STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157090	A. BUILDING 00 B. WING	11/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE HOME HEALTH SERVICES LLC	429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted of this Medicare and Medicaid home health agency, by the Indiana State Department of Health, in accordance with 42 CFR 484.102. Survey Dates: 11-9, 11-10, 11-12, 11-13, 11-16, 11-17, and 11-18-2020 Facility #: 005294 CCN #: 157090 Total Active Census: Unduplicated Skilled patients admitted prior 12 months: 426 Skilled patients 107 Home Health Aide only: 0 Total Patient Clinical Records Reviewed: 10 Patient Records with Home Visit: 4 Active Patient Records without Home Visit: 3 Discharged Patient Records: 3 At this Emergency Preparedness survey, Heritage Home Health Services, LLC, was found not to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR	E 0000	N 518 Patient Rights #1 Agency has now added the IN State Dept of Health Advance Directives 11/1/2018 to the SOC packets effective 11/20/2020. #2 Agency will follow up in the QAPI meetings every quarter to ensure this deficiency does not occur in the future. #3 Clinical Director and Administrator will directly monitor and be responsible for #1 and #2. #4 Deficiency has already been corrected by 11/20/2020.	

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

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	484.102, for home health agencies. Quality Review Completed on 12/03/2020 by Area 3			
E 0013 Bldg. 00	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the			

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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the agency failed to develop a policy and procedure ensuring staffing to meet the needs of the patients when needed during an emergency, such as COVID-19 Outbreak. The Finding included: Review of the record on 11/13/2020 at 12:00 p.m., the agency's emergency preparedness plan failed to evidence staffing strategies during an COVID-19 emergency. During an interview on 11/16/2020 2:15 p.m.,at p.m., the Director of Nursing was unable evidence in their policy and procedure where the agency addressed staffing strategies in the event of an emergency in the agency's emergency preparedness binder.	E 0013	E 0013 Development of EP Policies and Procedures Updated policy and procedure POC has now been updated from last update as of 2018. Approach our local staffing agencies to fulfill agency staffing needs. If they are not able to fulfill we will partner agency will transfer patients to local HH agencies and SNFs. Administrator will be responsible for #1 and #2. New policy is already in place as of 12/1/2020. Completion date of 12/1/2020.	12/01/2020
E 0021 Bldg. 00	484.102(b)(3) HHA- Procedures for Follow up Staff/Pts. [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must			

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	be reviewed and updated at least every 2 years.] At a minimum, the policies and procedures must address the following:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. Based on record review and interview, the agency failed to develop and implement emergency plan ensuring staffing to meet the needs of the patients when needed during an emergency, such as COVID-19 Outbreak. The Finding included: Review of the record on 11/13/2020 at 12:00 p.m., the agency's emergency preparedness plan failed to evidence staffing strategies during an COVID-19 emergency. During an interview on 11/16/2020 at 2:15 p.m.,at p.m., the Director of Nursing was unable evidence in their policy and procedure where the agency addressed staffing strategies in the event of an emergency in the agency's emergency preparedness binder.	E 0021	E 0021 HHA-Procedures for FU Staff/Pts Agency will partner with the state and local officials with an updated list of patient's in acute distress. Agency will also look into increasing the network of volunteers assisting with the EMG situations if and when as needed. Policy also states a complete run-down of each drill. 4 table top exercises, 1 exercise per quarter, updated materials from district 5 is now in the EMG binder. Exercises will be reviewed in each QAPI. Administrator and EMG Controller. Deficiency has been corrected as of 12/1/2020. Completion date of 12/1/2020.	12/01/2020
G 0000 Bldg. 00	This visit was for a Federal Recertification and State Re-licensure survey in conjunction with a Federal Focused Infection Control in relation to	G 0000	N 518 Patient Rights #1 Agency has now added the IN State Dept of Health Advance Directives 11/1/2018 to the SOC	

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	the COVID-19 pandemic. A complaint investigation was also conducted in conjunction with this survey. This was a full extended survey, and was announced to the administrator on 11-12-2020, at 11:10 A.M. Complaint #: IN 00273503; Substantiated; no deficiencies were cited. Survey Dates: 11-9, 11-10, 11-12, 11-13, 11-16, 11-17, and 11-18-2020 Facility #: 005294 CCN: 157090 Medicaid #: 200805010 Census unduplicated for prior 12 months: 426 Current census: Skilled patients: Indianapolis parent 66 Martinsville branch 41 Total Skilled patients: 107 Patients who received home health aide only services or personal services only: 0 Home Visits with Clinical Record Review: 4 Clinical record review only Active: 3 Clinical record review Closed: 3 Total Clinical Records Reviewed: 10		packets effective 11/20/2020. #2 Agency will follow up in the QAPI meetings every quarter to ensure this deficiency does not occur in the future. #3 Clinical Director and Administrator will directly monitor and be responsible for #1 and #2. #4 Deficiency has already been corrected by 11/20/2020.	

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	This deficiency reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Based on the Condition-level deficiencies identified during the 11-18-2020, survey, your home health agency was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act, on 11-12-2020 at 11:10 A.M.; for the following condition level deficiencies: 42 CFR 484.100, Compliance with Federal, State, and Local Law. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for two years beginning 11-18-2020, and continuing through 11-17-2022. Quality Review Completed on 12/03/2020 by Area 3			
G 0416 Bldg. 00	484.50(a)(1)(iii) OASIS privacy notice (iii) An OASIS privacy notice to all patients for whom the OASIS data is collected. Based on record review and interview, the agency failed to notify patients of their Outcome and Assessment Information Set (OASIS) rights at the start of care for 10 (Patients # 1-10) of 10 patients whose clinical records were reviewed. The findings included: 1. Review of a policy, "Rights/Responsibilities," revised April 2017, evidenced the policy stated, "Purpose Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with	G 0416	**G-0416 OASIS Privacy Notice** Agency did not have this form in the SOC binders at the time of the state audit. Agency has now added the OASIS Statement of Patient Privacy Rights to the SOC packets effective 11/20/2020. Form has been uploaded for ISDH review. Clinical Director will oversight both locations to ensure that when the SOC binders are made for use/delivery, the OASIS	11/20/2020

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	certain rights and responsibilities as described ... The patient will be informed verbally and in writing during the initial evaluation visit, in advance of furnishing care to the patient, of the following: ... Organization policy regarding confidentiality and disclosure of medical information; including, patient privacy rights related to the collection of the Outcome and Assessment Information Set (OASIS): 1. The right to be informed that OASIS information will be collected and the purpose of the collection. 2. The right to have the information kept confidential 3. The right to be informed that OASIS information will not be disclosed except for legitimate purposes allowed by the Federal Privacy Act 4. The right to be informed that the collected OASIS data, OASIS Outcome-Based Quality Improvement (OBQI), OASIS Outcome-Based Quality Monitoring (OBQM), and/or publicly reported Quality Measure reports will be shared with accreditation surveyors as appropriate and this data may be used to identify and prioritize performance improvement activities 5. The right to refuse to answer questions 6. The right to see, review, and request changes on his/her assessment ... " 2. The Admission Packet for new patients was provided by the nursing supervisor on 11-9-2020, at 11:30 A.M. During an interview on 11-13-2020, at 9:44 A.M., with the nursing supervisor, the supervisor verified the contents of the agency binder presented was the admission information given to patients at the start of care intake since 2019, when the nursing supervisor assumed the role of nursing supervisor, verified the policy requirement to inform patients of their OASIS patient rights. The nursing supervisor indicated		Statement of Patient Privacy Rights form is included in every SOC binder for clinician/patient verbal and written review and implementation at time of admission. OASIS Statement of Patient Privacy Rights form was reviewed with all clinician staff at mandatory meeting on 12/16/2020 to review the content of the form and initiating discussion with patient/caregiver at Admission. OASIS Statement of Patient Privacy Rights form was mailed to patient #2, 4, 8, 6, 9, 10, 1, 3, 5, 7. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Deficiency has already been corrected by adding this form (form has been uploaded for ISDH review) to ALL current SOC binders as of 11/20/2020 for implementation. Correction date of 11/20/2020.	

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	clinicians used the start of care binder provided to educate patients and their representatives of their patient rights, but it did not contain patient OASIS rights. 3. Review of the clinical record of patient #2, evidenced a start of care date of 11-3-2020, and failed to evidence OASIS patient rights, as required by policy, had been provided to patient #2 or their representative. 4. Review of the clinical record of patient #4, evidenced a start of care date of 11-3-2020, and failed to evidence OASIS patient rights, as required by policy, had been provided to patient #4 or their representative. 5. Review of the clinical record of patient #8, a closed record, evidenced a start of care date of 9-6-18, and failed to evidence OASIS patient rights, as required by policy, had been provided to patient #8. 6. Review of the clinical record for patient #6 was completed on 11/16/2020 and evidenced a start of care (SOC) date of 10/7/2020. The clinical record failed to evidence the patient or the patient's representative had received notification of OASIS patient rights, as required by policy. 7. Review of the clinical record for patient #9 was completed on 11/16/2020 and evidenced a SOC of 8/31/2020. The clinical record failed to evidence the patient or the patient's representative had received notification of OASIS patient rights, as required by policy. 8. Review of the clinical record for patient #10 was completed on 11/16/2020 and evidenced a SOC of 7/22/2020. The clinical record failed to evidence the patient or the patient's			

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	representative had received notification of OASIS patient rights, as required by policy. 9. Review of the clinical record of patient #1, evidenced a start of care date of 10-11-2020, and failed to evidence OASIS patient rights, as required by policy, had been provided to patient #1 or their representative. 10. Review of the clinical record of patient #3, evidenced a start of care date of 10-4-2020, and failed to evidence OASIS patient rights, as required by policy, had been provided to patient #3 or their representative. 11. Review of the clinical record of patient #5, evidenced a start of care date of 09-17-2020, and failed to evidence OASIS patient rights, as required by policy, had been provided to patient #5 or their representative. 12. Review of the clinical record of patient #7, evidenced a start of care date of 10-22-2020, and failed to evidence OASIS patient rights, as required by policy, had been provided to patient #7 or their representative.			
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			

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	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 provide written notice to patients of the disciplines and frequency of anticipated visits prior to furnishing services for 10 (Patients # 1-10) of 10 patients whose clinical records were reviewed. The findings included: 1. Review of a policy, "Rights/Responsibilities," revised April 2017, evidenced the policy stated, "A patient may designate someone to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by this organization ... The patient will be informed verbally and in writing during the initial evaluation visit, in advance of furnishing care to the patient ... The admitting clinician will provide each patient or his/her representative with a written copy of the Patient Rights ... " 2. The Admission Packet for new patients was provided by the nursing supervisor on 11-9-2020, at 11:30 A.M. Review of the patient start of care binder, undated, contained a document titled "Home Care Bill of Rights," which evidenced "Heritage Home Health Services supports the National Association of Home Care Bill of Rights as they apply to home care patients as follows: ... The Agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished ... " During an interview on 11-13-2020, at 9:44	G 0434	G 434 Participate in Care Agency is revising and revamp the SOC package. New package to include but not limited to, disciplines that will participate in the patient's care and state the purposed frequency of clinical visits. 10% of all SOCs will be audited weekly until agency has reached 100%. Clinical Director, Administrator and Office Administrator Clinical Director has already initiated to follow through purchasing new consent forms from Med Pass. As of this date, we should have a revised SOC package with an updated SOC package within 2-4 weeks. While waiting for revised SOC package, agency has added the required consent in the current SOC package as of 12/14/2020. Completion date of 12/14/2020.	12/14/2020

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	A.M., with the nursing supervisor, the supervisor verified the contents of the agency binder presented was the admission information given to patients at the start of care intake since 2019, when the nursing supervisor assumed the role of nursing supervisor, verified the policy requirement to inform patients of the disciplines, and frequency of proposed visits prior to furnishing care, and stated clinicians checked the consent form box of notification without having provided in writing, the disciplines and frequency of visits proposed to the patient or patient representative. 3. Review of Heritage Home Health policy titled "Informed Consent/ Refusal of Treatment Policy No. 1-002.1 Joint Commission Home Health/ Revised April 2017" ...Procedure 1. During the admission visit and follow up visits ....will be given information (verbally and / or in writing) that describes: A. The services and disciplines anticipated to be involved in the care of the patient. 4. Review of the clinical record of patient #2, evidenced a consent document dated 11-3-2020, signed by the patient's spouse representative, which indicated " ... I have been informed of all the services and frequency of such services that the Agency will provide .. " Patient #2 plan of care evidenced disciplines of skilled nursing (SN) 2 times a week for 9 weeks; home health aide (HHA) 2 times a week for 1 week, then 3 times a week for 8 weeks; physical therapy (PT) 2 times a week for 1 week, then 1 time a week for 2 weeks; occupational therapy (OT) 1 time a week for 1 week, then 2 times a week for 1 week, then 1 time a week for 1 week; and speech language therapy evaluation the week of 11-16-2020. Patient #1 had received care visits from nursing, physical, and			

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	occupational therapy, and home health aide. The consent failed to notify the patient and the patient spouse representative in writing of the frequency and duration of proposed visits prior to furnishing services. 5. Review of the clinical record of patient #4, evidenced a consent document dated 11-3-2020, signed by the patient's spouse representative, which indicated " ... I have been informed of all the services and frequency of such services that the Agency will provide .. " Patient #2 plan of care evidenced disciplines of skilled nursing (SN) 2 times a week for 9 weeks; home health aide (HHA) 2 times a week for 1 week, then 3 times a week for 8 weeks; physical therapy (PT) 2 times a week for 1 week, then 1 time a week for 2 weeks; occupational therapy (OT) 1 time a week for 1 week, then 2 times a week for 1 week, then 1 time a week for 1 week; and speech language therapy (SLT) evaluation the week of 11-16-2020. Patient #1 had received care visits from nursing, physical, and occupational therapy, and home health aide. The consent failed to notify the patient and the patient spouse representative in writing of the frequency and duration of proposed visits prior to furnishing services. 6. Review of the clinical record of patient #8, a closed record, evidenced a consent document dated 9-6-18, signed by the patient, which indicated " ... I have been informed of all the services and frequency of such services that the Agency will provide .. " Patient #8 plan of care evidenced disciplines of PT 1 time a week for 1 week, 2 times a week for 2 weeks, then 1 time a week for 3 weeks; OT 1 time a week for 6 weeks. Patient #4 had received care visits from nursing, physical, and occupational therapy. The consent failed to notify the patient in writing of the			

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	frequency and duration of proposed visits prior to furnishing services. 7. Review of the clinical record for patient #6 was completed on 11/16/2020 and revealed a start of care (SOC) date of 10/7/2020. The clinical record revealed the consent document "Home care bill of rights" which included the statement " ... the agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished ... " and " ... I have been informed of my rights, and of all the services and frequency of such services that the Agency will provide ... " The document was signed by the patient on 10/7/2020. The SOC plan of care (POC) dated 10/7/2020 revealed orders for skilled nursing (SN) once a week times one week for the completion of the SOC, then once a month for three months and twice weekly as needed (PRN) for catheter complication (sic), physical therapy (PT) once a week and occupational therapy (OT) once a week times one week then twice a week for three weeks. The consent failed to evidence the type and frequency of services of anticipated care visits to be provided. 8. Review of the clinical record for patient #9 was completed on 11/16/2020 and revealed a SOC date of 8/31/2020. The clinical record revealed the consent document "Home care bill of rights" that included the statement " ...the agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished ..." and " ...I have been informed of my rights, and of all the services and frequency of such services that the Agency will provide ..." The document was signed by the patient's daughter/Power of Attorney (POA) on 8/31/2020. The SOC POC dated 8/31/2020 revealed orders for SN once a week for four weeks, PT once a week			

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	times one week then twice a week for four weeks, and OT once a week times one week, zero times a week times one week, then once a week times two weeks. The consent failed to evidence the type and frequency of services of anticipated care visits to be provided. 9. Review of the clinical record for patient #10 was completed on 11/18/2020 and revealed a SOC date of 7/22/2020. The clinical record revealed the consent document "Home care bill of rights" that included the statement " ...the agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished ..." and " ...I have been informed of my rights, and of all the services and frequency of such services that the Agency will provide ..." The document was signed by the patient on 7/22/2020. The SOC POC dated 7/22/2020 revealed orders for SN twice a week times one week, then once a week for five weeks and social worker (MSW) to "eval and treat." The consent failed to evidence the type and frequency of services of anticipated care visits to be provided. 10. Review of clinical record for patient #1, start of care (SOC) 10/11/2020, orders evidenced SN- 1 day a week for 6 weeks/ PT- 1 day a week for 1 week; 2 days a week for 7 weeks/OT - 2 days a week for 8 weeks/ ST- referral order / HHA-referral order , included consent forms signed by the patient upon admission. Review of the Consent and Authorization for Disclosure of Information failed to establish the care to be furnished based on the comprehensive assessment and the frequency of visits anticipated upon admission. 11. Review of clinical record for patient #3, start of care (SOC) 10/14/2020, orders evidenced : SN- 2 times a week for 2 weeks /PT- 2 times a week for 2 weeks /ST- referral order , included consent forms			

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	signed by the patient upon admission. Review of the Consent and Authorization for Disclosure of Information failed to establish the care to be furnished based on the comprehensive assessment and the frequency of visits anticipated upon admission. 12. Review of clinical record for patient #5, start of care (SOC) 09/17/2020, orders evidenced : SN 1 day a week for 1 week, 2 days a week for 2 weeks and 1 day a week for 6 weeks; included consent forms signed by the patient upon admission. Review of the Consent and Authorization for Disclosure of Information failed to establish the care to be furnished based on the comprehensive assessment and the frequency of visits anticipated upon admission. 13. Review of clinical record for patient #7, start of care (SOC) 10/22/2020, orders evidenced : SN 1 day a week for 1 week, 2 days a week for 3 weeks, 1 day a week for 3 weeks/PT- 1 day a week for 1 week, 2 days a week for 6 weeks/OT - 3 days a week for 3 weeks, 2 days a week for 3 weeks/HHA- 2 days a week for 4 weeks, included consent forms signed by the patient upon admission. Review of the Consent and Authorization for Disclosure of Information failed to establish the care to be furnished based on the comprehensive assessment and the frequency of visits anticipated upon admission. 14. The findings for the above patients were reviewed with the Director of Nursing and Administrator on 11/10/20 at 3:00 p.m., in which she indicated services and disciplines anticipated communicated verbally during admission. 410 IAC 17-12-3(a)(1)(A)(B)			

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	410 IAC 17-12-3(a)(2) 410 IAC 17-12-3(b)(2)(D)(i)(AA)(BB)			
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the comprehensive assessment failed to be accurate and complete in the assessment of all patients current health status, psychosocial status, and cognitive status, including dialysis access site and treatments for 2 (Patient #1 and 7) of 7 active records reviewed and 1 (Patient #9) of 3 closed records reviewed. The findings included: 1. Review of the clinical record of patient #1, evidenced a comprehensive assessment which indicted (M1740) Cognitive, behavior, and psychiatric symptom that are demonstrated at least once a week: None of the above behavior demonstrated; Psychosocial WNL (Within Normal Limits). The comprehensive assessment of the Neuro/Emotional/Behavioral Status failed to accurately reflect the patient's current health status which include relevant cognitive health, psychosocial, functional, and cognitive status During the interview on 11/12/2020 at 9:25 A.M., employee E, indicated patient #1 has significant memory loss, and is currently living with a family because primary residence can not accommodate his needs due to mobility concerns, and may be in need for a social work consult to assess for community resources. 2. Review of the clinical record of patient #7,	G 0528	**G 0528-Health, Psychosocial, Functional, Cognition** **(Patient #1)** By educating and training all clinical staff to follow through, document and communicate with the team members when they observe any clinical status changes and/or additional services needs that needs to be addressed by HHA. The comprehensive assessment should include all current and past medical history and any concerns identified should be discussed with the patient/patient representative and the physician responsible for the POC. This deficiency was reviewed with all clinical staff on 12/9/2020 and 12/16/2020 with verbal understanding. Patient #1 was discussed with the clinical team that was providing direct care to the patient on 11/23/2020. Case Manager and OT decided MSW was not indicated at this time because the caregiver declined needs assessment by MSW. Agency will provide consistent all staff mandatory meetings and trainings every 3-6 months. The Administrator and Clinical	12/16/2020

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	limited review for coordination of care with an end stage renal disease provider, and dialysis access , assessment and care, evidenced a start of care date of 10-22-20, and contained a plan of care for the certification period of 10-22-2020 to 12-2-2020 with orders for SN- 1 day a week for 1 week, 1 days a week for 3 weeks, 1 day a week for 3 weeks/ PT-1 day week a 1 week, 2 days a week for 6 weeks/ HHA - 2 Under the narrative section, an end stage renal disease (ESRD) provider was identified for coordination of care. Review of a resumption of care comprehensive assessment, dated 10-22-20, performed by RN, employee K, failed to evidence patient #7 had a right upper extremity fistula access site. The assessment of the dialysis access fistula failed to evidence the presence or absence of bruit and thrill; and failed to describe the condition of the site and surrounding tissue. During the interview on 11-18-2020 at 3:00 P.M., with the director of nursing, the above findings were verified. When queried for further pertinent explanation, information, or documentation, the director of nursing stated having nothing further to present for review. 3. Patient #9 clinical record review was completed on 11/16/2020 and revealed a SOC date of 8/31/2020. Diagnoses included autonomic neuropathy, bilateral knee osteoarthritis, spondylosis, constipation, tubular adenoma of the colon, sick sinus syndrome, and obstructive sleep apnea (OSA). On 8/28/2020 at 9:41a.m., a physician's office sent a referral form to the agency with the admitting diagnosis listed as "constipated/pain and pressure." The referral revealed that the patient had presented to her physician's office for "		Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Correction date of 12/16/2020. **(Patient #7)** When agency is treating an active dialysis patient, agency will contact the dialysis center to inquire where, what days, and the times that patient is receiving dialysis and add this information into the patient's profile page for clinical review. When agency is treating a dialysis patient, fistula access site and surrounding access site will be assessed with supportive assessment documentation noted in the patient's visit note(s). Deficiencies was discussed with all employees on 12/9/2020 and 12/16/2020 with verbal understanding. Agency will provide consistent all staff mandatory meetings and trainings every 3-6 months. Clinical Director to hold additional meeting with all nursing staff after each case conference on a bi-weekly basis. Patient #7, dialysis center was contacted and chart was updated to add supportive information as to where, when and times the patient attends dialysis. RN was also contacted regarding the lack of	

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	...evaluation of constipation ..." and " ...she has lots of pain and bloating and takes numerous laxatives and will has (sic) small amounts of loose stool ..." and " ...she has a hx (history) of tubular adenoma (colon polyp) ..." The referral form also revealed a past medical history that included left ventricular hypertrophy, sinus node dysfunction, and pacemaker placement. Start of care (SOC) comprehensive assessment dated 8/31/2020 revealed the nursing review of the digestive system was incomplete and failed to evidence documentation related to bowel, constipation, or cardiac problems. The findings were discussed with the Director of Nursing (DON) at 2:26 p.m. on 11/18/2020, in which the DON had no further information or documentation to provide. 410 IAC 17-14-1 (a)		clinical documentation in regards to the fistula site assessment and surrounding tissue assessment on 11/23/2020. Education provided as to what the site assessment documentation should obtain. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. All clinical staff have been communicated to follow through on this concern on 12/9/2020 and 12/16/2020. Completion date of 12/16/2020. **(Patient #9)** SOC comprehensive assessment will include all current and past medical history and any concerns identified should be discussed with the patient/patient representative and the physician responsible for the POC. Comprehensive assessment should contain supportive information in relation to the admission diagnosis including specific interventions and goals related to the admission diagnosis. All clinical staff was educated on 12/9/2020 and 12/16/2020 regarding the deficiency with verbal understanding. RN was contacted on 11/23/2020 to discuss the deficiency. Patient	

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			has already been discharged from agency. 100% compliance is estimated to be achieved in 1 month or before. Agency will provide consistent all staff mandatory meetings and trainings every 3-6 months. Clinical Director to hold additional meeting with all nursing staff after each case conference on a bi-weekly basis. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. All clinical staff have been communicated to follow through on this concern on 12/9/2020. All staff mandatory meeting is scheduled for 12/16/2020. Completion date of 12/16/2020.	
G 0530 Bldg. 00	484.55(c)(2) Strengths, goals, and care preferences The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on clinical record review, the agency failed to include the patient's care preferences and strengths in the plan of care in 1 (Patient #9) of 3 closeed records reviewed in a sample of 10. Findings include:	G 0530	G 530-Strengths, Goals, and Care Preferences Patient #9 By educating and training all clinical staff to ensure evidence of patient stated strengths and care preferences are documented in the	12/16/2020

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	Patient #9 clinical record review was completed on 11/16/2020, for the certification period of 8/31/2020 to 10/29/2020, with SOC date of 8/31/2020. Diagnoses included autonomic neuropathy, bilateral knee osteoarthritis, spondylosis, constipation, tubular adenoma of the colon, sick sinus syndrome, and obstructive sleep apnea (OSA). Review of the intake referral form, dated 8/28/2020, evidenced patient #9 was referred to the agency by the primary care physician (PCP) for skilled nursing (SN) services for the management of constipation and abdominal pain and pressure, and for physical therapy (PT) for inability to walk. Review of the initial physical therapy (PT) evaluation, which was completed by employee G on 9/14/2020, evidenced four goals were established including improvement of strength of lower extremities, improved balance, improved gait, and transfer safety training. The PT reported limitations to achieving goals were the inability to stand fully upright and knee pain. Patient #9 stated goals were to " ... be able to walk further ... " Documentation failed to evidence patient stated strengths and care preferences were documented for development of the plan of care goals. Review of a PT visit completed by employee G on 10/2/2020, failed to evidence documentation of patient #9 stated strengths and care preferences. Review of the discharge PT visit, completed by employee G, dated 10/7/2020, failed to evidence documentation of patient #9's stated strengths and care preferences. The findings were discussed with the Director of		OASIS and Evaluations for POC development. Audits to be performed by the QA clinician at time of POC completion to ensure patient stated strengths and care preferences are documented within the chart. Clinical Director and Administrator will be responsible for A and B. All clinical staff have been communicated to follow through on this concern on 12/9/2020. All staff mandatory meeting is scheduled for 12/16/2020. Completion date of 12/16/2020.	

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	Nursing (DON) at 2:26 p.m. on 11/18/2020, in which the DON had no further information or documentation to provide.			
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 clinical record review and staff interview, the agency failed to ensure all medications were reviewed for potential adverse effects, drug reactions, ineffective drug therapy side effects, significant drug interactions, and duplicative drug therapy for 1 (Patient #7) of 7 active patient records reviewed and 1 (Patient #10) of 3 closed patient records reviewed. Findings include: 1. Review of the clinical record for patient #10 was completed on 11/18/2020 and revealed a start of care (SOC) date 7/22/2020. Orders included skilled nursing (SN) twice a week times one week, then once a week times five weeks for medication management. The SOC comprehensive assessment revealed a list of medications the patient was currently taking, but failed to reveal evidence that the medications were reconciled in order to identify any potential adverse effects, drug reactions and interactions, ineffective drug therapy, significant side effects, and duplicative drug therapy. During an interview with the agency Director of	G 0536	**G-0536 A Review of All Current Medications** **(Patient #10)** The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. All clinical staff have been communicated to follow through on this concern on 12/9/2020. All staff mandatory meeting is scheduled for 12/16/2020. Completion date of 12/16/2020. If agency is treating a patient that attends dialysis, Intake Coordinator will contact the dialysis center to request a list of administered medications at dialysis for the RN case manager's review. The RN will add these medications to the medication profile in the patient's chart and perform a medication reconciliation and drug interaction	12/16/2020

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	Nursing (DON) at 2:17 pm on 11/18/2020, she agreed that there was no evidence of medication reconciliation in the patient's clinical record. 2. Review of the clinical record for patient #7 on 11-18-2020, evidenced a start of care 10-22-2020, and contained a plan of care for the certification period 10-22-2020 to 12-2020. The plan of care diagnoses included end stage renal disease. Review of the comprehensive assessment dated 10-22-2020, evidenced patient went to in-center dialysis facility in the admission documentation. During a telephone interview with the Non-Employee DD a dietitian at patient #7's dialysis center on 11-15-20 at 1:15 p.m., Non-Employee DD stated patient #7 received the following medications patient #7 may need while at the dialysis center for hemodialysis and: Nifedipine (anti-hypertensive to treat high blood pressure) XR 60 mg (milligrams), Calcitriol (treat for low calcium and psoriasis), Sevelamer (lowers the amount of phosphorus in the blood), Erythropoietin (to treat low red blood cells), Iron (to treat iron deficiency anemia), Active vitamin D (supplement), Phosphorus binder (help to pass excess phosphorus out of the body), B-complex Vitamin (supplement), Folic acid (supplement), and Antihistamine (treatment of allergies). 410 IAC 17-14-1		review within 5 days of the admission. Patient #7-Dialysis center has been contacted with administered dialysis medications added and reconciled on the medication profile in the patient's chart. Audits to be performed by the QA clinician at the time of the POC completion to ensure all active medications (home and dialysis) are included on the medication profile and reconciled within 5 days of the SOC/ROC. All dialysis POCs will be audited for 1 month or until 100% compliance is achieved. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. All clinical staff have been communicated to follow through on this concern on 12/9/2020. All staff mandatory meeting is scheduled for 12/16/2020. Completion date of 12/16/2020.	
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and			

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	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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Based on clinical record review and interview, the agency failed to ensure the plan of care (POC) identified patient specific measurable outcomes and goals for 1 (Patient #9) of 3 closed patient records reviewed in a sample of 10. Findings include: Patient #9 clinical record review was completed on 11/16/2020 for the certification period of 8/31/2020 to 10/29/2020, with SOC date of 8/31/2020. Diagnoses included autonomic neuropathy, bilateral knee osteoarthritis, spondylosis, constipation, tubular adenoma of the colon, sick sinus syndrome, and obstructive sleep apnea (OSA). Review of the intake referral form, dated 8/28/2020, evidenced patient #9 was referred to the agency by the primary care physician (PCP) for skilled nursing (SN) for management of constipation and abdominal pain and pressure, and for physical therapy (PT) for inability to walk. Review of the POC for the certification period of 8/31/2020 to 10/29/2020, revealed SN goals including: " ... Covid-19 screening prior to skilled services being provided, patient and caregiver verbalizing understanding of the signs and symptoms of Covid-19, being free from injury, patient and caregiver verbalizing understanding of	G 0572	**G-0572 Plan of Care** **(Patient #9)** SOC comprehensive assessment will include all current and past medical history and any concerns identified should be discussed with the patient/patient representative and the physician responsible for the POC. Comprehensive assessment should contain supportive information in relation to the admission diagnosis including specific interventions and goals related to the admission diagnosis. All clinical staff was educated on 12/9/2020 and 12/16/2020 regarding the deficiency with verbal understanding. RN was contacted on 11/23/2020 to discuss the deficiency. Patient has already been discharged from agency. Agency will provide consistent all staff mandatory meetings and trainings every 3-6 months. Clinical Director to hold additional meeting with all nursing staff after each case conference on a bi-weekly basis. The Administrator and Clinical	12/16/2020

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	the individualized emergency plan, patient will remain free from signs and symptoms of respiratory distress, patient and caregiver will verbalize understanding of the medication regimen, patient will maintain regular diet compliance, home exercise program will be established by physical therapist, the patient will have no hospitalizations, and a home exercise program will be established by the occupational therapist ..." Review of the SN goals failed to evidence specific, measurable goals related to the admitting diagnosis of constipation and abdominal pain and pressure. During an interview with the Director of Nursing (DON) on 11/18/2020 at 2:26 P.M., the DON stated the plan of care and goals were adequate. 410 IAC 17-13-1 (a)		Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. All clinical staff have been communicated to follow through on this concern on 12/9/2020 and 12/16/2020. Completion date of 12/16/2020.	
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against			

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	injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Based on record review and interview, the agency failed to ensure the plan of care included care orders the patient's fluid intake and diet restrictions 1 (Patient #7) of 1 patient who received dialysis treatments, in a total sample of 10 patients. The finding included: Review of the clinical record of patient #7, start of care date of 10-22-2020 evidenced a plan of care for the certification period of 10-22-2020 to 12-2020, diagnosis included, but not lmited to, end stage renal disease. The plan of care failed to evidence a fluid restriction or any diet restrictions as part of patient #7s renal diet requirement. Review of coordination of care note dated 10-22-2020, evidenced team conference with DON (Director of nursing), employee K, employee J and employee L . The entry failed to evidence patient #7's dialysis diagnosis, sodium, diabetic, renal diet, and fluid intake restriction of 32 ounces per 24 hours as part of renal diet.	G 0574	**G-0574 Plan of Care Must Include the Following (Patient #7)** Intake Coordinator to coordinate services with active dialysis center to include diet, fluid restrictions and all medications. This information will be added to the patient's chart for clinical review by the RN Case Manager. Patient #7-Renal diet requirement and fluid restrictions were added to the patient's chart.th, 2021. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. All clinical staff have been communicated to follow through on this concern on 12/9/2020. All mandatory staff meetings were completed on 12/16/2020. Completion date of 12/16/2020.	12/16/2020

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	During a telephone interview on 11-17-2020 at 2:30 PM, Non-Employee DD, a Dietitian at patient #7's in-center dialysis facility, stated patient #7 was to have a low sodium, diabetic, renal diet with a 32-ounce fluid intake restriction per 24 hours. On 11-17-2020, at 3:30 PM, the DON verified the findings and stated patient #7's fluid and dietary restrictions should have been documented on the plan of care. 410 IAC 17-13-1(a)(1)(D)(viii)			
G 0576 Bldg. 00	484.60(a)(3) All orders recorded in plan of care All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review, policy review and interview, the agency failed to include all patient care orders in the care orders and failed to followed their policy to verify to ensure services were furnished, for 2 (Patients #1 and 5) of 7 active patient records reviewed in a sample of 10. Findings included: 1. Review of a policy, "Physician Orders," undated, evidenced the policy stated, "All medications, treatments, and services provided to patients must be ordered by a physician. The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature ... Additionally, an order or prescription will be verified when: There is a question or discrepancy in the order or prescription. Someone other than the physician	G 0576	=" b=""> **=" b="">** /b> **/b>** **Agency went by the last order received from the hospital, however there was confusion with an older order and the newest order of disciplines requested. Patient #1-Updated referral order contains referral for SN/PT/OT. Clarified with MD on 11/23/2020, ST and HHA services were not indicated at this time.** **Patient #5 All lab orders will be initiated by the Clinical Director to ensure labs are performed when ordered and lab results are received and uploaded into the patient's**	12/01/2020

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	(or other authorized licensed independent practitioner) or authorized prescriber or his/her agent communicates the order or prescription. Order is incomplete, illegible, or unclear. The order or prescription reviewed may be the original order or prescription, a facsimile copy (if permitted by law), or the direct transcription of a verbal order or prescription .... " 2. Review of the clinical record of patient # 1, evidenced a start of care date of 10-11-20, and contained a plan of care for the certification period of 10-11-20 to 12-09-20 , with skilled nursing (SN,) physical therapy (PT,) occupational therapy (OT,) Review of the referral order, dated 10-05-20, revealed physical therapy (PT,) occupational therapy (OT,) speech therapy (ST,) and home health aide (HHA,) During an interview on 11/13/20 at 3:00 PM , the DON (Director of Nursing) verified all disciplines should have been on the plan of care. No other information was provided. 3. Review of the clinical record of patient # 5, evidenced a start of care date of 9-17-20, and contained a plan of care for the certification period of 9-17-20 to 11-15-20 , with skilled nursing (SN,) and labs. The comprehensive assessment / OASIS dated 9-17-20 and care coordination noted dated 9-17-20 failed to evidence that Employee C, performed lab draw on admission. Review of referral order, dated 9-10-20, revealed home care order for SN and labs. During an interview on 11/13/20 at 3:15 PM , the DON (Director of Nursing) verified the SN perform labs draws during visits but acknowledged order		**chart by the Intake Coordinator. Patient #5-all labs have been obtained per current orders. Verified MD has received the lab results as of 11/23/2020 with no further lab orders.** **Agency to cross check different orders for services if more than 1 referral order is sent. The Clinical Director will initiate a lab binder to monitor all lab orders and verify completion of labs obtained per active order. This will be monitored daily by the Clinical Director. Deficiency was discussed with all employees on 12/9/2020 and 12/16/2020 with verbal understanding to ensure this deficient practice will not recur.** **The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.** **All protocols are in place as of 12/1/2020. Completion date of 12/1/2020.**	

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	clarification should have been documented for admission labs.			
G 0580 Bldg. 00	484.60(b)(1) Only as ordered by a physician Drugs, services, and treatments are administered only as ordered by a physician. Based on record review and interview, the agency failed to ensure services were furnished only after obtaining a physician's order for disciplines, frequency of visits, duration of visits, and care orders, for 5 (Patients #1 2, 4, 6, 8) of 7 active patients records reviewed and 1 (Patient #9) of 3 closed patient records was reviewed. The findings included: 1. Review of a policy, "Physician Orders," undated, evidenced the policy stated, "All medications, treatments, and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner ... When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order shall verify that the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed with the full name and title of the person receiving the order and be sent to the physician for signature ... " 2. Review of the clinical record of patient #2, evidenced a start of care date of 11-3-2020, and contained a plan of care for the certification period	G 0580	G 0580 Only as Ordered by a Physician (Pt#1, 2, 4, 6, 8) New Admission Order is now available in Kinnser. After the SOC has been completed, the SOC clinician will create an Admission Order to include: RVTO, time of VO given, name of physician representative providing the order, discipline requested frequency and duration orders, and focus of care. This order will be sent to the MD for signature immediately following. This is a new process in place based on the state auditor's findings. New admission order is now active for use for all new SOCs. All staff has been educated and trained. Ongoing in-services including all staff mandatory in-service on 12/16/2020 to go over new process. 10% of all charts will be audited to ensure process is in compliance until 100% accuracy is achieved. Clinical Director and Administrator will monitor to ensure that the deficient practice will not occur. Deficiency corrected as of	12/09/2020

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	of 11-3-2020 to 1-1-2021, with skilled nursing (SN,) physical therapy (PT,) occupational therapy (OT,) home health aide (HHA,) and speech language therapy (SLT.) Review of the start of care comprehensive assessment/OASIS, dated 11-3-2020, conducted by registered nurse (RN) employee H, evidenced at the end of the assessment "Orders for disciplines and treatment-- SN-2 week 9 for wound care, 3 PRN [as needed] visits for soiled or dislodged dressing; PT-2 wk 1, 1 wk 2; OT- 1 wk 1; 2 wk 1; 1 wk 1; ST-Eval [sic evaluate] and treat week of 11/16/2020; MSW-Eval and treat to assist patient LTC [sic long term care] planning HHA-2 w 1, 3 w 8 bathing and ADL [activities of daily living] assistance. All frequency orders are pending insurance authorization approval ... " and under "Physician contacted Re [sic regarding] SOC [sic start of care] report findings and nursing orders, POC [sic plan of care] I/G [sic interventions/goals, HHA [sic home health aide] orders, ST [sic speech therapy] & MSW [sic medical social worker] Evals." [sic evaluations] Review of the plan of care and the SN visit notes evidenced wound care was provided on 11-5, 11-10, and 11-13, which consisted of "SN to clean wounds with wound cleaner and pat fry. Apply hydrogel to wound and cover with foam dressing, change dressing 2 times a week; right heel: SN to cleanse area with wound cleanser and cover wound with a foam dressing twice weekly, may teach family how to change dressing. WOUND CARE: right buttock wound, left buttock wound and right hip: SN to clean wounds with wound cleanser and pat dry. Apply hydrogel to wound bed and cover with foam dressing, change dressing 2 times a week. May teach family to change dressing." The RN provided wound care		12/9/2020, however to be monitored on an on going basis. Deficiency-HHA provided care without the agency having obtained a specific VO. All HHA's have been educated not to provide any services until a care plan and an order is in place in the chart before providing any patient care services. So far, no similar problems have been found in other charts. However, agency to review all HHA charts and will address this issue if more deficiencies are found. Weekly audits will be performed on 25% or more of HHA charts to ensure a care plan and an order is obtained before HHA services are initiated. Audited to be continued until 100% compliance is accomplished. Clinical Director and Administrator to monitor and ensure the deficient practice will not occur. Deficiency corrected as of 12/9/2020. Completion date of 12/9/2020.	

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	without having obtained a specific verbal order, and prior to the physician signature having been received on the fully developed plan of care to authorize all plan of care orders. Review of the PT evaluation, dated 11-4-2020, by employee I, evidenced a check mark before "Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction." Review of the clinical record failed to evidence a specific verbal order with PT orders for care. Review of visit notes for PT evidenced the PT had furnished PT services during a care visit on 11-9-2020. The PT provided PT care without having obtained a specific verbal order, and prior to the physician signature having been received on the fully developed plan of care to authorize all plan of care orders. Review of the OT evaluation, dated 11-6-2020, by employee J, evidenced a check mark before "Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction." Review of the clinical record failed to evidence a specific verbal order with OT orders for care. Review of visit notes for OT evidenced the OT had furnished OT services during a care visit on 11-10-2020. The OT provided OT care without having obtained a specific verbal order, and prior to the physician having signed and returned the fully developed plan of care to authorize all plan of care orders. Review of HHA visit notes evidenced the HHA had made care visits on 11-6, 11-9, 11-11, 11-13, and 11-16-2020; to include the provision of hands on care such as bathing. Review of the clinical record failed to evidence a verbal order had been recorded in the clinical record for HHA services. The HHA had provided HHA care without the			

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	agency having obtained a specific verbal order, and prior to the physician signature having been received on the fully developed plan of care to authorize all plan of care orders. Review of the plan of care failed to evidence the attending physician had signed the written plan of care orders on 11-18-2020, when the clinical record review was completed. 3. Review of the clinical record for patient #4, evidenced a start of care date of 9-1-2020, and contained a plan of care for the certification period of 10-31 to 12-9-2020, with orders for PT 2 times a week for 4 weeks; OT 2 times a week for 1 week, then 1 time a week for 4 weeks, and SLT 2 times a week for 4 weeks. Review of the recertification OASIS, dated 10-29-2020, by a PT, employee G, evidenced a check mark before "Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction." The section "Orders for Disciplines and Treatments," evidenced PT 2 wk 4, effective 11-1-2020; OT 2 wk 1, 1 wk 4, effective 11-1-2020; and ST 2 wk 4, effective 11-1-2020. Review of the clinical record failed to evidence a specific verbal orders for PT, OT, ST care. Review of visit notes for PT evidenced the PT had furnished PT services during a care visit on 11-3, 11-5, 11-10, 11-12, and 11-16-2020. OT care visits were made on 11-2, 11-4, 11-9, and 11-16-2020; the ST had furnished services on 11-6 and 11-12-2020. The PT, OT, and ST had furnished care without having obtained a specific verbal order, and prior to the physician having signed and returned the fully developed plan of care to authorize all plan of care orders.			

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	Review of the plan of care failed to evidence the attending physician had signed the written plan of care orders on 11-18-2020, when the clinical record review was completed. 4. Review of the clinical record for patient #8, evidenced a start of care date of 9-6-18, and contained a plan of care for the certification period of 9-6 to 11-4-2020, with orders for SN, PT, and OT services. Review of the start of care OASIS/comprehensive assessment, dated 9-6-18, by former employee AA, a registered nurse, failed to evidence the attending physician had been contacted related to the completion of the comprehensive assessment and identified patient needs. Review of the clinical record failed to evidence verbal order(s) for SN, PT, and OT visits and care orders. The SN furnished care on 9-11, 9-18, 9-25, and 9-30-2018. The PT furnished care on 9-19 and 10-5-18. The OT furnished care on 9-25-18. The SN, PT, and OT furnished care without having obtained specific verbal orders for disciplines, frequency, duration of care visits and care orders. Review of the plan of care evidenced the attending physician had signed the fully developed plan of care on 10-8-2018. 5. Review of patient #6 clinical record revealed a start of care (SOC) date of 10/7/2020, and a plan of care (POC) for 10/7/2020 to 11/16/2020. The POC revealed orders for skilled nursing (SN) once a week for one week (for SOC) then once a month for three months and twice a week PRN (as needed) for catheter complication, physical therapy (PT) once a week for one week, eval week of 10/12 (sic) and occupational therapy (OT) once a week for one week then twice a week for three weeks.			

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	The POC was digitally signed by the admitting nurse on 10/7/2020 in the EMR field "Nurse Signature and Date of Verbal SOC Where Applicable" The POC was signed by the primary care provider (PCP) on 10/30/2020. Review of physician order failed to evidence verbal orders had been obtained, written down, read back and verified, and sent to the attending physician for counter-signature for orders for SN, PT, and OT. The patient received OT services on 10/8, 10/13, 10/15, 10/21, 10/22, and 10/27/2020, without the agency having obtained specific SOC orders and prior to obtaining a physician's signature on the POC. The patient received SN services on 10/28/2020, without the agency having obtained specific SOC orders and prior to obtaining a physician's signature on the POC. 6. Review of patient #9 clinical record revealed a SOC date of 8/31/2020, and a POC for the certification period of 8/31/2020 to 10/29/2020. The POC revealed orders for SN once a week for four weeks, PT once a week for one week then twice a week for four weeks, and OT once a week for one week, zero (sic) times a week for one week and once a week for two weeks. The POC was digitally signed by the admitting nurse on 8/31/2020, in the EMR field "Nurse Signature and Date of Verbal SOC Where Applicable." Review of the clinical record failed to evidence specific orders for disciplines, frequency, and care orders for SN, PT, and OT. At the date of survey exit, the plan of care had not been signed by the			

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	attending physician. 7. Review of patient #1 clinical record revealed a start of care (SOC) date of 10/11/2020, and a plan of care (POC) for 10/11/2020 to 12/09/2020. The POC revealed orders for skilled nursing (SN) once a week for six week, physical therapy (PT) once a week for one week and then twice a week for seven weeks, and occupational therapy (OT) twice a week for eight week. The POC was digitally signed by the admitting nurse on 10/11/2020 in the EMR field "Nurse Signature and Date of Verbal SOC Where Applicable" The POC was not signed by the primary care provider (PCP). Review of physician order failed to evidence verbal orders had been obtained, written down, read back and verified, and sent to the attending physician for counter-signature for orders for SN, PT, and OT. The patient received OT services on 10/12, 10/20, 10/23, 10/27, 10/28, and 11/03/2020, 11/04/2020 without the agency having obtained specific SOC orders and prior to obtaining a physician's signature on the POC. The patient received SN services on 10/19/2020, 10/26/2020, 11/02/202 without the agency having obtained specific SOC orders and prior to obtaining a physician's signature on the POC. 8. On 11-17-2020, at 3:50 P.M., the nursing supervisor reviewed the clinical records for the above patients, in relation to start of care procedures to include physician authorization of services furnished to patients. The nursing supervisor verified the above findings and indicated the agency had begun/continued services for their patients based on the clinician assessments and coordination of care with the			

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	physician's office after assessments, which they considered to satisfy the requirement of having obtained verbal orders for disciplines, frequencies, and specific care orders. The nursing supervisor indicated the agency clinicians had not followed the agency policy above, which required verbal orders be documented, read back and verified, dated and signed, must contain specific care orders for disciplines with frequencies, and be sent to the attending physician for countersignature. The nursing supervisor confirmed the comprehensive assessments were not sent to the physician for countersignature. The nursing supervisor verified the attending physician's plan of care signature was often obtained days to weeks after services had been furnished, and was the next physician order after the referral order had been received. Upon request for further pertinent information, explanation, or documentation, the nursing supervisor stated the electronic clinical record vendor had represented if field locator "Nurse Signature and Date of Verbal SOC [sic start of care] where applicable" was signed by a nurse, and the fully developed plan of care was later signed by the attending physician, a separate verbal order to authorize the furnishing of services was not required prior to providing care. 410 IAC 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) 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.	G 0590	/b>	12/16/2020

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	Based on record review and interview, the agency failed to ensure the attending physician was notified of a change in the patient's condition that might warrant a revision to the plan of care (POC) for 1 (Patient #9) of 3 closed patient records reviewed in a sample of 10. Findings include: Review of the clinical record for patient #9 was completed on 11/16/2020, for the certification period of 8/31/2020 to 10/29/2020, with SOC date being 8/31/2020. Diagnoses included autonomic neuropathy, bilateral knee osteoarthritis, spondylosis, constipation, tubular adenoma of the colon, sick sinus syndrome, and obstructive sleep apnea (OSA). Patient #9 was referred to the agency by the primary care physician (PCP) for skilled nursing (SN) for management of constipation and abdominal pain and pressure, and for physical therapy (PT) for inability to walk. Review of a physician's order dated 9/3/2020 the patient's daughter request to delay initial PT evaluation until 9/9/2020. On 9/9/2020 the patient's daughter again requested that the initial PT evaluation be rescheduled. Initial PT evaluation was completed on 9/14/2020. Subsequent visits were completed on 10/2/2020 and 10/7/2020. Review of a PT visit note dated 9/14/2020 evidenced that four goals were including improvement of strength of lower extremities, improved balance, improved gait, and transfer safety training. PT reported limitations to achieving goals were the inability to stand fully upright and knee pain Patient stated goals were to " ... be able to walk further ..." Review of a PT visit note dated 10/2/2020		**(Patient#9)** If a patient is being discharged for non-compliance, the DC discipline will discuss concerns with the patient/Pt representative, Case Manager, Physician and Clinical Director in advance prior to DC. All clinicians have been instructed to document evidence as to why we feel the patient is non-compliant, evidence barriers related to patient being compliant and efforts made to overcome any identified barriers. Patient #9 has been discharged from the agency. The Clinical Director spoke to the discharging clinician about the deficiency on 11/23/2020. Clinician stated the patient and her daughter agreed for the DC to take pace because she did not want to perform the HEP as directed and the patient did not want to work on any further goals with therapy. MD was notified of the agency DC by the discharging clinician with MD approval to perform the DC. Clinical Director will audit every discharge chart discharged as non-compliant for 1 month to ensure documentation contains the barriers related to patient being compliant and efforts made to overcome any identified barriers is discharged based on non-compliance concerns to ensure there is supportive	

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	157090	A. BUILDING 00 B. WING	11/18/2020

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	evidenced Employee G's documentation regarding patient #9's response to treatment " ... unsure of how often patient is compliant with HEP (home exercise program). Goals remained unchanged from the PT evaluation on 9/14/2020." The PT visit note failed to evidence what the HEP was, failed to evidence why employee G felt that the patient was not compliant with the HEP, and failed to evidence barriers related to patient being compliant with the HEP. Review of PT visit note dated 10/7/2020 evidenced employee G's documentation regarding patient #9's response to treatment " ... self-limiting behavior affecting patient's ability to have more independence in mobility .... " and " ... patient was minimally compliant with physical therapy and did not demonstrate sufficient compliance during sessions to justify further skilled care .... " Goals remained unchanged from the PT evaluation on 9/14/2020. The PT visit note failed to evidence what the HEP was, failed to evidence why employee G felt patient #9 was not compliant with the HEP, and failed to evidence barriers related to patient being compliant with the HEP and efforts made to overcome any identified barriers. One goal was documented as being met: transfer safety training. Goals of improving strength of the lower extremities, improving gait, and improving balance were documented by employee G as not being met. Review of the clinical record failed to evidence documentation that employee G had notified the PCP of changes in abilities to meet goals, failed to evidence documentation of efforts to modify interventions in order to obtain desired outcomes, and failed to evidence documentation of a consult with the PCP prior to discharging the patient due to agency's determination patient #9 was unable		documentation that shows evidence Based on further chart reviews, agency has not occurred the same deficiency yet. 100% compliance to be achieved on 1/15/2021 or before. Ongoing chart review during QAPI every 3 months. Ongoing in-services including all staff mandatory in-service on 12/9/2020 and 12/16/2020 to go over this deficiency to prevent this deficiency in the future. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion date of 12/16/2020.	

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	to achieve goals. During an interview with the DON on 11/18/2020 at 2:26 P.M., patient #9's discharge from therapy after three visits and lack of documentation of barriers to non-compliance were reviewed as well as the lack of documentation of attempts to adjust the POC in order to meet the patient's needs. The DON stated the documentation of the physical therapist during visits on 9/14/, 10/2, and 10/7 were adequate. 410 IAC 17-13-1(a)(2)			
G 0598 Bldg. 00	484.60(c)(3)(ii) Discharge plans communication (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview, the agency failed to ensure revisions to the discharge plan were communicated to the patient and/or caregiver and primary care physician (PCP) prior to discharging the patient in 1 (Patient #9) of 3 closed patient records reviewed in a sample of 10. Findings include: Review of the clinical record for patient #9 was completed on 11/16/2020 for the certification period of 8/31/2020 to 10/29/2020, with SOC date being 8/31/2020. Diagnoses included autonomic neuropathy, bilateral knee osteoarthritis,	G 0598	**G-0598 Discharge Plans Communication** If patient is being discharged for non-compliance, the discharging clinician will discuss compliance concerns and any barriers to compliance of POC with the patient/Pt Representative if applicable, Case Manager and Clinical Director and Physician prior to discharge. This will be evident by documentation in the patient's chart. All clinicians have been instructed to document evidence as to why we feel the	12/16/2020

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	spondylosis, constipation, tubular adenoma of the colon, sick sinus syndrome, and obstructive sleep apnea (OSA). Patient was referred to the agency by the primary care physician (PCP) for skilled nursing (SN) for management of constipation and abdominal pain and pressure, and for physical therapy (PT) for inability to walk. Review of the clinical record for patient #9 evidenced that the patient received three PT visits on 9/14/2020 for admission, 10/2/2020 for a follow-up visit, and on 10/4/2020 for a discharge visit. Review of the PT initial evaluation note dated 9/14/2020 evidenced documentation by employee G the discharge plan as "To self-care when goals met." Review of a PT visit note evidenced a follow up PT visit completed by employee G on 10/2/2020. Employee G documented " ...poor compliance with overall program and minimal self-initiation observed ..." and " ...expect to discharge patient from home health physical therapy during next visit ..." Documentation failed to evidence that the patient and/or caregiver were notified of plans for discharge and failed to evidence the PCP having been notified. Review of a PT visit note dated 10/7/2020 evidenced the patient was discharged on 10/7/2020, by employee G. Documentation failed to evidence that the patient and/or caregiver and PCP were notified prior to discharge. The findings were discussed with the Director of Nursing (DON) at 2:26 p.m. on 11/18/2020, in which the DON had no further information or documentation to provide.		patient is non-compliant, evidence barriers related to patient being compliant and efforts made to overcome any identified barriers. This deficiency was discussed with all clinicians on 12/16/2020 at all staff mandatory post survey in-service. Based on further chart reviews, agency has not occurred the same deficiency finding. All clinicians must report and document non- compliance concerns with the treating team prior to discontinuing service(s). If there is a non-compliance concern that arises, the clinician will notify the Case Manager, Clinical Director and Physician immediately after discussing the concerns with the patient and Pt Representative (if applicable) to work with the patient to identify barriers and modify the POC to meet the patient's identified goals. Documentation evidence of this communication will be added to the chart for review. If a patient is discharged from the agency due to non-compliance, a complete chart audit will be performed by the Clinical Director to ensure documentation supports evidence of identified barriers, attempts made to over come the barriers and evidence of reporting findings to the Physician. The Clinical Director spoke to the discharging clinician about the deficiency on 11/23/2020. Clinician stated the	

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			patient and her daughter agreed for the DC to take pace because she did not want to perform the HEP as directed and the patient did not want to work on any further goals with therapy. MD was notified of the agency DC by the discharging clinician with MD approval to perform the DC. Clinical Director will audit every discharge chart discharged as non-compliant for 1 month to ensure documentation contains the barriers related to patient being compliant and efforts made to overcome any identified barriers is discharged based on non-compliance concerns to ensure there is supportive documentation that shows evidence Based on further chart reviews, agency has not occurred the same deficiency yet. 100% compliance to be achieved on 1/15/2021 or before. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion date of 12/16/2020.	
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.			

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	Based on clinical record review and interview, the facility failed to coordinate care delivery to meet the patient's needs, and involve the patients, representative, and caregiver(s), as appropriate, in the coordination of care activities (Patient #7) 1 of 1 patient's reviewed who receive dialysis in a sample of 10. The finding included: Review of the clinical record of patient #7, start of care date of 10-22-2020 evidenced a plan of care for the certification period of 10-22-2020 to 12-2020, diagnoses included end stage renal disease. The plan of care failed to evidenced coordination of care with a dialysis center for patient #7, who receives dialysis on Monday, Wednesday and Friday. Review of the clinical record of patient #7, and admission documents dated 10-18-20, revealed the patient receives hemodialysis on Monday, Wednesday, Friday at the in-center dialysis facility. During an interview, on 11/18/20 at 3:15 PM, the DON (director of nursing) no additional information was given and indicted patient's #7 profile will be updated with their (Monday, Wednesday, Friday) dialysis schedule. 410 IAC 17-12-2 (h)	G 0608	/b> **(Patient#7)** RN Case Manager to coordinate services with active dialysis center to include dialysis location and telephone number, frequency days of dialysis. This information will be added to the patient's chart for a clinical review. Intake coordinator will call the dialysis center to request the following information upon referral acceptance and document in the chart for RN Case Manager review: Name of dialysis center, location, telephone number, days and times the patient attends dialysis, renal diet specifics, fluid restrictions, and request a medication list for RN review. Patient #7-dialysis center was called on 11/23/2020 to request information regarding the dialysis location, what days and times the patient attends dialysis, and medication list from dialysis center. All of the following content has been added to the patient's chart. Clinical Director will audit will every new dialysis admission upon POC development for 1 month to ensure the contents as stated above are included in the patient's chart and dialysis medications are included on the medication profile and reconciled with the home	12/09/2020

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			medications. Audits will continue until 100% compliance per month is achieved. 100% compliance is estimated to be achieved in 1 month or before. Agency will provide consistent all staff mandatory meetings and trainings every 3-6 months. Clinical Director to hold an additional meeting with all nursing staff after each case conference on a bi-weekly basis. All clinical staff have been communicated to follow through on this concern on 12/9/2020. All mandatory staff meetings were on 12/16/2020. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Deficiency corrected as of 12/9/2020 however, to be monitored on an ongoing basis during QAPI. Completion date of 12/9/2020.	
G 0682	484.70(a) Infection Prevention			

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Bldg. 00	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, policy review, and interview, the agency failed to ensure policies and procedures were put into place for Pre-Covid screening of visitors and failed to ensure they followed their policies and procedures in screening patients upon arrival of a home visit for 1 of 4 home visits conducted. The finding included: 1. Record review of the agency's undated policy titled, "Heritage Home Health COVID-19 Staff Prevention Plan," revealed staff are to perform COVID-19 Prescreening assessment questions as well as check patient's temperature at the beginning of the any patient visits. 2. Upon entering the agency on 11/09/2020 at 9:30 AM, the agency failed to evidence some form of signage posted at the entrance with visitation restrictions and screening procedures, instructions to individuals seeking medical care with symptoms of respiratory infection to immediately put on a mask and keep it on during their assessment, cover their mouth/ nose when coughing or sneezing, use and dispose of tissue, and perform hand hygiene after contact with respiratory secretions. The agency failed to actively screen visitors, check for fevers, signs and/or symptoms of respiratory infections, and other criteria such as travel or exposure to COVID-19. 3. During a home observation visit on 11/12/2020	G 0682	/b> After discussing further with the Case Manager/employee, it was an isolated incident where employee was nervous during the audit visit and did not follow through with the Heritage Policy and Procedure of the COVID-19 questionnaire/prescreening assessment. The Clinical Director has discussed this specific employee and feels confident that this will not happen again. Clinical Director will audit 10 visit notes weekly to ensure the covid questionnaire and patient/caregiver responses are documented in the chart until 100% compliance is achieved. Clinical Director will also monitor the infection prevention practices when attending home supervisory visits with clinicians ensuring the covid-19 questionnaire is asked to the patient/caregiver prior to any hands-on care is provided. Clinical Director will also ensure the clinician is abiding by the universal precaution policy including hand washing, practicing good bag technique and wearing appropriate protective wear per agency policy. After reviewing more charts, this	12/16/2020

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	at 12:45 PM, employee C failed to follow the agency's policies and procedures by performing the COVID-19 prescreening assessment questions toward the end of the home visit. During an interview on 11/13/2020 at 11:30 AM, the DON (Director of Nursing) stated the COVID-19 prescreening assessment questions should have been performed at the beginning of the home visit. 410 IAC 17-12-1(m)		deficiency has not been found with other employees. The Clinical Director will continue to monitor audits and during home supervisory visits to ensure 100% compliance on ongoing basis. All clinical staff have been communicated to follow through on this concern on 12/9/2020. All staff mandatory meetings took place on 12/16/2020. 100% compliance is expected as of 12/16/2020. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion date of 12/16/2020.	
G 0708 Bldg. 00	484.75(b)(2) Development and evaluation of plan of care Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); Based on record review, the agency failed to ensure that the patient and patient's caregiver were included in the re-evaluation of the plan of care (POC) in 1 (Patient #9) of 3 closed patient records reviewed.	G 0708	=”” span=””> **/b>(Patient#9)** **Agency must show evidence that the patient/Pt representative and physician, were included in Evals and**	12/16/2020

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	Findings include: Patient #9 clinical record review was completed on 11/16/2020 for the certification period of 8/31/2020 to 10/29/2020, with Start of care (SOC) date of 8/31/2020. SOC OASIS (outcome and assessment information set) listed diagnoses including autonomic neuropathy, bilateral knee osteoarthritis, spondylosis, constipation, tubular adenoma of the colon, sick sinus syndrome, and obstructive sleep apnea (OSA). Patient was referred to the agency by the primary care physician (PCP) for skilled nursing (SN) for management of constipation and abdominal pain and pressure, and for physical therapy (PT) for inability to walk. Review of a PT visit note dated 9/14/2020, revealed the PT established four goals during the evaluation including improvement of strength of lower extremities, improved balance, improved gait, and transfer safety training. PT reported limitations to achieving goals were the inability to stand fully upright and knee pain. The note indicated that Patient #9 goals were to " ...be able to walk further ...." Review of a PT visit note dated 10/2/2020 evidenced a visit was completed on 10/2/2020, by employee G. Employee G documented regarding patient response to treatment " ...unsure of how often patient is compliant with HEP (home exercise program). Goals remained unchanged from the PT evaluation on 9/14/2020. Employee G's visit note failed to evidence why employee G felt the patient was non-compliant and also failed to evidence employee G having spoken with the patient and/or her caregiver related to compliance and progression toward goals and the POC.		**Re-evaluations when developing the POC in-regards to setting patient specific goals. Interventions must reflect the goals set. If a patient is unable to meet the goals set due to non-compliance or functional inabilities and or barriers, the evaluating clinician will discuss concerns with the patient/Pt representative, Case Manager, Physician and Clinical Director in advance prior to initiated new goals and interventions or discharging services if required. All clinicians have been instructed to document evidence as to why we feel the patient is non-compliant, evidence barriers related to patient being compliant and efforts made to overcome any identified barriers on 12/9/2020 and 12/16/2020. Patient #9 has been discharged from the agency. The Clinical Director spoke to the discharging clinician about the deficiency on 11/23/2020. Clinician stated the patient and her daughter agreed for the DC to take pace because she did not want to perform the HEP as directed and the patient did not want to work on any further goals with therapy. MD was notified of the agency DC by the discharging clinician with MD**	

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	Review of a PT visit note dated 10/7/2020 evidenced the PT discharge visit was completed on 10/7/2020, by employee G. Employee G documented regarding patient response to treatment " ... self-limiting behavior affecting patient's ability to have more independence in mobility ... " and " ... patient was minimally compliant with physical therapy and did not demonstrate sufficient compliance during sessions to justify further skilled care ..." The clinical record failed to evidence documentation of the PT's/ agency's attempts to work with the patient and/or caregiver to determine barriers to compliance. The findings were discussed with the Director of Nursing (DON) at 2:26 p.m. on 11/18/2020, in which the DON had no further information or documentation to provide. 410 IAC 17-14-1(b)(4)		**approval to perform the DC.** **Clinical Director will audit every discharge chart discharged as non-compliant for 1 month to ensure documentation contains the barriers related to patient being compliant and efforts made to overcome any identified barriers is discharged based on non-compliance concerns to ensure there is supportive documentation that shows evidence Based on further chart reviews, agency has not occurred the same deficiency yet.** **Clinical Director will audit 5 therapy Re-evaluations weekly to ensure deficiency does not recur. Clinical Director will continue audits until 100% compliance has been achieved. 100% compliance is estimated to be achieved on or before 1/15/2021 before.** **Ongoing chart review during QAPI every 3 months. Ongoing in-services including all staff mandatory in-service on 12/9/2020 and 12/16/2020 to go over this deficiency to prevent this deficiency in the future.** The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this	

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			deficiency is corrected and will not recur. Deficiency was corrected as on 12/9/2020. Completion date of 12/16/2020.	
G 0716 Bldg. 00	484.75(b)(6) Preparing clinical notes Preparing clinical notes; Based on record review and interview, the Physical Therapist failed to ensure they documented within their visit notes all teaching and patient/caregiver response to the teaching for 1 (Patient #1) of 7 active records reviewed in a sample of 10. Findings include: During a home visit with employee E, (OT,) occupational therapist, on 11-12- 20 at 10:15 AM, employee E discussed with patient #1 their long toe nails and the need for a podiatrist referral. Patient #1 stated he could not afford to go. Patient #1, who sleeps on a pull out couch at the parent's home, discussed with employee E about DME (durable medical equipment), and stated "This noodle on the side of the bed railing is wore out." Review of clinical record on 11-17-20 at 2:30 PM, the 11-12-20 visit note failed to evidenced patient #1 long toe nails, podiatry suggestion, reason for patient's refusal, and failed document patient #1 durable medical equipment request. During the interview on 11-17-20, at 3:15 PM, the Director of Nursing stated the physical therapist conversation should have been document in the visit narrative.	G 0716	G0716 Preparing Clinical Notes (Pt #1)All visit notes must show evidence of the skilled teaching and the patient/caregiver response to the teaching. Clinical Director has discussed this deficiency with all clinicals with assured understanding of the deficiency and how to prevent re-occurrence in the future. Based on further chart reviews, agency has not occurred the same deficiency yet. Clinical Director to audit 25% of all visits weekly to ensure deficiency does not reoccur. Auditing to continue until 100% is achieved. Ongoing chart review during QAPI every 3 months. Ongoing in-services including all staff mandatory in-service on 12/16/2020 to go over this deficiency to prevent this deficiency in the future. Clinical Director and Administrator will monitor to ensure that the deficient practice will not occur. Deficiency corrected as of 12/9/2020, however to be monitored on an on going basis during QAPI. Completion date of 12/16/2020.	12/16/2020

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	157090	A. BUILDING 00 B. WING	11/18/2020

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HERITAGE HOME HEALTH SERVICES LLC	429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202

(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 0798 Bldg. 00	410 IAC 17-14-1(c)(5) 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 Registered Nurse failed to ensure they included dietary and fluid restriction on a home health aide care plan for 1 (Patient #7) of 1 patient record review of a patient receiving dialysis treatments and home health aide services in a sample of 10. The finding included Review of the clinical record of patient #7, start of care date of 10-22-2020 evidenced a plan of care for the certification period of 10-22-2020 to 12-2020, diagnoses included end stage renal disease. The home health aide care plan failed to evidence nutritional requirement fluid restriction as part of patient #7's renal diet requirement. Review of coordination of care note dated 10-22-2020, evidenced team conference with DON (Director of nursing), employee K, employee J and employee L . The entry failed to evidence patient #7's dialysis diagnosis, sodium, diabetic, renal diet, and fluid intake restriction of 32 ounces per 24 hours as part of renal diet.	G 0798	/b> **(Patient #7)** All HHA care plans must include diet and any applicable fluid restrictions. The Clinical Director has discussed this deficiency with all clinicians to ensure all HHA care plans must have dietary and fluid restrictions noted on the care plans. Patient #7-HHA care plan has been updated by adding the patient's fluid restrictions and renal diet on 11/23/2020. Based on further chart reviews, the agency has not had the same deficiency yet. Agency to continue auditing charts with HHA services to assure deficiency is not found. Clinical Director to audit 25% or more of all HHA care plans to ensure deficiency does not	12/09/2020

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	During a telephone interview on 11-17-2020 at 2:30 PM, Non-Employee DD, a Dietitian at patient #7's in-center dialysis facility, stated patient #7 was to have a low sodium, diabetic, renal diet with a 32-ounce fluid intake restriction per 24 hours. On 11-17-2020, at 3:30 PM, DON verified the findings and stated patient #7's fluid and dietary restrictions should have been documented on the home health aide care plan. 410 IAC 17-14-1(m)		reoccur. Auditing to continue until 100% is achieved. Ongoing chart review during QAPI every 3 months. 100% compliance is estimated to be achieved on or before 1/15/2021 or before. Ongoing in-services including all staff mandatory in-service on 12/16/2020 to go over this deficiency to prevent this deficiency in the future. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion date of 12/9/2020.	
G 0848 Bldg. 00	484.100 Compliance with Federal, State, Local Law Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients. The HHA and its staff must operate and furnish services in compliance with all applicable federal, state, and local laws and regulations related to the health and safety of patients. If state or local law provides licensing of HHAs, the HHA must be licensed.	G 0848	G0848	12/04/2020

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	Based on record review, observation, and interview, the home health agency failed to disclose a change to the ownership structure of the agency at the time the changes were made (See G 852;) failed to disclose to the state agency, the names and addresses of all persons involved when the agency had a change in ownership structure (See G 854;) failed to disclose a change in the officers, director, and managing agent of the home health agency at the time the changes were made (See G 856;) and failed to operate a home health agency only with a valid state license by having failed to submit a complete renewal application, to include the license fee, to renew its license prior to the expiration date (See G 860.) The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure the provision of quality of care in a safe environment for the Condition of Participation 42 CFR 484.100, Compliance with Federal, State, and local laws and regulations related to the health and safety of patients. 410 IAC 17-10-1(a)(2)(3)(4)(5) 410 IAC 17-10-1(c)(2) 410 IAC 17-10-1(d) 410 IAC 17-10-1(d)(1) 410 IAC 17-10-1(d)(2)(A)(B)(C)		Change of Information along with change in officers (share purchase and sale as of June 2020) have been submitted to ISDH as of 11/17/20. The renewal application for state license is currently pending with ISDH. All the requested or required documents have been summited to ISDH (Attn to Director of Home Health Division under ISDH) including renewal application fee and change of information. Administrator has extensively reviewed all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc. . Administrator to be up to date with all state and federal policies for Home Health Agency and to ensure to implement them as and when needed. A Governing body meeting was called on 12/04/2020 to go over all the deficiencies including administrative deficiencies. A plan in place to follow through by governing body. Administrator to update governing body every 3 to 6 months of upcoming changes of officials, license renewals etc. and to follow through as and when needed. Still waiting for renewed license form ISDH, however all the deficiencies rectified on or before 12/4/2020. Completion date of	

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G 0852 Bldg. 00	484.100(a) Information to the state survey agency Standard: The HHA also must disclose the following information to the state survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management: Based on interview and record review, the agency failed to disclose a change to the ownership structure of the agency at the time the changes were made, 6-1-2020, for 1 of 1 home health agency. The findings included: During the survey entrance conference on 11-9-2020, at 10:30 A.M., the administrator, employee A, indicated having become a new 30% owner and officer (CEO) of the home health agency 6-1-2020, and held the position of the agency's administrator effective 8-12-2020. The administrator indicated another person, person BB, became a new 30% owner and officer/managing agent of this home health agency on 6-1-2020. The administrator indicated person BB was not an employee of the home health agency. When asked on 11-10 -2020, at 11:50 A.M., if the agency had notified IDH (Indiana Department of Health) related to the home health agency's changes in ownership structure, whether characterized as a change in information, or a change in information, with all required accompanying documentation, the administrator answered, "No."	G 0852	12/4/2020. ="" p="">Change of Information along with change in officers (share purchase and sale as of June 2020) have been submitted to ISDH as of 11/17/20. All the requested or required documents have been summited to ISDH (Attn to Director of Home Health Division under ISDH) including COI. Administrator has extensively reviewed all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc. . Administrator to be up to date with all state and federal policies for Home Health Agency and to ensure to implement them as and when needed. A Governing body meeting was called on 12/04/2020 to go over all the deficiencies including administrative deficiencies. A plan in place to follow through by governing body. Administrator to update governing body every 3 to 6 months of upcoming changes of officials, license renewals etc. and to follow	12/04/2020

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	On 11-9-2020, at 4:29 P.M., review of the IDH database failed to evidence the state had been notified of the changes in the home health agency ownership structure, which occurred on 6-1-2020. 410 IAC 17-10-1(d)		through as and when needed. This deficiency rectified on or before 12/4/2020. Completion date of 12/4/2020.	
G 0854 Bldg. 00	484.100(a)(1) All persons with ownership interest The names and addresses of all persons with an ownership or controlling interest in the HHA as defined in §420.20l, §420.202, and §420.206 of this chapter. Based on interview and record review, the agency failed to disclose to the state agency, the names and addresses of all persons involved when the agency had a change in ownership structure for 1 of 1 home health agency. The findings included: During the survey entrance conference on 11-9-2020, at 10:30 A.M., the administrator, employee A, indicated having become a new 30% owner and officer (CEO) of the home health agency 6-1-2020, and held the position of the agency's administrator effective 8-12-2020. The administrator indicated another person, person BB, became a new 30% owner and officer/managing agent of this home health agency on 6-1-2020. The administrator indicated person BB was not an employee of the home health agency. When asked on 11-10-2020, at 11:50 A.M., if the agency had provided Indiana Department of Health with all required documentation related to the home health agency's changes in ownership	G 0854	**G-0854** **Change of Information along with change in officers (share purchase and sale as of June 2020) have been submitted to ISDH as of 11/19/20. All the requested or required documents have been summited to ISDH (Attn to Director of Home Health Division under ISDH) including COI. Administrator has extensively reviewed all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc. . Administrator to be up to date with all state and federal policies for Home Health Agency and to ensure to implement them as and when needed. A Governing body meeting was called on 12/04/2020 to go over all the deficiencies including administ**	12/04/2020

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	6-1-2020, whether characterized as a change in information, or as a change in ownership, the administrator answered, "No." On 11-9-2020, at 4:29 P.M., review of the IDH database failed to evidence the state had been informed of the changes in the home health agency ownership which occurred on 6-1-2020. 410 IAC 17-10-1(d)		**rative deficiencies. A plan in place to follow through by governing body. Administrator to update governing body every 3 to 6 months of upcoming changes of officials, license renewals etc. and to follow through with ISDH and CMS as and when needed. This deficiency rectified on or before 12/4/2020. Completion date of 12/4/2020.**	
G 0856 Bldg. 00	484.100(a)(2) Officer, a director, agent, managing employee The name and address of each person who is an officer, a director, an agent, or a managing employee of the HHA as defined in §420.20l, §420.202, and §420.206 of this chapter. Based on interview and record review, the agency failed to disclose a change in the officers, director, and managing agent of the home health agency at the time the changes were made, 6-1-2020, for 1 of 1 home health agency. The findings included: On 11-9-2020, at 10:30 A.M., during the survey entrance conference, the administrator, employee A, indicated having become a new 30% owner and officer (CEO) of the home health agency 6-1-2020, and held the position of the agency's administrator effective 8-12-2020. The administrator indicated another person, person BB, became a new 30% owner and officer/managing agent of this home health agency on 6-1-2020. The administrator indicated person BB was not an employee of the home	G 0856	**G-0856** **Change of Information along with change in officers, director, agent, (share purchase and sale as of June 2020) have been submitted to ISDH as of 11/19/20. All the requested or required documents have been summited to ISDH (Attn to Director of Home Health Division under ISDH) including COI. Administrator has extensively reviewed all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc. . Administrator to be up to date with all state and federal**	12/04/2020

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	health agency. When asked on 11-10-2020, at 11:50 A.M., if the agency had notified IDH (Indiana Department of Health) related to the changes made at the home health agency, whether characterized as a change in information, or as a change in ownership, the administrator answered, "No." When asked if the agency had notified the IDH of the administrator's role as managing owner, and officer of the home health agency, the administrator answered, "No." When asked if the agency had notified IDH person BB was a managing agent, officer, and director (member of the governing body) of the home health agency, the administrator answered, "No." On 11-9-2020, at 4:29 P.M., review of the IDH database failed to evidence the state had been notified of the changes in the home health agency related to new owners/officers/directors which occurred on 6-1-2020, except for notification of person A becoming administrator, approved on 8-12-2020. On 11-17-2020, at 9:30 A.M., review of the secretary of state website evidenced the home health agency notified the secretary of state of change in principal address, change in officer, and change of registered officer, on 11-10-2020. 410 IAC 17-10-1(d) 410 IAC 17-10-1(d)(2)		**policies for Home Health Agency and to ensure to implement them as and when needed. A Governing body meeting was called on 12/04/2020 to go over all the deficiencies including administ rative deficiencies. A plan in place to follow through by governing body. Administrator to update governing body every 3 to 6 months of upcoming changes of officials, license renewals etc. and to follow through with ISDH and CMS as and when needed. This deficiency rectified on or before 12/4/2020. Completion date of 12/4/2020.**	
G 0860 Bldg. 00	484.100(b) Licensing (b) Standard: Licensing. The HHA, its branches, and all persons furnishing services to patients must be licensed, certified, or registered, as			

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	applicable, in accordance with the state licensing authority as meeting those requirements. Based on record review, interview, and observation, the agency failed to operate a home health agency only with a valid state license by having failed to submit a complete renewal application, to include the license fee, to renew its license prior to the expiration date, for 1 of 1 home health agency. The findings included: Review of pre-survey documentation from the IDH (Indiana Department of Health) evidenced the agency state license expired on 10-31-2020. During the entrance conference on 11-9-2020, at 10:30 A.M., when queried if the state licensure had been renewed prior to expiration, the administrator indicated having sent in a renewal application but having forgotten to include the mandatory $250 application fee. The administrator indicated having sent the application check for $250 dollars to IDH [Indiana Department of Health] and that it was returned to the agency for wrong address. The nursing supervisor indicated the agency had approximately 107 patients. As of 11-9-2020, the agency had been operating without a state license for 9 days, because the issued license expired on 10-31-2020. During observation of the lobby on 11-17-2020, at 9:18 A.M., the agency's state license was observed posted and evidenced an expiration date of 10-31-2020. At the time of the exit conference on 11-18-2020, at	G 0860	**G-0860** The renewal application for state license is currently pending with ISDH as of October 2020. Application Fee was received on 11/5/20 or 11/6/20 by ISDH, however not cashed till 11/20/2020. All the requested or required documents have been submitted to ISDH (Attn to Director of Home Health Division under ISDH) including a change of information. Administrator to update the governing body every 3 to 6 months of upcoming changes of license renewals etc. and to follow through as and when needed. At this point, we are still waiting for renewed license form ISDH, however everything has been completed or provided by Administrator of Heritage HH to rectify this deficiency on or before 12/04/20. This deficiency will be rectified 100% once we receive our renewal license. The governing body and administrator will be monitoring any upcoming license renewal every 3-6 months and will be stated in the meeting notes. Any new renewal application will be sent at least 60-90 days before the due date and application will be reviewed by 1 more board member before mailing out to ensure that there is 100% compliance for any future	12/04/2020

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	3:15 P.M., the administrator indicated not yet having obtained a renewal of the home health agency's state licensure. On 11-18-2020, the agency had been operating 18 days without a state license. 410 IAC 17-10-1(a)(2)(3)(4) and (5) 410 IAC 17-10-1(c)(2)		application renewal. Administrator and board members will be responsible for monitoring. ="" p=""> ="" p="">	
G 0942 Bldg. 00	484.105(a) Governing body Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the governing body failed to ensure 3 policies of 20 policies reviewed were updated to comply with federal and state requirements. The findings included: Review of a policy, "Patient Discharge Process," undated, evidenced the policy stated, "Policy Discharge Planning is initiated for every home care patient at the time of the patient's admission for home care ... Purpose ... To facilitate patient's discharge or transfer to another entity. To ensure continuity of care, treatment, and services when needed. To assure collaboration with the physician patient, family and other disciplines in planning for discharge from the agency ... Patient's needs for continuing care to meet physical and psychological needs are identified	G 0942	**G-0942** **Administrator and governing body have reviewed all the policies and procedures. Administrator exte nsively reviewed three policies of 20 policies that governing body failed to comply. Administrator has extensively reviewed all current policy and procedures, and all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc. . Administrator to be up to date with all state and federal policies for Home Health Agency and to ensure to**	12/04/2020

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	and patients are told in a timely manner of the need to plan for discharge ... " The governing body failed to ensure the agency's policy required 15 days of verbal and written notice of discharge, as required by 410 IAC 17-12-2 (i), unless the health safety and welfare of employees would be at immediate and significant risk; the patient refuses services; the patients' services are no longer reimbursable; or the patient no longer meets regulatory criteria--such as having an attending physician. Review of a policy, "Physicians Orders," undated, evidenced the policy stated, "When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order shall verify the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed will the full name and title of the person receiving the order and be sent to the physician for signature ... " The governing body failed to ensure the agency's policy required the time of the order be documented on the verbal order, a recognized standard of practice for verbal orders in the clinical record. Review of a policy, "Plan of Care," undated, evidenced the policy failed to require the plan of care include the patients' risk for emergency department visits and hospital re-admission; patients' social and cognitive status, and information related to any advance directives; as required by federal regulations. The governing body failed to the agency's policy listed all the required content of the plan of care. The governing body failed to ensure the home health		**implement them as and when needed. A Governing body meeting was called on 12/04/2020 to go over all the deficiencies including all policies and procedures. A plan in place to follow through by governing body. Administrator to update governing body every 3 to 6 months to review all policy and procedures and upcoming changes of license renewals etc. and to follow through as and when needed. All the deficiencies related to G-0942 are rectified on or before 12/4/2020. Completion date of 12/4/2020.**	

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	agency updated all required policies to be in compliance with federal and state requirements. On 11-18-2020, at 3:15 P.M., the administrator verified the above findings. 410 IAC 17-12-1(b)			
G 0946 Bldg. 00	484.105(b)(1)(i) Administrator appointed by governing body (i) Be appointed by and report to the governing body; Based on record review and interview, the administrator failed to recognize and report to the governing body the need for the home health agency to update 3 of 20 policies reviewed. The findings included: Review of a policy, "Patient Discharge Process," undated, evidenced the policy stated, "Policy Discharge Planning is initiated for every home care patient at the time of the patient's admission for home care ... Purpose ... To facilitate patient's discharge or transfer to another entity. To ensure continuity of care, treatment, and services when needed. To assure collaboration with the physician patient, family and other disciplines in planning for discharge from the agency ... Patient's needs for continuing care to meet physical and psychological needs are identified and patients are told in a timely manner of the need to plan for discharge ... " The administrator failed to recognize and report to the governing body the agency's policy should have required 15 days of verbal and written notice of discharge, as required by 410 IAC 17-12-2 (i), unless the health safety and welfare of employees would be at immediate and significant risk; the patient refuses	G 0946	**G-0946** Administrator and governing body have reviewed all the policies and procedures. Administrator extensiv ely reviewed three policies of 20 policies that governing body failed to comply. Administrator acknowledged the 15 days of verbal and written policy to board and ensure that policy is being implemented in 100% compliance as of 12/1/2020. **Administrator has extensively reviewed all current policy and procedures, and all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc. . Administrator to be up to date with all state and federal policies for Home Health Agency and to ensure to implement them as and when needed. A Governing body meeting was called on 12/04/2020 to go over all the deficiencies including all**	12/04/2020

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	services; the patients' services are no longer reimbursable; or the patient no longer meets regulatory criteria--such as having an attending physician. Review of a policy, "Physicians Orders," undated, evidenced the policy stated, "When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. The verbal order shall verify the order was taken and verified by documenting this on the form and signing the form. The order must include the date, specific order, be signed will the full name and title of the person receiving the order and be sent to the physician for signature ... " The administrator failed to recognize and report to the governing body the need to ensure the agency's policy required the time of the order be documented on the verbal order, a recognized standard of practice for verbal orders in the clinical record. Review of a policy, "Plan of Care," undated, evidenced the policy failed to require the plan of care include the patients' risk for emergency department visits and hospital re-admission; patients' social and cognitive status, and information related to any advance directives; as required by federal regulations. The administrator failed to recognize and report to the governing body the requirement for the agency's policy to list all the required elements for the content of the plan of care. On 11-18-2020, at 3:15 P.M., the administrator verified the above findings. 410 IAC 17-12-1(b)(1)		**policies and procedures. A plan in place to follow through by governing body. Administrator to update governing body every 3 to 6 months to review all policy and procedures and upcoming changes of license renewals etc. and to follow through as and when needed. All the deficiencies related to G-0942 are rectified on or before 12/4/2020. Completion date of 12/4/2020.**	

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G 0948 Bldg. 00	484.105(b)(1)(ii) Responsible for all day-to-day operations (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to ensure day to day operations of the agency could continue with a valid state license, by having failed to timely submit the mandatory fee with the state licensure application for renewal, for 1 of 1 home health agency. The findings included: Review of the job description of the administrator, employee A, signed by employee A on 8-1-2020, evidenced duties included, but were not limited to " ... Ensure the agency complies with all state, federal, and company policies for operating a home health agency ..." Review of pre-survey documentation from the IDH (Indiana Department of Health) evidenced the agency state license expired on 10-31-2020. During the entrance conference on 11-9-2020, at 10:30 A.M., when queried if the state licensure had been renewed prior to expiration, the administrator indicated having sent in a renewal application but having forgotten to include the mandatory $250 application fee. The administrator indicated having been notified of the failure to submit the $250 fee, and then submitted a check for the fee to the IDH (Indiana Department of Health] and that the envelope was returned to the agency for wrong address. The nursing supervisor indicated the agency had approximately 107 patients between the parent and the branch locations.	G 0948	**G-0948**	12/04/2020

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	As of 11-9-2020, the agency had been operating without a state license for 9 days, because the previously issued license expired on 10-31-2020. During observation of the lobby on 11-17-2020, at 9:18 A.M., the agency's state license was observed posted and evidenced an expiration date of 10-31-2020. At the time of the exit conference on 11-18-2020, at 3:15 P.M., the administrator indicated not yet having obtained a renewal of the home health agency's state licensure. On 11-18-2020, the agency had been operating 18 days without a state license. 410 IAC 17-10-1(a)(2)(3)(4)(5) 410 IAC 17-10-1(c)(2) 410 IAC 17-12-1(c)(1) 410 IAC 17-12-6			
G 0974 Bldg. 00	484.105(d)(2) Direct support and administrative control The parent HHA provides direct support and administrative control of its branches. Based on record review and interview, the parent location of the home health agency failed to exercise its supervisory responsibility to oversee, monitor, and take corrective measures to manage the intake process conducted at the branch office, which caused 1 out of 2 lab orders at the start of care (Patients #5) and 1 out of 1 referral (Patient #1) for speech language therapy, not to be transcribed to the clinicians for start of care interdisciplinary assessment and care, out of a total of 10 clinical records reviewed. The findings included:	G 0974	G 0974-Directive Support and Administrative Control="" p=""> Clinical Director will monitor all referrals. QA RN will audit chart at time of POC completion to ensure deficiency is not re-occurrent. Clinical Director will audit 25% or more of all new admissions until 100% compliance is achieved. Clinical Director, Administrator and Intake Coordinator. They will monitor these corrective actions to ensure these deficiencies are corrected	12/04/2020

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	1. Review of the clinical record of patient # 1, evidenced a start of care date of 10-11-20, and contained a plan of care for the certification period of 10-11-20 to 12-09-20 , with skilled nursing (SN,) physical therapy (PT,) occupational therapy (OT,) Review of the referral order, dated 10-05-20, revealed physical therapy (PT,) occupational therapy (OT,) speech therapy (ST,) and home health aide (HHA,) During an interview on 11/13/20 at 3:00 PM , the DON (Director of Nursing) verified all disciplines should have been on the plan of care. 2. Review of the clinical record of patient # 5, evidenced a start of care date of 9-17-20, and contained a plan of care for the certification period of 9-17-20 to 11-15-20 , with skilled nursing (SN,) and labs. The comprehensive assessment / OASIS dated 9-17-20 and care coordination noted dated 9-17-20 failed to evidence that Employee C, performed lab draw on admission. Review of referral order, dated 9-10-20, revealed home care order for SN and labs. On 11-13-2020, at 3:15 P.M., the above missed intake orders were reviewed with the DON who indicated the branch location in Martinsville handled the intake process for the above patient, labs were not drawn and run as ordered, and the speech language pathologist had not yet conducted an initial evaluation as ordered. 410 IAC 17-12-1(c)(1)		and will not reoccur. All protocols are in place as of 12/1/2020. Completion date of 12/4/2020.	
G 1010	484.110(a) Contents of clinical record			

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Bldg. 00	Standard: Contents of clinical record. The record must include: Based on record review and interview, the agency to ensure the clinical record contained documentation within a patient record of their attempt to obtain a Medical Social Worker and the response/ denial received for 1 (Patient #1) of 7 active records reviewed in a sample of 10. Findings include: During a home visit with employee E, (OT,) occupational therapist, on 11-12- 20 at 10:15 AM, employee E discussed with patient #1 their long toe nails and the need for a podiatrist referral. Patient #1 stated he could not afford to go. During the interview on 11-12-20 at 10:25 AM, employee E was queried about social work involvement. Employee E indicated a request was sent on admission but was not approved. The clinical record for patient #1 evidenced the patient was admitted on 10-11-20. The clinical record failed to evidence any documentation about the agency's attempt to obtain Medical Social Worker services for patient #1. During the interview on 11-13-20 at 11:15 AM, DON (director of nursing), indicated an order for a social worker will be requested from the physician, but no additional information was provided. During the interview on 11-17-20, at 3:15 PM, DON stated patient #1 has a MSW (Medical Social Worker) benefit through their insurance.	G 1010	/b> **(Patient #1)** By educating and training all clinical staff to follow through, document and communicate with the team members when they observe needs to add additional disciplines services that need to be addressed by HHA. Additional discipline orders to be completed on a physician's order and approved by the Clinical Director then immediately schedule the evaluation. Patient #1 was discussed with the clinical team that was providing direct care to the patient on 11/23/2020. The case Manager and OT decided MSW was not indicated at this time because the caregiver declined needs assessment by MSW. Patient has been discharged from the agency. Clinical Director will audit 10 visit notes weekly to ensure any clinical status change in care and or additional service needs are reported to the Case Manager, Clinical Director, Physician and Pt representative when applicable. Clinical Director will continue audit until 100% compliance is achieved. 100% compliance to be achieved on or before 1/15/2021.	12/16/2020

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			Agency will provide consistent all staff mandatory meetings and trainings every 3-6 months. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion date of 12/16/2020.	
N 0000 Bldg. 00		N 0000	N 518 Patient Rights #1 Agency has now added the IN State Dept of Health Advance Directives 11/1/2018 to the SOC packets effective 11/20/2020. #2 Agency will follow up in the QAPI meetings every quarter to ensure this deficiency does not occur in the future. #3 Clinical Director and Administrator will directly monitor and be responsible for #1 and #2. #4 Deficiency has already been corrected by 11/20/2020.	
	This visit was for a State Re-licensure survey. A complaint investigation was conducted in conjunction with the State Re-licensure survey. Complaint #: IN 00273503; Substantiated; no deficiencies were cited. Survey Dates: 11-9, 11-10, 11-12, 11-13, 11-16, 11-17, and 11-18-2020 Facility #: 005294 CCN: 157090 Medicaid #: 200805010 Census unduplicated for prior 12 months: 426 Current census: Skilled patients: Indianapolis parent: 66			

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	Martinsville branch: 41 Total Skilled patients: 107 Patients who received home health aide only services or personal services only: 0 Home Visits with Clinical Record Review: 4 Clinical record review only Active: 3 Clinical record review Closed: 3 Total Clinical Records Reviewed: 10 Quality Review Completed on 12/03/2020 by Area 3			
N 0518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review and interview, the agency failed to inform patients and provide written materials which provided an accurate description of current Indiana law related to advance directives for 10 (Patients #1-10) of 10 patients. The findings included:	N 0518	N 518 Patient Rights Agency has now added the IN State Dept of Health Advance Directives 11/1/2018 to the SOC packets effective 11/20/2020. Agency will follow up in the QAPI meetings every quarter to ensure this deficiency does not occur in	11/20/2020

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	Review of an undated patient admission packet, failed to evidence a complete description of applicable Indiana advance directive law. The agency provided the 7-1-2013 version of "Your Right to Decide." The patient rights materials failed to include updated description of current Indiana law, updated 11-1-2018 On 11-18-2020, at 3:00 PM, the nursing supervisor indicated agency clinicians used the patient admission packet as a guide to advise all agency patients of the current description of Indiana state law in relation to advance directives, and stated the packets in each patient home did not provide the updated information in the 11-1-20218 description of current Indiana advance directive law. The administrator verified the above findings. When queried for any additional pertinent information, explanation, or documentation, the administrator stated having nothing further to present.		the future. Clinical Director and Administrator will directly monitor and be responsible for #1 and #2. Deficiency has already been corrected by 11/20/2020. Completion date of 11/20/2020.	