| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K091 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/09/2022 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HELP AT HOME SKILLED CARE | 9025 COLDWATER RD STE 400, FORT WAYNE, IN, 46825 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| G0000 | This visit was for a Federal Recertification of a home health agency. A State Re-licensure and complaint investigation survey was conducted in conjunction with the recertification survey.<br><br>The federal survey was partially extended on 2/07/2022 at 1:05 PM.<br><br>Complaint Number 29541 / IN00317234: Unsubstantiated: Lack of sufficient evidence<br><br>Survey Dates: January 31, and February 1, 2, 7, 8, 9, 2022<br><br>QA by Area 2 supervisor | G0000 | N/A | 2022-04-25 |
| N0000 | Initial Comments<br><br>This visit was for a State Re-licensure and complaint investigation survey, which was conducted in conjunction with the | N0000 | N/A | 2022-04-25 |

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| | federal recertification survey.<br><br>Complaint Number 29541 / IN00317234: Unsubstantiated: Lack of sufficient evidence<br><br>Survey Dates: January 31, and February 1, 2, 7, 8, 9, 2022<br><br>QA by Area supervisor | | | |
| N0458 | Home health agency administration/management<br><br>410 IAC 17-12-1(f)<br><br>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:<br><br>(1) Receipt of job description.<br><br>(2) Qualifications.<br><br>(3) A copy of limited criminal history pursuant to IC 16-27-2.<br><br>(4) A copy of current license, certification, or registration.<br><br>(5) Annual performance evaluations.<br><br>Based on record review and interview, the agency failed to ensure personnel records were current and complete for 2 of 4 personnel files reviewed of agency registered nurses (Employees J and K).<br><br>Findings include:<br><br>Personnel record review was | N0458 | 1. Administrator/designee to audit all internal personnel files to ensure current documentation of job description, job qualifications, copy of criminal background check, copy of current license, certification, or registration, and annual performance evaluation by 3/31/22. The audit data will be implemented into the QAPI program and will be monitored quarterly for process improvement needs.<br><br>2. The Administrator/designee will review all personnel files upon hire to ensure complete documentation and filing of job description, job qualifications, copy of criminal background check, copy of current license, certification, or registration. Administrator/designee will review annual evaluations and ensure proper filing within the personnel file.<br><br>3. The Administrator will be responsible for ensuring proper maintenance of personnel files.<br><br>4. This deficiency will be completed by 3/31/22. | 2022-03-31 |

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| | conducted on 02/7/2022, 02/8/2022, and 02/9/2022 and failed to evidence the following within the employee records:<br><br>Review of personnel record of employee J, a registered nurse [RN], with date of hire [DOH] 3/16/2020 and 1st patient contact of 5/10/2021, failed to evidence verification of a current nursing license, a national criminal background check and acknowledgement of receipt or signed job description upon hire, and an annual evaluation.<br><br>Review of personnel file of employee K, a RN, with DOH 02/19/2021 and 1st patient contact of 5/16/2021, filed to evidence verification of a current nursing license and an acknowledgement of receipt or signed job description upon hire.<br><br>During an interview on 2/8/2022 at 1:32 p.m., Employee A, Administrator, confirmed the agency did not have complete personnel records on site.<br><br>During an interview at the exit conference on 2/9/2022 at 1:09 p.m., Employee A, Administrator, confirmed additional personnel records were unavailable. | | | |
| G0572 | Plan of care | G0572 | | 2022-04-25 |

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| | 484.60(a)(1)<br><br>Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan.<br><br>Based on observation, interview, and record review, the agency failed to ensure patients received services as ordered by the physician on the plan of care in 4 of 7 records reviewed (#1, 4, 5, and 7).<br><br>Findings include:<br><br>1. During a home observation with patient #1, on 02/01/2022 at 8:44 a.m., employee G, a registered nurse, and employee M, a home health aide were present. Patient #1 was observed in the room playing with their toys; patient #1 was not wearing a helmet or head protection during the visit.<br><br>A record review for Patient #1 was completed on 02/02/2022. The record included a document titled Home Health Certification/ Recertification Plan of Care Order for the certification period 12/04/2021 to 02/01/2022, with a diagnosis of, but not limited to, seizure disorder and included physician orders for staff to ensure the patient & wears a helmet on waking hours.<br><br>Record review evidenced an | | 1. Administrator/designee educated all RN Case Managers on 'Medical Record Content' policy on 3/1/22 which includes what is contained in a medical record, as well as 'Nursing documentation of client assessment' policy which includes requirements of nurse documentation and follow-up. Administrator/designee initiated 100% medical record audit on 3/7/22 and completed on 3/15/22 to validate if physician orders were written as applicable to the patient's needs, and if orders were being carried out appropriately by staff including; following of physician ordered tasks and procedures, and following of physician ordered frequency and duration. The completed audit tool will be incorporated into Q1 2022 QAPI data and analyzed throughout Q2 2022 for continued improvement and maintenance of medical records. All RN Case Managers were placed on a Performance Improvement Plan which outlines their deficiencies and the need for complete and accurate plans of cares per client by April 25th, 2022.<br><br>2. Administrator/designee will complete a 20% audit on all RN Case Managers census on a quarterly basis to ensure documentation and medical record requirements are met. 1:1 education will be provided to those who do not meet standards. Those who do not meet standards will send 50% of their recertifications for review until 100% compliance is met. Once 100% compliance is met, they will once again be audited on a quarterly basis.<br><br>3. The Administrator/designee will be responsible for completion of the auditing requirements, as well as 1:1 education with those who do not meet the requirement.<br><br>4. This deficiency will be corrected by April 25th, 2022. | |

agency document titled Plan of Care Service Plan for certification period 12/04/2021 to 02/01/2022, and included instructions for the home health aide to ensure the patient had & Helmet on when awake.

During an interview on 2/8/2022 at 2:16 p.m., employee A, the administrator, confirmed the home health aide should ensure the patient wore the helmet during waking hours.

2. A record review for Patient #4 was completed on 2/4/2022. The record included a document titled Home Health Certification/ Recertification Plan of Care Order for the certification period 12/16/2021 to 02/13/2022 which included the diagnosis, but not limited to, fibromyalgia (a condition causing pain all over the body, sleep problems, fatigue, depression and anxiety, sleep problems, headaches, and problems with thinking, memory, and concentration). The Plan of Care included physician order for home health aide services 8 hours per day, five days a week, to provide assistance with showering, hair care, dressing, nail care, meal preparation, and light housekeeping. The record failed to evidence aide services were provided to the the patient from 12/16/2021 to 12/31/2021.

During an interview on 02/8/2022 at 2:00 p.m., employee A, the

administrator, confirmed the patient did not receive the services as ordered on the plan of care and relayed the assigned home health aide died and the agency was unable to provide the ordered services.

3. A record review for Patient #5 was completed on 02/07/2022, and included document titled Home Health Certification/ Recertification Plan of Care Order for certification period 12/17/2021 to 02/14/2022 with an order for home health aide services 5 hours a day, 3 days a week for assistance with mobility, showering, hair care, dressing, oral care, skin care, and meal preparation. Diagnosis included, but not limited to, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).

The record failed to evidence aide services were provided after day 1 of the certification period. Services were provided only on 12/17/2021 [day one of the certification period].

During an interview on 02/08/2022 at 1:54 p.m., Employee A, the administrator, confirmed the visits were missed due to staffing issues.

4. A record review for Patient #7 was completed on 02/07/2022. The record included document titled Home Health Certification/

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| | for the recertification period 12/8/2021 to 02/05/2022 which evidenced a start of care date of 02/11/2021. The plan of care included the diagnosis of Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of nerves, which results in nerve damage that disrupts communication between the brain and the body) and paraplegia (paralysis of the legs and lower body). The plan of care included an order for home health aide care services for 2-hour visits twice daily, 7 days a week, to aid with bathing, dressing, transferring (moving from wheelchair to bed, for example), and meal preparation.<br><br>The record failed to evidence a second visit was provided on dates December 12, 19, 26, 2021 and on January 9, and 30, of 2022.<br><br>During an interview on 02/08/2022 at 2:05 p.m., Employee A, the administrator, confirmed the patient did not receive the aide services as ordered and relayed the agency did not have the staff available for the missed shifts / hours.<br><br>410 IAC 17-13-1(a) | | | |
| G0592 | Revised plan of care<br><br>484.60(c)(2)<br><br>A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals | G0592 | 1. Administrator/designee educated all RN Case Managers on 'Medical Record Content' policy on 3/1/22 which includes what is contained in a medical record, as well as 'Nursing documentation of client assessment' policy which includes requirements of nurse documentation and follow-up such as updating of the comprehensive assessment with patient recertifications and changes in patient condition | 2022-04-25 |

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| | identified by the HHA and patient in the plan of care.<br><br>Based on record review and interview, the agency failed to ensure the plan of care was accurate and reflected the most recent comprehensive assessment in 1 of 2 clinical records reviewed that received skilled nursing services (Patient #6).<br><br>The findings include:<br><br>Review of an agency policy dated 1/04/2022, titled Plan of Care indicated & agency must promptly alert the physician of any changes in the client s condition & that suggests & the plan of care should be altered &.<br><br>Review of document titled Recertification / Follow-Up Assessment, completed by Employee H, a RN (registered nurse) and dated 12/02/2021 included documentation that the patient was assessed and had one (1) unhealed pressure ulcer / injuries [injury to the skin and tissues from pressure] at a Stage 3 [a break in the top two layers of skin to the fatty tissue below].<br><br>The clinical record for patient #6 was reviewed on 02/03/2022. The record included document titled Home Health Certification and Plan of Care for the certification period 12/06/2021 to 02/03/2022 which included but not limited to the diagnoses of a pressure ulcer [injury to the skin and tissues from pressure] at | | and/or status such as new or worsening wounds. Administrator/designee initiated 100% medical record audit on 3/7/22 and completed on 3/15/22 to validate if physician orders were written as applicable to the patient's needs, and if orders were being carried out appropriately by staff including; following of physician ordered tasks and procedures, and following of physician ordered frequency and duration. The completed audit tool will be incorporated into Q1 2022 QAPI data and analyzed throughout Q2 2022 for continued improvement and maintenance of medical records. All RN Case Managers were placed on a Performance Improvement Plan which outlines their deficiencies, and the need for updated comprehensive assessments as applicable.<br><br>2. Administrator/designee will complete a 20% audit on all RN Case Managers census on a quarterly basis to ensure documentation and medical record requirements are met. 1:1 education will be provided to those who do not meet standards. Those who do not meet standards will send 50% of their recertifications for review until 100% compliance is met. Once 100% compliance is met, they will once again be audited on a quarterly basis.<br><br>3. The Administrator/designee will be responsible for completion of the auditing requirements, as well as 1:1 education with those who do not meet the requirement.<br><br>4. This deficiency was corrected on 4/25/2022. | |

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| | stage 2 [a break in the top two layers of skin. The plan of care failed to evidence a revision and to include the stage 3 wound as identified and documented on the Recertification Assessment, dated 12/02/2021.<br><br>During an interview on 2/07/2022 at 4:00 PM, the administrator indicated the nurse entered the incorrect staging of the pressure ulcer in the plan of care. | | | |
| G0706 | Interdisciplinary assessment of the patient<br><br>484.75(b)(1)<br><br>Ongoing interdisciplinary assessment of the patient;<br><br>Based on record review and interview, the skilled nurse failed to follow the plan of care for 1 of 2 clinical records reviewed receiving skilled nursing services (Patient #6).<br><br>Findings include:<br><br>Review of an agency policy dated 1/04/2022, titled Plan of Care indicated & the plan of care/treatment shall & include all services to be provided if a skilled service is being provided &.<br><br>The clinical record of patient #6, with start of care date 02/09/2021, was reviewed on 2/07/2022. The record included a document titled Home Health Certification and Plan of Care" for the certification period | G0706 | 1. Administrator/designee educated all RN Case Managers on 'Medical Record Content' policy on 3/1/22 which includes what is contained in a medical record including the client's plan of treatment to be followed. All RN Case Managers and all RN and LPN field nurses were educated on the 'Nursing documentation of client assessment' policy which includes requirements of nurse documentation and follow-up such as updating of the comprehensive assessment with patient recertifications and changes in patient condition and/or status such as new or worsening wounds. All RN Case Managers and all RN and LPN field nurses were educated on the 'Head to toe assessment' in service which includes how to assess a patient and following of physician orders such as with wound care. Administrator/designee initiated 100% medical record audit on 3/7/22 and completed on 3/15/22 to validate if physician orders were written as applicable to the patient's needs, and if orders were being carried out appropriately by staff including; following of physician ordered tasks and procedures, and following of physician ordered frequency and duration. The completed audit tool will be incorporated into Q1 2022 QAPI data and analyzed throughout Q2 2022 for continued improvement and maintenance of medical records. All RN Case Managers were placed on a Performance Improvement Plan on 3/22/22 which outlines their deficiencies and need for all comprehensive assessments to be uploaded by 4/25/22. | 2022-04-25 |

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| | 12/06/2021 to 02/03/2022 with skilled nurse orders that included but not limited to & RN [registered nurse] orders & 7 d/week [7 days a week] ... for VS [vital signs], full body assessment [head to toe physical exam], ADLs / IDLs [tasks of everyday life such as eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet] & pressure wound [injury to the skin and tissues from pressure] & SN [skilled nurse] to remove old dressing & cleanse daily & apply Drawtex [wound dressing] & cover with Superabsorber [wound dressing] & notify MD [physician] of worsening wound symptom &.<br><br>Review of an agency document titled Recertification/Follow-Up Assessment, completed by Employee H, a RN, dated 02/01/2022 and relayed employee H visited the patient and no wound care was completed. The documentation included but not limited to, & wound care done during this visit & no & size (cm) [measurement of length] (L x W x D) [length and width and depth of a wound] & 1 cm x 1 cm x 3 cm & tunneling [wound that tunnels underneath the skin] & length 3 cm & surrounding skin & pink and no signs of infection & drainage/amount & small & color & clear & consistency & thin &. The nurse visit note failed to evidence the wound care was completed as ordered on the plan care.<br><br>During an interview on 2/07/2022 at | | 2. Administrator/designee will complete a 20% audit on all RN Case Managers census on a quarterly basis to ensure documentation and medical record requirements are met. 1:1 education will be provided to those who do not meet standards. Those who do not meet standards will send 50% of their recertifications for review until 100% compliance is met. Once 100% compliance is met, they will once again be audited on a quarterly basis.<br><br>3. The Administrator/designee will be responsible for completion of the auditing requirements, as well as 1:1 education with those who do not meet the requirement.<br><br>4. This deficiency will be corrected by 4/25/22. | |

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| | how he / she determined the wound characteristics and measurements as documented on the Recertification Assessment as employee H documented, on same assessment, that he / she did not complete the wound care during the visit. Employee H relayed that another nurse made a visit to the patient, on that date and performed the wound care, and must have left a note for employee H with the wound characteristics.<br><br>Review of agency documents titled "Skilled Nursing Visit Note," completed by Employee K, a RN, and dated 12/11/2021, 12/25/2021, 1/15/2022, 1/16/2022, 1/29/2022 and 1/30/2022 failed to evidence the patient's wound was assessed or that wound care was provided during the visits.<br><br>During an interview on 2/07/2022 at 1:50 PM, the administrator indicated the nurse should have documented the assessment and care provided within the nurse visit note. | | | |
| G0798 | Home health aide assignments and duties<br><br>484.80(g)(1)<br><br>Standard: Home health aide assignments and duties.<br><br>Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).<br><br>Based on record review and interview, the registered nurse (RN) | G0798 | 1. Administrator/designee educated all RN Case Managers on 'Medical Record Content' policy on 3/1/22 which includes what is contained in a medical record including the client's plan of treatment to be followed which includes the client's individualized home health aide service plan. On 3/1/22 all RN Case Managers were educated on the 'Home health aide care service plan' policy which includes requirements that documentation of individualized care for the client's specific needs. Administrator/designee initiated 100% medical record audit on 3/7/22 and completed on 3/15/22 to validate if all service plans were individualized to the client with specified tasks and frequencies. The | 2022-04-25 |

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| | failed to ensure the home health aide [HHA] care plans were appropriate and specific to the needs of the patient for 1 of 6 clinical records reviewed with HHA services (Patient #2).<br><br>Findings include:<br><br>The agency policy dated 1/04/2022, and titled Home Health Aide Care Service Plan was reviewed and indicated & a complete and appropriate Care Service Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse & provide a means of assigning duties to the Home Health Aide that are clear & provide documentation that the client s care is individualized to his/her specific needs &.<br><br>Clinical record review for patient #2 was conducted on 02/01/2022. The record indicated a start of care date of 9/14/2021 and included the document Plan of Care Service Plan for the certification period 01/12/2022 to 3/12/2022. The plan of care included the home health aide tasks to be provided and included, but not limited to, medication reminder(s), patient oral care, patient nail care, laundry, and general cleaning of living areas. The plan of care failed to evidence a frequency in which the aide was to provide these services with or for the patient. | | completed audit tool will be incorporated into Q1 2022 QAPI data and analyzed throughout Q2 2022 for continued improvement and maintenance of medical records. All RN Case Managers were placed on a Performance Improvement Plan on 3/22/22 which outlines their deficiencies and the need for updating of all service plans with individualized tasks and frequencies by 4/25/22.<br><br>2. Administrator/designee will complete a 20% audit on all RN Case Managers census on a quarterly basis to ensure documentation and medical record requirements are met. 1:1 education will be provided to those who do not meet standards. Those who do not meet standards will send 50% of their recertifications for review until 100% compliance is met. Once 100% compliance is met, they will once again be audited on a quarterly basis.<br><br>3. The Administrator/designee will be responsible for completion of the auditing requirements, as well as 1:1 education with those who do not meet the requirement.<br><br>4. This deficiency will be corrected by4/25/22. | |

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| | During an interview on 2/07/2022 at 4:45 PM, the administrator indicated the HHA care plan should have a frequency entered for each task. | | | |
| G1012 | Required items in clinical record<br><br>484.110(a)(1)<br><br>The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders;<br><br>Based on record review and interviews, the agency failed to ensure patient records contained the current comprehensive assessment(s) for 2 of 5 active records reviewed (Patients #2 and 3) and failed to ensure patient records included the skilled nurse visit notes for 1 of 2 active records reviewed with orders for skilled nursing (Patients #6 ).<br><br>Findings include:<br><br>Review of an agency policy titled Confidentiality Notices revealed the necessity of medical information to & be accurate, timely, complete, and available &.<br><br>Review of an agency policy titled Medical Record Content revealed Clinical notes are incorporated into the clinical record within fourteen (14) days.<br><br>A record review for Patient #7 was completed on 2/7/2022, start of care date 2/11/2021, revealed a schedule with skilled nursing services on 12/21/2021 and 1/12/2022. The record failed to evidence the nursing notes in the medical record.<br><br>During an interview on 12/9/2022 at 11:15 a.m., Employee A, administrator, confirmed the notes | G1012 | 1. Administrator/designee educated all RN Case Managers on 'Medical Record Content' policy on 3/1/22 which includes what is contained in a medical record such as all comprehensive assessments, clinical notes, plans of cares, and physician orders which includes ordered frequency and duration and all care tasks to complete, as well as appropriate and timely filing. All RN Case Managers were educated on 'Nursing documentation of client assessment' policy which includes requirements of nurse documentation and follow-up. Administrator/designee initiated 100% medical record audit on 3/7/22 and completed on 3/15/22 to validate if physician orders were written as applicable to the patient's needs, and if orders were being carried out appropriately by staff including; following of physician ordered tasks and procedures, and following of physician ordered frequency and duration. The completed audit tool will be incorporated into Q1 2022 QAPI data and analyzed throughout Q2 2022 for continued improvement and maintenance of medical records. All RN Case Managers were placed on a Performance Improvement Plan which outlines their deficiencies and the need for complete and accurate plans of cares, physician orders, and validation physician orders are being carried out appropriately per client by 4/25/22.<br><br>2. Administrator/designee will complete a 20% audit on all RN Case Managers census on a quarterly basis to ensure documentation and medical record requirements are met. 1:1 education will be provided to those who do not meet standards. Those who do not meet standards will send 50% of their recertifications for review until 100% compliance is met. Once 100% compliance is met, they will once again be audited on a quarterly basis.<br><br>3. The Administrator/designee will be responsible for completion of the auditing requirements, as well as 1:1 education with those who do not meet the requirement. | 2022-04-25 |

were not in the medical record.

410 IAC 17-15-1(a)(3,4)

A record review for Patient #2, the start of care date 9/14/2021, was reviewed on 2/01/2022 for the certification period of 1/12/2022 - 3/12/2022. The clinical record failed to evidence the comprehensive assessment for this certification period was incorporated into the record within 14 days.

During an interview on 2/02/2022 at 10:15 AM, Employee A, administrator indicated would check with the nurse to find the comprehensive assessment. At 10:25 AM, Employee H, RN [registered nurse] provided a copy of the 1/11/2022 comprehensive assessment.

A record review for Patient #3, the start of care date 12/12/2016, was reviewed on 2/02/2022 for the certification period of 1/15/2022 3/15/2022. The clinical record failed to evidence the comprehensive assessment for this certification period was incorporated into the record within 14 days.

During an interview on 2/02/2022 at 10:15 AM, the administrator indicated would check with the nurse to find the comprehensive assessment. At 10:25 AM, the administrator indicated Employee G, RN will upload the 1/10/2022

4. This deficiency will be corrected by 4/25/22.

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| | clinical record that day.<br><br>A record review for Patient #6, the start of care date 2/09/2021, was reviewed on 2/07/2022 and contained a plan of care for the certification period of 12/06/2021 2/03/2022, with orders for Skilled Nurse services 3 hours daily for 7 days a week starting on 12/06.2021. Order dated 12/30/2021 indicated a change in Skilled Nurse service to 3 hours daily for 5 days a week. Order dated 1/27/2022 indicated a change in Skilled Nurse service to 3 hours daily for 7 days a week. The record failed to evidence skilled nursing visit notes for 37 days of service.<br><br>During an interview on 2/07/2022 at 12:45 PM, the administrator indicated the missing skilled nurse visit notes had not been turned into the agency by the skilled nurse. | | | |
| G1028 | Protection of records<br><br>484.110(d)<br><br>Standard: Protection of records.<br><br>The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164.<br><br>Based on observation, interview, and agency document, the agency failed to follow their agency policy and ensure the patient records, which were of paper, were secured, for 1 of 1 agency with the potential to effect | G1028 | 1. Administrator/designee ensured all filing and storage cabinets containing client information were locked and behind a locked office door on 2/10/22 and only the Administrator/designee to have key to access the filing and storage cabinets.<br><br>2. Administrator/designee will complete spot checks on filing and storage cabinets containing client information to ensure the cabinets are in fact locked and behind a locked office door at all times.<br><br>3. The Administrator/designee will be responsible for ensuring the filing and storage cabinets containing client information are locked. | 2022-02-10 |

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| | all patients.<br><br>Findings include:<br><br>1. Review of the agency Patient Admission Booklet included but not limited to, Section III. Patient Rights and Responsibilities, which relayed the patient's right to & Have a confidential clinical record & All confidential client information, whether it be paper & is stored & behind two locks.<br><br>2. Review of the agency document titled, Notice of Privacy Practices included a statement that the agency was & legally required to protect the privacy of your medical information."<br><br>3. During a tour of the agency on 1/31/2022 at 10:45 a.m., Employee A, the Administrator, opened an unlocked metal cabinet which revealed paper medical records. The cabinet was unlocked.<br><br>4. During an interview on 1/31/2022 at 10:45 a.m., Employee A, the Administrator, confirmed the paper records observed were kept in unlocked cabinets in the nursing office, which was often left unlocked when the office was unoccupied.<br><br>410 IAC 17-15-1(c) | | 4. The deficiency was corrected on 2/10/22. | |
| G1030 | Retrieval of records<br><br>484.110(e) | G1030 | Administrator/designee updated the notice of Privacy Practices on 3/22/22 to reflect that a patient's medical record must be made | 2022-04-25 |

Standard: Retrieval of clinical records.

A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first).

Based on record review and interview, the agency failed to ensure patient's clinical records would be made available to the patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first) for all current and future patients.

The findings include:

Review of an agency document, dated 4/2021, and titled Notice of Privacy Practices for Protected Health Information included but not limited to & right to see and get copies of your medical information & we will respond to you within 30 days after receiving your written request & we will charge you a reasonable fee as permitted &.

During an interview on 02/01/2022 at 4:00 PM, the administrator indicated that information provided to patients did not meet the regulation.

410 IAC 17-12-3(b)(3)

available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). All RN Case Managers were placed on a Performance Improvement Plan on 3/22/22 which outlines their deficiencies and need for all clients to receive an updated 'Patient Orientation for Home Health Care' booklet by 4/25/22.

2. Administrator/designee will complete a 20% audit on all RN Case Managers census on a quarterly basis to ensure documentation and medical record requirements are met, including the filing of a new 'Patient Orientation for Home Health Care' booklet. 1:1 education will be provided to those who do not meet standards. Those who do not meet standards will send 50% of their recertifications for review until 100% compliance is met. Once 100% compliance is met, they will once again be audited on a quarterly basis.

3. The Administrator/designee will be responsible for completion of the auditing requirements, as well as 1:1 education with those who do not meet the requirement.

4. This deficiency will be corrected by 4/25/22.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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