical, sexual or mental abuse, neglect,	11/24/2020

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	documented follow-up actions to include a complete nursing assessment of an injury of unknown origin and interventions to protect all agency patients; failed to ensure the agency quality assurance and performance improvement (QAPI) program tracked adverse events and complaints, and conducted performance improvement plans, for 1 of 1 agency administrator. The findings included: After request on 9-16-2020 at 12 noon, for the names and current addresses of the members of the governing body, the administrator failed to provide the information prior to survey exit. The administrator failed to ensure all complaints were recognized and documented in the complaint log; failure to ensure all complaints had a responsive and complete resolution documented (See G 484.) The administrator failed to ensure allegations of abuse/neglect had documented follow-up actions to include a complete nursing assessment of an injury of unknown origin and failure to implement interventions to protect all agency patients (See G 482.) The administrator failed to ensure plans of care had frequency of visit orders were rationally based on the patient's assessed needs (See G 572.) The administrator failed to ensure the agency quality assurance and performance improvement (QAPI) program identified areas for improvement in care and safety from available data, failed to ensure the agency conducted performance		injuries of unknown origin or misappropriation of property. No additional concerns regarding new or previously reported or unreported abuse (verbal/physical/emotional/sexual), neglect, misappropriation of property or injuries of unknown origin have been identified. Additionally, the Administrator and Director of Clinical Services completed a 100% review of all patients who filed complaints in 2020 regarding abuse or neglect in 2020. Those complainants have been contacted by the Administrator and/or Director to ensure they have no further concerns regarding the reported complaint, or any ongoing issues or concerns related to Patient Rights. The Administrator has verified that all allegations of abuse or neglect have been thoroughly investigated and resolved, and no further actions are required to ensure patient safety. To ensure that the Agency's investigative process is thorough and clear, the Agency's Patient Complaint Policy (C-381) was modified to include more detailed instructions for obtaining and reviewing evidence in the investigative process, including requesting, reviewing and documenting the contents of any audio or video evidence related to the complaint. An Investigation Guidance form was created to	

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	improvement plans, tracked adverse events, and trended complaints as required by agency policy (See G 642, G 644, G 648, G 654, and G 658.) On 9-18-2020, at 4:20 P.M., when asked for additional pertinent information, explanation, or documentation, the administrator indicated having nothing further to present for review. 410 IAC 17-12-1 (c)(1)		further facilitate a thorough investigative process and will be utilized for each complaint to ensure a thorough and complete investigation with proper follow-up. The complaint form has also been updated to ensure that a complete and responsive resolution is documented and communicated to the complainant following the Agency's investigation. All internal employees were educated on the new complaint policy (C-381) and complaint forms. The Administrator and Director of Clinical Services are responsible for documenting and investigating all complaints in accordance with Agency policy and state and federal regulations, and to ensure patients are free from all abuse, injuries of unknown origin and misappropriation of property at all times. Administrator and Director of Clinical Services will audit 100% of complaints for 60 days to ensure the investigative process is thoroughly documented and complies with Agency's policy (C-381). Once Agency has maintained 100% compliance for 60 days, Administrator and Director of Clinical Services will audit 20% of complaints quarterly to ensure compliance is maintained. All active nurses have been re-educated regarding the	

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			completion of a full patient assessment for any change in condition, including injuries of unknown origin or stemming from alleged/suspected abuse or neglect. The re-education included the requirement of all comprehensive assessments to include a full description of any wounds, including description of the wound and measurements, as well as a skin assessment to look for any additional wounds. All active nurses have acknowledged understanding of this re-education. The Administrator will be responsible for ensuring that any inactive employee receives all in-services distributed as part of the Agency's plan of correction, prior to being switched to "active" status and placed in the schedule. Administrator and Director of Clinical Services will audit 100% of complaints for 60 days to ensure they contain evidence of a completed head-to-toe assessment in situations of alleged abuse or injuries of unknown origin. Once Agency has maintained 100% compliance for 60 days, Administrator and Director of Clinical Services will audit 20% of complaints quarterly, as part of the Agency's QAPI program, to ensure compliance is maintained. All internal employees have been	

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			re-educated that each patient's individualized frequency and duration is developed in collaboration with the patient and/or family and will be approved by the managing Physician. The frequency and duration may evolve based on the patient condition or informal support status, Physician order, and patient/family request. Any such changes must be documented accordingly in the clinical record. Missed visit notes and/or supplemental orders will continue to be utilized to report any deviations from the ordered frequency and duration. Agency will make every effort to make up any missed visits within the work week. The Director of Clinical Services or RN designee will audit 100% of outgoing plans of care for 30 days to ensure that each patient's nursing or home health aide frequency and duration remains compliant with the requirement. Once 100% compliance has been maintained for 30 days, the Director of Clinical Services or RN designee will continue to include evaluation of the frequency and duration and adherence to the ordered frequency and duration as part of the Agency's quarterly 10% clinical record audit to ensure continued compliance. The Administrator and Director of Clinical Services have been	

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			re-educated on the Agency's QAPI program, including review of the Agency's Performance Improvement Policy (B-260). The Director of Clinical Services has also enrolled in HHQI University for additional QAPI education and guidance. Beginning with the Agency's 3rd quarter QAPI report, the Director of Clinical Services and Administrator will review the Agency's quarterly report against the Agency's Performance Improvement Policy to ensure the QAPI report is compliant with Agency's policy, including the analysis of adverse events and presence of performance improvement plans for high-risk, high-volume or problem-prone areas. This validation will continue quarterly to ensure compliance is maintained. Conformance of the Agency's QAPI efforts to the Performance Improvement Policy will be reported to the Governing Body during the quarterly QAPI review. The Director of Clinical Services and Administrator will propose and construct an annual performance improvement project for 2020 prior to the end of the calendar year. The performance improvement project will address the Agency's past performance and will be designed to measure the progress of the project's implementation. This project will be included in the	

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			Agency's 4th quarter QAPI report. The Administrator and Director of Clinical Services will ensure that at least one annual Performance Improvement Project is implemented for each calendar year. The Administrator and Director are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	
G 0966 Bldg. 00	484.105(c)(4) Assure patient needs are continually assessed Assuring that patient needs are continually assessed, and Based on record review and interview, the director of clinical services failed to ensure 1 (Patient #4) of 1 patient with an injury of unknown origin needs were continually assessed, out of a sample of 6 patients. The findings included: Review of the clinical record of patient #4 evidenced an untimed entry, dated 8-24-2020, into the Client Logging Report made by employee D, registered nurse case manager, which evidenced employee D made a home visit at patient #4's parent request, to supervise, re-educate and train employee B, a registered nurse (RN,) and was shown patient #4's right upper thigh bruise. The entry evidenced the supervisory nurse arrived around 10 A.M. and patient #4's parent alleged the "full-time nurse may have hit the patient with her [patient #4's] gait belt." The home had cameras located everywhere except the	G 0966	G 966 All active nurses, including the Director of Clinical Services, have been re-educated regarding the completion of a full patient assessment for any change in condition, including injuries of unknown origin or stemming from alleged/suspected abuse or neglect. The re-education included the requirement of all comprehensive assessments to include full documentation of any wounds, including description of the wound and measurements, as well as a skin assessment for any additional wounds. All active nurses have acknowledged understanding of this re-education. An assessment of Patient #4 completed by the Director of Clinical Services in the presence	11/24/2020

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	bathrooms. The parent of patient #4 stated believing the incident may have occurred inside the bathroom, because there is no video camera in the bathroom, and the other home cameras failed to show patient #4 being hit. The RN Logging Report entry by RN, employee D, evidenced "called administration to inform them of the situation." The RN, employee D, requested the parent send the videos and pictures "to administration and further investigation will begin." The parent was informed "the patient's full-time nurse is not allowed inside of the home during this investigation." The director of clinical services failed to ensure a complete head to toe comprehensive assessment for patient #4 was conducted to determine if any other injuries of unknown origin were present. During a query to the director of clinical services (DOCS), on 9-11-2020, at approximately 2 P.M., the DOCS indicated having viewed videos #1 and #2, described above. The DOCS indicated patient #4's was not provided a comprehensive assessment for further injuries of unknown origin on 8-24-2020. When asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.		of the patient's mother has revealed no evidence of injuries related to abuse or injuries of unknown origin, and the patient's mother has affirmed that she has no additional concerns, including any concerns about abuse, since the survey. The Administrator and Director of Clinical Services will audit 100% of complaints for 60 days to ensure they contain evidence of a completed head-to-toe assessment in situations of alleged abuse or injuries of unknown origin. Once Agency has maintained 100% compliance for 60 days, Administrator and Director of Clinical Services will audit 20% of complaints quarterly, as part of the Agency's QAPI Program, to ensure compliance is maintained. The Director of Clinical Services is responsible for monitoring this corrective action to ensure the deficiency is corrected and will not recur.	
G 0968 Bldg. 00	484.105(c)(5) Assure implementation of plan of care Assuring the development, implementation, and updates of the individualized plan of care. Based on record review and interview, the director of clinical services (DOCS) failed to ensure patients' plans of care were evaluated and updated for 3 (Patients #1, 4, and 6) of 6 patients whose clinical records were reviewed.	G 0968	G 968 All internal employees have been re-educated that each patient's individualized frequency and duration is developed in collaboration with the patient	11/11/2020

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	The findings included: 1. Review of a policy, "Plan of Care," last reviewed/revised 8-21-2029, evidenced "Home care services are furnished under the supervision and direction of the patient's physician. The plan of care is based on a comprehensive assessment and information provided by the patient/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days ... The Plan of Care shall be completed in full to include: ... Frequency and duration of visits to me made ... All medications and treatments ... Patient-specific interventions and education; measurable outcomes and goals ... " 2. Review of the clinical record for patient #1, evidenced a start of care of 7-5-19, and contained a plan of care for the certification period of 7-5 to 9-2-2019, with orders for home health aide (HHA) "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week for 9 weeks ... Medicaid PA [sic prior authorization] Program Hours: The patient has chosen to schedule PA hours as follows: 1-5 hours/day X 3-5 days/week, 2-6 hours a day X 1-2 days/week, 0.5- 4 hours/day X 1-3 days/week ... Medicaid Waiver Program Hours: The patient has chosen to schedule Waiver hours as follows: 3-7 hours/day X 3-5 days/week, 2-6 hours/day X 1-2 days/week, 4-8 hours/day X 1-3 days/week." Review of HHA visit notes with the director of clinical services (DOCS) on 9-8-2020, at 1:15 P.M., evidenced the HHA visits were most often 3 hours for PA, and 4-5 hours for Waiver. When		and/or family and will be approved by the managing Physician. The frequency and duration may evolve based on the patient condition or informal support status, Physician order, and patient/family request. Any such changes must be documented accordingly in the clinical record. Missed visit notes and/or supplemental orders will continue to be utilized to report any deviations from the ordered frequency and duration. Agency will make every effort to make up any missed visits within the work week. The Director of Clinical Services or RN designee will audit 100% of outgoing plans of care for 30 days to ensure that each patient's frequency and duration is compliant with the requirement. Once 100% compliance has been maintained for 30 days, the Director of Clinical Services or RN designee will continue to review the frequency and duration as part of the Agency's QAPI quarterly 10% clinical record audit to ensure continued compliance. The Administrator and Director of Clinical Services are responsible for monitoring these corrective actions to ensure the deficiency is corrected and will not recur.	

queried what the HHA could accomplish in a 0.5 hour visit, the clinical director indicated, "I don't know." When asked what justified the difference between a 1 hour and a 5 hour visit, a 2 hour and 6 hour visit, or a 0.5 hour visit and 4 hour visit, based on patient's #1 needs identified in the comprehensive assessment, the clinical director had no explanation. Review of the plan of care for the certification period of 9-3 to 11- 1-2019, evidenced orders for home health aide (HHA) "Medicaid State Frequency and Duration: 1 visit/day X 6-7 days/week for 9 weeks ... Medicaid PA [sic prior authorization] Program Hours: The patient has chosen to schedule PA hours as follows: 1-5 hours/day X 3-5 days/week, 2-6 hours a day X 1-2 days/week, 0.5- 4 hours/day X 1-3 days/week ... Medicaid Waiver Program Hours: The patient has chosen to schedule Waiver hours as follows: 3-7 hours/day X 3-5 days/week, 2-6 hours/day X 1-2 days/week, 4-8 hours/day X 1-3 days/week." The DOCS failed to ensure the plan of care was evaluated and updated to ensure HHA visit hours which reflected patient #1's needs -- 3 hours for PA, and 4-5 hours for Waiver, 7 days per week.

3. On 9-8-2020, at approximately 1:15 P.M., when asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.

4. Review of the clinical record for patient #4, evidenced a start of care date of 5-12-2020, and contained a plan of care for the certification period of 5-12 to 7-10-2020, with orders for skilled nursing services 6.5 to 10.5 hours 4-6 days per week. The plan of care evidenced diagnoses of Dravet Syndrome and comorbidities of developmental delay; cognitive delay; attention and

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	concentration deficit; sleep related non-obstructive alveolar hypoventilation; other generalized epilepsy and epileptic syndromes; obesity; and gastrostomy [feeding tube] status. Review of the skilled nursing visit notes for the certification period evidenced the nurse visits were consistently 8 to 10 hours to provide the care ordered on the plan of care. The nurse visit hour range from 6.5 to 10.5 hours per visit was too wide of a variation for care orders and was not individualized to meet the patient's needs. The DOCS failed to ensure the plan of care was updated to reflect the hours of care required to meet patient #4's needs. Review of the plan of care for patient #4, for the certification period of 7-11 to 9-08-2020, with orders for skilled nursing services 6.5 to 10.5 hours 4-6 days per week. The DOCS failed to ensure the plan of care was updated to reflect the hours of care required to meet patient #4's needs. On 9-8-2020 at 2:01 P.M., the parent guardian of minor patient #4, when queried about plan of care hours for the skilled nurse, stated the nurses had to stay 8-10 hours to provide all the care patient #4 required. When queried whether guardian had chosen to schedule the skilled nursing care hours on a range of 6.5 to 10.5 hours, the guardian stated wanting all the hours patient #4 was allowed, to include respite care. The guardian of patient #4 stated the agency had never provided respite care hours due to lack of staffing. 5. Review of the clinical record of patient #6 evidenced a start of care date of 8-17-2020, and contained a plan of care for the certification period of 8-17 to 10-15-2020, with orders for HHA care visits "Medicaid State Frequency and Duration: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING 00 B. WING	09/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOGETHER HOMECARE	555 E COUNTY LINE ROAD SUITE 105 GREENWOOD, IN 46143

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	visit/day X 6-7 days/week X 9 weeks; Medicaid PA Program Hours (HHA) The patient and his wife have chosen to schedule his PA [prior authorization] hours as follows: 0.5 to 4 hours/day X 1-3 days/week, and 5-9 hours/day X 4-6 days/week Medicaid Waiver Program Hours (HHA) The patient and his wife have chosen to schedule his Waiver hours as follows: 0.5 - 4.5 hours/day X 4-6 days/week." Patient #6 primary diagnosis was documented as Multiple Dystrophy, and evidenced wheelchair dependence and use of Hoyer lift for transfers. HHA care duties ordered for PA were Assist patient to keep DME [durable medical equipment]/ Assistive Devices clean, and notify Clinical Supervisor if any items are in disrepair or require attention ... assist with wheelchair every visit, assist with ambulation/transfers every visit, Hoyer lift must be used for ALL patient transfers [use Hoyer lift or Stander] ... Shower chair/bench to be used during bathing, assist with shower ... (Tuesday and Friday) .. Change bed linens weekly and PRN [as needed,] Light Housekeeping every visit, assist with laundry weekly ... assist with dishes every visit, vacuum/sweep weekly and PRN, dust weekly and PRN ... Assist with Shampoo weekly and PRN, Assist with Dressing Every visit, Peri care Every visit ... Handling/Bringing meds [sic medications] to patient (No administering,) Verbal Medication Reminders Every visit ... Prepare/Serve Meals Every visit, Follow Aspiration Precautions, Assist with feeding, to include cut food into small bites PRN, Encourage Fluids Every visit ... Notify Clinical Supervisor if no BM in 3 days, Document last BM date PRN, Change brief/peri pad PRN, Assist to Commode Every Visit. Patient #6 was identified as a high risk for falls. The plan of care evidenced patient #6's wife worked outside home full time and was unable to provide necessary care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K141	A. BUILDING 00 B. WING	09/18/2020

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	during working hours. The plan of care failed to individualize the HHA visit hours to a minimum of greater than 0.5 hours for a visit, and failed to individualize the HHA care plan orders to ranges of visits which were rationally related to patient #6's need for assistance with ADLs [activities of daily living] when wife was at full time job. 6. On 9-18-2020, at 4 P.M., the administrator and the DOCS verified the above findings, and when asked for additional pertinent information, explanation, or documentation, the administrator and DOCS indicated having nothing further to present for review.			