STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K083	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURPOSE HOME HEALTH	**5455 HARRISON PARK LANE STE B , INDIANAPOLIS, Indiana, 46216**

(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
G0000	INITIAL COMMENTS This survey was for a Recertification, State Re-licensure, and Complaint survey of Purpose Home Health. The complaint investigation was initiated by the Indiana Department of Health. Complaint #62359: Substantiated; with findings Survey dates were 3/14/22 - 3/18/22. This report also reflects State findings in accordance with 410 IAC 17-12 et seq. QR by Area 3 on 3-31-2022	G0000	POC accepted on 4-13-2022 Deborah Franco	
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on record review, observation, and interview, the agency failed to implement their policy which required all patients received a complete and accurate medication review/reconciliation at admission, recertification; and with skilled visits for 6 of 12 active records reviewed. (Patient #2, 4, 6, 7, 8, 17) Findings include: 410 IAC 17-14-1(a)(1)(B) 1. A review of agency policy 3-145, titled Comprehensive Assessment," indicated the agency	G0536		

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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G0536	Continued from page 1 comprehensive assessment included "Medications, adverse events/reaction, reconciliation and follow up." 2. A review of agency policy #3-709, titled "Medication Reconciliation," indicated "Purpose Home Health will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, before and after inpatient facility stays, and at the time of discharge." Further review of the policy indicated "Medications will be reviewed with the client on each home visit to determine if other prescriptions or non-prescription drugs are being taken." 3. A review of the plan of care for Patient #4, for the certification period of 3/8/22 - 5/6/22, indicated the patient received "Humalog KwikPen Subcutaneous Solution Pen-injector, 100 unit/ml (milliliter)/100 unit/ml/sliding scale/subcutaneous/three times a day." The plan of care failed to include the patient's sliding scale doses for Humalog and failed to evidence the patient's physician was contacted to review medications. A review of the recertification comprehensive assessment, dated 3/3/22, failed to evidence the clinician completed a full medication review that included screening for new, discontinued, or changed medications; failed to evidence a review of all medications to determine concerns, including but not limited to, compliance, effectiveness, side effects, duplication, and knowledge of all medications ordered; failed to indicate the patient's sliding scale for insulin; and failed to indicate the patient's physician was contacted to review medications. 4. A review of the plan of care for Patient #6, for the certification period of 1/16/22 - 3/16/22, indicated orders for Antifungal External Cream 1%, 1 application/external/4 times every 1 day(s), apply to bilateral buttocks and posterior bilateral knees [for] redness and irritation, but failed to indicate the correct amount/dose for "1 application" of cream, and identify all sites, including but not limited to, under the breasts, sternum, and arm folds; azithromycin oral tablet 500mg (milligram), take 500mg once/day but failed to include duration of delivery, or when the mediation was discontinued; topiramate oral tablet 100mg, take 200mg orally twice a day; and nystatin powder, 1 application, topical, PRN (as needed) 1 time every 12 hours but failed to include the correct amount/dose for "1 application", the specified topical sites to apply the medication, and any PRN qualifier(s) such as "for yeast rash" or "for redness and itching. The plan of care failed to evidence the patient	G0536		

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G0536	Continued from page 2 received a complete review of all medications, including but not limited to, compliance, significant side effects, ineffective drug therapy, and addition/discontinuation/change of medications, and failed to indicate the physician was contacted to review medications. 5. A review of the plan of care for patient #7, for the certification period of 2/7/22 - 4/7/22, failed to evidence the patient received a review of all medications taken and failed to evidence the physician was contacted to review medications. A review of a skilled nurse visit note completed by employee BB, RN (Registered Nurse), dated 2/8/22, indicated the RN changed the site of the patient's Libre sensor (a small sensor for measuring blood sugar, applied externally to the skin), and "set up meds (medications) and insulin x2 weeks as ordered." The visit note failed to evidence the patient received a review of all medications that included determining new, discontinued, or changed medications; failed to evidence a review of all medications to determine concerns, including but not limited to, compliance, effectiveness, and side effects; and failed to evidence the patient's physician was contacted to review medications. A review of a skilled nurse visit note completed by employee CC, registered nurse (RN), dated 2/22/22, indicated the RN gave the patient an insulin injection, "set up medications and insulin x2 weeks," and applied a new Libre sensor to the patient's arm. The visit note failed to evidence the patient received a review of all medications as indicated in agency policy #3-70; and failed to evidence the patient's physician was contacted to review medications. A review of a skilled nurse visit note completed by employee CC, dated 3/8/22, indicated the RN provided "medications and insulin set up x2 weeks as ordered," gave an insulin injection, and changed the patient's Libre sensor. The visit note failed to evidence the patient received a review of all medications taken as indicated in agency policy #3-709; and failed to evidence the patient's physician was contacted to review medications. 6. A review of the plan of care for Patient #8, for the certification period of 2/11/22 - 4/11/22, failed to evidence the patient received a review of all medications that included new/discontinued/changed medications and failed to evidence a review of all medications to determine concerns, including but not limited to, compliance, effectiveness, side effects, duplication, and interactions; and failed to evidence the patient's physician was contacted to review medications. On 3/17/22 at 9:30 AM, the	G0536		

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G0536	Continued from page 3 patient's facility medication record was reviewed and indicated active medication orders for hydrocortisone cream, fluconazole, vitamin D3, and vitamin B12. The agency plan of care for the certification period 2/11/22 - 4/11/22 was compared to the patient's electronic medication profile provided by entity V (assisted living facility/ALF) and failed to include hydrocortisone, fluconazole, Vitamin D3, and Vitamin B12 included on the ALF electronic medical record as active medications. 7. On 3/17/22 at 12:10 PM employee A (administrator in training) and person A ,employee of entity DD [a consulting company] who was responsible for training employee A as administrator) were interviewed concerning the agency's policy and process for medication reviews. Person A indicated that medication reviews are done on admission, recertification, discharge/transfer, and any time a nurse makes a home visit. Person A stated the nurse calls the physician after the comprehensive assessment is completed, at which time all medications are reviewed for accuracy, changes, additions, and discontinuations. At this time the clinician was supposed to discuss any concerns, including but not limited to effectiveness, side effects, interactions, compliance, and any discrepancies identified, and document the contact. 8. The clinical record of Patient #2 was reviewed on 3-15-2022, with a start of care date of 1-18-22, and an initial certification period of 1-18-2022 to 3-18-2022. The record contained an agency document titled “Start of Care Assessment” dated 1-18-2022, and electronically signed by the RN, employee O. The initial comprehensive assessment contained a section subtitled “Respiratory” that indicated, “…Oxygen Flow Settings Nasal Cannula: 2 liters (l)…” The agency document titled “Medication Profile” failed to list Oxygen 2 liters per nasal cannula continuously. During a home visit on 3-17-2022 at 12:30 PM, Patient #2 was observed sitting upright in a recliner. The patient was observed with a nasal cannula in their nose with oxygen infusing. Patient #2 confirmed they were always on oxygen due to their lung issues. 9. The clinical record of Patient #17 was reviewed on 3-16-2022 with a start of care date of 12-22-20. The record contained a plan of care for the recertification period of 2-15-2022 to 4-15-2022. The record contained an agency document titled “Home Health	G0536		

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G0536	Continued from page 4 Certification and Plan of Care" dated 2-10-2022, and electronically signed by the RN, employee Z. The plan of care contained a section subtitled "60 Day Summary" that indicated but was not limited to, "… Patient continues to wear supplemental oxygen at 2 liters per minute intermittently to keep saturations above 90 percent…" The agency document titled "Medication Profile" failed to list Oxygen 2 liters per nasal cannula intermittently. During an interview on 3-17-2022 at 4:02 PM, patient #17 confirmed being on oxygen. 10. During an interview on 3-16-2022 at 11:30 AM, the administrator, and director of clinical services, when queried about Patient #4's insulin dose and sliding scale on the plan of care or medication profile, confirmed it was not listed on the plan of care or medication profile. 11. During a daily conference on 3-18-2022 at 12:20 PM, the administrator and clinical director confirmed that the RN should list all the medications the patient is taking on the medication profile.	G0536		
G0572	Plan of care CFR(s): 484.60(a)(1) 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure services were furnished as ordered for 6 (Patients 1, 2, 3, 14, 15, 16, and 17) of 12 patients whose clinical records were reviewed. 1. The clinical record of Patient #1 was reviewed on 3-15-2022, with a start of care date of 10-28-20. The record contained a plan of care for	G0572		

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G0572	Continued from page 5 the recertification period of 2-20-2022 to 4-20-2022. The plan of care included, but was not limited to, orders to provide home health aide (HHA) services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 2-20-22, for up to 1-hour visit 5-7 times per week for 9 weeks. 2. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee O, on 2-19-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: ambulation “stand by assist,” shower, partial bath, skincare, hair care, shaving-electric razor, dressing, foot care, assist with making bed/changing bed linens, removing clutter from pathways, empty trash, cleaning up soiled linens, clean up after any care is preformed, oral care, observe safety/seizure precautions, and fall risk precautions. Review of untitled documents for Patient #1, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee J, provided a partial bath and shaved with the electric razor on the following dates: 2-21, 2-22, 2-23, 2-24, 2-25, 2-28, 3-2, 3-3, 3-4, 3-7, 3-8, 3-9, 3-10, and 3-14-22. The HHA failed to provide services as directed in the aide care plan. During a home visit on 3-17-2022 at 9:00 AM, Patient #1 confirmed that they always receive showers never partial baths. Patient #1 further confirmed they will not allow the HHA to shave them. During an interview on 3-17-2022 at 9:05 AM, the HHA, employee J, when queried about Patient #1 refusing shave and partial bath confirmed that Patient #1 always refuses those tasks. When queried about care plan tasks and changes in a patient's condition confirmed the HHA is to let the RN case manager know. 3. The clinical record of Patient #2 was reviewed on 3-15-2022 with a start of care date of 1-18-22. The record contained a plan of care for the initial certification period of 1-18-2022 to 3-18-2022. The plan of care included but was not limited to orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 1-18-22, for up to 1 hour a visit for 3-5 times per week for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee O, on 2-4-22, the HHA	G0572		

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G0572	Continued from page 6 care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: a shower, partial bath, skincare, hair care, dressing, foot care, and light housekeeping. Review of untitled documents for Patient #2, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee L, provided a partial bath, shower, or hair care on the following dates: 1-18, 1-21, 1-24, 1-25, 1-26, 1-27, 1-28, 2-3, 2-4, 2-7, 2-8, 2-9, 2-10, 2-11, 2-14, 2-15, 2-16, 2-18, 2-21, 2-22, 2-23, 2-25, 2-28, 3-1, 3-2, 3-4, 3-7, 3-8, 3-9, 3-10, 3-11, 3-14, 3-15, 3-16, and 3-17-22. The HHA failed to provide services as directed in the aide care plan. 4. The clinical record of Patient #3 was reviewed on 3-15-2022 with a start of care date of 11-11-20. The record contained a plan of care for the recertification period of 3-6-2022 to 5-4-2022. The plan of care included but was not limited to orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 3-6-22, for up to 1 hour a visit for 1-2 times per week for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee O, on 3-2-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: ambulation, shower, partial bath, skincare, hair care, catheter care, dressing, fall risk precaution “report falls or injury,” foot care, light housekeeping, and oral care “denture care.” Review of untitled documents for Patient #3, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee K, provided a partial bath, catheter care, oral care on the following dates: 3-8, 3-10, 3-15, and 3-17-22. The HHA failed to provide services as directed in the aide care plan. During an interview on 3-17-2022 at 10:15 AM, Patient #3 confirmed they complete their own oral care and catheter care. 5. The clinical record of Patient #14 was reviewed on 3-16-2022 with a start of care date of 9-28-20. The record contained a plan of care for the	G0572		

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G0572	Continued from page 7 recertification period of 1-21-2022 to 3-21-2022. The plan of care included but was not limited to orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 1-21-22, for up to 1 hour a visit for 3-5 times per week for 9 weeks. A review of an agency document titled "Paraprofessional Assignment Sheet" electronically signed by the RN, employee X, on 1-20-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: transfer assist "bed to chair, walker," a shower, partial bath, peri care, oral care, ambulation "walker, touching assist," fall risk precautions, skin care, hair care, dressing, foot care, and light housekeeping. Review of untitled documents for Patient #14, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee K, provided a shower, or oral care on the following dates:1-24, 1-25, 1-26, 1-27, 1-28, 1-31, 2-1, 2-2, 2-7, 2-8, 2-10, 2-11, 2-14, 2-15, 2-16, 2-17, 2-22, 2-23, 2-24, 2-28, 3-1, 3-2, 3-3, 3-4, 3-8, 3-9, 3-10, 3-11, 3-14, 3-15, 3-16, and 3-17-22. The HHA failed to provide services as directed on the aide care plan. During an interview on 3-17-22 at 3:41 PM, patient #14 confirmed they would never take a shower due to vertigo and completed their denture care. Patient #14 further confirmed the HHA gives the patient a bed bath and then washes the patient's hair at the sink. 6. The clinical record of Patient #15 was reviewed on 3-16-2022 with a start of care date of 11-15-21. The record contained a plan of care for the recertification period of 1-14-2022 to 3-14-2022. The plan of care included but was not limited to orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 1-14-22, for up to 1 hour a visit for 5-7 times per week for 9 weeks. A review of an agency document titled "Paraprofessional Assignment Sheet" electronically signed by the RN, employee U, on 1-10-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: transfer assist "bed to chair, walker," a shower, partial bath, peri care, oral care, ambulation "walker, touching assist," fall risk	G0572		

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G0572	Continued from page 8 precautions, skin care, hair care, dressing, foot care, and light housekeeping. Review of untitled documents for Patient #15, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that employees Q, provided a shower on 1-19, failed to provide a shower or partial bath, and assist with feeding on 3-7-2022. The HHA, employee R, failed to provide to provide a shower or partial bath on the following dates: 1-20, 1-23, 1-27, 1-28, 2-5, 2-8, 2-14, 2-17, 2-19, 2-22, 2-23, 2-24, 3-3, 3-6, and 3-10-2022. The HHA, employee S, failed to provide a shower or partial bath on 1-21 and 2-20-2022. The HHA, employee T, failed to provide a shower or partial bath on the following dates: 1-22, 1-24, 1-25, 1-26, 1-29, 1-31, 2-1, 2-4, 2-7, 2-9, 2-10, 2-11, 2-12, 2-18, 2-21, 2-25, 2-26, 2-27, 2-28, 3-1, and 3-2-2022. The HHA, employee AA, failed to provide a shower or partial bath on 1-30-2022. The HHA, employee BB, failed to provide a shower or partial bath on 2-15, and 2-16-2022. The HHA, employee CC, failed to provide a shower or partial bath on 3-8, and 3-13, and failed to provide a shower on 3-9-2022. The HHA, employee DD, failed to provide a shower or partial bath on 3-11-2022. The HHA, employee EE, failed to provide a shower or partial bath on 3-14, and 3-15-2022. The HHAs failed to provide services as directed in the aide care plan. 7. The clinical record of Patient #16 was reviewed on 3-16-2022 with a start of care date of 10-19-21. The record contained a plan of care for the recertification period of 2-16-2022 to 4-16-2022. The plan of care included but was not limited to orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 2-16-22, for up to 1 hour a visit 1time per week for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee V, on 2-23-22, the HHA care plan indicated the tasks the HHA was to perform 5-7 days a week at every visit and tasks to perform as patient requests. The care plan included: transfer assist “uses an electric wheelchair cannot ambulate,” a shower, partial bath, peri care, oral care, ambulation “walker, touching assist,” fall risk precautions, skincare, hair care, dressing “help the patient put in hearing aid,” foot care, and light housekeeping. Review of untitled documents for Patient #16, included HHA tasks completed each	G0572		

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G0572	Continued from page 9 visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee W, provided a shower on the following dates: 2-15, 2-16, 2-17, 2-18, 2-19, 2-20, 2-21, 2-22, 2-23, 2-24, 2-25, 2-26, 2-27, 2-28, 3-1, 3-2, 3-4, 3-5, 3-6, 3-7, 3-8, 3-9, 3-10, 3-11, 3-12, 3-13, 3-14, and 3-15-2022. The HHA failed to provide services as directed on the aide care plan. 8. The clinical record of Patient #17 was reviewed on 3-16-2022 with a start of care date of 12-22-20. The record contained a plan of care for the recertification period of 2-15-2022 to 4-15-2022. The plan of care included but was not limited to orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 2-15-22, for up to 1 hour a visit 3-5 times per week for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee Z, on 2-11-22, the HHA care plan indicated the tasks the HHA was to perform at every visit and tasks to perform as patient requests. The care plan included: fall risk precaution, transfer assist, repositioning, oral care, housekeeping, dressing, shaving electric razor, hair care, skin care, partial bath, peri care, shower, and assist with ambulation. Review of untitled documents for Patient #17, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee Y, provided a shave on the following dates: 2-15, 2-17, 2-21, 2-22, 2-23, 2-24, 2-25, 2-28, 3-2, 3-3, 3-4, 3-7, 3-8, 3-9, 3-10, 3-11, 3-14, and 3-15-2022. The documents failed evidence documentation the employee Y provided a shower on the following dates: 2-15, 2-17, 2-21, 2-23, 2-24, 2-28, 3-1, 3-2, 3-3, 3-7, 3-8, 3-10, and 3-15-2022. The documents failed to evidence employee Y provided a partial bath on the following dates: 2-22, 2-25, 3-1, 3-4, 3-8, 3-11, and 3-14-2022. The HHA failed to provide services as directed in the aide care plan. During an interview on 3-17-2022 at 4:02 PM, Patient #17 confirmed he/he takes showers three times a week and is never to be shaved. The patient further confirmed showers are three times a week due to fear of falling and fainting when they stand up. 9. During an interview on 3-18-2022 at 12:20 PM, the administrator and clinical	G0572		

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G0572	Continued from page 10 director confirmed aides are to report changes to the RN case managers for changes/updates to the care plan to individualize the plan to address the patients' needs.	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.	G0574		

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G0574	Continued from page 11 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all patients received a complete and accurate plan of care that included all pertinent diagnoses, an accurate psychosocial status, the supplies and equipment required, rehabilitation potential, functional limitations, nutritional requirements, all medications/treatments, all safety measures, hospitalization risk, patient/caregiver education and training, individualized, patient-specific, and measurable goals, and additional items, such as discharge plans for 7 of 12 active records reviewed. (Patients #2, 4, 5, 6, 7, 8, 17) Findings include: 410 IAC 17-13-1(a)(1)(B)410 IAC 17-13-1(a)(1)(C)410 IAC 17-13-1(a)(1)(D)(i-xiii) 1. A review of agency policy #3-660, titled “Care Plans” indicated “The Care Plan shall include, but not be limited to: Nursing diagnosis(es)/problems and needs identified. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. A list of specific interventions with plans for implementation. Indicators for measuring goal achievement and identified time frames. The physician Plan of Care may be used as a care plan if specific interventions are clearly identified for home care staff to address client needs." 2. A review of the plan of care for Patient #4, for the certification period of 3/8/22 - 5/6/22, failed to include the patient's sliding scale for Humalog (a short acting injectable insulin); failed to indicate that Humalog is injected 15 minutes before meals or immediately after eating; failed to include PRN (as needed) qualifiers/indicators for interventions and medications ordered as needed; failed to include all DME (durable medical equipment) and supplies including lancets, glucometer strips, alcohol wipes, weekly medication box, and briefs/pads; failed to include all safety measures, functional limitations, and nutritional requirements including diabetic precautions, type of diet, and dyspnea with minimal exertion; failed to indicate all medications were reviewed; failed to include patient specific blood pressure and blood sugar	G0574		

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G0574	Continued from page 12 parameter; failed to include patient specific, individualized, and measurable goals; failed to indicate the patient's progress toward goals; failed to include the patient's knowledge level and understanding of diabetes and self-care; failed to include the patient's rehabilitation potential; and failed to include any discharge plans. On 3/17/22 at 4:30 PM, Patient #4 was interviewed during a home visit. The patient was an unreliable historian due to cognitive delays and verbally indicated being unable to identify or set up their own medications and injectables. During the home visit, the nurse was observed using the patient's glucometer, strips, and lancets. A weekly medication box belonging to the patient was observed on the kitchen table. 3. A review of the plan of care for Patient #5, for certification period 2/17/22 – 4/17/22, failed to indicate all medications included the reason prescribed; failed to indicate the patient's complete health status including pain level and response to pain medication; failed to include all functional limitations including the suprapubic catheter and bilateral foot drop; failed to include all pertinent diagnoses, including but not limited to, chronic pain, bladder dysfunction, presence of a suprapubic catheter, and heart disease; failed to indicate all nutritional requirements and type of diet, related to the absence of all teeth or dentures; failed to include realistic, individualized, and patient-specific goals which were measurable; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC (skilled nursing facility/long term care)" but failed to include patient-specific and individualized discharge plans. On 3/17/22 at 8:30 AM, Patient #5 was interviewed during a home visit. When queried as to whether the patient needed help with oral care, the patient denied wearing dentures and stated not having teeth at all. 4. A review of the clinical record for Patient #6, for the certification period of 1/16/22 – 3/16/22, failed to include accurate and pertinent diagnoses including candida skin infection, seizure disorder, and short term memory impairment; failed to indicate all medications included the correct dose, frequency, the reason for use; failed to include the discontinued date for azithromycin; failed to include a comprehensive seizure plan that included	G0574		

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G0574	Continued from page 13 how to position the patient and how to protect the airway; failed to include individualized, patient-specific goals that are measurable; failed to include the patient's progress toward goals; failed to include the patient's psychosocial status, including effects of memory loss, ability to accurately use judgment to direct self-care needs; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC " but failed to include patient-specific and individualized discharge plans. 5. On 3/17/22 at 9:30 AM, person U (representative for Patient #6) was interviewed concerning Patient #6. Person U stated the patient currently had a dormant glioblastoma (a type of brain tumor). The patient had a history of 2 surgical resections, chemotherapy, and radiation therapy which caused significant personality changes and affected the patient's social awareness, judgment, and memory, which rendered Patient 6 incapable of living independently. Person U stated the patient had not fallen in over a year and never had a history of falling. Person U stated Patient #6 had a history of frequent candida (yeast) skin infections due to obesity, particularly under the breasts, abdominal folds, and behind the knees, and was to receive a full shower 3x/week from the agency and 2x/week from entity V (assisted living facility), for a total of 5 full showers/week. Individual U indicated becoming aware approximately 2 months ago that the patient was refusing baths and had a rash, and requested an immediate phone call any time the patient refused a shower because person U could redirect the patient without causing distress. Person U stated the agency agreed to call if the patient refused bathing, but person U had received no calls since November 2021. On 3/8/22, individual U entered the patient's room and smelled a foul odor, specifically of yeast, and noted drainage had seeped through the patient's shirt over the sternum and under the breasts. The patient was having difficulty walking due to the irritation caused by the rash and excoriation behind the patient's knees. Person U also noted the patient had a rash from below the sternum to the top of the sternum and under both breasts. Person U stated the drainage was puss-like and bleeding. Person U contacted a nurse from entity V, who assisted the patient with a shower. Person U stated the nurse indicated the rash and signs of infection were significant enough to consider calling 911, but ultimately decided not to call. Patient #6 saw their Primary	G0574		

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G0574	Continued from page 14 Care Physician on 3/9/22, and was prescribed antifungal cream 2x/day and nystatin powder 4x/day, to be applied by entity V employees. 6. A review of the clinical record for Patient #7, for the certification period of 2/7/22 – 4/7/22, failed to include that the patient was profoundly hard of hearing bilaterally and required the aide to shout directly into the patient's ear from very close range; failed to include the hearing impairment in safety measures; failed to include goals that were patient-specific, individualized, and measurable; failed to indicate the patient's progress toward goals; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC " but failed to include patient-specific and individualized discharge plans. 7. A review of the clinical record for Patient #8, for the certification period of 2/11/22 – 4/11/22, indicated medications were reviewed and reconciled, with no changes, but failed to evidence the patient was receiving hydrocortisone cream 1%, fluconazole cream 5%, vitamin D3, and Vitamin B12 per the patient's active medical record provided by the facility. The plan of care also failed to include individualized, patient-specific goals that were measurable; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC " but failed to include patient-specific and individualized discharge plans. 8. The clinical record of Patient #2 was reviewed on 3-15-2022, with a start of care date of 1-18-22, and an initial certification period of 1-18-2022 to 3-18-2022. The plan of care included, but was not limited to, the following diagnosis: chronic obstructive pulmonary disease, unspecified asthma, and rheumatoid arthritis with rheumatoid factor. Review on an agency document titled "Start of Care Assessment" dated 1-18-2022, was electronically signed by the registered nurse (RN,) employee O. The initial comprehensive assessment contained a section subtitled "Respiratory" that indicated, "…Oxygen Flow Settings Nasal Cannula: 2 liters (l)…" The plan of care failed to list Oxygen 2 liters per nasal cannula continuously on the medication list. During a home visit on 3-17-2022 at 12:30 PM, Patient #2 was observed sitting upright in a recliner. The patient was observed with a nasal	G0574		

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G0574	Continued from page 15 cannula in their nose with oxygen infusing. Patient #2 confirmed they were always on oxygen due to their lung issues. 9. The clinical record of Patient #17 was reviewed on 3-16-2022, with a start of care date of 12-22-20. The record contained a plan of care for the recertification period of 2-15-2022 to 4-15-2022. The record contained an agency document titled “Home Health Certification and Plan of Care” dated 2-10-2022 and electronically signed by the RN, employee Z. The plan of care contained a section subtitled “60 Day Summary” that indicated but was not limited to, “… Patient continues to wear supplemental oxygen at 2 liters per minute intermittently to keep saturations above 90 percent…” The plan of care failed to evidence on the medication list Oxygen 2 liters per nasal cannula intermittently. 10. During an interview on 3-14-2022 at 4:20 PM, the administrator, confirmed medication review was at every start of care and every recertification and should be listed on the plan of care.	G0574		
G0606	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure integration of services with all disciplines involved in 8 of 12 active records reviewed. (Patients #1, 2, 3, 6, 14, 15, 16, 17) Findings include: 410 IAC 17-12-2(g)410 IAC 17-12-2(h) 1. A review of agency policy 3-360, titled "Coordination of Client Services", indicated "All personnel furnishing services shall maintain a liaison to assure their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care Plans and written and verbal interaction."	G0606		

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G0606	Continued from page 16 The purpose of care coordination included ensuring services were coordinated between all Providers; ensuring services were appropriate and quality care was provided; ensuring continuity of care. Further review of the policy evidenced "Ongoing care conferences shall be conducted to evaluate the client's status and progress ... All caregivers ... shall have access to the Client Plan of Care and will be expected to participate in ... coordination activities, as appropriate." The policy indicated the primary care nurse assumed responsibility for updating or changing the care plan, and communicating changes to caregivers within 24 hours following the care conference of changes. 2. A review of the clinical record for Patient #6, for the certification period of 1/16/22 - 3/16/22 indicated "Orders for Discipline and Treatment" of a home health aide (hha) up to 1 hour/visit, with 3 - 5 visits/week x 9 weeks, to assist with bathing, grooming, hygiene, mobility, IADL (Instrumental Activities of Daily Living), and housekeeping needs in accordance with patient-specific, written instructions provided by a Registered Nurse. Further review of Patient 6's medical plan of care evidenced a section labeled "Problems and Interventions" which indicated "HHA (home health aide) to assist with ADLs (Activities of Daily Living), Personal Care, and Housekeeping needs. Patient/Family is cognitively able to make the choice regarding bathing and ADL/IADL (Instrumental Activities of Daily Living) needs. A review of an untimed case communication note, created on 3/9/22, by employee B (alternate director of nursing), indicated "HHA (home health aide) called and said [Name of Patient #6] has a rash on his/her bottom and is red under his/her breasts. [HHA] let [name of entity V] nurses know and they are ordering her some cream." A review of an untimed case communication note, dated 3/10/22, indicated "Per Team Lead follow up: I wasn't clear on what the concern was. I did speak with [name of employee N] ... looks like facility is now using Nystatin powder under breast, and has been using a barrier cream to bottom. HHA (home health aide) reported it was looking better. HHA didn't seem to have any concerns at this time. Reported that the client sometimes will refuse an actual shower at times. But will allow a partial in place of a shower."	G0606		

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G0606	Continued from page 17 A review of the aide visit notes for 1/18/22, 1/19/22, 1/20/22. 1/21/22, 1/25/22, 1/26/22, 1/28/22, 2/1/22, 2/2/22, 2/3/22, 2/4/22, 2/7/22, 2/8/22, 2/9/22, 2/11/22, 2/14/22, 2/15/22, 2/16/22, 2/17/22, 2/18/22, 2/19/22, 2/22/22, 2/23/22, 2/25/22, 2/28/22, 3/1/22, 3/2/22, 3/3/22, 3/7/22, 3/8/22, 3/9/22, and 3/11/22, indicated the patient refused a full shower and accepted a partial bath and skincare. The notes failed to evidence what was included in the partial bath; failed to indicate what type of skincare was provided; failed to evidence the aide notified the supervisory nurse that the patient was not bathing for days at a time; and failed to evidence the aide inspected the patient's skin to identify and report concerns. A review of the plan of care, for the certification period of 1/16/22 - 3/16/22, failed to evidence Patient 6's representative/POA (power of attorney) had been contacted when Patient #6 refused a full shower, as the POA had requested. 3. The clinical record of Patient #1 was reviewed on 3-15-2022, with a start of care date of 10-28-20. The record contained a plan of care for the recertification period of 2-20-2022 to 4-20-2022. The plan of care included but was not limited to orders to provide home health aide (HHA) services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 2-20-22, for up to 1 hour, visit 5-7 times per week, for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee O, on 2-19-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: ambulation “stand by assist,” shower, partial bath, skincare, hair care, shaving-electric razor, dressing, foot care, assist with making bed/changing bed linens, removing clutter from pathways, empty trash, cleaning up soiled linens, clean up after any care is preformed, oral care, observe safety/seizure precautions, and fall risk precautions. Review of untitled documents for Patient #1, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation the HHA, employee J, provided a partial bath and shaved with the electric razor on the following	G0606		

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G0606	Continued from page 18 dates: 2-21, 2-22, 2-23, 2-24, 2-25, 2-28, 3-2, 3-3, 3-4, 3-7, 3-8, 3-9, 3-10, and 3-14-22. The HHA failed to document communication with the RN case manager that tasks were not completed, and changes needed to be made to the care plan. During a home visit on 3-17-2022 at 9:00 AM, Patient #1 confirmed they always receive showers never partial baths. Patient #1 further confirmed they will not allow the HHA to shave them. During an interview on 3-17-2022 at 9:05 AM, the HHA, employee J, when queried about patient #1 refusing shave and partial bath confirmed that patient #1 always refuses those tasks. When queried about care plan tasks and changes in a patient's condition confirmed the HHA is to let the RN case manager know. 4. The clinical record of Patient #2 was reviewed on 3-15-2022, with a start of care date of 1-18-22. The record contained a plan of care for the initial certification period of 1-18-2022 to 3-18-2022. The plan of care included but was not limited to orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 1-18-22, for up to 1 hour a visit, for 3-5 times per week, for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee O, on 2-4-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks the HHA was to perform as the patient requested. The care plan included: a shower, partial bath, skincare, hair care, dressing, foot care, and light housekeeping. Review of untitled documents for Patient #2, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee L, provided a partial bath, shower, or hair care on the following dates: 1-18, 1-21, 1-24, 1-25, 1-26, 1-27, 1-28, 2-3, 2-4, 2-7, 2-8, 2-9, 2-10, 2-11, 2-14, 2-15, 2-16, 2-18, 2-21, 2-22, 2-23, 2-25, 2-28, 3-1, 3-2, 3-4, 3-7, 3-8, 3-9, 3-10, 3-11, 3-14, 3-15, 3-16, and 3-17-22. The HHA failed to document communication with the RN case manager the tasks were not completed and changes needed to be made to the care plan. 5. The clinical record of Patient #3 was reviewed on 3-15-2022 with a start of care date of 11-11-20. The record contained a plan of care for the recertification period of 3-6-2022 to 5-4-2022. The plan of care included, but was not limited to, orders to provide HHA services to assist with bathing,	G0606		

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(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
G0606	Continued from page 19 grooming, hygiene, mobility, and housekeeping needs starting 3-6-22, for up to 1 hour a visit for 1-2 times per week for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee O, on 3-2-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: ambulation, shower, partial bath, skincare, hair care, catheter care, dressing, fall risk precaution “report falls or injury,” foot care, light housekeeping, and oral care “denture care.” Review of untitled documents for Patient #3, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee K, provided a partial bath, catheter care, oral care on the following dates: 3-8, 3-10, 3-15, and 3-17-22. The HHA failed to document communication with the RN case manager that tasks were not completed, and changes needed to be made to the care plan. During a home visit on 3-17-22 at 10:00 AM, observed patient #3 showing the HHA, employee K, a rash covering her abdominal and upper thighs. HHA, employee K was discussing with the patient discoloration on left should from fall earlier that am. During an interview on 3-18-2022 at 10:01 AM, the RN case manager for Patient #3, employee O, confirmed the HHA did not inform them of the rash or fall. Employee O confirmed the director of clinical informed the RN of the fall, the HHA called the office and reported the fall. 6. The clinical record of Patient #14 was reviewed on 3-16-2022, with a start of care date of 9-28-20. The record contained a plan of care for the recertification period of 1-21-2022 to 3-21-2022. The plan of care included, but was not limited to, orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 1-21-22, for up to 1 hour a visit for 3-5 times per week for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee X, on 1-20-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requests. The care plan included: transfer assist “bed to chair, walker,” a shower, partial bath, peri care, oral care, ambulation “walker, touching assist,” fall risk precautions, skin care, hair care, dressing, foot care, and light	G0606		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K083	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2022

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G0606	Continued from page 20 housekeeping. Review of untitled documents for patient #14, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee K, provided a shower, or oral care on the following dates:1-24, 1-25, 1-26, 1-27, 1-28, 1-31, 2-1, 2-2, 2-7, 2-8, 2-10, 2-11, 2-14, 2-15, 2-16, 2-17, 2-22, 2-23, 2-24, 2-28, 3-1, 3-2, 3-3, 3-4, 3-8, 3-9, 3-10, 3-11, 3-14, 3-15, 3-16, and 3-17-22. The HHA failed to document communication with the RN case manager that tasks were not completed, and changes needed to be made to the care plan. During an interview on 3-17-22 at 3:41 PM, Patient #14 confirmed they would never take a shower due to vertigo and completed their denture care. Patient #14 further confirmed the HHA gives the patient a bed bath and then washes the patient's hair at the sink. 7. The clinical record of Patient #15 was reviewed on 3-16-2022, with a start of care date of 11-15-21. The record contained a plan of care for the recertification period of 1-14-2022 to 3-14-2022. The plan of care included, but was not limited to, orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 1-14-22, for up to 1 hour a visit, for 5-7 times per week, for 9 weeks. A review of an agency document titled "Paraprofessional Assignment Sheet" electronically signed by the RN, employee U, on 1-10-22, the HHA care plan indicated the tasks the HHA was to perform every visit and tasks to perform as patient requested. The care plan included: transfer assist "bed to chair, walker," a shower, partial bath, peri care, oral care, ambulation "walker, touching assist," fall risk precautions, skincare, hair care, dressing, foot care, and light housekeeping. Review of untitled documents for Patient #15, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that employee Q, provided a shower on 1-19, failed to provide a shower or partial bath, and assist with feeding on 3-7-2022. The HHA, employee R, failed to provide to provide a shower or partial bath on the following dates: 1-20, 1-23, 1-27, 1-28, 2-5, 2-8, 2-14, 2-17, 2-19, 2-22, 2-23, 2-24, 3-3, 3-6, and 3-10-2022. The HHA, employee S, failed to provide a shower or partial bath on 1-21 and 2-20-2022. The HHA,	G0606		

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G0606	Continued from page 21 employee T, failed to provide a shower or partial bath on the following dates: 1-22, 1-24, 1-25, 1-26, 1-29, 1-31, 2-1, 2-4, 2-7, 2-9, 2-10, 2-11, 2-12, 2-18, 2-21, 2-25, 2-26, 2-27, 2-28, 3-1, and 3-2-2022. The HHA, employee AA, failed to provide a shower or partial bath on 1-30-2022. The HHA, employee BB, failed to provide a shower or partial bath on 2-15, and 2-16-2022. The HHA, employee CC, failed to provide a shower or partial bath on 3-8, and 3-13, and failed to provide a shower on 3-9-2022. The HHA, employee DD, failed to provide a shower or partial bath on 3-11-2022. The HHA, employee EE, failed to provide a shower or partial bath on 3-14, and 3-15-2022. The HHA failed to document communication with the RN case manager that tasks were not completed, and changes needed to be made to the care plan. 8. The clinical record of Patient #16 was reviewed on 3-16-2022, with a start of care date of 10-19-21. The record contained a plan of care for the recertification period of 2-16-2022 to 4-16-2022. The plan of care included, but was not limited to, orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 2-16-22, for up to 1 hour a visit, 1time per week, for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee V, on 2-23-22, the HHA care plan indicated the tasks the HHA was to perform 5-7 days a week at every visit and tasks to perform as patient requests. The care plan included: transfer assist “uses an electric wheelchair cannot ambulate,” a shower, partial bath, peri care, oral care, ambulation “walker, touching assist,” fall risk precautions, skincare, hair care, dressing “help the patient put in hearing aid,” foot care, and light housekeeping. Review of untitled documents for Patient #16, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee W, provided a shower on the following dates: 2-15, 2-16, 2-17, 2-18, 2-19, 2-20, 2-21, 2-22, 2-23, 2-24, 2-25, 2-26, 2-27, 2-28, 3-1, 3-2, 3-4, 3-5, 3-6, 3-7, 3-8, 3-9, 3-10, 3-11, 3-12, 3-13, 3-14, and 3-15-2022. The HHA failed to document communication with the RN case manager that tasks were not completed, and changes needed to be made to the care plan. 9. The clinical record of Patient #17 was reviewed on 3-16-2022, with a start of care date of 12-22-20. The record	G0606		

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G0606	Continued from page 22 contained a plan of care for the recertification period of 2-15-2022 to 4-15-2022. The plan of care included, but was not limited to, orders to provide HHA services to assist with bathing, grooming, hygiene, mobility, and housekeeping needs starting 2-15-22, for up to 1 hour a visit, 3-5 times per week, for 9 weeks. A review of an agency document titled “Paraprofessional Assignment Sheet” electronically signed by the RN, employee Z, on 2-11-22, the HHA care plan indicated the tasks the HHA was to perform at every visit and tasks to perform as the patient requested. The care plan included: fall risk precaution, transfer assist, repositioning, oral care, housekeeping, dressing, shaving electric razor, hair care, skincare, partial bath, peri care, shower, and assist with ambulation. Review of untitled documents for patient #17, included HHA tasks completed each visit by the HHA and any communication of comments regarding changes in condition, COVID questions screening and comments, and any changes needed to the care plan. The documents failed to evidence documentation that the HHA, employee Y, provided a shave on the following dates: 2-15, 2-17, 2-21, 2-22, 2-23, 2-24, 2-25, 2-28, 3-2, 3-3, 3-4, 3-7, 3-8, 3-9, 3-10, 3-11, 3-14, and 3-15-2022. The documents failed evidence documentation the employee Y provided a shower on the following dates: 2-15, 2-17, 2-21, 2-23, 2-24, 2-28, 3-1, 3-2, 3-3, 3-7, 3-8, 3-10, and 3-15-2022. The documents failed to evidence employee Y provided a partial bath on the following dates: 2-22, 2-25, 3-1, 3-4, 3-8, 3-11, and 3-14-2022. The HHA failed to document communication with the RN case manager that tasks were not completed, and changes needed to be made to the care plan. During an interview on 3-17-2022 at 4:02 PM, Patient #17 confirmed took showers three times a week and is never to be shaved. The patient further confirmed showers are three times a week due to fear of falling and fainting when standing up. 10. During an interview on 3-18-2022 at 12:20 PM, the administrator and clinical director confirmed aides are to report changes to the RN case managers.	G0606		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.	G0608		

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G0608	Continued from page 23 This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview the agency failed to ensure care coordination with other home care agencies and assisted living facilities, failed to coordinate care between the clinician and home health aide, failed to coordinate care with the patient's physician, and failed to include the patient's representative in care coordination in 5 of 12 clinical records reviewed.(Patients #1, 3, 4, 6, 7) Findings Include: 410 IAC 17-14-1(a)(1)(F)410 IAC 17-12-2(g) 1. A review of agency policy 3-360, titled "Coordination of Client Services", indicated "All personnel furnishing services shall maintain a liaison to assure their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current Care Plans and written and verbal interaction." The purpose of care coordination included ensuring services were coordinated between all Providers; ensuring services were appropriate and quality care was provided; ensuring continuity of care. Further review of the policy evidenced "Ongoing care conferences shall be conducted to evaluate the client's status and progress ... All caregivers ... shall have access to the Client Plan of Care and will be expected to participate in ... coordination activities, as appropriate." The policy indicated the primary care nurse assumed responsibility for updating or changing the care plan, and communicating changes to caregivers within 24 hours following the care conference of changes. 2. A review of the plan of care for Patient #4, for the certification period of 3/8/22 - 5/6/22, failed to evidence the clinician contacted the physician for case coordination purposes and to review the care plan. A review of the comprehensive recertification assessment, dated 3/3/22, indicated "Physician contacted: No." The document failed to evidence the clinician contacted the patient's physician or a representative of the patient's assisted living facility for case coordination purposes and to review findings during the patient's	G0608		

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G0608	Continued from page 24 recertification assessment. A review of the nurse visit note dated 3/16/22 evidenced the patient had a fasting blood sugar of 223. The visit note failed to evidence parameters for the patient's blood sugar and failed to evidence the clinician notified the physician of the patient's blood sugar. On 3/17/22 at 4:30 PM, the surveyor observed the clinician obtaining vital signs for Patient #4. Upon completion of the blood pressure, the clinician stated, "188/90. You must be upset. Are you nervous?" The clinician failed to repeat the blood pressure, failed to review the patient's medication box to determine if the patient's blood pressure medication was missed, and failed to notify the patient's physician of the elevated blood pressure results. 3. A review of the plan of care for Patient #6, for the certification period of 1/16/22 - 3/16/22, failed to evidence the clinician contacted the patient's assisted living facility to review medications and determine if any changes occurred since the previous recertification period; failed to indicate the clinician contacted the patient's physician to review the medications and update the plan of care, including the patient's active and pertinent diagnoses. A review of the patient's comprehensive reassessment, dated 1/13/22, failed to evidence the clinician contacted the patient's physician to review findings and update the plan of care and failed to evidence the clinician contacted the assisted living facility to coordinate care and services. A review of the home health aide visit notes dated 1/17/22 - 3/14/22 failed to evidence the home health aide reported any concerns to the Registered Nurse or case manager; failed to report the patient was refusing a shower multiple days in a row; and failed to notify the Registered Nurse concerning the patient's skin rash and breakdown, drainage, and odor. On 3/17/22 at 12:11 PM, person U (representative for patient #6) was interviewed concerning services and patient care. Person U stated they had not received a call from the agency for at least 2 months. Person U specified that no one had called to report the patient was refusing a	G0608		

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G0608	Continued from page 25 shower, or to report the patient had a rash and had open areas with foul-smelling drainage. On 3/18/22 at 9:30 AM, employee N was interviewed as to why they did not contact the clinician concerning the patient's skin, odor, rash, and refusal to bath, Employee N had no additional comments. 4. A review of the plan of care for Patient #7, for the certification period of 2/7/22 - 4/7/22 evidenced a section for coordination of care, which indicated the clinician spoke with the patient's waiver provider and verified the patient received 15 hours per week with no duplication of services. The plan of care failed to evidence the clinician verified services provided by both agencies to determine if the patient's needs were met, and failed to evidence the agency contacted the patient's physician to review the plan of care and continuing orders. 5. The clinical record of Patient #1 was reviewed on 3-15-2022, with a start of care date of 10-28-20. The record contained a plan of care for the recertification period of 2-20-2022 to 4-20-2022. The patient’s diagnosis included, but was not limited to: Type 2 diabetes mellitus, Other seizures, Other polyosteoarthritis, Chronic kidney disease stage 3, Abscess of the lung without pneumonia, Myelodysplastic syndrome, mild intellectual disabilities, and Other psoriasis. The plan of care further contained a section titled, “60 Day Summary” which indicated Patient #1 resided in a group home, Entity J. Review of an agency document Titled, “Care Conference” dated 2-19-2022, was electronically signed by the registered nurse (RN), employee O. The RN indicated that patient #1 remained appropriate for services. Employee O further indicated care coordinated between all interdisciplinary team members. The document failed to evidence care coordination with Entity J and review the medications, blood sugars, and what care Entity J employees were completing. During a home visit with Patient #1 on 3-17-2022 at 8:55 AM, observed patient #1 receiving an injection with an insulin pen in the right upper arm by direct care staff, for Entity J, person K. During an interview on 3-17-2022 at 9:02 AM, direct care staff for Entity J, person K confirmed that they cared for patient #1 and give insulin injections. Person K, further indicated they care for one other person who lives	G0608		

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G0608	Continued from page 26 in the home. 6. The clinical record of Patient #3 was reviewed on 3-15-2022, with a start of care date of 11-11-20. The record contained a plan of care for the recertification period of 3-6-2022 to 5-4-2022. The plan of care included but was not limited to the following diagnosis: Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, Type 2 diabetes mellitus with diabetic nephropathy, Atherosclerotic heart disease, Essential hypertension, Major depressive disorder, Neuromuscular dysfunction of the bladder, Chronic kidney disease stage 3, and Generalized anxiety disorder. The plan of care further contained a section titled, “60 Day Summary” that indicated patient #3 is at risk for falls, and an increased risk for infection due to suprapubic catheter. Review of an agency document Titled, “Care Conference” dated 3-2-2022, was electronically signed by the RN, employee O. The RN indicated that patient #3 remained appropriate for services. Employee O further indicated care coordinated between all interdisciplinary team members. The document failed to evidence care coordination with Entity Z. The document failed to evidence review of the services being provided by a skilled nurse of the catheter changes, and therapy progress by Entity Z. During a home visit observation on 3-17-2022 at 10:02 AM, observed Patient #3 telling the home health aide, employee K that she fell at 4:30 AM that morning. The patient pointed out her glasses made an abrasion above her left eyebrow. Observed Patient #3 had a purple-blue discoloration around her lower left and left upper arm. Patient #3 had a suprapubic catheter located under her abdominal fold that Patient #3 lifted to show the red discharge and 2 pieces of skin protruding out of the suprapubic insertion site that caused bleeding. During an interview on 3-17-2022 at 10:15 AM, patient #3 confirmed Entity Z, a home care agency, was to send a nurse and therapist to change the catheter and to help prevent all the falls. During an interview on 3-18-2022 at 10:01 AM, the RN for patient #3, employee O, when queried about when the catheter was changed, and about the therapy could not name staff or when. Employee O named Entity Z was the name of the agency only. 7. During an interview on 3-18-2022 at 12:05 PM, when reviewed the above record reviews and was notified of home visits findings, the owner, person F confirmed the agency could do a better job coordinating care.	G0608		
G0682	Infection Prevention	G0682		

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G0682	Continued from page 27 CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on record review, observation, and interview the agency failed to ensure all personnel having direct patient contact implemented standard precautions, including proper hand hygiene, proper bathing, and proper personal care; and failed to ensure all clinicians used aseptic technique during subcutaneous injection of a medication and blood glucose monitoring in 4 of 7 home visits observed. (Patient #1, 4, 5, 7) Findings include: 410 IAC 17-12-1(m) 1. A review of agency policy #2-360, titled "Infection Prevention/Control," indicated "Standard precautions apply to blood, all body fluids, secretions, excretions, non-intact skin, and mucous membranes ... Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganisms ... Gloves are worn when touching blood body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items." 2. A review of agency policy #4-330, titled "Handwashing/Hand Hygiene" indicated thorough hand washing//hand antisepsis is required of all employees. Indications for handwashing included before invasive procedures, before and after client care, when there is prolonged or intense contact with the client (bathing), between tasks on the same client, before putting on and after removing gloves, after touching potentially contaminated objects, and when hands are visibly soiled. Decontaminate hands after contact with intact skin, body fluids, excretions, non-intact skin, and wound dressings. Decontaminate hands after contact with inanimate objects including	G0682		

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G0682	Continued from page 28 equipment in the immediate vicinity of the client. 3. On 3/17/22 at 4:30 PM, employee M was observed preparing to obtain a blood sugar and administer insulin to Patient #4. Employee M was observed completing hand hygiene with soap and water for approximately 10 seconds, and then donned gloves. Employee M was observed changing gloves after arranging supplies, but failed to complete had hygiene between changes. Employee M obtained an alcohol swab and cleaned the finger of Patient #4, who stated, "We don't usually use alcohol." Employee M used the lancet pen but failed to obtain blood from the patient. Employee M notified the patient of another "stick" and repeated the attempt using the same alcohol swab and lancet, without results. Employee M obtained a new lancet, cleaned the patient's finger with the same alcohol swab, and successfully obtained the blood sample. Employee M was then observed to give the patient the same alcohol swab to hold pressure/wipe the finger while employee M administered the patient's Humalog in the abdomen. Employee M failed to swab the injection site with alcohol prior to the administration of the insulin. When queried as to why the employee used the same alcohol swab 4 times, and why a dirty lancet was used, employee M stated being nervous. 4. On 3/17/22 at 8:10 AM, a home visit was initiated with Patient #5, observed employee G (home health aide/hha) providing personal care for Patient 5. At the opening of the visit, the aide was observed completing appropriate handwashing with soap and water. Employee G then donned nitryl gloves and proceeded to remove slide the patient's pants off, remove the patient's soiled brief, roll the brief up and discard it in the trash, followed immediately by assisting the patient to remove a layer of socks from the patient's feet, revealing white socks underneath, and don a black sock over the patient's white socks, leaving the patient wearing white socks from under the ones just removed. The employee failed to change gloves after handling the patient's discarded brief. Employee G was then observed assisting with the removal of the patient's pants and catheter bag adjustment. The patient was noted to have a towel over their genitals, and was observed emptying the catheter bag in the toilet, but was not observed washing the genitals, completing catheter care, or completing hand hygiene after the catheter bag was emptied. Employee G assisted patient #5 in putting on a new brief and was observed sorting through	G0682		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURPOSE HOME HEALTH	5455 HARRISON PARK LANE STE B , INDIANAPOLIS, Indiana, 46216

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G0682	Continued from page 29 the patient's closet for a pair of sweats requested by the patient without changing gloves since donning the first pair. The aide failed to remove gloves and complete hand hygiene after handling contaminated or soiled material and before moving to a clean task. 5. On 3/17/22 at 8:20 AM, employee H (home health aide), was observed completing hand hygiene appropriately prior to donning gloves and preparing to assist Patient #7 with a sink bath. The aide was observed to fill the sink with warm soapy water, rinse the patient's washcloth, and return it so the patient could complete peri-care. Upon completion of peri-care, the aide rinsed the cloth in the sink water, and was observed washing vigorously between the patient's buttocks, followed immediately by washing the patient's buttock cheeks and down both thighs. Employee G was then observed to rinse the washcloth in the sink water again, and hand it to the patient with instructions to "wash your front one more time." Employee G assisted patient #7 to dress without changing gloves or completing hand hygiene. 6. During a home visit observation on 3-17-2022 at 9:05 AM, with Patient #1, the home health aide (HHA), employee J was observed providing shower assistance. Employee J completed hand hygiene and donned clean gloves assisted patient #1 to the shower chair and pulled the shower curtain. The patient sat in the shower chair and began to wash independently as much as possible. At 9:20 AM, the HHA washed the patient's back, legs, peri area, and buttocks, then used the handheld shower to rinse. The HHA handed the handheld shower to the patient for the patient to do an independent final rinse. At 9:26 AM, the HHA placed the towel on the floor and helped the patient step out of the shower and onto the towel without removing soiled gloves and performing hand hygiene, and donning new gloves. Employee J handed the patient a clean towel to dry off with and assisted as the patient needed. At 9:30 AM, employee J assisted the patient in drying their posterior legs, buttocks, and peri areas. The HHA then assisted the patient in getting their brief on. Employee J hung the towels from the floor that was used on the patient on the hooks on the wall. The HHA handed Patient #1 a comb to comb their hair without removing gloves and performing hand hygiene. Employee J assisted the patient to their room and applied lotion to the patient's legs, back, and arms. At 9:31 AM, employee J removed their gloves without performing hand hygiene. Employee J then dressed;	G0682		

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G0682	Continued from page 30 first socks, then shorts, shirt, and tennis shoes. The HHA failed to change gloves and sanitize hands after coming in contact with possible body fluids, excretions, or mucous membranes. The HHA failed to change gloves and sanitize hands after coming in contact with soiled linens and contaminated items. 7. During an interview on 3-17-2022 at 12:50 PM, the HHA, employee L, when queried about hand hygiene and gloves changes, confirmed gloves are changed and hand hygiene is to be completed between dirty to clean procedures. 8. During an interview on 3-18-2022 at 9:45 AM, the director of clinical services, employee A, confirmed hand hygiene and glove changes are to be completed by staff between dirty and clean procedures.	G0682		
G0708	Development and evaluation of plan of care CFR(s): 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure the nurse updated and evaluated the plan of care to ensure all the patients' needs were being met and failed to ensure the plan of care was individualized based on the patient's needs for 12 of 12 active records reviewed. (Patient #1, 2, 3, 4, 5, 6, 7, 8, 14, 15, 16, 17) Findings include: 1. A review of agency policy #3-660, titled “Care Plans,” indicated “The Care Plan shall include, but not be limited to: Nursing diagnosis(es)/problems and needs identified. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. A list of specific interventions with plans for implementation. Indicators for measuring goal achievement and identified time frames. The physician Plan of Care may be used as a care plan if specific interventions are clearly identified for home care staff to address client needs." 2. A review of the plan of care for Patient #4, for the certification period of 3/8/22 - 5/6/22, failed to include the patient's sliding scale for Humalog (a short acting injectable insulin); failed to indicate that Humalog is injected 15 minutes before meals or immediately	G0708		

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G0708	Continued from page 31 after eating; failed to include PRN (as needed) qualifiers/indicators for interventions and medications ordered as needed; failed to include all DME (durable medical equipment) and supplies including lancets, glucometer strips, alcohol wipes, weekly medication box, briefs/pads; failed to include all safety measures, functional limitations, and nutritional requirements including diabetic precautions, type of diet, and dyspnea with minimal exertion; failed to indicate all medications were reviewed; failed to include patient specific blood pressure and blood sugar parameter; failed to include patient specific, individualized, and measurable goals; failed to indicate the patient's progress toward goals; failed to include the patient's knowledge level and understanding of diabetes and self-care; failed to include the patient's rehabilitation potential; and failed to include any discharge plans. The nurse failed to update and evaluate the effectiveness of the plan of care for Patient 6. On 3/17/22 at 4:30 PM, Patient #4 was interviewed during a home visit. The patient was an unreliable historian due to cognitive delays and verbally indicated being unable to identify or set up their own medications and injectables. During the home visit, the nurse was observed using the patient's glucometer, strips, and lancets. A weekly medication box belonging to the patient was observed on the kitchen table. 3. A review of the plan of care for Patient #5, for certification period 2/17/22 – 4/17/22, failed to indicate all medications included the reason prescribed; failed to indicate the patient's complete health status including pain level and response to pain medication; failed to include all functional limitations including the suprapubic catheter and bilateral foot drop; failed to include all pertinent diagnoses, including but not limited to, chronic pain, bladder dysfunction, presence of a suprapubic catheter, and heart disease; failed to indicate all nutritional requirements and type of diet, related to the absence of all teeth or dentures; failed to include realistic, individualized, and patient-specific goals which were measurable; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC (skilled nursing facility/long term care)" but failed to include patient-specific and individualized discharge plans. The nurse failed to update and evaluate the effectiveness of the plan of care for Patient 6. On 3/17/22 at 8:30 AM, Patient #5 was interviewed during a home visit.	G0708		

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G0708	Continued from page 32 When queried as to whether the patient needed help with oral care, the patient denied wearing dentures and stated having no teeth at all. 4. A review of the clinical record for Patient #6, for the certification period of 1/16/22 – 3/16/22, failed to include accurate and pertinent diagnoses including candida skin infection, seizure disorder, and short term memory impairment; failed to indicate all medications included the correct dose, frequency, the reason for use; failed to include the discontinued date for azithromycin; failed to include a comprehensive seizure plan that included how to position the patient and how to protect the airway; failed to include individualized, patient-specific goals that are measurable; failed to include the patient's progress toward goals; failed to include the patient's psychosocial status, including effects of memory loss, ability to accurately use judgment to direct self-care needs; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC " but failed to include patient-specific and individualized discharge plans. The nurse failed to update and evaluate the effectiveness of the plan of care for Patient 6. 5. On 3/17/22 at 9:30 AM, person U was interviewed concerning Patient #6. Person U stated the patient currently had a dormant glioblastoma (a type of brain tumor). The patient had a history of 2 surgical resections, chemotherapy, and radiation therapy which caused significant personality changes and affected the patient's social awareness, judgment, and memory, which rendered the patient incapable of living independently. Person U stated the patient had not fallen in over a year and had no history of falling. Person U stated patient #6 had a history of frequent candida skin infections due to obesity, particularly under the breasts, abdominal folds, and behind the knees, and was to receive a full shower 3x/week from the agency and 2x/week from entity V (assisted living facility), for a total of 5 full showers/week. Person U indicated becoming aware approximately 2 months ago that the patient was refusing baths and had a rash, and requested an immediate phone call any time the patient refused a shower because person U could redirect the patient without causing distress. Person U stated the agency agreed to call if the patient refused bathing, but person U had received no calls since November 2021. On 3/8/22, person U entered the patient's room and smelled a foul odor, specifically of yeast, and noted drainage	G0708		

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G0708	Continued from page 33 had seeped through the patient's shirt over the sternum and under the breasts. The patient was having difficulty walking due to the irritation caused by the rash and excoriation behind the patient's knees. person U also noted the patient had a rash from below the sternum to the top of the sternum and under both breasts. Individual U stated the drainage was puss-like and bleeding. Individual U contacted a nurse from entity V, who assisted the patient with a shower. Person U stated the nurse stated after seeing the rash, they would have called 911 due to the pain and extent of the rash. Patient #6 saw their PCP on 3/9/22 and was prescribed antifungal cream 2x/day and nystatin powder 4x/day, to be applied by entity V employees. The nurse failed to update and evaluate the effectiveness of the plan of care for Patient 6. 6. A review of the clinical record for Patient #7, for the certification period of 2/7/22 – 4/7/22, failed to include that the patient was profoundly hard of hearing bilaterally and required the aide to shout directly into the patient's ear from very close range; failed to include the hearing impairment in safety measures; failed to include goals that were patient-specific, individualized, and measurable; failed to indicate the patient's progress toward goals; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC " but failed to include patient-specific and individualized discharge plans. The nurse failed to update and evaluate the effectiveness of the plan of care for Patient 7. 7. A review of the clinical record for Patient #8, for the certification period of 2/11/22 – 4/11/22, indicated medications were reviewed and reconciled, with no changes, but failed to evidence the patient was receiving hydrocortisone cream 1%, fluconazole cream 5%, vitamin D3, and Vitamin B12 per the patient's active medical record provided by the facility. The plan of care also failed to include individualized, patient-specific goals that were measurable; and included discharge plans of "Patient will discharge when home health services no longer needed or upon permanent transfer to SNF/LTC " but failed to include patient-specific and individualized discharge plans. The nurse failed to update and evaluate the effectiveness of the plan of care for Patient 8.	G0708		