STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K021	A. BUILDING 00 B. WING	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELP AT HOME SKILLED CARE	8401 OHIO STREET MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This visit was a focused infection control and complaint survey with 3 complaints. The survey visit took place 5/18/2021 to 5/21/2021. Facility ID: 004456 Complaint: IN003316856-substantiated with related and unrelated findings IN00331045-unsubstantiated IN00331376-substantiated with related and unrelated findings This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G 0000	All staff is comped yearly on infection control. PPE is provided for all staff.	
G 0434 Bldg. 00	484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in care Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure the patient was informed of and consented to the changes in the frequency of	G 0434	1. Action Steps to ensure completion: In-service to all internal staff that hours cannot be	07/09/2021

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

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	visits in 1 of 3 discharged records reviewed (#3). The findings include: Record review on 5/21/2021, evidenced an undated agency policy titled, "Patient Bill of Rights and Responsibilities", which stated, " ... Patients have the right: ... Receive all services in the plan of care ... Participate in, be informed about and consent or refuse care ... with respect to: Completion of all assessments. The care to be furnished based on the comprehensive assessment. Establishing and revising the plan of care. The disciplines that will furnish the care. The frequency of visits ... Any changes in the care to be furnished...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Care Planning Process", which stated, " ... In order to assure that care provided is appropriately planned to meet each patient's specific needs and problems, the Agency will utilize data / information gathered during patient assessments in the care planning process ... PROCEDURE 1. The patient care plan for Skilled Nursing will be: Initial care plan will be developed and implemented with the physician. Demonstrates problems (diagnoses), interventions (physician orders) and long range goals ... 3. Care will be coordinated initially and ongoing among staff providing care. Care planning for each patient will be individualized to include: Problems and needs ... Specific care or services to be provided including frequency, type and duration ... Review and revision as indicated...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Plan of Care - CMS #485 and Physician Orders", which stated, " ...		manipulated without an order to the MD and a notification to the client, 100% of clients will receive handbook by 7/9/21 to notify of Administrator and office hours, discharge notice to clients if unable to staff for 30 days (give 15 day notification at that 30 days), missed shift notifications to MD. 2. Date of Compliance: New client handbook will be distributed by 7/9/21. MD"s will be notified of missed shifts via fax. Discharge notice to clients if unable to staff for 30 days, client will receive 15 day notification of discharge. 3 Responsible for correction: Administrator and or assigned designee. 4. Monitoring Process to prevent Reoccurrences: The Administrator and or designee will assume responsibility by auditing 80% of charts and 100% compliance of client notification receiving handbook by 7/9/21. Administrator and or assigned designee will complete 80% chart audits for 60 days (9/20/21). Once 100% compliance met We will continue to monitor 80% of charts quarterly. Administrator and or assigned designee will continue to monitor and track clients care plans for service hours are being staffing in accordance with the POC.	

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	PROCEDURE ... 2. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment ... 3. 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 ... 14. ... Revisions to the plan of care must be communicated as follows: Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver and all physicians issuing orders for the Agency plan of care ... 16. Consultation with the physician on any modification in the Plan of Care will be documented and the physician's signature obtained ... 18. Care and services will be provided according to physician orders...." Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "Admission Service Agreement Home Health", dated 11/11/2019, signed by the nurse and patient #3. This service agreement stated, "Consent for Care / Service: I hereby consent and authorize the organization, its agents and associates to provide care and treatment to me in my home as prescribed by my Physician ... I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and anticipated outcomes), my involvement with the plan of care,			

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	and how changes will be made if needed ... Home Health Aide - Predicted Freq 1-2 hr/vs [hours per visit] 5-7d/wk [days per week]...." Clinical record review evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 5/19/2020. This plan of care had a subcategory titled, "Orders for Discipline and Treatments:" which stated, "HHA [home health aide]: 1-2 hr/d [hours per day], 2-3 d/wk [days per week] X 9 [for 9 weeks] ...." Clinical record review failed to evidence an update to the service agreement or physician's order reflecting the decrease in hours of care provided. Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. Review of these documents evidenced the agency provided the following HHA hours: week of 5/10/2020 to 5/16/2020, 2 hours per day for 2 days; week of 5/17/2020 to 5/23/2020, 2 hours per day for 3 days; week of 5/24/2020 to 5/30/2020, 2 hours per day for 1 day; no further HHA visits were evidenced through 10/12/2020, when the patient was discharged from the agency. Clinical record review failed to evidence the agency provided the hours of care as ordered in the plan of care. Clinical record review failed to evidence the patient was informed of and consented to the reduction of hours of care provided. During an interview on 5/21/2021 at 12:10 p.m., the alternate administrator indicated the number and			

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	frequency of hours of care provided on the service agreement and the plan of care should match. She indicated if there was a change in the hours provided, the service agreement should be updated. When informed of the findings, employee C, LPN [licensed practical nurse], stated, "I know they were short staffed down there. I can't imagine she didn't offer another agency, but I don't see where she documented it". The alternate administrator and employee C indicated the agency did not meet the patient's needs. During an interview on 5/20/2021 at 5:50 p.m., patient #3 indicated they did not receive the number of hours they agreed on with the agency. Patient #3 indicated they did not consent to a reduction of hours of care provided. 17-12-3(b)(2)(D)(ii)(BB) 17-12-3(b)(2)(D)(iii)			
G 0468 Bldg. 00	484.50(d)(5)(iii) Provide contact info other services (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and Based on record review and interview, the agency failed to provide the patient with contact information for other agencies who may be able to provide care in 1 of 3 discharged records reviewed (#3). The findings include: Record review on 5/21/2021. evidenced an undated agency policy titled, "Discharge Criteria", which stated, " ... PROCEDURE 1. Patient will be	G 0468	1. Action Steps to ensure completion: Care staff will be re-educated and in-serviced on MD/family/client on client service hour's notification. In the event service hours are not able to be met in 30 days the Agency will issue a 15-day discharge notice. The Agency will notify MD/Family/patient of the need to find additional service resources	07/10/2021

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	discharged from services as follows: ... Discharge is necessary for the patient's welfare because the Agency and the physician who is responsible for the home health plan of care agree that the Agency can no longer meet the patient's needs, based on the patient's acuity. The Agency will arrange a safe and appropriate discharge to other care entities when the needs of the patient exceed the Agency's capabilities ... The Agency will do the following before it discharges ... Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care...." Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "Admission Service Agreement Home Health", dated 11/11/2019, signed by the nurse and patient #3. This service agreement stated, "Consent for Care / Service: I hereby consent and authorize the organization, its agents and associates to provide care and treatment to me in my home as prescribed by my Physician ... I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and anticipated outcomes), my involvement with the plan of care, and how changes will be made if needed ... Home Health Aide - Predicted Freq 1-2 hr/vs [hours per visit] 5-7d/wk [days per week]...." Clinical record review evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 5/19/2020. This plan of care had a subcategory titled, "Orders for Discipline and Treatments:" which stated, "HHA [home health aide]: 1-2 hr/d [hours per day], 2-3 d/wk [days per week] X 9 [for		on day of discharge notification, this will be included in discharge notification. 2. Date of Compliance: The Administrator and or assigned designee will be assigned to complete 100% patient discharge audit to ensure discharge/additional resources have been provided. Compliance will be met 7/10/2021. 3. Responsible for correction: The Administrator and or assigned designee will complete family/patient discharge notification additional resource services by audits by 7/10/2021. 4. Monitoring Process to prevent Reoccurrences: Compliance will continue to be tracked by Administrator and or assigned designee by completing 80% discharge notification audits until 7/30/2021. If errors are found Administrator and or assigned designee will re-educate Case Manager on MD/Family/Patient discharge and service resource notification. Agency will continue to audit up to 25% discharge/service resource notification.	

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	9 weeks] ...." Clinical record review failed to evidence an update to the service agreement or physician's order reflecting the decrease in hours of care provided. Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. Review of these documents evidenced the agency provided the following HHA hours: week of 5/10/2020 to 5/16/2020, 2 hours per day for 2 days; week of 5/17/2020 to 5/23/2020, 2 hours per day for 3 days; week of 5/24/2020 to 5/30/2020, 2 hours per day for 1 day; no further HHA visits were evidenced through 10/12/2020, when the patient was discharged from the agency. Clinical record review failed to evidence the agency provided the hours of care they determined the patient needed. Clinical record review evidenced a group of agency documents titled, "Clinical Note". Review of all clinical notes from 4/30/2020 to 10/12/2020, failed to evidence the agency provided contact information to patient #3 for other agencies who may be able to provide care. Clinical record review evidenced an agency document titled, "COMPREHENSIVE ADULT ASSESSMENT Type of visit ... Discharge....", dated 10/12/2020, signed by employee G, RN [registered nurse], which stated, " ... DISCHARGE PLANS: Discussed with patient? ... No...." The discharge assessment failed to evidence the agency provided contact information for other agencies who may be able to provide care.			

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	Clinical record review evidenced an agency document titled, "Discharge Summary", undated, signed by employee G, RN. This document stated, " ... OVERALL STATUS OF PATIENT: Assistance [with] ADLs / IADLs [activities of daily living / instrumental activities of daily living], endurance, up as tolerates, seizure precautions, diabetic precaution...." This summary indicated the patient required assistance at time of discharge, but failed to evidence the agency provided contact information for other agencies who may be able to provide care. When informed of the findings, employee C, LPN [licensed practical nurse], stated, "I know they were short staffed down there. I can't imagine she didn't offer another agency, but I don't see where she documented it". During an interview on 5/20/2021 at 5:50 p.m., patient #3 indicated after not receiving the care expected, they found another home health agency by researching online. Patient #3 indicated Help at Home failed to provide contact information for other agencies who may be able to provide care.			
G 0478 Bldg. 00	484.50(e)(1)(i) Investigate complaints made by patient (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: Based on record review and interview, the agency failed to record, track and investigate patient complaints and their resolutions. This had the potential to affect all patients of the home health agency. The findings include:	G 0478	1. Action Steps to ensure completion: Failure to comply with agency Patient Bill of Rights to report a compliant is proven to be in violation. On 5/18/2021 area Administrator received education on the Agency Patient Bill of	07/07/2021

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	Record review on 5/21/2021, evidenced an undated agency policy titled, "Patient Bill of Rights and Responsibilities", which stated, " ... Patients have the right: ... Voice concerns related to care, treatment or services and patient safety issues: Please call Agency Nursing Supervisor ... To have complaints investigated. The Agency will investigate complaints made by a patient, the patient's representative (if any) and the patient's caregivers and family...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Complaint Resolution", which stated, " ... Agency will: Investigate complaints made ... Document both the existence of the complaint and the resolution of the complaint ... Take action to prevent further potential violations, including retaliation, while the complaint is being investigated...." Review of the agency's complaint log binder evidenced 2 pages of a form titled, "Complaint log". When queried on 5/18/2021 at 2:58 p.m., the administrator indicated the binder was the log in its entirety. The complaint log form had 6 columns, titled: Date, Person Reporting, Nature of Complaint, Resolution, Supervisor's Initials, and Branch Manager's Signature. The complaint log failed to evidence documentation of investigation and patient notification / acceptance of resolution. During an interview on 5/21/2021 at 11:16 a.m., employee C, LPN [licensed practical nurse], indicated the administrator handles all complaints. Employee C indicated there was a second agency form the administrator should use to document complaint investigation and resolution. Employee C indicated the administrator was aware of the second form. Employee C indicated the		Rights complaint form. 2. Date of Compliance: Administrator and or assigned designee will re-educate all staff by 7/1/2021 on patient right to report a complaint and the form to complete the patient compliant process. 3. Administrator and or assigned designee will review weekly compliant log to ensure compliance is being met. Will had patient compliant log to QAPI monthly review to address completeness of complaint log. 4. Administrator and or assigned designee will ensure Agency Patient Bill of Rights reporting complaint log is met by 7/7/2021.	

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	administrator was recently educated on use of the second form. During the interview, the alternate administrator was present, and silent.			
G 0534 Bldg. 00	484.55(c)(4) Patient's needs The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on clinical record review and interview, the home health agency failed to meet the patient's needs in 1 of 3 discharged records reviewed (#3). The findings include: Record review on 5/21/2021, evidenced an undated agency policy titled, "Care Planning Process", which stated, " ... In order to assure that care provided is appropriately planned to meet each patient's specific needs and problems, the Agency will utilize data / information gathered during patient assessments in the care planning process ... PROCEDURE 1. The patient care plan for Skilled Nursing will be: Initial care plan will be developed and implemented with the physician. Demonstrates problems (diagnoses), interventions (physician orders) and long range goals ... 3. Care will be coordinated initially and ongoing among staff providing care. Care planning for each patient will be individualized to include: Problems and needs ... Specific care or services to be provided including frequency, type and duration ... Review and revision as indicated...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Plan of Care - CMS #485 and Physician Orders", which stated, " ... PROCEDURE ... 2. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of	G 0534	1. Action Steps to ensure completion: In-service to all internal staff that hours cannot be manipulated without an order to the MD and a notification to the client. Discharge notice to clients if unable to staff for 30 days (give 15 day notification at that 30 days), missed shift notifications to MD 2. Date of Compliance: Will audit 100% charts by 7/9/21 to ensure 100% compliance. When 100% compliance met, will audit 50% of opened charts every 60 days when auditing recertification's. 3 Responsible for correction: Administrator and or assigned designee will be responsible for Monitor and tracking to monitor and tracking for 100% compliance 4. Monitoring Process to prevent Reoccurrences: In-service for all internal staff that MD and client/family must be notified of missed shifts, inability to staff. At Help at Home we communicate with client/family/MD regarding missed shifts, unable to staff, etc. After 30 days of being unable to	07/09/2021

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	care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment ... 3. 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 ... 14. ... Revisions to the plan of care must be communicated as follows: Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver and all physicians issuing orders for the Agency plan of care ... 16. Consultation with the physician on any modification in the Plan of Care will be documented and the physician's signature obtained ... 18. Care and services will be provided according to physician orders...." Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "Admission Service Agreement Home Health", dated 11/11/2019, signed by the nurse and patient #3. This service agreement stated, "Consent for Care / Service: I hereby consent and authorize the organization, its agents and associates to provide care and treatment to me in my home as prescribed by my Physician ... I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and anticipated outcomes), my involvement with the plan of care, and how changes will be made if needed ... Home Health Aide - Predicted Freq 1-2 hr/vs [hours per visit] 5-7d/wk [days per week]...."		staff, Administrator and or designee will inform the client of inability to staff and assist them in possibly finding a new agency. Administrator and or designee will also inform the NWICA Case Manager. When 100% compliance met, will audit 50% of opened charts every 60 days when auditing recertification's. If still unable to staff we will send a 15 day discharge letter with the home care compare report to help them decide on another agency. This will be an ongoing practice effective immediately.	

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	Clinical record review evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 5/19/2020. This plan of care had a subcategory titled, "Orders for Discipline and Treatments:" which stated, "HHA [home health aide]: 1-2 hr/d [hours per day], 2-3 d/wk [days per week] X 9 [for 9 weeks] ...." Clinical record review failed to evidence an update to the service agreement or physician's order reflecting the decrease in hours of care provided. Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. Review of these documents evidenced the agency provided the following HHA hours: week of 5/10/2020 to 5/16/2020, 2 hours per day for 2 days; week of 5/17/2020 to 5/23/2020, 2 hours per day for 3 days; week of 5/24/2020 to 5/30/2020, 2 hours per day for 1 day; no further HHA visits were evidenced through 10/12/2020, when the patient was discharged from the agency. Clinical record review failed to evidence the agency provided the hours of home health aide care they determined the patient needed. During an interview on 5/21/2021 at 11:35 a.m., the alternate administrator indicated the plan of care was created based on the skilled nurse's assessment of the patient's needs. During an interview on 5/21/2021 at 12:10 p.m., the alternate administrator indicated the number and frequency of hours of care provided on the service agreement and the plan of care should			

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	15K021	A. BUILDING 00 B. WING	05/21/2021

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	match. She indicated if there was a change in the hours provided, the service agreement should be updated, and there should be a physician order. When informed of the findings, employee C, LPN [licensed practical nurse], stated, "I know they were short staffed down there. I can't imagine she didn't offer another agency, but I don't see where she documented it". The alternate administrator and employee C indicated the agency did not meet the patient's needs. 17-14-1(a)(1)(B)			
G 0536 Bldg. 00	484.55(c)(5) A review of all current medications 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. Based on record review and interview, the home health agency failed to review identified medication concerns with the physician, in 2 of 3 discharged records reviewed (#3, #4). The findings include: 1. Record review on 5/21/2021, evidenced an undated agency policy titled, "Medication Reconciliation", which stated, "The Agency will reconcile patient's medications at time of admission and on an ongoing basis ... the admitting RN [registered nurse] will create and document a complete list of medications that patient is taking at home, including dose, strength, route, and frequency. Any discrepancies will be reconciled by a RN with the	G 0536	1. Action Steps to ensure completion: In the past #2 for major “Drug Interaction Reporting between cyclobezaprine and esctalopram when we did the SOC we would write on the order be aware of Major drug interaction and fax it to the md along with web-md medication interaction. We would also do this with any medication changes. Now we run med-interactor in Matrix and fax it to the MD with any SOC or medication changes. This way the patients name is on it and it is a permanent part of the record 2. Date of Compliance: Moving	06/07/2021

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	patient's physician. Discrepancies include duplications, omissions, changes, contraindications and/or unclear information...." 2. Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced a document titled "Drug Interaction Report", printed from website E, dated 5/6/2020. This report evidenced a major drug reaction between the cyclobenzaprine [a muscle relaxant] and escitalopram [a medication used to treat anxiety and/or depression]. This report stated, " ... Using cyclobenzaprine together with escitalopram can increase the risk of a rare but serious condition ... which may include symptoms such as confusion, hallucination, seizure, extreme changes in blood pressure, increased heart rate, fever ... severe cases may result in coma and even death...." This report failed to include any patient, staff, or physician identifier or information shared regarding the major interaction identified on the drug interaction report. Clinical record review evidenced an agency document titled, "Medication Profile", signed by former employee D, RN, dated 5/5/2020. This medication profile stated, " ... Escitalopram 20 mg [milligram] by mouth daily ... Cyclobenzaprine 10 mg by mouth three times daily...." Clinical record review failed to evidence physician notification of the major drug interaction. During an interview on 5/18/2021 at 10:18 a.m., the administrator indicated if a severe medication interaction was found during medication reconciliation, the nurse should write an order and send it to the physician to be signed.		forward with a whole new system we are running interaction on all new and existing patients at 100% and sending it to the MD this was completed when we went live with Matrix on June 7, 2021. Administrator and or designee will audit 100% of charts by 7/14/21 and 100% every 60 days when charts are reviewed by Administrator and or designee upon each recertification. 1. 3. Responsible for correction: 1. 4. Monitoring Process to prevent Reoccurrences: 4.	

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	On 5/21/2021 at 12:22 p.m., when informed of the findings, the alternate administrator and employee C, LPN [licensed practical nurse], reviewed the patient chart. No order notifying the primary care physician of the major drug interaction was evidenced. 3. Clinical record review on 5/20/2021 for patient #4, start of care 6/30/2016, certification period 6/9/2020 to 8/7/2020, primary diagnosis of spinal stenosis [a narrowing of the spinal canal which can cause pain, numbness, muscle weakness, and impaired bladder or bowel control] evidenced a document titled "Drug Interaction Report", printed from website E, dated 6/5/2020. This report evidenced four major drug reactions: buspirone [a medication used to treat anxiety] and mirtazapine [an anti-depressant], labetalol [a medication used to treat high blood pressure] and clonidine [a medication used to treat high blood pressure], mirtazapine and duloxetine [an anti-depressant], and buspirone and duloxetine. This report failed to include any patient, staff, or physician identifier or information shared regarding the major interaction identified on the drug interaction report. What Clinical record review evidenced an agency document titled, "Medication Profile", signed by employee G, RN, dated 5/5/2020. This medication profile stated, " ... Buspar [brand name of buspirone] 15 mg by mouth twice a day ... Clonidine HCL 0.2 mg by mouth three times a day as needed for diastolic Blood Pressure (lower number) greater than 100 ... Clonidine HCL 0.2 mg by mouth Three times a day as needed for systolic Blood Pressure (upper number) greater than 200 ... Labetalol 300 mg by mouth twice a day ... Mirtazapine 30 mg by mouth at bedtime ...			

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	Duloxetine 60 mg by mouth twice a day...." Clinical record review failed to evidence documentation of any primary care physician notification of the major drug interaction. During an interview on 5/18/2021 at 10:18 a.m., the administrator indicated if a severe medication interaction was found during medication reconciliation, the nurse should write an order and send it to the physician to be signed. On 5/21/2021, at 12:42 p.m., when informed of the findings, the alternate administrator and employee C, LPN, reviewed the patient chart. No order notifying physician of the major drug interaction was evidenced. 17-14-1(a)(1)(B)			
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or 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. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care was individualized and followed 5 of 5 records reviewed. (#1, #2, #3, #4, #5)	G 0572	1) 1. Action Steps to ensure completion: During home visit Auditor witnessed Employee E, HHA was not compliant with HHA	07/30/2021

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	The findings include: 1. Record review on 5/21/2021, evidenced an undated agency policy titled, "Care Planning Process", which stated, " ... In order to assure that care provided is appropriately planned to meet each patient's specific needs and problems, the Agency will utilize data / information gathered during patient assessments in the care planning process ... PROCEDURE 1. The patient care plan for Skilled Nursing will be: Initial care plan will be developed and implemented with the physician. Demonstrates problems (diagnoses), interventions (physician orders) and long range goals ... 3. Care will be coordinated initially and ongoing among staff providing care. Care planning for each patient will be individualized to include: Problems and needs ... Specific care or services to be provided including frequency, type and duration ... Review and revision as indicated...." 2. Record review on 5/21/2021, evidenced an undated agency policy titled, "Plan of Care - CMS #485 and Physician Orders", which stated, " ... PROCEDURE ... 2. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment ... 3. 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...."		Plan of care 2) Date of Compliance: HHA's are given a yearly competency in the patient's home specific to that patient' needs by a RN/Case Manager. Administrator and or administrator designee will monitor 100% of HHA and will be re-comped and re-educated by 7/30/21 in patient specific home to ensure patient safety by RN/Case Manager, Administrator and or qualified designee 3) Responsible for correction: On May 27th RN/Case Manger C.P. re-educated HHA to above patient and did a re-competency training with the slide board and keeping the side rails up. 4) Monitoring Process to prevent Reoccurrences: We will continue to do yearly competencies for HHA's specific to patient's needs in the patients home for 100% compliance. Upon orientation, they are to receive report on each patient the will be seeing. if they have any question the RN/Case Managers will go out with HHA and educate on patient specific equipment. Also upon hire, Administrator assigned designee and RN/Case Manager will go out after their initial competency 30 days to the patients home to assess HHA's skills	

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	3. Clinical record review on 5/19/2021 for patient #1, start of care 4/1/2019, certification period 3/21/2021 to 5/19/2021, primary diagnosis of walking disability, evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 4/8/2021. This plan of care had a subcategory titled, "Orders for Discipline and Treatments (Specify Amount / Frequency / Duration):", which stated, "Services Provided: Home Health Aide up to 1-2 hours per day, 1-2 days per week x 9 weeks...." The plan of care failed to evidence a minimum number of hours of home health aide care the agency was to provide. Clinical record review evidenced a document from entity A, titled " [entity A] Form 10-7080 - Approved Referral For Medical Care", dated 1/28/2021, which stated, " ... No less than 3 hours per week and up to 6 hours per week Homemaker / home health aide services...." During an interview on 5/21/2021 at 11:35 a.m., the alternate administrator indicated the plan of care should include a minimum number of hours of care provided, individualized to the needs of the patient. 4. Clinical record review on 5/19/2021 for patient #2, start of care 9/4/2019, certification period 3/17/2021 to 5/15/2021, primary diagnoses of spinal cord injury and urostomy [a surgically-created opening for the urinary system], evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 5/17/2021. This plan of care had a subcategory titled, "Safety Measures", which stated, "Side rails up...."			

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	During a home visit on 5/20/2021 at 12:25 p.m., employee E, HHA [home health aide], was observed giving a bed bath to patient #2. At 12:35 p.m., the HHA entered the patient's bedroom. The patient was lying in a hospital bed, both side rails down, with a rolling bedside table on each side of the bed. At 12:40 p.m., the HHA gathered basins, soap, and towels. After washing the front of the patient, at 1:05 p.m., the HHA was observed assisting the patient to turn to their left side. Both side rails of the bed remained down. After washing the patient's back, at 1:15 p.m., the HHA was observed assisting the patient to turn to their right side. The HHA instructed the patient to hold on to the rolling bedside table for support. At 1:18 p.m., the HHA assisted to dress the patient, assisting the patient to turn side to side in the bed, instructing the patient to hold on to the rolling bedside table each time. At 1:37 p.m., the HHA went to the patient's bathroom to empty the basins, leaving the side rails down. At 1:38 p.m., the HHA was observed assisting the patient to turn side to side while she placed an underpad beneath the patient. The side rails remained down. The repeated turning resulted in the patient's body being near the edge of the right side of the mattress. At 1:39 p.m., the HHA assisted the patient to turn to their left side, and hold the rolling bedside table for support. The HHA indicated she needed to reposition the patient to the center of the bed. At 1:40 p.m., the HHA picked up a slider board from a wheelchair near the end of the bed. The HHA looked at the slider board and indicated she did not know how to use it. The HHA called for the patient's family member to come to the room and asked the family member if they knew how to use the slider board. The family member manually lifted the patient and moved her to the center of the bed. At 1:43 p.m., the bath was complete. The HHA failed to put the			

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	side rails up on the patient's bed. During an interview on 5/21/2021 at 11:53 a.m., the alternate administrator indicated safety measures in the plan of care should be maintained at each visit. The alternate administrator indicated the HHA failed to implement safety measures as ordered in the plan of care. 5. Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "Admission Service Agreement Home Health", dated 11/11/2019, signed by the nurse and patient #3. This service agreement stated, "Consent for Care / Service: I hereby consent and authorize the organization, its agents and associates to provide care and treatment to me in my home as prescribed by my Physician ... I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and anticipated outcomes), my involvement with the plan of care, and how changes will be made if needed ... Home Health Aide - Predicted Freq 1-2 hr/vs [hours per visit] 5-7d/wk [days per week]...." Clinical record review evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 5/19/2020. This plan of care had a subcategory titled, "Orders for Discipline and Treatments:" which stated, "HHA [home health aide]: 1-2 hr/d [hours per day], 2-3 d/wk [days per week] X 9 [for 9 weeks] ...." Clinical record review failed to evidence an update to the service agreement or physician's order reflecting the decrease in hours of care provided.			

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	15K021	A. BUILDING 00 B. WING	05/21/2021

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	Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. Review of these documents evidenced the agency provided the following HHA hours: week of 5/10/2020 to 5/16/2020, 2 hours per day for 2 days; week of 5/17/2020 to 5/23/2020, 2 hours per day for 3 days; week of 5/24/2020 to 5/30/2020, 2 hours per day for 1 day; no further HHA visits were evidenced through 10/12/2020, when the patient was discharged from the agency. Clinical record review failed to evidence the agency provided the hours of care they determined the patient needed. During an interview on 5/21/2021 at 12:10 p.m., the alternate administrator indicated the number and frequency of hours of care provided on the service agreement and the plan of care should match. She indicated if there was a change in the hours provided, the service agreement should be updated, and there should be a physician order. The alternate administrator indicated the agency failed to provide care as ordered in the plan of care. 6. Clinical record review on 5/20/2021 for patient #4, start of care 6/30/2016, certification period 6/9/2020 to 8/7/2020, primary diagnosis of spinal stenosis [a narrowing of the spinal canal which can cause pain, numbness, muscle weakness, and impaired bladder or bowel control] evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 6/22/2020. This plan of care had a subcategory titled, "Orders for Discipline and Treatments:" which stated, "HHA [home health aide] up to 12			

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	hours / day, 3-5 days week x 9 weeks for assistance with ADL's [activities of daily living] and IADL's [instrumental activities of daily living]. HHA to perform passive ROM [range of motion] to BLE [bilateral lower extremities][both legs] every visit...." During an interview on 5/21/2021 at 12:29 p.m., the alternate administrator and employee C, LPN [licensed practical nurse], indicated the plan of care failed to be specific to the patient needs. After reviewing the hours of care ordered in the plan of care, employee C stated, "I wish they wouldn't write 'up to' like that". Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. These visit notes failed to evidence passive ROM was performed on 6/29/2020, 6/30/2020, 8/4/2020, 8/5/2020, 8/6/2020, 8/7/2020, 8/10/2020, 8/12/2020, and 8/14/2020. During an interview on 5/21/2021 at 12:42 p.m., the alternate administrator and employee C indicated passive ROM should be documented on each home visit note, and offered no further documentation. 7. Clinical record review on 5/20/2021 for patient #5, start of care 2/2/2010, certification period 6/11/2020 to 8/9/2020, primary diagnosis of Alzheimer's disease, evidenced an agency document titled, "Home Health Plan of Care / Certification", signed by the physician on 7/29/2020. This plan of care had a subcategory titled, "Safety Measures", which stated, "Anticoagulant precautions...." Clinical record review evidenced an agency			

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	document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee H, RN on 6/10/2020. This care plan had a subcategory titled, "PRECAUTIONARY AND OTHER PERTINENT INFORMATION-Check all that apply...." The box indicating "Bleeding Precautions" was marked with an "X". Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. The HHA visit notes with the following dates failed to evidence bleeding or anticoagulant precautions: 6/8/2020, 6/9/2020, 6/10/2020, 6/11/2020, 6/12/2020, 6/17/2020, 6/18/2020, 6/19/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/29/2020 and 6/30/2020. During an interview on 5/21/2021 at 12:52 p.m., employee C, LPN, indicated safety should be addressed at each visit by all disciplines. When informed of the findings, employee C and the alternate administrator were silent. 17-13-1(a)			
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to ensure the physician was alerted to changes in the patient's condition in 1 of 1 active clinical records reviewed with a hospitalization. (#2).	G 0590	1) Action Steps to ensure completion: Record 5/21/21, patient #2 was at the would clinic and then sent to hospital for what the RN/CM thought was an	07/06/2021

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	15K021	A. BUILDING 00 B. WING	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELP AT HOME SKILLED CARE	8401 OHIO STREET MERRILLVILLE, IN 46410

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	The findings include: Record review on 5/21/2021, evidenced an undated agency policy titled, "Care Planning Process", which stated, " ... In order to assure that care provided is appropriately planned to meet each patient's specific needs and problems, the Agency will utilize data / information gathered during patient assessments in the care planning process ... 3. Care will be coordinated initially and ongoing among staff providing care. Care planning for each patient will be individualized to include: Problems and needs ... Specific care or services to be provided including frequency, type and duration ... Review and revision as indicated...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Coordination of Patient Care", which stated, " ... The Agency must: Assure communication with all physicians involved in the plan of care ... Staff provides the physician with patient information on an ongoing basis regarding: Current condition and changes in condition...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Skilled Professional Services", which stated, " ... Skilled professional services include skilled nursing services ... Skilled professionals must assume responsibility for, but not to be restricted to ... Communication with all physicians involved in the plan of care...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Nursing Services", which stated, " ... Nursing care will be provided in accordance with the patient's plan of care, under the supervision of a registered nurse.		infected wound when she called hospital, she found out is was aspiration pneumonia which didn't match the transfer Oasis vs Transfer forms. 2) Date of Compliance: All clinical staff will be in serviced 7/6/21 on transfer summary to receiving facility to coordinate all care, send hold order to MD with admitting diagnosis and date of admission to which facility. If diagnosis changes send clarification order to MD. Administrator and or designee will monitor 100% of transferred charts for the next 60 days to meet 100% compliance. When 100% compliance is met 25% of charts will be audited monthly to ensure clinical records are 100% accurate. 3) Responsible for correction: This in-service is scheduled for Tuesday July 6th to correct the mismatched diagnoses. Administrator and or assigned designee will audit 100% of transfer chart for the next 60 days to meet 100% compliance. When 100% of compliance is met, then will monitor 25% of charts to make sure compliance is met. 4) Monitoring Process to prevent Reoccurrences: If Administrator and or designee finds discrepancies. RN/CM will	

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	15K021	A. BUILDING 00 B. WING	05/21/2021

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	Professional nursing service will be provided by a registered nurse and include: ... Informing the physician and other staff of changes in the patient's needs...." Clinical record review on 5/19/2021 for patient #2, start of care 9/4/2019, certification period 3/17/2021 to 5/15/2021, primary diagnoses of spinal cord injury and urostomy [a surgically-created opening for the urinary system], evidenced an agency document titled, "Completion of Care, OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] Data Sets, and Discharge / Transfer Summary", dated 4/15/2021, signed by employee F, RN [registered nurse]. This document had a subsection titled, "Additional Comments / Notes:", which stated, "Patient had appt [appointment] [with] wound clinic [physician B]. [Physician B] had patient admitted to hospital for possible aspiration pneumonia." Clinical record review evidenced an agency document titled, "TRANSFER SUMMARY - 9.24.A", dated 4/16/2021, signed by employee F, RN, faxed to physician C on 4/16/2021. This summary stated, " ... REASON FOR TRANSFER: WOUND...." The transfer summary failed to evidence possible aspiration pneumonia. During an interview on 5/21/2021 at 11:58 a.m., the alternate administrator indicated the agency used the transfer summary to inform the physician of the patient's transfer to the hospital. During an interview on 5/21/2021 at 12:00 p.m., employee F, RN, indicated she completed the transfer summary before finding out what happened at physician B's office. Employee F		be re-educated and re-in serviced on proper coordination of care with a follow up order to match Transfer Oasis as to meet 100% compliance.	

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	indicated the reason for the transfer was possible aspiration pneumonia, and the transfer summary was incorrect. When informed of the findings, the alternate administrator and employee F failed to evidence communication of the physician being informed of the correct reason the patient was transferred to the hospital. 17-13-1(a)(2)			
G 0682 Bldg. 00	484.70(a) Infection Prevention 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. Based on observation, record review, and interview, the home health agency failed to follow accepted standards of practice for screening employees, visitors and patients for COVID-19 in 2 of 2 active patient records reviewed (#1, #2). The findings include: 1. Record review on 5/21/2021, evidenced an agency document dated September 2020, titled, "Back to Work Packet", identified by employee C, LPN [licensed practical nurse], as the agency's COVID policies. Page 5 of this packet stated, "Policy: Disease Response and Management [COVID-19] Infection Control Date Originated: 4/1/2020 Date Implemented 4/15/2020 EXPOSURE TO COVID-19 PURPOSE: The purpose of this policy is to follow the recommendation of the CDC [Centers for Disease Control] by supplementing the Company's existing policies and procedures pertaining to infection prevention and control...."	G 0682	1. Action Steps to ensure completion: Agency failed to follow prior to entry COVID screening by not having the HHA document screening prior to entering patients home. 2. Date of Compliance: Administrator and or assigned designee will complete 100% HHA time sheet audit to ensure prior to patient entry signs and symptoms of COVID screening is completed. All direct staff will receive education on prior to patient entry screening for COVID Signs and Symptoms as evidenced by having Signs and Symptoms of COVID on all Service Plans by 6/30/2021. 100% Audit's will be completed by	06/30/2021

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	This policy had a subsection titled, "CLIENT PROCEDURE", which stated, " ... 1. Clients should be screened prior to any home visit...." 2. Clinical record review on 5/19/2021 for patient #1, start of care 4/1/2019, certification period 3/21/2021 to 5/19/2021, primary diagnosis of walking disability, evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. The HHA notes were dated: 3/22/2021, 3/25/2021, 3/29/2021, 4/1/2021, 4/5/2021, 4/12/2021, 4/15/2021, 4/19/2021, 4/22/2021, 4/26/2021, 4/29/2021, 5/3/2021, and 5/6/2021. Each of these notes failed to evidence a COVID-19 screening for the patient. During an interview on 5/21/2021 at 11:49 a.m., employee C, LPN, indicated case managers were doing COVID-19 screening of patients by phone before their visits, but home health aides were not being instructed to perform COVID-19 screening before their visits. The alternate administrator was silent and nodded. 3. Clinical record review on 5/19/2021 for patient #2, start of care 9/4/2019, certification period 3/17/2021 to 5/15/2021, primary diagnoses of spinal cord injury and urostomy [a surgically-created opening for the urinary system], evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. The HHA notes were dated: 3/25/2021, 4/1/2021, 4/5/2021, 4/8/2021, 4/9/2021, 4/12/2021, 4/29/2021, and 5/6/2021. Each of these notes failed to evidence a COVID-19 screening for the patient. On 5/21/2021 at 12:04 p.m., the alternate administrator and employee C were informed of		7/14/2021 by Administrator and or assigned designee. 3. Responsible for correction: Administrator and or assigned designee will continue to audit up to 25% HHA prior to patient entry screening for COVID sins and symptoms monthly to ensure compliance is met, if errors occur will re-educate HHA and RN/Case Managers on follow prior to patient entry Signs and Symptoms COVID screening. 4. Monitoring Process to prevent Reoccurrences: Administrator and or assigned designee will be responsible compliance will be met by 7/25/2021. Continuation of 25% of chart audits will be completed on a monthly basis to ensure COVID compliance.	

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	the findings and were silent. 17-12-1(m)			
G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. 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). Based on record review and interview, the agency failed to ensure the registered nurse provided a complete care plan for the home health aide [HHA] in 5 of 5 clinical records reviewed (#1, #2, #3, #4, #5). The findings include: 1. Record review on 5/21/2021, evidenced an undated agency policy titled, "Home Health Aide Supervision", which stated, " ... The agency shall provide Home Care aide services under the direction and supervision of a Registered Nurse Case Manager when personal care services are indicated and ordered by the physician. PURPOSE To assure the appropriateness of home health aide services and to maintain quality of care...." 2. Record review on 5/21/2021, evidenced an undated agency policy titled, "JOB DESCRIPTION Registered Nurse Case Manager (RN)....", which stated, " ... RESPONSIBILITIES: 1. Provides services in accordance with the plan	G 0798	1) 1. Action Steps to ensure completion: Regarding PRN tasks for HHA's. Administrator and or assigned designee will audit 100% of charts to ensure PRN task have been removed. Effective 6/7/21 2) Date of Compliance: All HHA's have been re-educated on documentation on how to complete task. Administrator and or assigned designee will audit 100% of charts for 30 days, if 100% compliance met. Administrator and or designee will monitor 80% daily x 60 days. If compliance is met in the 60 days will audit 50% of completion of tasks when 100% compliance is met, will audit 3x per week. 3) Responsible for correction: We have effectively been able to change Service Plans	06/07/2021

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	of care ... 7. Coordinates services. ... JOB RELATIONSHIPS: ... 2. Workers Supervised: Licensed Practical Nurse, Home Health Aide...." 3. Record review on 5/21/2021, evidenced an undated agency policy titled, "JOB DESCRIPTION Home Health Aide (HHA)....", which stated, "JOB SUMMARY: A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the Registered Nurse Case Manager (RN)...." 4. Record review on 5/21/2021, evidenced an undated agency policy titled, "Care Planning Process", which stated, " ... The patient care plan for the Home Health Aide will be: Home Health Aide assignment sheet: developed by a Registered Nurse ... The assignment sheet / plan of care will include: Type service / procedure to be provided ... Specific procedure to be performed including amount, frequency and duration. Safety measures including use of equipment. Instructions for completion of documentation...." 5. Clinical record review on 5/19/2021 for patient #1, start of care 4/1/2019, certification period 3/21/2021 to 5/19/2021, primary diagnosis of walking disability, evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee D, RN [registered nurse] on 3/18/2021. The following HHA tasks were indicated to be performed "PRN [as needed] Per Pt/Cg [Patient or caregiver]" : Bed Bath-Partial / Complete, Assist Bath-Chair, Nail care, shave, Assist with elimination, Medication reminder, Assist with Ambulation, Assist with Hoyer lift,		for the HHA to reflect no PRN's, unless caregiver/patient is cognitively able to make decisions. Service Plans can be updated in real time, if the patients' needs change. Administration/assigned designee will track and trend to reflect no PRN's per 25% chart audits. 1. 4. Monitoring Process to prevent Reoccurrences:	

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	Chair/Bed, Dangle/Commode, Meal Preparation, Assist with Feeding, Wash Clothes, Bedroom, Kitchen, Change Bed Linen, Equipment Care, Other: trash. The skilled nurse failed to list the indications for when the home health aide was to perform the "as needed" tasks. During an interview on 5/21/2021 at 11:30 a.m., the alternate administrator indicated the nurse case manager created the aide care plan based on patient needs. When queried, the alternate administrator and employee C, LPN [licensed practical nurse], indicated the nurse was not directing care when most tasks were "as needed". 6. Clinical record review on 5/19/2021 for patient #2, start of care 9/4/2019, certification period 3/17/2021 to 5/15/2021, primary diagnoses of spinal cord injury and urostomy [a surgically-created opening for the urinary system], evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee F, RN [registered nurse] on 5/14/2021. The following HHA tasks were indicated to be performed "PRN [as needed] Per Pt/Cg [Patient or caregiver]" : Bed Bath-Partial / Complete, Shampoo, Nail care, Ostomy care-urostomy / empty bag, Assist with Wheelchair, Chair/Bed, Dangle/Commode, Meal Preparation, Assist with Feeding, Wash Clothes, Kitchen, Change Bed Linen. The skilled nurse failed to list the indications for when the home health aide was to perform the "as needed" tasks. During an interview on 5/21/2021 at 11:30 a.m., the alternate administrator indicated the nurse case manager created the aide care plan based on patient needs. When queried, the alternate administrator and employee C, LPN, indicated the nurse was not directing care when most tasks			

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	were "as needed". 7. Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by former employee D, RN on 5/5/2020. The following HHA tasks were indicated to be performed "PRN [as needed] Per Pt/Cg [Patient or caregiver]" : Assist Bath-Chair, Assist with Dressing, Hair Care, Shampoo, Foot care, Nail care, Oral care, Assist with Ambulation, Meal Preparation, Wash Clothes, Light housekeeping, Bedroom, Bathroom, Kitchen, Change Bed Linen, Other: Trash. The skilled nurse failed to list the indications for when the home health aide was to perform the "as needed" tasks. During an interview on 5/21/2021 at 11:30 a.m., the alternate administrator indicated the nurse case manager created the aide care plan based on patient needs. When queried, the alternate administrator and employee C, LPN, indicated the nurse was not directing care when most tasks were "as needed". 8. Clinical record review on 5/20/2021 for patient #4, start of care 6/30/2016, certification period 6/9/2020 to 8/7/2020, primary diagnosis of spinal stenosis [a narrowing of the spinal canal which can cause pain, numbness, muscle weakness, and impaired bladder or bowel control] evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by former employee D, RN on 6/5/2020 and 8/3/2020. The following HHA tasks were indicated to be performed "PRN [as needed] Per Pt/Cg [Patient or caregiver]" : Tub/shower, Assist Bath-Chair, Shampoo, Nail			

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	care, Dangle/Commode, Shower/Tub, Positioning, Assist with Feeding, Wash Clothes, Bedroom, Bathroom, Kitchen, Change Bed Linen, Equipment Care, Other: TED hose [anti-embolism stockings], Other: Trash...." The skilled nurse failed to list the indications for when the home health aide was to perform the "as needed" tasks. During an interview on 5/21/2021 at 11:30 a.m., the alternate administrator indicated the nurse case manager created the aide care plan based on patient needs. When queried, the alternate administrator and employee C, LPN, indicated the nurse was not directing care when most tasks were "as needed". 9. Clinical record review on 5/20/2021 for patient #5, start of care 2/2/2010, certification period 6/11/2020 to 8/9/2020, primary diagnosis of Alzheimer's disease, evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee H, RN on 6/10/2020. The following HHA tasks were indicated to be performed "PRN [as needed] Per Pt/Cg [Patient or caregiver]" : Shampoo, Foot care, Nail care, Shower/Tub, Wash Clothes, Light Housekeeping, Bedroom, Bathroom, Kitchen, and Change Bed Linen. During an interview on 5/21/2021 at 11:30 a.m., the alternate administrator indicated the nurse case manager created the aide care plan based on patient needs. When queried, the alternate administrator and employee C, LPN, indicated the nurse was not directing care when most tasks were "as needed". 17-13-2(a)			

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HELP AT HOME SKILLED CARE	8401 OHIO STREET MERRILLVILLE, IN 46410

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G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review and interview, the home health aide failed to provide services as indicated in the aide care plan in 5 of 5 clinical records reviewed (#1, #2, #3, #4, #5). The findings include: 1. Record review on 5/21/2021, evidenced an undated agency policy titled, "JOB DESCRIPTION Home Health Aide (HHA)....", which stated, "JOB SUMMARY: A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the Registered Nurse Case Manager (RN)...." 2. Record review on 5/21/2021, evidenced an undated agency policy titled, "Care Planning Process", which stated, " ... The patient care plan for the Home Health Aide will be: Home Health Aide assignment sheet: developed by a Registered Nurse ... The assignment sheet / plan of care will include: Type service / procedure to be provided ... Specific procedure to be performed including amount, frequency and duration. Safety measures including use of equipment. Instructions for completion of	G 0800	1) Action Steps to ensure completion: During home visit Auditor witnessed Employee E, HHA was not compliant with HHA Plan of care 2) Date of Compliance: HHA's are given a yearly competency in the patient's home specific to that patients' needs by a RN/Case Manager. Administrator and or administrator designee will monitor 100% of HHA and will be re-comped and re-educated by 7/30/21 in patient specific home to ensure patient safety by RN/Case Manager, Administrator and/or qualified designee. 3) Responsible for correction: Administration and or designee will make sure 100% compliance is met by 5/27/21 On May 27th RN/Case Manager C. P. reeducated HHA to above patient and did a re-competency with the slide board and keeping the side rails up. 4) Monitoring Process to	05/27/2021

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	15K021	A. BUILDING 00 B. WING	05/21/2021

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	documentation...." 3. Clinical record review on 5/19/2021 for patient #1, start of care 4/1/2019, certification period 3/21/2021 to 5/19/2021, primary diagnosis of walking disability, evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee D, RN [registered nurse] on 3/18/2021. This care plan indicated the patient was on oxygen precautions. Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. The HHA notes with the following dates failed to evidence oxygen precautions: 3/22/2021, 3/25/2021, 3/29/2021, 4/1/2021, 4/5/2021, 4/12/2021, 4/15/2021, 4/19/2021, 4/22/2021, 4/26/2021, 4/29/2021, 5/3/2021, and 5/6/2021. During an interview on 5/21/2021 at 11:45 a.m., the alternate administrator indicated safety should be assessed at each visit by the HHA. The alternate administrator indicated the HHA failed to document oxygen precautions at each visit. 4. Clinical record review on 5/19/2021 for patient #2, start of care 9/4/2019, certification period 3/17/2021 to 5/15/2021, primary diagnoses of spinal cord injury and urostomy [a surgically-created opening for the urinary system], evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee F, RN on 5/14/2021. This care plan had a subcategory titled, "PRECAUTIONARY AND OTHER PERTINENT INFORMATION....", which stated, " ... Special Equipment: ... Transfer Board ... Other (specify): Clear pathways Lock w/c [wheelchair] with transfers; Transfer Board...."		prevent Reoccurrences: We will continue to do yearly competencies for HHA's specific to patient's needs in the patient's home for 100% compliance. Upon orientation, they are to receive report on each patient they will be seeing, if they have any questions the RN/Case Managers will go out with them and show them how to use patient specific equipment. Also upon Hire, Administrator, Assigned designee and RN/CM will go out after 30 days to patients home to assess HHA's skills. Administrator and or assigned designee will do 15 supervisory visits per week to ensure HHA's are following the Plan of care at 100% accuracy	

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	During a home visit on 5/20/2021 at 12:25 p.m., employee E, HHA [home health aide], was observed giving a bed bath to patient #2. At 12:35 p.m., the HHA entered the patient's bedroom. The patient was lying in a hospital bed, both side rails down, with a rolling bedside table on each side of the bed. At 12:40 p.m., the HHA gathered basins, soap, and towels. After washing the front of the patient, at 1:05 p.m., the HHA was observed assisting the patient to turn to their left side. Both side rails of the bed remained down. After washing the patient's back, at 1:15 p.m., the HHA was observed assisting the patient to turn to their right side. The HHA instructed the patient to hold on to the rolling bedside table for support. At 1:18 p.m., the HHA assisted to dress the patient, assisting the patient to turn side to side in the bed, instructing the patient to hold on to the rolling bedside table each time. At 1:37 p.m., the HHA went to the patient's bathroom to empty the basins, leaving the side rails down. At 1:38 p.m., the HHA was observed assisting the patient to turn side to side while she placed an underpad beneath the patient. The side rails remained down. The repeated turning resulted in the patient's body being near the edge of the right side of the mattress. At 1:39 p.m., the HHA assisted the patient to turn to their left side, and hold the rolling bedside table for support. The HHA indicated she needed to reposition the patient to the center of the bed. At 1:40 p.m., the HHA picked up a slider board from a wheelchair near the end of the bed. The HHA looked at the slider board and indicated she did not know how to use it. The HHA called for the patient's family member to come to the room and asked the family member if they knew how to use the slider board. The family member manually lifted the patient and moved her to the center of the bed. At 1:43 p.m.,			

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	15K021	A. BUILDING 00 B. WING	05/21/2021

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	the bath was complete. The HHA failed to put the side rails up on the patient's bed. During an interview on 5/21/2021 at 11:50 a.m., employee C, LPN indicated HHA should be knowledgeable on how to use a slider board. The alternate administrator was silent and nodded. 5. Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by former employee D, RN on 5/5/2020. This care plan indicated the patient was on seizure precautions. Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. The HHA notes with the following dates failed to evidence oxygen precautions: 5/11/2020, 5/15/2020, 5/18/2020, 5/20/2020, 5/22/2020, and 5/27/2020. During an interview on 5/21/2021 at 12:15 p.m., the alternate administrator indicated safety should be assessed at each visit by the HHA. The alternate administrator indicated the HHA failed to evidence seizure precautions at each visit. 6. Clinical record review on 5/20/2021 for patient #4, start of care 6/30/2016, certification period 6/9/2020 to 8/7/2020, primary diagnosis of spinal stenosis [a narrowing of the spinal canal which can cause pain, numbness, muscle weakness, and impaired bladder or bowel control] evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by former employee D, RN on 6/5/2020 and 8/3/2020. This care plan indicated			

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	Assist with elimination and Passive ROM [range of motion] BLE [bilateral lower extremities][both legs], were to be performed at each HHA visit. Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet", identified by the administrator as the home health aide visit notes. These visit notes failed to evidence assist with elimination was performed on 8/24/2020, 8/25/2020, 8/26/2020. 8/27/2020, and 8/28/2020. These visit notes failed to evidence passive ROM was performed on 6/29/2020, 6/30/2020, 8/4/2020, 8/5/2020, 8/6/2020, 8/7/2020, 8/10/2020, 8/12/2020, and 8/14/2020. During an interview on 5/21/2021 at 12:42 p.m., the alternate administrator and employee C indicated assist with elimination and passive ROM should be documented on each home visit note, and offered no further documentation. 7. Clinical record review on 5/20/2021 for patient #5, start of care 2/2/2010, certification period 6/11/2020 to 8/9/2020, primary diagnosis of Alzheimer's disease, evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee H, RN on 6/10/2020. This care plan had a subcategory titled, "PRECAUTIONARY AND OTHER PERTINENT INFORMATION-Check all that apply...." The box indicating "Bleeding Precautions" was marked with an "X". This care plan indicated the following tasks were to be completed at every visit by the HHA: Bed Bath-Partial/Complete, Hair Care, Assist with feeding, Assist with Ambulation: Chair/Bed, Dangle/Commode, Positioning. Clinical record review evidenced a group of documents titled, "Home Health Aide Timesheet",			

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	15K021	A. BUILDING 00 B. WING	05/21/2021

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	identified by the administrator as the home health aide visit notes. The HHA visit notes with the following dates failed to evidence bleeding or anticoagulant precautions: 6/8/2020, 6/9/2020, 6/10/2020, 6/11/2020, 6/12/2020, 6/17/2020, 6/18/2020, 6/19/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/29/2020 and 6/30/2020. Review of the HHA visit notes failed to evidence a bed bath was completed on 6/9/2020, 6/10/2020, 6/17/2020, 6/18/2020, 6/19/2020, 6/23/2020, 6/24/2020, 6/26/2020, 6/28/2020, and 6/30/2020. Review of the HHA visit notes failed to evidence hair care was performed on 6/8/2020, 6/9/2020, 6/10/2020, 6/11/2020, 6/12/2020, 6/17/2020, 6/18/2020, 6/19/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/29/2020 and 6/30/2020. Review of the HHA visit notes failed to evidence assist with feeding was performed on 6/8/2020, 6/9/2020, 6/10/2020, 6/11/2020, 6/12/2020, 6/17/2020, 6/18/2020, and 6/19/2020. Review of the HHA visit notes failed to evidence "Chair/Bed" was completed on 6/17/2020, 6/18/2020, 6/19/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/29/2020, and 6/30/2020. Review of the HHA visit notes failed to evidence "Dangle/Commode" was completed on 6/17/2020, 6/18/2020, 6/19/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/29/2020, and 6/30/2020. Review of the HHA visit notes failed to evidence "Positioning" was completed on 6/17/2020,			

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	6/18/2020, 6/19/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/29/2020, and 6/30/2020. During an interview on 5/21/2021 at 12:52 p.m., employee C, LPN, indicated safety should be addressed at each visit by all disciplines. The alternate administrator and employee C indicated Bed Bath-Partial/Complete, Hair Care, Assist with feeding, Assist with Ambulation: Chair/Bed, Dangle/Commode and Positioning should be documented on each home visit note, and offered no further documentation. Review of the HHA visit notes evidenced Medication Reminders were completed by the HHA on 6/8/2020, 6/9/2020, 6/10/2020, 6/11/2020, 6/12/2020, 6/17/2020, 6/18/2020, 6/19/2020, 6/22/2020, 6/23/2020, 6/24/2020, 6/25/2020, 6/26/2020, 6/29/2020 and 6/30/2020. Clinical record review evidenced an agency document titled, "HOME HEALTH AIDE CARE PLAN", signed by employee H, RN on 6/10/2020, failed to evidence Medication Reminders were an assigned HHA task. The HHA performed a task not assigned by the nurse in the aide care plan. On 5/21/2021 at 12:50 p.m., when informed of the findings, the alternate administrator and employee C, LPN, were silent.			
G 0818 Bldg. 00	484.80(h)(4)(i-vi) HH aide supervision elements Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home			

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	health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on observation, record review and interview, the agency failed to ensure home health aide supervision ensured safe and effective home health aide care in 1 of 1 home visits where the home health aide was observed (#2). The findings include: Record review on 5/21/2021, evidenced an undated agency policy titled, "Home Health Aide Supervision", which stated, " ... The agency shall provide Home Care aide services under the direction and supervision of a Registered Nurse Case Manager when personal care services are indicated and ordered by the physician. PURPOSE To assure the appropriateness of home health aide services and to maintain quality of care...." Record review on 5/21/2021, evidenced an undated agency policy titled, "JOB DESCRIPTION Registered Nurse Case Manager (RN)....", which stated, " ... RESPONSIBILITIES: 1. Provides services in accordance with the plan of care ... 7. Coordinates services. ... JOB RELATIONSHIPS: ... 2. Workers Supervised: Licensed Practical Nurse, Home Health Aide...."	G 0818	1) Action Steps to ensure completion: Regarding PRN tasks for HHA. Administrator and or assigned designee will audit 100% of charts to ensure PRN task have been removed. Effective 6/7/21 2) Date of Compliance: All HHA's have Been re-educated on documentation on how to complete task Administrator and or assigned designee will audit 100% of charts for 30 days, if 100% compliance met Administrator and or assigned designee will monitor 80% daily of HHA task x 60 days if compliance is met in the 60 days will audit 50% of completion of tasks when 100% compliance is met will audit 3 x per week. 3) 3. Responsible for correction: Administrator and assigned designee 4. Monitoring Process to prevent Reoccurrences: We have	06/07/2021

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	Record review on 5/21/2021, evidenced an undated agency policy titled, "JOB DESCRIPTION Home Health Aide (HHA)....", which stated, "JOB SUMMARY: A paraprofessional person who is specifically trained, competent and performs assigned functions of personal care to the patient in their residence under the direction, instruction and supervision of the Registered Nurse Case Manager (RN)...." Record review on 5/21/2021, evidenced an undated agency policy titled, "Care Planning Process", which stated, " ... The patient care plan for the Home Health Aide will be: Home Health Aide assignment sheet: developed by a Registered Nurse ... The assignment sheet / plan of care will include: Type service / procedure to be provided ... Specific procedure to be performed including amount, frequency and duration. Safety measures including use of equipment. Instructions for completion of documentation...." Clinical record review on 5/19/2021 for patient #2, start of care 9/4/2019, certification period 3/17/2021 to 5/15/2021, primary diagnoses of spinal cord injury and urostomy [a surgically-created opening for the urinary system], evidenced a group of agency documents titled, "Supervisory Visit", each signed by employee F, RN [registered nurse]. Supervisory visit notes dated 4/12/2021, 5/12/2021, and 5/14/2021 failed to evidence the name of the employee being supervised. During an interview on 5/18/2021 at 10:14 a.m., the administrator indicated home health aide supervisory visits were documented on the Supervisory Visit form, and kept in the patient		effectively been able to change Service Plans for the HHA to reflect no PRN's, unless caregiver/patient is cognitively able to make decisions. Service Plans can be updated in real time if the patients' needs change. Administration /assigned designee will track and trend to reflect no PRN's per 25% chart audits	

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	record. On 5/21/2021 at 12:06 p.m., when informed of the findings, employee C, LPN [licensed practical nurse], indicated the supervising nurse will leave the employee name line on the form blank if the aide was not present during the supervisory visit. Employee C indicated the supervision may be of the HHA care in general because there might be several HHA assigned to that patient. While employee C spoke, the alternate administrator was silent and nodded. The agency failed to evidence direct supervision of the HHA by the supervising nurse. During a home visit on 5/20/2021 at 12:25 p.m., employee E, HHA [home health aide], was observed giving a bed bath to patient #2. At 12:35 p.m., the HHA entered the patient's bedroom. The patient was lying in a hospital bed, both side rails down, with a rolling bedside table on each side of the bed. At 12:40 p.m., the HHA gathered basins, soap, and towels. After washing the front of the patient, at 1:05 p.m., the HHA was observed assisting the patient to turn to their left side. Both side rails of the bed remained down. After washing the patient's back, at 1:15 p.m., the HHA was observed assisting the patient to turn to their right side. The HHA instructed the patient to hold on to the rolling bedside table for support. At 1:18 p.m., the HHA assisted to dress the patient, assisting the patient to turn side to side in the bed, instructing the patient to hold on to the rolling bedside table each time. At 1:37 p.m., the HHA went to the patient's bathroom to empty the basins, leaving the side rails down. At 1:38 p.m., the HHA was observed assisting the patient to turn side to side while she placed an underpad beneath the patient. The side rails remained down. The repeated turning resulted in			

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	the patient's body being near the edge of the right side of the mattress. At 1:39 p.m., the HHA assisted the patient to turn to their left side, and hold the rolling bedside table for support. The HHA indicated she needed to reposition the patient to the center of the bed. At 1:40 p.m., the HHA picked up a slider board from a wheelchair near the end of the bed. The HHA looked at the slider board and indicated she did not know how to use it. The HHA called for the patient's family member to come to the room and asked the family member if they knew how to use the slider board. The family member manually lifted the patient and moved her to the center of the bed. At 1:43 p.m., the bath was complete. The HHA failed to put the side rails up on the patient's bed. During an interview on 5/21/2021 at 11:53 a.m., the alternate administrator indicated when turning a patient in a hospital bed, the HHA should have the side rail up on the side the patient was turning toward to maintain patient safety. During an interview on 5/21/2021 at 11:50 a.m., employee C, LPN indicated HHA should be knowledgeable on how to use a slider board. The alternate administrator was silent and nodded. When informed of the findings, the alternate administrator stated, "Oh, I'm so sorry about that", and indicated the HHA failed to maintain safety precautions. 6. Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "Supervisory Visit", dated 7/15/2020, signed by employee G, RN. This supervisory visit note failed to evidence the name			

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	of the employee being supervised. On 5/21/2021 at 12:06 p.m., when informed of the findings, employee C, LPN, indicated the supervising nurse will leave the employee name line on the form blank if the aide is not present during the supervisory visit. Employee C indicated the supervision may be of the HHA care in general because there might be several HHA assigned to that patient. While employee C spoke, the alternate administrator was silent and nodded. The agency failed to evidence direct supervision of the HHA by the supervising nurse. 17-14-1(n)			
G 1024 Bldg. 00	484.110(b) Authentication Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure all clinical record entries were legible, clear, complete, and appropriately authenticated in 2 of 5 clinical records reviewed (#2, #3). The findings include: 1. Record review on 5/21/2021, evidenced an undated agency policy titled, "Medical Record Entries and Authentication", which stated, "POLICY - 11.3.1 All medical record entries will be dated and authenticated. Only authorized individuals make entries in the patient's record ...	G 1024	1. Action Steps to ensure completion: This deficiency regarding failure to verify patient's plan of care prior to medical record documentation will be corrected by in-servicing on 7/1/21 and re-educating nurses on medical entries and authentication of medical care. 2. Date of Compliance: Administrator and or assigned designee will complete chart audits of 100% for accurate and complete documentation for	07/28/2021

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	PROCEDURE ... All entries in patient records will be legible, clear, complete and appropriately authenticated, dated and timed...." 2. Clinical record review on 5/19/2021 for patient #2, start of care 9/4/2019, certification period 3/17/2021 to 5/15/2021, primary diagnoses of spinal cord injury and urostomy [a surgically-created opening for the urinary system], evidenced an agency document titled, "Completion of Care, OASIS [Outcome and Assessment Information Set] [a standardized assessment used in home health] Data Sets, and Discharge / Transfer Summary", dated 4/15/2021, signed by employee F, RN [registered nurse]. This document had a subsection titled, "Additional Comments / Notes:", which stated, "Patient had appt [appointment] [with] wound clinic [physician B]. [Physician B] had patient admitted to hospital for possible aspiration pneumonia." Clinical record review evidenced an agency document titled, "TRANSFER SUMMARY - 9.24.A", dated 4/16/2021, signed by employee F, RN [registered nurse], faxed to physician C on 4/16/2021. This summary stated, " ... REASON FOR TRANSFER: WOUND...." The transfer summary failed to evidence possible aspiration pneumonia. During an interview on 5/21/2021 at 12:00 p.m., employee F, RN, indicated she completed the transfer summary before finding out what happened at physician B's office. Employee F indicated the reason for the transfer was possible aspiration pneumonia, and the transfer summary was incorrect. The nurse failed to correct the error on the transfer summary.		complete and accurate documentation 7/28/21 to ensure medical record and documents are authenticated and no errors we found. 3. Responsible for correction: Administrator and assigned designee will be responsible to ensure All patients that have a potential to be affected by verification of medical record documentation will be audited to ensure 100% accuracy has been completed. 100% of charts will be audited by 7/28/21, Administrator and assigned designee will audit 80% of each weekly recertification's. If errors are found RN Case Managers will be re-educated. Also nurses will be re-educated to fill out each line of form's at 100% accuracy completely and thoroughly. 4. Monitoring Process to prevent Reoccurrences: Administrator and or assigned designee will complete 80% chart audits for 60 days to ensure medical record authenticities meets compliance. When 100% compliant Administrator and or designee will audit 25% of charts monthly to ensure compliance is met.	

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	Clinical record review for patient #2 evidenced a group of agency documents titled, "Supervisory Visit", each signed by employee F, RN. The supervisory visit notes had a line titled, "Employee Name". This line was left blank on supervisory visit notes dated 4/12/2021, 5/12/2021, and 5/14/2021. These visit notes failed to indicate the names of the employees being evaluated. On 5/21/2021 at 12:06 p.m., when informed of the findings, employee C, LPN, indicated the supervising nurse will leave the employee name line on the form blank if the aide is not present during the supervisory visit. Employee C indicated the supervision may be of the HHA care in general because there might be several HHA assigned to that patient. While employee C spoke, the alternate administrator was silent and nodded. The agency failed to ensure the supervisory visit forms evidenced the name of the employee being evaluated. 3. Clinical record review on 5/20/2021 for patient #3, start of care 11/11/2019, certification period 5/9/2020 to 7/7/2020, primary diagnosis of stiffness of unspecified shoulder, evidenced an agency document titled, "Supervisory Visit", dated 7/15/2020, signed by employee G, RN. The supervisory visit notes had a line titled, "Employee Name". This line was left blank. This visit note failed to indicate the name of the employee being evaluated. On 5/21/2021 at 12:06 p.m., when informed of the findings, employee C, LPN, indicated the supervising nurse will leave the employee name line on the form blank if the aide is not present during the supervisory visit. Employee C indicated the supervision may be of the HHA care in general because there might be several HHA			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K021	A. BUILDING 00 B. WING	05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	assigned to that patient. While employee C spoke, the alternate administrator was silent and nodded. The agency failed to evidence direct supervision of the HHA by the supervising nurse. 17-15-1(a)(7)			
N 0447 Bldg. 00	410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview, the administrator failed to ensure accuracy of public information for the home health agency. The findings include: Record review on 5/21/2021, evidenced an undated agency policy titled, "Admission Information", which stated, "POLICY During the admission process (and on an ongoing basis when changes occur), the Agency will provide each patient and family with written information about the Agency ... Office hours are 9 a.m. to 5 p.m. with a closure from 12 p.m. - 1 p.m. Monday through Friday...." Review of the agency admission packet evidenced a folder with a sticker on the front cover. The sticker stated, " ... Hours: 8 AM-5 PM...." Review of the admission packet evidenced an agency welcome letter which stated, " ... If there are ever any problems, please feel free to call me at any time during office hours (M-F 8:00 a.m. to 5:00	N 0447	1. Action Steps to ensure completion: All clinical care staff have been informed of changes in office hours and branch locations on 4/5/21 by electronic communication. Clients will receive updated handbook with new office locations and hours by 7/9/21. 2. Date of Compliance: Administrator and assigned designee called patients, MD's and families to inform them of new office hours and in our new welcome packet, it states our new hours of operation as well as letting them know we do have 24/7 phone answering distributing Welcome packets will be completed by 7/9/21. Administrator and or assigned designee will audit 100% of patients, MD's to assure they are aware of new office hours. Also, a	07/09/2021

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	p.m.)...." During an interview on 5/18/2021 at 2:50 p.m., the administrator indicated the agency's office hours were 9 a.m. to 5 p.m., Monday through Friday. The administrator indicated the folder and the welcome letter failed to indicate the correct office hours for the agency. During an interview on 5/18/2021 at 12:38 p.m., the administrator indicated in September 2020, the agency removed skilled nursing from their branch in Rensselear, IN. Review of the agency website, Helpathome.com, evidenced a list of branches and services available. This list indicated skilled nursing services were available at the Rensselear branch. On 5/21/2021 at 9:45 a.m., when informed of the findings, the alternate administrator and employee C, LPN [licensed practical nurse], indicated they did not know why the website said that.		Registered nurse is on call 24/7 which is also in our new welcome packet 3. Administrator and assigned designee Responsible for correction: New welcome packets will be distributed by 7-9-21 Administrator and or assigned designee will audit 100% of patients, MD's and all care staff are aware of office hours. 4. Monitoring Process to prevent Reoccurrences: Administrator and or assigned designee will review 25% of patients charts monthly to ensure patient received new welcome packed making patient and families aware of office locations and hours.	