STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157600	A. BUILDING 00 B. WING	02/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME HEALTH CARE INC	9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0000 Bldg. 00	A relicensure and complaint investigation survey was conducted at Alpha Home Health Care. Complaint # IN00209424 - unsubstantiated Survey Dates: 2/9/2021, 2/10/2021, 2/11/2021, 2/12/2021, 2/15/2021 Facility ID: 006648 Quality Review Completed 03/05/2021 Area 1	N 0000		
N 0444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on record review and interview, the administrator failed to direct and organize the ongoing functions of the home health agency. The findings include: An agency policy number 7.9.2, titled "Administrator: Defined" revised March 2018, stated "Policy ... The Administrator is responsible	N 0444	Administration has reviewed the Administrator's job descriptions with a focus on duties and responsibilities to organize and direct the home health agency's ongoing functions and all day-to-day operations. Responsibilities include planning, organizing, directing, and	03/12/2021

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

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	for the Agency's functions and all day-to-day operations of the Agency ... Purpose ... The Administrator has a job description that identifies his/her respective duties and responsibilities ... Responsibilities ... 6. The Administrator of the Agency has the following responsibilities: planning, organizing, directing and evaluating operations to ensure the provision of adequate and appropriate care and services ... Complying with applicable laws and regulations ... Ensuring the development of personnel qualifications and policies ... Directing and monitoring organizational quality assessment and performance improvement activities ... Ensuring the accuracy of the public information materials and activities.... " An agency document numbered 4.17A.2, titled "Job Description Administrator" revised March 2018, stated "Job summary: The Administrator ensures quality and safe delivery of home health care services; coordinates services that reflect the Agency's philosophy and standards of care; plans, develops, implements and evaluates Agency services, programs and activities and responsible for all day-to-day operations of the Agency ... Responsibilities: ... 3. Ensures the accuracy of public information materials and activities ... 6. Consistently follows Agency policies and procedures to set example for employees ... 14. Directs the agencies on going functions ... 19. Maintains compliance with applicable federal, state, accrediting bodies and local rules and regulations... 27. Recruits employees and retains qualified personnel to maintain appropriate staffing levels by employing qualified staff ... 32. Coordinates with other program areas and management as appropriate.... " Record review on 2/15/2021, of the Agency's		evaluating operations to ensure the provision of adequate and appropriate care and services, complying with applicable laws and regulations, ensuring the development of personnel qualifications and policies, directing and monitoring organizational quality assessment and performance improvement (QAPI) activities, and ensuing the accuracy of the public information materials and activities. The Administrator has begun meeting with the clinical supervising team, which includes the alternate clinical supervisor, daily to review and update records pertaining to daily patient census of both active and discharged patients. A part of the process, and as required by Agency software, includes manually removing discharged patients from the active list. This practice is to continue daily. If the Administrator is unable to attend said meetings, the alternate administrator will step in. QAPI Coordinator conducted an inservice meeting with administrator, alternate administrator, alternate clinical supervisor, field clinicians and office staff. Reviewed current QAPI activities, which are Functional Improvement in Bed Transferring and Home Health Error – Record Submitted Late. Meeting addressed reasons for and	

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	Active Patient List evidenced patient #8 had discharged on 1/14/2021. The administrator failed to provide an accurate active patient census. During an interview on 2/12/2021, at 9:48 AM, in response to an inquiry of the current census, the administrator stated, "I think 33, approximately." During an interview on 2/15/2021, at 2:29 PM, the alternate clinical supervisor indicated patient #8 was discharged, but the name would have to be manually removed to the discharge list, as the electronic health record does not automatically remove it. The administrator remained silent. The administrator failed to demonstrate knowledge of an accurate daily active patient list. Record review on 2/12/2021, of the agency's Quality Assessment and Performance Improvement (QAPI) program, with the alternate administrator and employee D evidenced the agency had 2 main QAPI focuses; Safe bed transfers and timely submission of OASIS [Outcome and Assessment Information Set]. During an interview on 2/12/2021, at 9:50 AM, an inquiry of the current QAPI focus, or multiple foci, was made, in which the administrator responded, "Safety - fall prevention." The administrator failed to demonstrate knowledge of the agency's QAPI focus. Record review on 2/12/2021, of the Indiana Department of Health form titled "Employee Records" indicated the administrator did not have patient contact, as evidenced by "NA [not applicable]" written in beneath the section titled "1st PT [patient] contact." Clinical record review on 2/15/2021, for patient #8,		importance of quality improvement projects. Administrator to continue to oversee QAPI activities and goals. The Clinical Supervisor's personnel file was reviewed. There was evidence of complete requirements for patient contact and to ensure patient safety. Evidence includes active RN license, job description, job orientation, skilled nurses initial & ongoing competency assessment, performance evaluation, initial TB test result and annual TB assessment, appropriate physical examination result, and CPR. HR has been instructed to update administrator's 'date of first patient contact'. As of 2/22/21, the Agency's updated hours of operation have been reported to the Indiana Department of Health. Hours on records were 9 a.m. to 5:30 p.m., M-F. Updated hours are 9 a.m. to 5 p.m., M-F. All Administrator responsibilities will be evaluated quarterly in 2021 for evidence that the Administrator directs and organizes the ongoing functions of the home health agency. Results, feedback, and deficiencies will be shared with the Administrator and stored in the personnel file. An annual performance evaluation will resume in 2022. The Alternate Administrator will be responsible for monitoring these	

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	start of care 11/16/2020, evidenced a document titled "OASIS D-1 Start of Care." This document evidenced an assessment on the patient, including but not limited to, vital signs, skin integrity, cardiovascular [heart], pulmonary [lungs], and gastrointestinal [digestive] systems. This document was electronically signed by the administrator on 11/16/2020. The assessments performed would require patient contact. Record review failed to evidence the administrator complied with the required state rules 410 IAC 17-12-1(f), IAC 17-2-1(h), and IAC 17-12-1(i) which have been put in place to ensure patient safety. During an interview on 2/15/2021, at 2:40 PM, the administrator/clinical supervisor, alternate administrator, and alternate clinical supervisor were present. The administrative agency staff were queried if the administrator performed the start of care assessment for patient #8 and if the administrator has had patient contact. The alternate administrator asked the administrator if he/she performed the start of care, the administrator stated "yes." The alternate administrator indicated it must have been a situation when no one else was available. The administrator did not offer any further comment. During an interview on 2/12/2021, at 9:53 AM, the administrator was queried about the hours of operation in the home health agency. The administrator stated, "9 [AM] to 5 [PM], Monday through Friday. " The administrator failed to ensure the agency hours were correctly reported to the Indiana Department of Health.		corrective actions and for the evaluation of administrator performance to ensure that these deficiencies are corrected and will not occur again.	

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N 0446 Bldg. 00	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on record review and interview, the administrator failed to ensure qualified personnel were employed in all positions within the home health agency. (employee E) The findings include: An agency policy number 7.9.1, titled "Administrator: Defined" revised March 2018, stated "Policy... The Administrator is responsible for the Agency's functions and all day-to-day operations of the Agency ... Purpose ... the Administrator has a job description that identifies his/her respective duties and responsibilities ... Responsibilities ... 6. The administrator of the agency has the following responsibilities: ... Planning , organizing, directing and evaluating operations to ensure the provision of adequate and appropriate care and services ... Complying with applicable laws and regulations ... Ensuring the development of personnel qualifications an policies ... recruiting, employing and retaining qualified personnel to maintain appropriate staffing levels by employing qualified staff ... Ensuring staff development including orientation, in-service education, continuing education and evaluation of staff ... Assuring the development and qualifications for professional services and	N 0446	Administration has met and reviewed the Administrator's responsibility of employing qualified personnel and ensuring adequate staff education and evaluations for all positions. The Administrator reviewed the Case Manager/RN's personnel record and found that it did indeed contain a copy of the employee's nursing license. Surveyor noted and took a copy of the license. Case Manager E is no longer employed with Agency (resignation date 2/26/21). Administrator/Clinical Supervisor, alternate administrator, and alternate clinical supervisor will take call as outlined in Agency's on-call schedule/calendar. All have been oriented and trained to telephone triage duties. Administrator will ensure that Case Manager E's replacement hire will be oriented and trained to perform telephone triage duties and will be provided with a job description for the role as	03/12/2021

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	the assignment of personnel ... " An agency policy number 7.11.1, titled "Organization and Services Administration" revised March 2018, stated "Policy ... Organization, services furnished, administrative control and the lines of authority for the delegation of responsibility for patient care are clearly defined in writing and are readily identifiable ... Procedure ... 10. The agency will continually monitor and manage all services provided at its locations to ensure that services are delivered in a safe and effective manner and to ensure that each patient receives the necessary care and services outlined in the plan of care ... An agency policy number 4.17A.2, titled "Job Description Administrator" revised March 2018, stated "job summary: the administrator ensures quality and safe delivery of home health care services; coordinates services that reflect the agency's philosophy and standards of care; plans, develops, implements and evaluates Agency services, programs and activities and responsible for all day-to-day operations of Agency ... Responsibilities: 2. Employees qualified personnel and ensures adequate staff education and evaluations. 3. Ensures the accuracy of public information materials and activities ... 6. Consistently follows Agency policies and procedures to set an example for employees ... 14. Directs the Agency's on going functions ... 19. Maintains compliance with applicable federal, state, accrediting bodies and local rules and regulations ... 25. Plans and directs operations to ensure the provision of adequate and appropriate care and services ... 27. Recruits employees and retains qualified personnel to maintain appropriate staffing levels by employing qualified staff ... 29. Ensures Agency personnel have current clinical		registered nurse. All nursing personnel records were audited by the Administrator for evidence of appropriate personnel information including a copy of verified nursing license, job description, job orientation, initial & ongoing competency assessment, performance evaluation, initial TB test result and annual TB assessment, appropriate physical exam result, and CPR. 100% of newly hired registered nurse personnel records will be audited within 3 days of hire and annually for evidence of qualifications and responsibilities. All Administrator responsibilities will be evaluated quarterly in 2021 for evidence that the Administrator directs and organizes the ongoing functions of the home health agency. Results, feedback, and deficiencies will be shared with the Administrator and stored in the personnel file. An annual performance evaluation will resume in 2022. The Alternate Administrator will be responsible for monitoring these corrective actions and for the evaluation of administrator performance to ensure that these deficiencies are corrected and will not occur again.	

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	information and current practices ... 31. Ensures staff development including orientation, in service education and continuing education ... 34. Ensures that appropriate personnel qualifications and policies are developed and implemented. 35. direct staff in performance of their duties including admission, discharge and provision of service to patients ... " An agency policy number 7.11.1, titled "Job Description: Registered Nurse (RN)" revised March 2018, stated "Job Summary: A Registered Nurse administers skilled nursing care to patients on an intermittent basis in their place of residence ... Qualifications: 1. graduate of an approved school of professional nursing an currently licensed in the state(s) in which practicing ... Responsibilities: ... 7. coordinate services ... 12. Processes orders and notifies physician of patient needs and changes in condition ... 19. Takes on call duty nights, weekends and Holidays, as assigned ... " On 2/12/2021, at 6:25 PM, the after-hours telephone line was called. Case Manager E answered and indicated they were the nurse on-call. Personnel record review on 2/12/2021, for Case Manager E, evidenced a start date of 6/28/2017. Record review failed to evidence a nursing license in the employee file. Record review failed to evidence an orientation/training to perform telephone triage duties and job description for the role as registered nurse. Record review failed to evidence administrative control of the day-to-day operations regarding the nurse on call. The administrator failed to ensure all employees were oriented to their job roles. The			

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	administrator failed to ensure appropriate personnel information was kept current to verify qualifications. Record review evidenced an agency document titled "Job Description: Case Manager " which was signed by Case Manager E on 1/11/2021. This document stated "Description of Responsibilities: Under supervision, verify patient's demographic information, signed consents of assigned patients ... Responsibilities of the registered nurse include the following: 1. Monitors/follow-up hospitalized patients and coordinate with disciplines regarding discharge date of the patient in the hospital. 2. Track all field staff visit notes in compliance to ordered frequency of visit and ensure all field staff submit their visit notes, care coordination and reports on timely manner. 3. Review all visit notes from all disciplines involved in the patient care, ensure it is complete and accurate in accordance to agency policies and procedure for documentation. Report/notify The DON [director of nursing] for any inconsistencies and non-compliance. 4. Ensure completion, maintenance, submission and receiving reports, records and notes as required by the AGENCY. 5. Organize and maintains clinical records of the assigned patients. 6. Maintains confidentiality and security of patient's information in the patient's clinical records. 7. Takes telephone referral information if no nursing staff is available in passes referral on to the Director of Nursing or her alternate as soon as possible. 8. Adheres to basic responsibilities of all employees. 9. Performs other duties as assigned by administrator and Director of Nursing ... " The signed job description failed to evidence During an interview on 2/12/2021, at 2:22 PM, the alternate administrator indicated that Case			

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	Manager E previously worked in the agency's office doing clerical work and recently passed the NCLEX-RN (National Counsel Licensure Examination for a Registered Nurse), which resulted in a promotion to Case Manager. During an interview on 2/15/2021, at 1:38 PM, the alternate administrator indicated the role of a Case Manager would include, but not limited to coordinate patient and visiting nurse schedules, ensure orders and labs are carried out, review the Plan of Care and ensure the patient is aware of any changes. Record review evidenced the job duties described were listed on the RN job description. Record review failed to evidence the duties described were stated on the Job Description signed by Case Manager E.			
N 0447 Bldg. 00	410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview, the administrator failed to ensure accuracy of public information for the home health agency. The findings include: 1. Information provided to the Indiana Department of Health (IDOH), by Alpha Home Health Care evidenced the office hours of operation were Monday through Friday, 9:00 AM through 5:30 PM. Record review of the agency's admission packet	N 0447	As of 2/22/21, the Agency's updated hours of operation have been reported to the Indiana Department of Health. Hours on record were 9 a.m. to 5:30 p.m., M-F. Updated hours are 9 a.m. to 5 p.m., M-F. The Administrator will immediately report any future changes to IDOH, including public information to ensure accuracy of public information for the agency.	03/12/2021

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	on 2/9/2021, stated "Our office hours are from 9:00 a.m. to 5:00 p.m., Monday through Friday...." Record review failed to evidence the public information provided to the patients matched the information provided to IDOH. During the daily conference on 2/9/2021, at 4:30 PM, the alternate administrator indicated the hours of operation are 9:00 AM to 5:00 PM, Monday through Friday. During an interview on 2/12/2021, at 9:53 AM, the administrator stated the hours of operation in the office are "9 [AM] to 5 [PM], Monday through Friday. "		The Administrator will monitor to ensure the deficient practice will not recur by reviewing the Agency's public information provided to patients match the information provided to IDOH during the Agency's annual license renewal.	
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure all employee files were kept current with a copy of current licensure and a copy of a criminal background check within	N 0458	The Administrator has reviewed all direct care employees' personnel records to ensure documentation of orientation to the job and 1)	03/12/2021

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	3 days of their first patient contact, in 5 of 9 personnel records reviewed. (employee E, G, H, J, K) The findings include: 1. An agency policy number 4.8.1, titled "Personnel Records" revised March 2018, stated "Policy ... Personnel files will be established and maintained for all staff. All information will be considered confidential and will be made available to authorized management personnel only ... Purpose ... To maintain personnel files on current and former employees ... Procedure ... 1. The personnel record or personnel information for an employee will include, but not be limited to, the following: ... Verification of education, certification and or licensure ... Agency employee orientation ... Other data which is directly related to the employment, promotion, additional compensation, disciplinary action or termination ... Criminal history check , if required by law ... Job description: reviewed and signed by employee... " 2. An agency document titled "Job Description Registered Nurse (RN)" revised March 2018, stated "A Registered Nurse administers skilled nursing care to patients on an intermittent basis in their place of residence. This is performed in accordance with physician orders and plan of care under the direction and supervision of the Director of Clinical Services/Clinical Manager ... RESPONSIBILITIES ... 19. takes on-call duty nights, weekends and holidays, as assigned ... " 3. On 2/12/2021, at 6:25 PM, the after-hours telephone line was called for Alpha Home Health Care. Case Manager E answered and indicated they were the nurse on-call.		receipt of job description, 2) qualifications, 3) a copy of limited criminal history pursuant to IC 16-27-2, 4) a copy of current license, certification, or registration, and 5) annual performance evaluations. The Administrator reviewed agency policy titled “Personnel Records” revised March 2018 and “Job Description Registered Nurse (RN)” revised March 2018. The Administrator reviewed the Case Manager E’s personnel record and found that it did indeed contain a copy of the employee’s nursing license. (Surveyor noted and took a copy of the license.) Case Manager E is no longer employed with Agency (resignation date 2/26/21). The Administrator will obtain a completed criminal background check for all newly hired direct-care employees prior to first patient contact. Employees will not be allowed to have patient contact until a criminal background check is completed. 50% of all direct care personnel records will be audited quarterly for evidence of 1) a copy of limited criminal history pursuant to IC 16-27-2 and 2) a copy of current license, certification, or registration.	

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	Personnel record review on 2/12/2021, for Case Manager E, evidenced a start date of 6/28/2017. Record review failed to evidence a nursing license in the employee file. Record review failed to evidence an orientation/training and job description for the role as registered nurse. During an interview on 2/12/2021, at 2:22 PM, the alternate administrator indicated that Case Manager E recently passed the NCLEX-RN (National Counsel Licensure Examination for a Registered Nurse), and was not added to the file yet. 4. Personnel record review on 2/12/2021, for PT (physical therapist) G, evidenced a first patient contact date was 7/29/2007. Record review evidenced a criminal background check was completed on 11/12/2007. Record review failed to evidence a criminal background check was completed prior to patient contact. 5. Personnel record review on 2/12/2021, for RN H, evidenced a first patient contact date was 10/8/2017. Record review evidenced a criminal background check was completed on 12/21/2017. Record review failed to evidence a criminal background check was completed prior to patient contact. 6. Personnel record review on 2/12/2021, for HHA (home health aide) J, evidenced a first patient contact date was 6/25/2009. Record review failed to evidence a criminal background check was completed prior to patient contact. 7. Personnel record review on 2/12/2021, for HHA (home health aide) K, evidenced a first patient contact date was 6/5/2018. Record review		The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	evidenced a criminal background check was completed on 12/5/2018. Record review failed to evidence a criminal background check was completed prior to patient contact. During an interview on 2/12/2021, at 3:55 PM, the alternate administrator nodded and stated "Okay."			
N 0460 Bldg. 00	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on record review and interview, the agency failed to ensure the personnel records of the clinical supervisor included documentation of orientation to the job. (A) Record review on 2/15/2021 evidenced an agency policy titled, "Employee Orientation", revised March 2018. This policy stated, "Policy Each employee of the Agency will complete an orientation period ... Purpose To provide a mechanism whereby all employees are oriented to and become acquainted with the Agency policies and procedures ... Orientation for each employee will minimally include: Review of the individual's job description and duties performed and their role in the organization...."	N 0460	On 3/8/21, the Alternate Clinical Supervisor gave an orientation to the Clinical Supervisor, a record of which has been placed in the Clinical Supervisor's personnel file. The Administrator has reviewed and ensured that the Clinical Supervisor's personnel record is current and includes a copy of 1) a criminal background check pursuant to IC 16-27-2, 2) nursing license, 3) annual performance evaluations performed every 9 to 15 months, and 4) documentation	03/12/2021

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	Record review on 2/15/2021 evidenced an agency policy titled, "Personnel Records", revised March 2018. This policy stated, "Policy Personnel files will be established and maintained for all staff ... The personnel record or personnel information for an employee will include, but not be limited to ... Agency employee orientation...." During an interview on 2/9/2021 at 11:10 a.m., the alternate administrator indicated employee A was the clinical supervisor. Review of employee A's personnel record failed to evidence documentation of orientation to the job. During an interview on 2/12/2021 at 2:22 p.m., the alternate administrator indicated the agency failed to ensure the personnel records of the clinical supervisor included documentation of orientation.		of orientation to the job. The Clinical Supervisor's personnel record will be audited by the Administrator annually for evidence of annual performance evaluation. Administrator to ensure that all new hires will be oriented to their positions. The Administrator will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	
N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review and interview, the home health agency failed to ensure all employees had a required physical exam, within 180 days prior to having direct patient care, in effort to not spread infectious or communicable disease for 2 of 10 personnel records reviewed. (employees A, G)	N 0462	On 3/8/21, the Alternate Administrator inserviced the entire office staff, including the Administrator, Clinical Supervisor, and Alternate Clinical Supervisor, on the requirement of a physical	03/12/2021

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	The findings include: 1. An agency policy number 4.8.1, titled "Personnel Records" revised March 2018, stated "Policy ... Personnel files will be established and maintained for all staff. All information will be considered confidential and will be made available to authorized management personnel only ... Purpose ... To maintain personnel files on current and former employees ... Procedure ... 2. The health record for applicable employees will include: ... Any other Agency required health requirements ... 3. Employee health information must be maintained in files separate from personnel files and in a separate location .... " 2. An agency document numbered 4.17A.2, titled "Job Description Administrator" revised March 2018, stated "Job summary: The Administrator ensures quality and safe delivery of home health care services; coordinates services that reflect the Agency's philosophy and standards of care ... Responsibilities: 6. consistently follows agency policies and procedures to set an example for employees... 19. Maintains compliance with applicable federal, state, accrediting bodies in local rules and regulations ... Work Environment: Works indoors in the Agency office...." 3. Record review on 2/12/2021, evidenced the Indiana State Department of Health form titled "Employee Records" which indicated employee A, administrator / clinical manager, did not have patient contact. Clinical record review on 2/15/2021, for patient #8, start of care 11/16/2020, evidenced an agency document titled "OASIS-D1 Start of Care" signed by the administrator (employee A) on 11/16/2020.		examination by a physician or nurse practitioner no more than one hundred eighty (180) days before date of first patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Although not a regular part of the Clinical Supervisor's job, the Clinical Supervisor makes patient visits in emergencies and/or when coverage is lacking. The Clinical Supervisor's date of first patient contact was 3/14/17. Upon review of the Clinical Supervisor's medical record file, there is evidence of a physical exam on 8/15/17. It is noted that this date is non-compliant. As it occurred over three years ago, Agency can only work to ensure compliance moving forward. The Administrator has audited all direct care employees' personnel records to ensure documentation of a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact 100% of newly hired direct care employee personnel records will be audited upon hire for evidence of a physical examination by a	

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	This document evidenced vital signs assessed, including but not limited to, temperature (97.6), blood pressure (144/68), heart rate (76), and respirations (18). This document also reported assessments on the major body systems, including but not limited to, integumentary (skin) status, respiratory status, cardiac status, genitourinary (pertaining to the genitals), and gastrointestinal (digestive system) status, which would require patient contact. During an interview on 2/15/2021, at 2:40 PM, the administrator indicated they performed the start of care assessment for patient #8. The alternate administrator added it was "Probably one of those cases where there was no one else to do it." The administrator and alternate administrator were informed that a physical examination is required prior to patient contact to ensure patient safety, to which they nodded. 4. Personnel record review on 2/12/2021, for employee G, evidenced a first date of patient contact date of as 7/29/2007. Record review evidenced the earliest physical examination was performed on 11/5/2007. The employee's physical examination date was 99 days past their first patient contact. Record review failed to evidence a physical examination was performed prior to the employee's first patient contact.		physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and	N 0470	On 3/8/21,the Clinical Supervisor	03/12/2021

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	interview, the home health agency failed to ensure all employees followed standard / universal precautions and infection control practices, in 2 of 3 home visits conducted. (#1, #2) The findings include: 1. Record review on 2/15/2021 evidenced an agency policy titled, "Specific Procedures for Employee and Patient Infection Control Training", revised March 2018. This policy stated, "Policy To ensure that all Agency staff and patients are educated and understand specific procedures regarding infection control. Staff will be trained during orientation and annually as specific to their jobs ... Procedure Staff 1. All employees who come into contact with blood, body fluids, tissue, solids or any moist body part or substance of any patient will use the following specific procedures in compliance with Standard Precautions procedures: ... Wash hands before and after wearing gloves...." 2. During a home visit for patient #1, with a primary diagnosis of radiculopathy, lumbosacral region [pinched nerve in the lower back], on 2/11/2021 at 10:07 a.m., employee F, RN [registered nurse] was observed removing and disposing gloves worn while checking patient's vital signs. At 10:08 a.m., employee F, RN applied new gloves. The nurse failed to perform hand hygiene before applying new gloves. At 10:15 a.m., the nurse was observed covering the patient with a blanket, then removed her gloves. At 10:16 a.m., the nurse applied new gloves. The nurse failed to perform hand hygiene before applying new gloves. The skilled nurse failed to follow standard precaution practices.		inserviced all employees on Infection Control and Standard /Universal Precautions, with a focus on hand hygiene. Practical training and Peer Assessment on hand hygiene was included for each direct-care employee to demonstrate proper hand hygiene compliance when using personal protective equipment. Specifically, employees were reminded to perform hand hygiene in between glove changes. 100% of newly hired direct care employees will be trained on Infection Control and Standard /Universal Precautions during orientation. The Clinical Supervisor will train and assess all direct care employees on infection control and standard/universal precaution annually to ensure compliance (before, during and after patient care). The hand hygiene assessment will occur on a quarterly basis, and the data will be included and analyzed as a part of QAPI activities and quarterly report. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that these deficiencies are corrected and will not recur.	

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	3. During a home visit for patient #2, with a primary diagnosis of pressure ulcer of sacral region, stage 2, on 2/11/2021 at 1:10 p.m., employee J, HHA [home health aide] was observed removing and disposing gloves worn while removing patient's diaper. Immediately after, the HHA was observed applying new gloves. The HHA failed to perform hand hygiene after the removal of the old gloves and before applying new gloves. The home health aide failed to follow standard precaution practices. 4. During an interview on 2/12/2021 at 9:53 a.m., the alternate administrator indicated hand hygiene was to be performed by all staff before applying gloves. When informed of observation findings, the alternate administrator nodded and offered nothing further.			
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer			

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	reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the home health agency failed to develop and implement the required 15 day discharge notice policy for 2 of 3 discharged patient clinical records reviewed, in a total sample of 8 clinical records reviewed. (#4, #8) The findings include: 1. An agency policy number 9.30.1, titled "Discharge Criteria and Planning" revised January 2020, stated "Policy ... Patients are discharged by Agency based on specifically defined criteria ... Purpose ... To establish guidelines for discharge of patients from the Agency ... Procedure ... 2. The patient is informed of discharge plan in a timely manner and acknowledges understanding reason. The evaluation of a patient's discharge needs and discharge plan must be documented in a timely manner. That evaluation must be included in the medical record and discussed with patient or patient representative. All relevant information from the Agency will be incorporated into the discharge plan to avoid delays.... " 2. Clinical record review on 2/15/2021, for patient #8, start of care 11/16/2020, primary diagnosis hypertension with heart failure, evidenced a document titled "SN [skilled nurse] Observation & Assessment Visit" from 1/5/2021, and	N 0488	Patient #8 – Patient received notice 9 days prior to discharge. Patient #4 – Agency failed to provide 15-day notice of discharge to patient. Also, patient was not informed of community resources to assist the patient following discharge. The Administrator has revised policy number 9.30.1, titled “Discharge Criteria and Planning” on March 1, 2021 stating that the evaluation of a patient's discharge needs, and discharge plan must be documented at least fifteen (15) calendar days. The fifteen (15) day period described does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on	03/12/2021

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	electronically signed by RN [registered nurse] L. This document had an area subtitled "Discharge Planning" which stated "Discharge Planning Discussed with ... Patient ... Caregiver ... Patient Received Discharge Notices per Agency Policy and Procedures.... " Record review of the agency's Active Patient List evidenced patient #8 had been discharged on 1/14/2021. Record review evidenced an agency document titled "Notice of Medicare Non-Coverage" signed by patient #8 on 1/5/2021, which stated "The effective Date Coverage of Your Current Home Health Services Will End: 1/14/21.... " Record review evidenced the patient received the discharge notice 9 days prior to discharge. Record review failed to evidence the patient was given the required 15 day discharge notice. During an interview on 2/15/2021, at 2:35 PM, the alternate administrator indicated the agency's practice has been to inform and review discharge the skilled visit prior to the last scheduled visit. 3. Clinical record review on 2/10/2021 for patient #4, with start of care 7/27/2020 and certification period 7/27/2020 to 9/3/2020, with a primary diagnosis of hypertensive chronic kidney disease, evidenced an agency document titled, "SN [skilled nurse] Discharge Summary", dated 9/3/2020, and signed by employee C, RN. This document contained a subcategory titled, "Patient Condition and Outcomes", which indicated "Goals Partially Met". This document also contained a subcategory titled, "Condition of discharge...." which stated, " ... Patient discharge from Alpha Home Health Care effective today 9/03/2020 due to denial of insurance provider to continue Home		applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. On 3/8/21, the Administrator inserviced all employees on this requirement that a notice of discharge of service is to be given to the patients, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. The fifteen (15) day period described does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or	

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	Health services at this time." This document contained a subcategory section which stated, "Discharge Instructions Given To:", which failed to evidence any documentation. Clinical record review failed to evidence documentation that the patient received a 15 day notice of discharge. During an interview on 2/10/2021 at 2:14 p.m., when queried about a 15 day notice of discharge, patient #4 stated, "I don't remember getting that. They just stopped coming. They called and said it was insurance." On 2/15/2021 at 3:20 p.m., when informed of the findings, the alternate administrator indicated the agency failed to provide a 15 day notice of discharge to the patient.		(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. The Clinical Supervisor has reviewed all active clinical records and will ensure that upcoming discharges comply with revised 15-day discharge notice policy. 20% of clinical records will be audited quarterly for evidence of a 15-day notice of discharge to patients, patient's legal representative, or other individual responsible for the patient's care. The data will be included and analyzed as a part of QAPI activities and quarterly report. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0490 Bldg. 00	410 IAC 17-12-2(k) Q A and performance improvement Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the five (5) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented.			

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	Based on record review and interview, the agency failed to continue to provide services during the 15 days from time of notification of discharge until time of discharge in 1 of 2 discharged patient clinical records reviewed, out of 8 total clinical records reviewed. (#4) 1. Record review on 2/15/2021 evidenced an agency document titled, "Discharge Criteria and Planning", revised in January 2020. This policy stated, "... The patient is informed of discharge plan in a timely manner and acknowledges understanding reason. The evaluation must be included in the medical record and discussed with patient or patient representative ... The patient's continuing care needs, if any, are assessed at discharge ... A patient who occasionally declines a service is distinguished from a patient who refuses services altogether, or who habitually declines ,skilled care visits. It is the patient's right to refuse services. It is the Agency's responsibility to educate the patient to the risks and potential adverse outcomes that can result from refusing services. In the case of patient refusals of skilled care, the Agency must document its communication with the physician who is responsible for the patient's home health plan of care, as well as the measures the Agency took to investigate the patient's refusal and the interventions the Agency attempted in order to obtain patient participation with the plan of care...." 2. Clinical record review on 2/10/2021 for patient #4 with primary diagnosis of hypertensive chronic kidney disease, start of care 7/27/2020 and certification period 7/27/2020 to 9/3/2020 evidenced an agency document titled, "SN [skilled nurse] Discharge Summary", dated 9/3/2020, and signed by employee C, RN [registered nurse].	N 0490	Patient #4 – The patient's insurance coverage changed. Patient was informed Agency will do its best to work with new insurance, but patient may be responsible for new insurance copay. Before Agency could reach out to new insurance to discover plan details, patient refused all services. Agency did not follow policies and will develop a plan of correction with the following focus items: 1. Agency did not document patient education on risks and potential adverse outcomes that can result from refusing services. 2. Agency did not document its communication with the physician who is responsible for the patient's home health plan of care, as well as the measures that the Agency took to investigate the patient's refusal. 3. Agency did not provide discharge instructions. 4. Agency must improve on communication with clients who refuse services. On 3/8/21, the Clinical Supervisor inserviced all direct care employees on Agency's revised discharge policy, including that a home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) day period. If the home health agency cannot provide such services during that period, its continuing attempts to provide the	03/12/2021

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	This document contained a subcategory titled, "Patient Condition and Outcomes", which stated "Goals Partially Met". This document also contained a subcategory titled, "Condition of discharge...." which stated, "... Patient discharge from Alpha Home Health Care effective today 9/03/2020 due to denial of insurance provider to continue Home Health services at this time." This subcategory contained another section which stated, "Discharge Instructions Given To:", which evidenced no documentation. Clinical record review of patient's electronic medical record (Axxess) on 2/11/2021, failed to evidence any communication notes from 7/27/2020 to 9/3/2020. During an interview on 2/10/2021 at 2:14 p.m., when queried as to why she stopped receiving services from the agency, patient #4 stated, "Someone thought I didn't need it. Insurance I guess. No one asked me." During an interview on 2/15/2021 at 3:20 p.m., the alternate administrator indicated if a patient's payor source runs out, it is the agency's policy to absorb the cost to continue services until needs are met or other source of services are established for the patient. The alternate administrator indicated the agency would discuss this with the patient and their physician, and it should be documented in a communication note. When queried about the discharge of patient #4, the alternate administrator indicated the patient was offered to continue services, but refused. The clinical record failed to evidence documentation of any communication with the patient or the physician regarding the patient's continued need for services.		services must be documented. In-service also focused on Discharge Criteria and Planning: The patient is informed of discharge plan at least fifteen (15) calendar days and acknowledges understanding reason. The evaluation must be included in the medical record and discussed with patient or patient representative. The patient's continuing care needs, if any, are assessed at discharge. A patient who occasionally declines a service is distinguished from a patient who refuses services altogether, or who habitually declines skilled care visits. It is the patient's right to refuse services. It is the Agency's responsibility to educate the patient to the risks and potential adverse outcomes that can result from refusing services. In the case of patient refusals of skilled care, the Agency must document its communication with the physician who is responsible for the patient's home health plan of care, as well as the measures the Agency took to investigate the patient's refusal and the interventions the Agency attempted to obtain patient participation with the plan of care. Moving forward, starting 3/1/21, 100% of clinical records of clients who refuse home health services will be audited. This is to ensure that attempts to fully investigate	

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			the patient's refusal were made and documented. Also, to ensure that Agency educates the patient on risks and potential adverse outcomes that can result from refusing services, communicates situation with prescribing provider, and provides discharge instructions. The data will be included in quarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on observation and record review, the agency failed to ensure all patients received the most current advanced directives information for 3 of 3 patient home visits conducted. (#1, #2, #3) The findings include: 1. An agency policy number 12.4.1, titled "Patient Self-Determination Act: Advanced Directives"	N 0518	On 3/8/21, The Administrator reviewed and updated the Indiana State document titled "Advanced Directives. Your Right To Decide" to the most current version with a revised date of November 1, 2018 in the admission packet. Every active client of Agency has been given a copy of the current version.	03/12/2021

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	revised March 2018, stated "Policy... Patients have the right to make decisions concerning their care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives as permitted under state statutory and case law ... Purpose ... To define and assure the rights of adult patients in the healthcare decision-making ... Procedure ... 1. Prior to coming under Agency care, the patient will be provided with written information concerning the patient's rights under state law (both statutory and case law) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advanced directives. This information will be provided by Agency employees at time of 1st home visit before care is provided and documented in the medical record.... " 2. Record review on 2/9/2021, of the agency's sample admission folder, evidenced an Indiana State document titled "Advanced Directives ... Your Right To Decide" with a revised date of July 1, 2013. Record review failed to evidence the most current version of the Indiana State Advanced Directive, which was updated November 1, 2018. 3. During an observation on 2/11/2021, at 9:54 AM, a home visit for patient #1, start of care 7/15/2020, was conducted. During the observation, review of the patients home admission folder evidenced an Indiana State document titled "Advanced Directives ... Your Right To Decide" with a revised date of July 1, 2013. Review of the patients home admission folder failed to evidence the most current version of the Indiana State Advanced Directive, which was updated November 1, 2018.		A meeting was held with all Agency staff to inform of this change. These findings are fully corrected. On 3/8/21, the Administrator inserviced all Agency staff that the home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Every single patient packet will be monitored as it is produced. The Administrator to randomly check newly produced packets monthly and review/update packets annually. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	4. During an observation on 2/11/2021, at 12:30 PM, a home visit for patient #2, start of care 4/10/2020, was conducted. During the observation, review of the patients home admission folder evidenced an Indiana State document titled "Advanced Directives ... Your Right To Decide" with a revised date of July 1, 2013. Review of the patients admission folder failed to evidence the most current version of the Indiana State Advanced Directive, which was updated November 1, 2018. 5. During an observation on 2/11/2021, at 3:00 PM, a home visit for patient #3, start of care 12/31/2020, was conducted. During the observation, review of the patients home admission folder evidenced an Indiana State document titled "Advanced Directives ... Your Right To Decide" with a revised date of July 1, 2013. Review of the patients admission folder failed to evidence the most current version of the Indiana State Advanced Directive, which was updated November 1, 2018. During an interview on 2/12/2021, at 3:55 PM, the alternate administrator was informed the most current Indiana State form for Advanced Directives had been revised in November of 2018. The alternate administrator nodded and stated "Okay."			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review an interview, the agency failed to ensure the medical plan of care was	N 0522	Patient #5 – Patient weight was not documented at every nursing	03/12/2021

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	followed in 1 of 2 discharged patient clinical records reviewed, in a total sample of 8 clinical records reviewed. (#5) The findings include: 1. An agency policy number 9.10.1, titled "Plan of Care - CMS #485 and Physician Orders" revised March 2018, stated "Skilled nursing and other home health services will be in accordance with a Plan of Care based on the patient's diagnosis and assessment of immediate and long range needs in resources. Each Plan of Care must be signed and dated by the physician ... Procedure ... 2. Each patient must receive an individualized written plan of care ... 5. All patient care orders, including verbal orders, must be recorded in the plan of care ... 20. Care and services provided will be provided according to physician orders. Orders are current and updated ... 25. All clinical services are implemented only in accordance with a Plan of Care established by a physician's written order.... " 2. Clinical record review on 2/15/2021, for patient #5, start of care 8/13/2020, primary diagnosis of Type 2 diabetes mellitus with diabetic neuropathy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 8/13/2020 - 10/11/2020, signed by the patient's physician on 10/2/2020. This document had an area subtitled "Orders for Discipline and Treatment" which stated "SN [skilled nurse] Frequency: 1WEEK9 [Once a week, for nine weeks] ... SN to check weight every visit and PRN [as needed] to monitor for weight gain.... " Record review evidenced an agency document titled "SN Teaching / Training Visit" electronically signed by RN H, on 8/19/2020. This document		visit as ordered. The Clinical Supervisor reviewed the agency policy number 9.10.1, titled "Plan of Care - CMS #485 and Physician Orders" revised March 2018. On 3/8/21, the Clinical Supervisor inserviced all Agency staff on this policy: Medical care shall follow a written medical plan of care established and periodically reviewed by the home health ordering provider. Furthermore, the Clinical Supervisor met individually with Clinician in record #5. The Clinical Supervisor emphasized that importance of following all provider orders as outlined in the plan of care. Specifically, Clinician of record #5 was reminded of the importance of tracking weight, especially with CHF patients. All active charts of Patient #5 Clinician were reviewed to ensure that all orders, including weights, were carried out. Moreover, 100% of active charts were audited by QAPI team to ensure that care and services are being provided according to provider orders in the plan of care. The Clinical Supervisor also developed and directly participated in a more comprehensive QA program, which monitors to ensure that the care and services provided	

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	failed to evidence a weight had been assessed as ordered on the plan of care. During an interview on 2/15/2021, at 1:55 PM, the alternate clinical supervisor and the alternate administrator indicated the weight was not documented in the clinical record.		will be provided according to physician orders. Inservice included specific training on proper documentation of patient's weight weekly/every visit and physician's order for treatments. Monitoring will occur at different time points 1. QAPI team will audit all charts at end of episode to ensure compliance with this requirement. 2. 20% of all clinical records will be audited quarterly by QAPI team for evidence that Medical care follows the written medical plan of care established and periodically reviewed by the home health ordering provider. The data will be included in quarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the agency failed to re-evaluate the patient's nursing needs in 1 of 2 discharged patients, in a total sample of 8	N 0541	Patient #5 – Patient had a missed visit on 8/25/20. Agency called twice and left a message on the	03/12/2021

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	clinical records reviewed. (#5) The findings include: 1. An agency policy titled "Nursing Services", revised March 2018, stated, "Policy Patients receiving nursing services will have appropriate assessments, reassessments, care planning and established outcomes performed. Procedure ... Professional nursing service will be provided by a registered nurse and include: ... Informing the physician and other staff of changes in the patient's needs...." 2. Clinical record review on 2/15/2021, for patient #5, start of care 8/13/2020, primary diagnosis of Type 2 diabetes mellitus with diabetic neuropathy, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 8/13/2020 - 10/11/2020. This document had an area subtitled "Caregiver Status" which stated "Patient lives alone .[sic] Patient's 2 brothers available as needed ... " Another area subtitled "Orders for Discipline and Treatment" stated "SN [skilled nurse] Frequency: 1WEEK9 [Once a week, for nine weeks] ... Patient assessed to be high risk for emergency department visits and / or hospital readmission ... " Record review evidenced an agency document titled "Missed Visit" which was electronically signed by RN H on 8/25/2020. This document stated "Reason ... No Answer to Phone Call ... CALLED X2. LEFT MESSAGE ON VOICEMAIL ... " Record review evidenced an agency document titled "Physician Order" dated 8/29/2020, which was signed by the patient's physician. This document stated "HOLD ALL ALPHA HOME		second call. Three days later, on 8/28/20, Agency called patient again; there was no answer. Agency then called the emergency contact on file. There was no answer; a message was left. The emergency contact called Agency back the following day, on 8/29/20, to inform Agency that patient has been hospitalized. To improve on client follow-up process, Agency has instituted a new Client Follow-up policy and procedures. After 3 attempts as reaching clients, Agency to reach out to emergency contact on file. If after 2 unsuccessful attempts, Agency to reach out to overseeing provider. Successive steps to be decided/planned in collaboration with provider. On 3/8/21, the Clinical Supervisor inserviced all Agency staff on newly instituted policy on client follow-up. Clinical Supervisor also reviewed the requirement to regularly reevaluate the patient's nursing needs. Inservice included specific training on proper documentation of contact attempts. Training clarified process by which ordering provider is informed of unsuccessful attempts to contact clients/family/emergency contacts. 100% of active records were audited by QAPI team to ensure	

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	HEALTH CARE SERVICES PATIENT ADMITTED AT [entity A, a hospital] WITH CHIEF COMPLAINT OF ALTERED MENTAL STATUS ... " Record review evidenced the patient was admitted to the hospital with altered mental status 4 days after the missed visit on 8/25/2020. Record review failed to evidence the agency staff contacted the patient's family members listed on the plan of care to re-evaluate and ensure patient needs were being met. During an interview on 2/15/2021, at 1:54 PM, the alternate administrator indicated when a patients services are put on hold due to hospitalization, there would communication with the hospital and family. This would be documented in a nursing or communication note. During an interview on 2/15/2021, at 1:59 PM, the alternate administrator indicated they could not find documentation regarding communication with the patient, family, entity A, or physician regarding the patient's status. During an interview on 2/15/2021, at 2:02 PM, the alternate clinical supervisor indicated the patient was still at entity A as of the discharge date 9/22/2020, when the agency was notified the patient would be transferred to a skilled nursing facility. During an interview on 2/15/2021, at 2:24 PM, the alternate administrator indicated the process to follow in the event a patient did not answer the phone prior to a scheduled visit included staff would call at least twice, reach out to the emergency contact. If attempts to contact the patient and emergency contact were		proper procedures and documentation regarding client follow-up. All records with incomplete or lacking documentation prompted an immediate phone by the Clinical Supervisor. This tag/finding is fully corrected. 20% of clinical records will be audited quarterly for evidence of proper client follow-up and documentation. The data will be included in quarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	unsuccessful, the the agency would reach out to the patient's physician.			
N 0543 Bldg. 00	410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on observation, record review, and interview, the agency failed to ensure the skilled nurse initiated appropriate preventative and rehabilitative nursing measures in 1 of 1 home visits performed with a skilled nurse for a patient with a healed wound. (#1) The findings include: Record review on 2/15/2021 evidenced an agency policy titled, "Nursing Services", revised March 2018. This policy stated, "Policy Patients receiving nursing services will have appropriate assessments, reassessments, care planning and established outcomes performed ... Professional nursing service will be provided by a registered nurse and include: Initial and ongoing comprehensive assessments of the patient's needs ... Initiating the plan of care and revising as necessary ... Initiating appropriate preventative and rehabilitative nursing procedures...." Clinical record review of the electronic medical record (Axxess), for patient #1, with primary diagnosis of radiculopathy, lumbosacral region [pinched nerve in the lower back], indicated the patient started care on 7/15/2020 with diagnoses	N 0543	Patient #1 – To correct the deficient practice, the Clinical Supervisor met individually with Employee F and re-educated on proper wound care, including preventative measures. Employee F has thoroughly assessed patient's healed wound at every visit following the survey visit on 2/11/21. Employee F cares for other clients with wounds and they have all been assessed and treated as ordered. Preventative measures have been implemented in all cases; this includes a skin assessment as a preventative measure for clients who have had wounds in the past, but no current wound(s). On 3/8/21, the Clinical Supervisor inserviced all Agency nurses: required to perform initial and ongoing comprehensive assessments of the patient's needs, initiate the plan of care, and revise as necessary, and initiate appropriate preventative	03/12/2021

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	of acute pyelonephritis [kidney infection] and a stage 4 sacral pressure ulcer to the sacral region. During an interview on 2/11/2021 at 9:59 a.m., patient #1 indicated she started receiving services from the home care agency following a hospitalization in July 2020 for a kidney infection and wound to her sacral area. During observation of a home visit for patient #1 on 2/11/2021 at 10:15 a.m.,employee F, RN [registered nurse], asked the patient if she had a bowel movement. The patient answered, "no". The nurse failed to be observed removing the patient's diaper or assessing the patient's skin in the sacral area. The skilled nurse failed to provide appropriate preventative practices for a patient with a history of wounds. During an interview on 2/12/2021 at 3:57 p.m., the alternate administrator indicated a skin assessment is an expected preventative nursing measure for a patient who has had a wound. When informed of the home visit findings, the alternate administrator indicated the nurse should have assessed the patient's skin in the sacral area.		and rehabilitative nursing procedures. Inservice included specific training on Initiating appropriate preventative and rehabilitative nursing procedures for a patient with a history of wounds. 100% of active records were audited by the QAPI team to ensure evidence of appropriate preventative and rehabilitative nursing procedures for a patient with active or a history of wounds. All charts of active patients with a history of wounds were audited to ensure safe practices. 20% of clinical records with will be audited quarterly for evidence of appropriate preventative and rehabilitative nursing procedures for a patient with active or a history of wounds. The data will be included in the quarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the			

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	following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on observation, record review and interview, the agency failed to ensure the registered nurse informed the physician of changes in the patient's condition and needs in 1 of 3 home visits conducted. (#1) The findings include: 1. Record review on 2/15/2021, evidenced an agency policy titled "Nursing Services", revised March 2018. This policy stated, "Policy Patients receiving nursing services will have appropriate assessments, reassessments, care planning and established outcomes performed. Procedure ... Professional nursing service will be provided by a registered nurse and include: ... Informing the physician and other staff of changes in the patient's needs...." 2. Record review on 2/15/2021 evidenced an agency policy titled "Coordination of Patient Care", revised March 2019. This policy stated, "Procedure The Agency must: Assure communication with all physicians in the plan of care ... Staff provides the physician with patient information on an ongoing basis regarding: Current condition and changes in condition. Outcomes of care and service. Changes in the environment and / or caregiver support. Results of relevant laboratory tests...." 3. During observation of a home visit for patient	N 0546	Patient #1 – The Clinical Supervisor met individually with Employee F to re-educate on catheter care, provider coordination, and proper documentation. Employee F has regularly reported catheter issues to the provider. Employee F was reminded to take credit for her work and document these reportings. Employee F was informed that her notes failed to evidence communication with the provider regarding the patient's catheter and the characteristics of the urine. Employee F was also reminded that even if the provider gave no new orders, that communication should be documented in the chart. The Clinical Supervisor reviewed the agency policy titled "Nursing Services", revised March 2018 and the agency policy titled "Coordination of Patient Care", revised March 2019. On 3/8/21, the Clinical Supervisor inserviced all Agency nurses: requirement to inform provider(s) of changes in the patient's condition and needs and proper documentation of all	03/12/2021

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	#1 on 2/11/2021 at 10:08 a.m., employee F, RN [registered nurse] stated the following about the patient's foley catheter [tube inserted to drain the bladder], "It leaks a lot. The doctor is aware". At 10:13 a.m., employee F, was observed looking at the patient's urine draining from the catheter. The urine was observed to be very cloudy and dark yellow. Employee F stated, "Doctor is aware of urine". Clinical record review for patient #1 with primary diagnosis of radiculopathy, lumbosacral region [pinched nerve in the lower back], start of care 7/15/2020 and certification period 1/11/2021 to 3/11/2021 evidenced skilled nurse's notes dated 1/19/2021 and 2/11/2021. These notes failed to evidence communication with the physician regarding the patient's catheter or the characteristics of the urine. Review of patient #1's electronic medical record (Axxess), for certification period 1/11/2021 to 3/11/2021, failed to evidence any communication notes. During an interview on 2/15/2021 at 3:10 p.m., the alternate administrator indicated the nurse should have communicated the urine appearance and frequent leaking of the catheter to the physician. The alternate administrator indicated this communication should be documented in the narrative of the nurse's notes or a communication note. When informed of the concerns, the alternate administrator stated, "OK", and offered no further documentation.		communication. 100% of active records were audited by the QAPI team to ensure evidence of documentation of all communication with provider(s) regarding patient needs and changes in condition. 20% of clinical records will be audited quarterly for evidence of communication with provider(s) regarding patient needs and changes in condition. The data will be included in quarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0565 Bldg. 00	410 IAC 17-14-1(c)(4) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall:			

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	(4) help develop the plan of care (revising as necessary); Based on record review and interview, the home health agency failed to ensure the physical therapist revised the plan of care in 1 of 1 home visits of patients receiving physical therapy. (#1) The findings include: Record review on 2/15/2021, evidenced an agency policy titled, "Care Planning Process", revised March 2018. This policy stated, "Policy In order to assure that care provided is appropriately planned to meet each patient's specific needs and problems, the Agency will utilize data / information gathered during patient assessments in the care planning process ... Procedure 1. The patient care plan for therapy services (PT [physical therapy] OT [occupational therapy] and SLP [speech-language pathologist]) will be: ... Will be revised as problems are identified. Review and revision will be ongoing with each home visit and will be based on patient's health status, environment and relevant baseline data from assessments to determine current needs, problems, interventions and goals...." Record review evidenced an agency policy titled "Skilled Professional Services", revised March 2018. This policy stated, "Policy Patients receiving skilled professional services will receive appropriate assessments, reassessments, care planning, established outcomes and care per physician orders ...Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, occupational therapy, physician and medical social work services. Skilled professionals who provide services to Agency patients ... must participate in the coordination of care ... Skilled	N 0565	Patient #1 – "PT PLAN OF CARE", dated 1/4/2021 was not revised to include a current diagnosis. Agency failed to ensure a physical therapy revised plan of care. To correct practice, the Clinical Supervisor met with the physical therapist and reviewed finding of unrevised plan of care. Agency to improve coordination of services and communication by conducting telephone conferences between therapist and alternate clinical supervisor at the following time points: PT evaluation, PT re-evaluations, and whenever there is a change in the patient condition/plan of care. Therapy plan of care to be audited to ensure that diagnoses are accurate and consistent with nursing plan of care. The Clinical Supervisor reviewed the agency policy titled " Care Planning Process", revised March 2018 and the agency policy titled " Skilled Professional Services", revised March 2018. On 3/8/21, the Clinical Supervisor inserviced all Agency therapists (PT, OT, ST) that they must help develop the plan of care and revise as necessary. Inservice included specific training on care planning process, coordination of care, and ongoing interdisciplinary assessment of the patient.	03/12/2021

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	professionals must assume responsibility for, but not be restricted to ... ongoing interdisciplinary assessment of the patient. Development and evaluation of the plan of care in partnership with the patient, representative (if any) and caregiver(s)...." Clinical record review for patient #1, with primary diagnosis of radiculopathy, lumbosacral region [pinched nerve in the lower back], start of care 7/15/2020 and certification period 1/11/2021 to 3/11/2021 evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. This plan of care stated, "Principal Diagnosis Radiculopathy, lumbosacral region [a pinched nerve in the lower back]. Other Diagnosis ... Lymphedema [swelling in a limb] ... Venous insufficiency [circulation problems] ... Encounter for fitting and adjustment of urinary device ... Essential (primary) hypertension ... Hyperlipidemia [high cholesterol] ... Gastro-esophageal reflux disease without esophagitis ... Major depressive disorder ... Morbid (severe) obesity ... Body mass index [BMI] 38.0 -38.9, adult...." Clinical record review evidenced an agency document titled, "PT [physical therapy] PLAN OF CARE", dated 1/4/2021, signed by employee M, PT. This plan of care had a subcategory titled, "Medical Diagnosis" which stated, "Medical Diagnosis: Acute pyelonephritis [kidney infection] Onset 7/15/2020 PTDiagnosis: Pressure ulcer of sacral region, stage 4 Onset 7/15/2020." Clinical record review evidenced two agency documents titled, "SN [skilled nurse] TEACHING / TRAINING VISIT", dated 1/19/2021 and 2/11/2021. These assessments both indicated the patient did		100% of the active records with therapy services were audited by QAPI team for evidence of appropriate therapists' participation in developing and revising as necessary the plan of care. All records without the therapy plan of care being revised with current diagnosis prompted an immediate phone by the Clinical Supervisor. This tag/finding is fully corrected. 20% of clinical records with therapy services will be audited quarterly for evidence of appropriate therapists' participation in developing and revising as necessary the plan of care. The data will be included in quarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	not have signs or symptoms of a urinary tract infection, and the patient had no wounds. During an interview on 2/11/2021 at 9:59 a.m., employee F, RN [registered nurse] stated, "it's healed" in regards to the patient's sacral wound. During an interview on 2/15/2021 at 3:10 p.m., the alternate administrator indicated the agency failed to ensure the physical therapist revised the plan of care to include a current diagnosis.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency failed to ensure clinical records contained pertinent findings in accordance with accepted professional standards in 2 of 8 clinical records reviewed (#4, #6).	N 0608	Patient #4/Employee L – The nurse failed to update the clinical assessment each visit as evidenced by multiple duplicate assessment narratives. The Clinical Supervisor met individually	03/12/2021

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	The findings include: 1. Record review on 2/15/2021, evidenced an agency policy titled, "Care Planning Process", revised March 2018. This policy stated, "... Visit Notes: documents modifications to care / service current problems, interventions and short term goals; individualized...." 2. Clinical record review on 2/10/2021 for patient #4, primary diagnosis of hypertensive chronic kidney disease, start of care 7/27/2020 and certification period 7/27/2020 to 9/3/2020, evidenced an agency document titled, "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] -D1 Start of Care", dated 8/1/2020, and signed by employee A, RN [registered nurse], clinical manager. This assessment had a subcategory titled, "Admission Summary/F2F [face to face] Addendum", which stated, "Visit Narrative Hx [history of] afib [atrial fibrillation][an irregular heartbeat], HTN [hypertension][high blood pressure], Heart disease. AAOX3 [awake, alert, oriented] forgetful 96 yo [year-old] female who resides with her husband who also is in poor health. Upon arrival up to answer door. Requires frequent rest periods with activity. Has cane but, no [sic] using at present. HR [heart rate] states has been fluttering and is currently wearing a Heart Monitor to see whats going on with her heart. HR irregular at times, states she experiences dizziness especially with sudden movement. No edema [swelling] present to BLE [bilateral lower extremities][both legs], toes warm pink PP+. Lungs clear, slight SOBOE [shortness of breath on exertion]. Abd. [abdomen] soft denies abd. pain appetite fair, Voiding freely, occasional stress incont.[incontinence]. Skin remains intact. No falls reported."		with Employee L and re-educated on proper documentation: Clinical records must contain pertinent past and current findings in accordance with accepted professional standards and must be maintained for every patient. The Clinical Supervisor focused on the requirement for signed and dated clinical notes that contain pertinent findings in accordance with accepted professional standards. When asked about duplicate notes, Employee L admitted to copying and pasting notes. Employee L apologized and informed the Clinical Supervisor that her son had recently passed. The Clinical Supervisor offered condolences and worked with the employee in providing a more flexible schedule and additional time off if needed. Employee was instructed to keep open communication with the Clinical Supervisor. Employee was reassured that refusing an assignment was not a problem. However, once an assignment is accepted, quality and safe care must be provided with proper documentation in accordance with accepted professional standards. Employee L verbalized understanding and agreement. A written letter of reprimand has been placed in Employee L's file. No supervisory visit conducted, as this was a discharged patient.	

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	Clinical record review evidenced an agency document titled, "SN [skilled nurse] TEACHING / TRAINING VISIT", dated 8/6/2020, signed by employee L, RN. This document had a subcategory titled, "Visit Narrative" which stated, "AAOX3 [awake, alert, oriented] forgetful 96 yo [year-old] female who resides with her husband who also is in poor health. Upon arrival up to answer door. Requires frequent rest periods with activity. Has cane but, no [sic] using at present. HR [heart rate] states has been fluttering and is currently wearing a Heart Monitor to see whats going on with her heart. HR irregular at times, states she experiences dizziness especially with sudden movement. No edema [swelling] present to BLE [bilateral lower extremities][both legs], toes warm pink PP+. Lungs clear, slight SOBOE [shortness of breath on exertion]. Abd. [abdomen] soft denies abd. pain appetite fair, Voiding freely, occasional stress incont. [incontinence]. Skin remains intact. No falls reported." Clinical record review evidenced an agency document titled, "SKILLED NURSE VISIT", dated 8/13/2020, signed by employee L, RN. This document had a subcategory titled, "Visit Narrative" which stated, "AAOX3 [awake, alert, oriented] forgetful 96 yo [year-old] female who resides with her husband who also is in poor health. Upon arrival up to answer door. Requires frequent rest periods with activity. Has cane but, no [sic] using at present. States she experiences dizziness especially with sudden movement. No edema [swelling] present to BLE [bilateral lower extremities] [both legs], toes warm pink PP+. Lungs clear, slight SOBOE [shortness of breath on exertion]. Abd. [abdomen] soft denies abd. pain appetite fair, Voiding freely, occasional stress		Patient #6/Employee A – The Alternate Clinical Supervisor individually met with Employee A and re-educated on OASIS completion, accuracy, and documentation. The OASIS in Patient #6 was incorrectly filled out and indicated that patient was receiving IV or infusion therapy; that was not accurate. However, Employee A properly developed a plan of care for the patient, which did not include IV or infusion therapy. Patient #6/Employee L - The same issue of duplicate notes was discovered in Patient #6. Narrative notes did not match the weekly assessments and were not pertinent to each visit. The nurse failed to update the clinical assessment each visit. When asked about duplicate notes, Employee L admitted to copying and pasting notes. Employee L apologized and informed the Clinical Supervisor that her son had recently passed. The Clinical Supervisor offered condolences and worked with the employee in providing a more flexible schedule and additional time off if needed. Employee was instructed to keep open communication with the Clinical Supervisor. Employee was reassured that refusing an assignment was not a problem. However, once an assignment is accepted, quality and safe care	

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	incont.[incontinence]. Skin remains intact. No falls reported. No s/s [signs / symptoms] of covid-19 exposure." This visit note contained a subcategory titled, "Respiratory", in which "No problems identified" was indicated. The skilled nurse failed to update the clinical assessment each visit as evidenced by multiple duplicate assessment narratives as evidenced below. Clinical record review evidenced an agency document titled, "SN OBSERVATION & ASSESSMENT VISIT", dated 8/18/2021, signed by employee L, RN. This document had a subcategory titled, "Visit Narrative" which stated, "AAOX3 [awake, alert, oriented] forgetful 96 yo [year-old] female who resides with her husband who also is in poor health. Upon arrival up to answer door. Requires frequent rest periods with activity. Has cane but, no [sic] using at present. States she experiences dizziness especially with sudden movement. No edema [swelling] present to BLE [bilateral lower extremities][both legs], toes warm pink PP+. Lungs clear, slight SOBOE [shortness of breath on exertion]. Abd. [abdomen] soft denies abd. pain appetite fair, Voiding freely, occasional stress incont. [incontinence]. Skin remains intact. No falls reported. No s/s [signs / symptoms] of covid-19 exposure." This visit note contained a subcategory titled, "Respiratory", in which "No problems identified" was indicated. Clinical record review evidenced an agency document titled, "SN TEACHING / TRAINING VISIT", dated 8/25/2021, signed by employee L, RN. This document had a subcategory titled, "Visit Narrative" which stated, "AAOX3 [awake, alert, oriented] forgetful 96 yo [year-old] female		must be provided with proper documentation in accordance with accepted professional standards. Employee verbalized understanding and agreement. A written letter of reprimand has been placed in Employee L's file. Patient #6 – The Clinical Supervisor made a supervisory visit on 2/24/21 to evaluate nurse and ensure accurate patient assessment. All nursing notes for Employee L have been reviewed and all notes, from the week of 2/14/21 onward, are accurate and pertinent. The Clinical Supervisor reviewed the agency policy titled " Care Planning Process", revised March 2018. On 3/8/21, the Clinical Supervisor inserviced all Agency staff on the requirement: All clinical records must contain pertinent past and current findings in accordance with accepted professional standards and must be maintained for every patient, including signed and dated clinical notes contributed to by all assigned personnel and must contain pertinent findings in accordance with accepted professional standards. Clinical notes shall be written the day service is rendered and incorporated in chart within fourteen (14) days.	

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	who resides with her husband who also is in poor health. Upon arrival up to answer door. Requires frequent rest periods with activity. Has cane but, no [sic] using at present. States she experiences dizziness especially with sudden movement. No edema [swelling] present to BLE [bilateral lower extremities][both legs], toes warm pink PP+. Lungs clear, slight SOBOE [shortness of breath on exertion]. Abd. [abdomen] soft denies abd. pain appetite fair, Voiding freely, occasional stress incont.[incontinence]. Skin remains intact. No falls reported. No s/s [signs / symptoms] of covid-19 exposure." This visit note contained a subcategory titled, "Respiratory", in which "No problems identified" was indicated. During an interview on 2/15/2021 at 3:25 p.m., the alternate administrator indicated the narrative in a nurse's note should include what happened during that particular visit. When informed of the findings, he stated, "they copied and pasted those". The alternate administrator indicated the narrative notes did not match the daily assessments and were not pertinent to each days' visit. 3. Clinical record review for patient #6, primary diagnosis hypertensive heart disease with heart failure, start of care 12/31/2020 and certification period 12/31/2020 to 2/28/2021, evidenced an agency document titled "OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health]-D1 Start of Care", dated 12/31/2020 and signed by employee A, RN, clinical manager. This document had a subcategory titled, "Therapies the Patient Receives at Home". In this section, the box indicating "1-Intravenous or infusion therapy (excludes TPN) [total parenteral nutrition][feeding intravenously]" was marked with a check-mark.		Inservice included specific training on documentation of visit notes, in which skilled staff must document modifications to care / service, current problems, interventions and short-term goals; individualized. Visit notes will be revised as problems are identified. Review and revisions will be ongoing with each home visit and will be based on patient's health status, environment, and relevant baseline data from assessments to determine current needs, problems, interventions and goals. Visit notes will reflect goal evaluation/goal resolution. The skilled nurses must update the clinical assessment each visit, and the narrative and intervention notes must match a pertinent current assessment of the patient. Inservice also included specific training on documentation of appropriate comprehensive assessment. The assessment will reflect the patient's current health status and include information to demonstrate the patient's progress toward achievement of desired outcomes. 100% of active records were audited by the QAPI team to ensure that clinical records contain pertinent findings in accordance with accepted professional standards.	

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	Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician, and dated 2/11/2021. This plan of care failed to evidence any intravenous or infusion therapy. During an interview on 2/15/2021 at 3:28 p.m., the alternate administrator indicated the documentation on the OASIS assessment was an error. The patient was not receiving intravenous therapy. Clinical record review of the OASIS start of care also evidenced a subcategory titled, "Admission Summary / F2F [face to face] Addendum", which stated, "Visit Narrative AAO X 3 [awake, alert and oriented] obese male who resides alone. Intermittent family assistance. Upon arrival sitting in chair, clear appearance, difficulty with mobility due to obesity. Demonstrates weakness/ poor endurance. C/O [complains of] aching in Lumbar and legs with [sic] further limits mobility. Lungs clear, SOBOE [short of breath on exertion] requires frequent rest periods. Use of Nebulizer Tx [treatment] PRN [as needed]. HR [heart rate]regular rate Hx [history] HTN [hypertension] has been difficult to control with current medication. Edema 2+ pitting BLE [bilateral lower extremities][both legs] which has had gradual increase. F/U [follow-up] MD appt. schedule. C/O legs feel heavy. Diabetic foot inspection per protocol, no problem identified. Denies hyper/hypoglycemia [high or low blood sugar]. Lungs clear all fields SOBOE Abd. [abdomen] soft BS [bowel sounds] active. Voiding freely, occasional stress incont. [incontinence]. Skin remains intact.		20% of clinical records will be audited quarterly to ensure that clinical records contain pertinent findings in accordance with accepted professional standards. The data will be included in quarterly Clinical Record Review report as a part of QAPI activities. The Clinical Supervisor will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	Clinical record review evidenced an agency document titled "SN [skilled nurse] TEACHING / TRAINING VISIT", dated 1/6/2021, signed by employee L, RN [registered nurse]. This nurse's note contained a subcategory titled "Visit Narrative", which stated, "AAO X 3 [awake, alert and oriented] obese male who resides alone. Intermittent family assistance. Upon arrival sitting in chair, clear appearance, difficulty with mobility due to obesity. Demonstrates weakness/ poor endurance. C/O [complains of] aching in Lumbar and legs with [sic] further limits mobility. Lungs clear, SOBOE [short of breath on exertion] requires frequent rest periods. Use of Inhaler PRN [as needed]. HR [heart rate]regular rate Hx [history] HTN [hypertension] has been difficult to control with current medication. Edema 2+ pitting BLE [bilateral lower extremities][both legs] which has had gradual increase. F/U [follow-up] MD appt. schedule. C/O legs feel heavy. Diabetic foot inspection per protocol, no problem identified. Denies hyper/hypoglycemia [high or low blood sugar]. Lungs clear all fields SOBOE Abd. [abdomen] soft BS [bowel sounds] active. Voiding freely, occasional stress incont. [incontinence]. Skin remains intact." This assessment had a subcategory titled, "Respiratory" which indicated, "No problems identified". This assessment did not indicate the patient had edema. This assessment did not indicate the patient had stress incontinence. The skilled nurse failed to update the clinical assessment each visit as evidenced by multiple duplicate assessment narratives as evidenced below. Clinical record review evidenced an agency document titled "SN [skilled nurse] TEACHING / TRAINING VISIT", dated 1/13/2021, signed by			

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	employee L, RN [registered nurse]. This nurse's note contained a subcategory titled "Visit Narrative", which stated, "AAO X 3 [awake, alert and oriented] obese male who resides alone. Intermittent family assistance. Upon arrival sitting in chair, clear appearance, difficulty with mobility due to obesity. Demonstrates weakness/ poor endurance. C/O [complains of] aching in Lumbar and legs with [sic] further limits mobility. Lungs clear, SOBOE [short of breath on exertion] requires frequent rest periods. Use of Inhaler PRN [as needed]. HR [heart rate]regular rate Hx [history] HTN [hypertension] has been difficult to control with current medication. Edema 2+ pitting BLE [bilateral lower extremities][both legs] which has had gradual increase. F/U [follow-up] MD appt. schedule. C/O legs feel heavy. Diabetic foot inspection per protocol, no problem identified. Denies hyper/hypoglycemia [high or low blood sugar]. Lungs clear all fields SOBOE Abd. [abdomen] soft BS [bowel sounds] active. Voiding freely, occasional stress incont. [incontinence]. Skin remains intact." This assessment had a subcategory titled, "Respiratory" which indicated, "No problems identified". This assessment did not indicate the patient had edema. This assessment did not indicate the patient had stress incontinence. During an interview on 2/15/2021 at 3:25 p.m., the alternate administrator indicated the narrative in a nurse's note should include what happened during that particular visit. When informed of the findings, he stated, "they copied and pasted those". The alternate administrator indicated the narrative notes did not match the daily assessments and were not pertinent to each days' visit. Review of the clinical nurse's note dated 1/6/2021,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157600	A. BUILDING 00 B. WING	02/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME HEALTH CARE INC	9222 INDIANAPOLIS BLVD UNIT A HIGHLAND, IN 46322

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	evidenced a subcategory titled "Interventions", which stated, "Skilled nursing assessment performed. Vital signs checked and recorded. Piccline [a long-term IV access] dressing changed and patient tolerated the procedure. Noted no signs of infection to the site such as redness and pain. No fever noted also." Review of the clinical nurse's note dated 1/13/2021 evidenced a subcategory titled "Interventions", which stated, " ... Skilled nursing assessment performed. Vital signs checked and recorded. Piccline [a long-term IV access] dressing changed and patient tolerated the procedure. Noted no signs of infection to the site such as redness and pain. No fever noted also." During an interview on 2/15/2021 at 3:30 p.m., the alternate administrator indicated the intervention notes were copied and pasted, and the patient did not have a picc line. The alternate administrator indicated the nurse failed to document a pertinent current assessment of the patient.			