STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	201058730	A. BUILDING B. WING	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTYLES HOMECARE LLC	107 FEDERAL DRIVE, CHESTERFIELD, IN, 46017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 7/11, 7/12, 7/13 and 7/14/2022 Census: 55	N0000	The Plan of Correction is submitted under Federal and State Regulations and status applicable to health care providers. This Plan of Correction does not constitute an admission of liability on the part of the agency and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.	2022-08-19

G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home Health Care Agency. Survey Dates: 7/11, 7/12, 7/13 and 7/14/22 Partially Extended Survey Announced 7/11/2022 at 12:20PM. Extended survey was announced on 7/12/2022 at 3:33PM. Facility Number: IN012685 Census: 55 These deficiencies reflect State findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G0000	The Plan of Correction is submitted under Federal and State Regulations and status applicable to health care providers. This Plan of Correction does not constitute an admission of liability on the part of the agency and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as our credible allegation of compliance.	2022-08-19

G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review, observation, and interview, the agency failed to ensure all patients were informed of the following Patient Bill of Rights: the disciplines that will furnish care, factors that could impact treatment effectiveness, and any changes in the care to be furnished for 3 of 3 active patients with home visits [Patient # 5, 6, and 7] and the potential to affect all 55 current patients. Findings include: Review of an undated agency document titled Client Handbook included an undated section	G0434	Based on the deficiency above, the following addendums have been made on 8-1-2022 by the DON, to the Home Health Care Bill of Rights. The Home Health Care Bill of Rights have been updated to include: Patients have the right to: Participate in and be informed about, and consent or refuse care in advance of and during treatment with respect to: Completion of all assessments The care to be furnished, based on the comprehensive assessment Establishing and revising the plan of care The disciplines that will furnish care The frequency of visits Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits Any factors that could impact treatment effectiveness and Any changes in the care to be furnished Receive all services outlined in the plan of care Meeting with all case managers held on 8-1-2022, DON and ADON educated case managers and RN staff on the addendums to the Home Health Care Bill of Rights. Case managers instructed to provide all current active clients with a copy of this addendum to the Home Health Care Bill of Rights by 8-12-2022 and place into their home folders. The case managers will be responsible to provide each of their current active clients with a copy of this addendum. All Client Handbooks were revised on 8-1-2022 to include the addendum for all future client admissions.	2022-08-12

	that was missing the following information that was to be provided to the patient: the disciplines that will furnish care, factors that could impact treatment effectiveness, and any changes in the care to be furnished. A home observation visit for Patient #5 was conducted on 07/12/2022 at 10:00AM. Observed agency folder in home with the undated Home Health Care Patient Bill of Rights missing the following information that was to be provided to the patient: the disciplines that will furnish care, factors that could impact treatment effectiveness, and any changes in the care to be furnished During an interview on 07/11/2022 at 11:35AM, when asked where in the Patient Bill of Rights this patient information is found, the Administrator reviewed the Patient Bill of Rights and indicated could not find. IAC 410 17-12-3(b)(2)(D)(i)(AA) IAC 410 17-12-3(b)(2)(D)(ii)(BB) A home observation visit for Patient #6 was conducted on 07/12/2022 at 12:58PM. Observed agency folder in home with the undated Home Health Care Patient Bill of Rights missing the following information that was to be provided to the patient: the disciplines that will furnish care, factors that could impact treatment effectiveness, and any changes in the care to be furnished. A home observation visit for Patient #7 was conducted on 07/13/2022 at 10:04AM. Observed agency folder in home with the undated Home Health Care Patient Bill of Rights missing the following information that was to be provided to the patient: the disciplines that will furnish care, factors that could impact treatment effectiveness, and any changes in the care to be furnished.			

N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. The home health agency failed to follow their own policy and ensure their personnel files included the current home health aide (HHA) certification for in 1 of 4 HHA personnel files reviewed (HHA #1). Findings include: 1. An agency policy D-180 Personnel Records indicated, but not limited to, &The personnel record for an employee will include &updated license/certifications &	N0458	Based on the deficiency above one of the employee files did not contain a current home health aide license. The employee had a current license but the copy was not in the employee file at the time of the survey. The employees home health aide license was printed off and placed into the employee file on 7-15-2022. All employee files received an audit by the human resource director on 7-15-2022 to ensure that all employees have a current license on file. The audit report was given to the DON on 7-15-2022 for review. No other files were found out of compliance. The human resource director will complete employee file audits on 50% of the employee files quarterly to ensure that copies of the employees current license certifications are maintained in the employee files. Results of the employee file audits will be reviewed and discussed in the QA meetings.	2022-07-15

	2. Employee record review of HHA #1 was reviewed on 7/13/22 and failed to evidence an active certification. The most recent HHA certification with an expiration date of 9/20/21. 3. During an interview on 7/13/22, beginning at 3:15PM, Administrative Staff #1 was unable to demonstrate an up to date HHA certification within HHA #1 s personnel file. IAC 410 17-12-1(f)(4)			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.	N0460	Based on the deficiency above, one administrative staff failed to have an annual performance evaluation completed and placed in the employee record. DON/ADON reviewed the Personnel Records Policy and it indicates a competency based performance evaluation will be conducted for all employees after one year of employment and at least annually thereafter. Job performance will be documented on the appropriate form by the evaluator and will become a permanent part of the employee personnel file. A member of the governing body will perform the annual evaluation on the administrator. The evaluation was completed on the administrator on 7-29-2022 by a member of the governing body, reviewed with the administrator and placed into the employees file. The Human Resource Director completed an audit on all the active current employees, no other employees were found to be missing the annual evaluation. The human resource director will complete random chart audits on 50% of employee files quarterly to ensure that annual performance evaluations are being completed when they come due. The results of the audit will be reviewed and discussed at the QA meetings.	2022-07-29

	The home health agency failed to ensure an annual performance review was performed for 1 of 3 administrative staff personnel records reviewed [Administrative Staff (AS) #1]. Findings include: 1. An agency policy D-180 Personnel Records indicated, but not limited to, &The personnel record for an employee will include &performance appraisals & 2. An agency policy D-260 Performance Evaluations indicated, but not limited to, &A competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter &Job performance will be documented on the appropriate form by the evaluator and will become a permanent part of the employee personnel file & 3. Employee record review on 7/13/22 indicated the agency failed to include an annual employee performance evaluation for AS #1 since 10/3/12. 4. During an interview on 7/13/22 beginning at 3:15PM, AS #1 indicated they conduct all employee performance evaluations and indicated there was no governing body to which they report or evaluates AS #1.			
N0468	Home health agency administration/management 410 IAC 17-12-1(k) and (l) Rule 12 Sec. 1(k) The following records shall be made available, on request, to the department for review: (1) Personnel records and policies that	N0468	Based on the deficiency above the Human resource director and DON/Administrator reviewed the policy on Annual TB risk assessments on 7-18-2022. Policy states TB screening with an individual risk assessment and symptom evaluation completed as baseline (upon hire) and annually. Human resource director understood content in the inservice provided by the DON/Administrator. Human resource director will complete random chart audits on 50% of the employee files quarterly to ensure that annual TB risk evaluations are completed timely. The results	2022-07-18

	document the home health agency's compliance with subsection (f). (2) Records of physical examinations that document the agency's compliance with subsection (h). (3) Records of the following: (A) Tuberculosis evaluations. (B) Appropriate clinical follow-up for positive findings. (C) Any other records that document the home health agency's compliance with subsection (i). (l) The department shall: (1) treat the information described in subsection (k) as confidential medical records; and (2) use it only for the purposes for which it was obtained. The home health agency failed to ensure an annual tuberculosis (TB) risk assessment was conducted for 1 of 3 administrative staff personnel records reviewed [Administrative Staff (AS) #1] and the agency failed to store confidential employee health information separately from the non-confidential personnel record in 8 of 12 employee personnel records reviewed (AS #2, #4, RN #1, LPN #1, HHA #1, #2, #3, and #4). Findings include: 1. An agency policy D-240 Health Screening, containing an Addendum Tuberculosis dated 1/5/20, indicated but was not limited to &TB		of the quarterly audit will be reviewed and discussed during the QA meeting. Educated and Inservice provided to Human resource director on 7-18-2022 by the DON/Administrator in regards to the employee confidential file and its contents. The employee confidential files will be stored in a locked cabinet separate from the regular employee files and contains personal health information, medical information, covid related information, doctors notes, return to work notes, physical exams, drug screens, TB evaluations, TB risk assessments, criminal history report. Agency purchased a locked filing cabinet for just the confidential employee files to be stored separately than the other employee records. Human resource director understood all the contents of the inservice education. The Human Resource director will complete random employee file audits on 50% of the employee files to ensure that confidential records are stored separately than regular employee files and are in the locked filing cabinet. The results of the audits will be reviewed and discussed at the QA meeting.	

	and symptom evaluation completed as baseline and annually. 2. An agency policy D-180 Personnel Records indicated, but not limited to, &The personnel record for an employee will include &Medical History / Health Status Maintained Confidentially..." 3. An agency document Employee File Checklist indicated, but not limited to, &Confidential File &TB Forms & 4. Employee record review on 7/13/22, failed to evidence an annual TB risk assessment was completed annually for AS #1; the last assessment was dated 10/11/19. 5. An employee record review was completed on 7/14/22 for AS #2 indicated an Declination of Covid-19 Vaccine form and 7 doctor s notes/ return to work forms were placed in the regular personnel binder, and was not secured in a separate, confidential employee file. 6. An employee record review completed on 7/14/22 for AS #4 indicated an Annual TB Risk Assessment form and a doctor s note slip were placed in the regular personnel binder rather than in a separate, confidential employee file. 7. An employee record review completed on 7/14/22 for RN #1 indicated a Declination of Covid-19 Vaccine form, a letter from the [County] County Health Dept. indicating RN #1 was COVID positive and required quarantine, and 3 doctor s notes forms were placed in the regular personnel binder rather than in a separate, confidential employee file. 8. An employee record review completed on			

	7/13/22 for LPN #1 indicated an Annual TB Risk Assessment form and a doctor s note slip were placed in the regular personnel binder and was not secured in a separate, confidential employee file. 9. An employee record review completed on 7/14/22 for HHA #1 indicated an Annual TB Risk Assessment form, a Declination of Covid-19 Vaccine form, and a doctor s note slip were placed in the regular personnel binder and was not in a secure, separate, confidential employee file. 10. An employee record review completed on 7/13/22 for HHA #2 indicated an Annual TB Risk Assessment form was placed in the regular personnel binder rather than in a separate, confidential employee file. 11. An employee record review completed on 7/13/22 for HHA #3 indicated an Annual TB Risk Assessment form was placed in the regular personnel binder rather than in a separate, confidential employee file. 12. An employee record review completed on 7/13/22 for HHA #4 indicated an Annual TB Risk Assessment form was placed in the			

	regular personnel binder rather than in a separate, confidential employee file. 13. During an interview on 7/13/22 beginning at 3:15PM, AS #1 indicated the annual TB risk assessments are to be completed annually at the time of the employee s evaluation and relayed theirs was not completed because they have not received an annual performance evaluation. AS #1 indicated employee health information were to be stored separately from the other employee information.			
G0470	Document efforts to resolve problems 484.50(d)(5)(iv) (iv) Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records; Based on record review and interview, the agency failed to ensure documentation reflected efforts made to resolve problem before discharging patient in 1 of 2 discharged record reviews (Patient #4). Findings include: Review of an undated agency document titled Client Handbook included an undated section titled Home Health Care Patient Bill of Rights that indicated & patients have the right to & receive reasonable continuity of care services outlined in the plan of care &.	G0470	The DON/ADON held an inservice meeting with all RNs and LPNs on 8-1-2022. The inservice education meeting content included discussion of the Discharge and Transfer Policy. Reviewed the policy and educated staff about the goal of planning for client discharge in advance to ensure continuity of care including client and family in the discharge planning process and informing the client of the reason for the discharge. Staff educated to document the communication with client regarding potential discharge, efforts to improve the problem and the reason for potential discharge. Notify the physician of the Discharge or Transfer and document that in the clinical record. The DON or ADON will perform chart audits on 100% of discharges occurring from 8-1-2022 to 8-12-2022. 50% of all discharge charts will receive a chart audit quarterly to ensure that Discharge and Transfer Policy is being followed. The results of the chart audits will be reviewed and discussed at the QA meetings.	2022-08-12

Review of an undated agency document titled Client Handbook included an undated section titled Discharge and Transfer Policy that indicated & the goal of planning for discharge & & in advance is to ensure continuity of care & includes & client, family & in the discharge planning process & clients are informed of the reason for discharge &.

Record review for Patient #4, start of care date 08/09/2021 and discharge date of 03/07/2022, contained a plan of care for certification period 02/05/2022-04/05/2022 with SN (skilled nurse) orders for 1-4 hours, 0-2 days/week for 10 weeks & D/C (discharge) plans & when services are no longer needed, a higher level of care is required & per request &.

Review of an agency document dated 02/28/2022, titled Nursing Visit Note indicated & SN told patient that he/she needs to be here on Mondays at 1:00PM for & visit to set up meds & can change the date or time if that doesn t work & assures nurse he/she will be here next week & this is the 2nd time he/she hasn t been present &.

Review of an agency document dated 03/07/2021 [sic], titled Daily Care Logs indicated & received call from patients case manager & unable to see patient again this week & was not home when nurse arrived &.

Review of an agency document dated 03/10/2022, titled Daily Care Logs indicated & sister & called & back & nurse & had standing appt (appointment) with patient every Monday for assessment, med set up, injection and that patient has not been home

	for 2 weeks, nor has & returned & phone call & are DC ing (discharging) at the time &. The documentation failed to evidence communication with patient regarding potential discharge, efforts to improve the problem, and the reason for discharge. Review of an agency document dated 03/14/2022, titled Discharge Assessment Including Oasis Elements indicated & Oasis completed based on visit date: 02/24/2022 & reason for discharge & patient refuses services, or elects to be transferred or discharged & patient has not been home for 2 weekly scheduled SN visits and has not returned phone calls & was the discharge planned & no .... During an interview on 07/13/2022 at 3:15PM, The administrator indicated that there was no documentation of the agency efforts to resolve the problem, indicated the patient would not be home, no documentation was provided by survey exit.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient s current respiratory status and mental status in the development and implementation of the plan of care for 2 of 7 patients (Patient #2 and #4).	G0528	An inservice meeting was held on 7-28-2022 by DON. All nursing staff present and educated on Comprehensive Assessment notes. The instructions given to nursing staff were for the following" The electronic form for comprehensive Assessment notes includes a section under Cardiopulmonary that does not allow you to "unclick" a box once you have made that selection. If that is a box that does not need to be clicked based on your assessment of the client you will be required to upload a new (blank) document and make a new note with the correct responses. All nursing staff received this information and were required to sign a form that all content in the inservice was understood. All nursing staff re-educated on physical assessments of the client to include precise and accurate information in all fields of the comprehensive assessment. The DON or ADON will conduct random chart audits on 50% of all clinical	2022-08-12

	Findings include: 1. Review of an undated agency policy C-145, copyright Briggs Healthcare, Operational Guidelines titled Comprehensive Client Assessment , indicated & the comprehensive assessment must accurately reflect the client s (patient) status &. 2. Record review for Patient #2, included an agency document, dated 06/08/2022, titled Comprehensive Assessment that documented & breath sounds & clear & wheeze (high pitched whistling sound) all lobes (sections of lung) / dim (diminished) lower post (back of lung) lobes &. 3. Record review for Patient #4, discharge date of 03/07/2022, contained an agency document dated 02/01/2022, titled Comprehensive Assessment indicated & mental status & compliant with meds and regime, and daily problems & summary of setbacks/improvements since prior assessment & still poor at follow thru with medications &. 4. During an interview on 07/11/2022 at 4:25PM, the administrator indicated the documentation form may be the problem, to explain why Patient # 2's comprehensive assessment included contradictory information of breath sounds documented as clear and wheezing within the same assessment. The agency did not provide further documentation, or information regarding the inconsistent documentation within the comprehensive assessment, by survey exit.		records quarterly for evidence that comprehensive assessments are completed with precise and accurate information of the clients assessment. The results of the audits completed on the clinical records will be reviewed and discussed at the QA meetings.	

	5. During an interview on 07/13/2022 at 3:30PM, the administrator indicated Patient #4 managed their own medications and no further documentation, or information regarding the documentation within the comprehensive assessment, was received, by survey exit.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced	G0574	Based on the deficiency above an inservice meeting was held on 7-28-2022 by DON. All nursing staff present and educated on The plan of care and what must be included on the physicians signed plan of care and advance directives. The instructions given to nursing staff were for the following" The policy for the plan of care should include information related to any advanced directives." Also educated all nursing staff when a client has selected to complete an advance directive, the information contained on the Advance Directive will be placed on the Plan of Care signed by the physician. All nursing staff received this information and were required to sign a form that all content in the inservice was understood. The DON or ADON will conduct random chart audits on 50% of all clinical records quarterly for evidence that the Plan of Care reflects the clients advance directive choices. The results of the clinical chart audits will be reviewed and discussed at the QA meetings.	2022-08-12

directives; and

(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.

Based on record review and interview, the agency failed to ensure patients plan of care included all required elements, and included the Patient's advance directive choice and the functional limitations for 1 of 5 active patient record reviews (Patient #2).

Findings include:

Review of an undated agency policy C-660, Home Care Operational Policy titled Care Plans, indicated & following the initial assessment, a Care Plan shall be developed with the client & Care Plan shall be & evaluated, and revised & based upon & ongoing client assessments &.

Review of a document titled Indiana Physician Orders for Scope of Treatment (POST), dated 02/10/2022 by physician, and documented status pf Patient # 2 as & Do Not Attempt Resuscitation &.

Review of an agency document dated 06/08/2022, titled Comprehensive Assessment, indicated & gastrointestinal & no problem & genitourinary & no problem & DNR-Do Not Resuscitate (do not begin CPR) &.

	Record review for Patient #2, contained a plan of care for certification period 06/11/2022-08/09/2022 that documented & Risk Factors & incontinence & safety measures & full code &. During an interview on 07/11/2022 at 4:26PM, the administrator had no response to explain why the plan of care for Patient #2 did not include the information obtained from the comprehensive assessment and POST order. The agency failed to provide further documentation or information by survey exit. IAC 410 17-13-1(a)(1)(D)(vi,xiii)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to notify the physician of missed visits for 1 of 3 active skilled nursing records reviewed (Patient #7.) 1. An agency policy C-680 titled Clinical	G0590	Based on the deficiency above an inservice was conducted on 8-1-2022 by the DON to educate all nursing staff (RNs and LPNs) that the agency must promptly alert the physician to any changes in the patients condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. The physician should be notified of missed visit, services not provided and the reason for the missed visit. This should be documented in the clinical record. Also educated staff on writing hold orders, if the patient or primary caregiver requests the services be held on a specific date or time period, a physicians order will be written to hold home care services for that time requested, notify the physician that services will be placed on hold, how long the services are on hold, the reason the services are on hold and who will provide the care to the client while home care services are on hold. The signed physicians order will be placed in the clinical record. All staff understood the	2022-08-12

	Documentation, included, but not limited to, &Services not provided and the reason for the missed visits will be documented and reported to the physician &. 2. The clinical record of Patient #7, with start of care (SOC) of 6/13/22, was reviewed on 7/12/22 and 7/13/22. The plan of care for the certification period 6/13/22 8/11/22 included orders for skilled nursing 6-14 hours per day, 3-6 days per week x 9 weeks to provide total care, administer medications and feedings via G-tube, assess, and teach family. The documentation included a Clinical Note, dated 06/30/22, which indicated a call was received from the patient s primary caregiver who reported that they would be available from July 1 to July 10 and would provide the patient's care and they did not need agency services during that time. The clinical record failed to evidence notification to the physician that the skilled nurse visits would not be provided to Patient #7, nor notification to the physician that the primary caregiver would provide the Patient's care, during the time period. 3. During an interview on 7/12/22 which began at 3:15PM, the Administrative Staff (AS) #1 indicated when a patient s family member informs the agency they are canceling visits and they will provide the care, a nurse note should be made to document the request and		content of the Inservice and will follow this policy. The DON or ADON will complete random chart audits of 50% of the clinical records quarterly for evidence that all nursing visits are being followed on the plan of care signed by the physician, or that missed visits and hold orders are being completed correctly. The results of the clinical record audits will be reviewed and discussed at the QA meetings.	

	the staff would be notified. AS #2 relayed there was no notification to the physician nor was an physician order received and within the clinical record; they didn t write an order. IAC 410 17-13-1(a)(2)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on record review, observation and interview, the agency failed to ensure all staff followed standard precautions and infection control for 1 of 3 home visits observed (Patient #5). Findings include: 1. Review of an undated agency policy N-140, copyright Briggs Healthcare, Clinical Procedures titled Infection Control indicated & gloves are disposable and are not meant to be reused &. 2. Review of the Centers for Disease Control and Prevention (CDC) web reference, https://www.cdc.gov/handhygiene/providers/index.html, indicated & Change gloves and perform hand hygiene during patient care &	G0682	Based on the deficiency above an inservice is scheduled for 8-3-2022 to all home health aides. The DON will hold an inservice on Standard infection prevention procedures. Educate home health aides on the purpose of the policy to prevent the transmission of infections and communicable disease. To comply with the guidelines of the CDC in creating a safe environment for all health care workers and clients. Review the Infection Control policy with all home health aides that indicates gloves are disposable and not meant to be reused. Gloves should be changed and handwashing completed during patient care when moving from a soiled area of the body to a clean area on the body. Gloves should also be removed, perform handwashing and apply a new pair of gloves prior to performing perineal care. After perineal care is performed the gloves should be removed and handwashing performed. Each home health aide will receive a written test of competency to assure compliance, knowledge of the infection control policy and procedures for changing gloves and handwashing. All staff will follow policies in place. The RNs will observe that these policies are being enforced during the supervisory visits of the home health aides. RNs will report to the DON/ADON any concerns that policies are not being followed by the home health aides during the supervisory visits. The DON/ADON will intervene at that time and re-educate the individual home health aide that is non-compliant. The DON/ADON will ensure that this deficiency is corrected and will not occur in the future.	2022-08-12

	clean body site on the same patient or if another clinical indication for hand hygiene occurs &. 3. During a home observation visit of home health aide (HHA) #1 while providing care to Patient #5, was conducted on 07/12/2022 at 10:00AM. Observed HHA #1, who wore the same pair of gloves throughout the care. Observed HHA #1 don gloves and assisted Patient with a sponge bath, began with Patients hands and ended with peri-area. Then, while wearing the same gloves, HHA #1 applied deodorant and lotion to Patients' arms and legs, applied incontinency brief and pajama bottoms. Then, observed HHA #1 wipe these same gloves with a disinfectant wipe and then assisted Patient with their walker. 4. During an interview on 07/12/22 at 3:15PM, the administrator indicated the employee should not have worn the same gloves throughout the care, should have completed hand hygiene, and was to follow standard infection control mitigation processes and the agency policies. 410 IAC 17-12-1(m)			
G0768	Competency evaluation 484.80(c)(1)(2)(3) Standard: Competency evaluation.	G0768	Based on the deficiency above the DON has an inservice scheduled for 8-3-2022 for Home Health Aide education on recognizing and reporting changes in skin condition of the client and tub bath. The home health aide competency evaluation form was revised on 7-29-2022. The revised competency form will include the task of performing a tub bath and recognizing and reporting the changes in skin condition. Each Home Health Aide will receive a written test of competency to assure compliance and knowledge of education provided. The competency evaluation is performed by a registered nurse at the time of	2022-08-12

An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section.

(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation.

(2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section.

(3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.

Based on record review and interview, the agency failed to ensure the orientation of the competency evaluation of home health aides (HHA) included the tasks of performing a tub bath and recognizing and reporting changes in skin condition that had the potential to affect all patients receiving home health aide services.

Findings include:

Review of an undated agency policy D-220, copyright Briggs Healthcare, Home Care

hire and annually. The registered nurse will assure the home health aide is competent to furnish home health services after the home health aide has successfully completed a competency evaluation. The RN will observe during the home health aide supervisory visits that home health aides are knowledgeable of tub baths and recognizing and reporting skin changes in the client. The RNs will report to the DON/ADON any concerns of home health aides that will require immediate additional individual training.

	Operational Guidelines titled Competency Evaluation of Home Care Staff indicated & all new employees will be assessed for competency based on expected requirements for the position &. Review of an undated agency document D-145, copyright Briggs Healthcare titled Competency Evaluation-Home Health Aide was missing the evaluation of the following skills: tub bath and recognizing and reporting changes in skin condition. During an interview on 07/13/2022 at 3:30PM, when asked when the D-145 Competency Evaluation is used, the administrator indicated is used on hire with home health aides during orientation. 410 IAC 17-14-1(l)(A)			
G0772	Documentation of competency evaluation 484.80(c)(5) The HHA must maintain documentation which demonstrates that the requirements of this standard have been met. Based on record review and interview, the agency failed ensure the home health aide (HHA) competency skills were evaluated with a patient or with a pseudo-patient (live person can be volunteer or staff) and follow their agency policy for 5 of 5 HHA employee records reviewed [Home Health aides #1, 2, 3, 4, and 5). Findings include:	G0772	Based on the deficiency above the Home Health Aide competency evaluation was revised on 7-29-2022 by DON/ADON to include the location where the competency took place and whether the competency was on a client or pseudo patient. The DON/ADON will ensure that the RNs completing the competency evaluation is made aware of this additional information revised on the competency evaluation. The DON/ADON will audit 50% of the employee files quarterly to ensure the competency evaluation includes the location of the competency and if it was performed on a client or pseudo patient.	2022-07-29

	1. Review of an undated agency document D-145, titled Competency Evaluation-Home Health Aide for HHA #2, HHA #3 and HHA #4 failed to evidence the location of the skill observations, which skills were evaluated on a patient and or a pseudo patient, and which skills required teaching during the competency. 2. Review of an undated agency document titled Home Health Aide Competency Evaluation for HHA 1 and HHA 5 failed to evidence the location of the competency observation and the type of patient used for the competency. 3. During an interview on 07/13/22 at 3:30PM, the administrator indicated the registered nurse and HHA are to go to a patient's home to observe the task provided by the HHA, to evaluate the skill and competency of the individual. No further information was provided by survey exit.			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review, observation and interview, the agency failed to ensure the home	G0800	Based on the deficiency above an inservice is scheduled with all staff on 8-3-2022 regarding the plan of care, specifically to the services provided by the home health aide. The inservice will be conducted by the DON. The care plan is developed by the registered nurse at the time of admission, every 60 days and as needed. The plan of care includes duties to be performed by the home health aide. Educated staff that if any part of the careplan does not contain current and accurate information that the RN must be notified so that changes can be made on the care plan to reflect the correct information needed to provide care to the client. Educated the home health aides if a task was assigned to a client incorrectly the home health aide must notify the RN so that the task can be removed or revised. Educated the RNs to review the care plan with the client and/or primary caregiver on admission, every 60 days or as needed. The DON/ADON will perform random chart audits on 50% of the clients	2022-08-03

	health aide (HHA) followed the plan of care for 2 of 3 record reviews with home health aide only services (Patient #2 and 3). Findings include: 1. Review of an undated agency policy C-751, Home Care Operational Guidelines titled Home Health Aide Care Plan included, but not limited to, & a complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse & all home health aide staff will follow the identified plan. 2. Record review for Patient #2 on 07/11/22, contained a plan of care for certification period 06/11/2022-08/09/2022, with physician orders HHA & weeks 2-9 & 2-8 hour [sic], 4-7 days/week &. A. Review of a document titled Assessments & Care Plan, dated 06/10/2022, indicated & task: assist into and out of shower & Mon, Wed, Fri &. B. Review of untitled agency documents used by HHA for documenting their aide care visit notes, indicated the task of assisting into and out of the shower was not completed for the visits made on 6/13/22, 6/15/22, 6/17/22, 6/20/22, 6/22/22, and 6/24/22. There were no visit notes dated after 6/26/22 within the clinical record. C. During an interview on 7/11/22 at 4:40PM, the administrator indicated the HHA monitored the patients bath, and indicated the patient may not require the assistance in and out of the shower. No further information was received by survey exit.		clinical records quarterly to ensure that the care plan is being followed.	

	3. Record review for Patient #3, discharge date of 02/16/2022, contained a plan of care for certification period 01/26/2022-03/26/2022, that indicated &HHA & week 1 & 10 hours, 1-2x (times)/day, 1-2 days/week & weeks 2-9 & 10 hours, 1-2x/day, 5-7 days/week &. A. Review of a document titled Assessments & Care Plan, dated 01/26/2022, indicated & task: assist into and out of shower & all shifts & all days & task: assist with shampoo & all shifts & all days &. B. Review of untitled agency documents used by HHA for documenting visit notes, indicated the task of assisting into and out of the shower and the task of assisting with shampoo were not completed for visits made on 01/27/22, 02/01/22, 02/03/22, 02/05/22, 02/08/22, 02/10/22, 02/12/22 and 02/13/22. C. During an interview on 7/13/22 at 3:15PM, the administrator indicated the patients family member may be providing this care and therefore the aide did not assist during these visits. No further information was provided by the agency by survey exit.			
G0946	Administrator appointed by governing body 484.105(b)(1)(i) (i) Be appointed by and report to the governing body; Based on record review and interview, the agency failed to evidence the administrator reports to the governing body for 1 of 1 agency. 1. An agency policy C-105 titled Position: Administrator, indicated, but not limited to, &Reports to: Governing Body &maintains	G0946	Based on the deficiency above a meeting was conducted on 7-29-2022 with the governing body to discuss the deficiency stated above. The administrator is appointed by the governing body. The administrator will report to the governing body. The organizational chart was revised on 7-29-22 and approved by the governing body to reflect the administrator reports to the governing body. The governing body oversees the administrator.	2022-07-29

	ongoing liaison between the Governing Body and the Agency staff & 2. The agency s document Organizational Chart was reviewed on 7/11/22. The Organizational Chart failed to indicate the administrator reported to the Governing Body. 3. The agency s document titled Organizational Chart For Governing Body was reviewed on 7/12/22 and failed to indicate the Governing Body oversees the administrator. 4. During and interview on 7/13/22 beginning at 3:15PM, Administrative Staff (AS) #1, indicated the organizational chart did not reflect the administrator reported to anyone or body, and indicated they had the governing body on a separate organizational chart. The Organizational Chart For Governing Body was reviewed and did not indicate their was a Governing Body was over the administrator. AS #1 indicated they were the owner, administrator, and the director of nursing and reported to self, indicating their was no governing body for the agency. IAC 410 17-12-1(a)(1)			
G1012	Required items in clinical record 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments	G1012	Based on the deficiency above the policy for Clinical Records was revised and approved on 8-19-2022 by the DON and ADON. The new revision states the required documentation for each service or care provided must be completed on the day the service is rendered and filed in the clinical record within 14 days. Inservice conducted by DON on 8-19-2022, all	2022-08-19

	from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; Based on record review and interview, the home health agency failed to follow their own policies and ensure that documentation of home visits be incorporated into the clinical record within seven (7) days for 3 of 5 active records reviewed (Patient #1, 2, and 5). Findings include: The clinical record of Patient #2, with start of care (SOC) of 11/03/2017, was reviewed on 7/11/22. The plan of care (POC) for the certification period 06/11/2022 08/09/2022 indicated, but not limited to, orders for home health aide (HHA) services 2-8 hours, 4-7 days per week x 9 weeks to assist with ADLs, observe bowel and bladder patterns, observe behavior, and notify nurse of concerns regarding bowel, bladder, and behavior. The clinical record failed to evidence HHA visits past 06/27/22. The clinical record of Patient #5, with start of care of 03/11/2016, was reviewed on 07/12/2022. The plan of care for the certification period 06/10/2022 08/08/2022 indicated, but not limited to, orders for home health aide services 8-12 hours, 1-2 times per day, 3-5 days per week to assist with ADLs, patient reminders, and observe behavior and notify nurse of concerns The clinical record failed to evidence HHA visits past 07/02/22.		staff reviewed the revised policy and informed that all documents must be filed into the clinical record within 14 days. All staff understood the content of the inservice. The DON/ADON will perform random chart audits on 50% of clinical records quarterly to ensure the documentation is in the clinical records timely based on the revised policy. The information gathered in the audits will be reviewed and discussed at the QA meetings.	

	An agency policy C-870 Clinical Records/Medical Record Retention indicated, but limited to, &Documentation must be returned to agency within twenty-four (24) hours of the most recent home care visit pertinent to that discipline and filed in the clinical record within seven (7) days & An agency policy C-680 Clinical Documentation indicated, but not limited to, &Documentation the services ordered on the plan of care will be completed the day the service is rendered and incorporated into the clinical record within seven (7) days after the care has been provided & The clinical record of Patient #1, with start of care (SOC) of 3/18/22, was reviewed on 7/11/22. The plan of care (POC) for the certification period 5/17/22 7/15/22 indicated, but not limited to, orders for skilled nursing 0-1 hours per day x 9 weeks to assess vital signs, evaluate pain, and monitor for signs and symptoms of infection and orders for home health aide (HHA) services 2-6 hours, 1-3 times per day, 4-7 days per week x 9 weeks to assist with ADLs, monitor for seizure and fall precautions, and notify nurse of concerns regarding urine output, constipation, and skin integrity. The clinical record failed to evidence HHA visits past 7/3/22. During an interview with Administrative Staff (AS) #1 on 7/11/22 at 4:43PM, AS #1 indicated HHA notes are typically in the chart quick, usually within the week after.			
G1030	Retrieval of records 484.110(e)	G1030	Based on the deficiency above the Notice of Privacy Practices for Protected Health information form that is in the client handbook was revised and approved on 7-28-2022 by the DON and ADON. The previous form indicated a reasonable fee may be charged to	2022-07-28

Standard: Retrieval of clinical records.

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

Based on record review, observation, and interview, the agency failed to ensure patient's clinical records would be made available to the patient, free of charge with the potential to affect all 55 current patients, for 1 of 1 agency.

Findings include:

Review of an undated document titled Notice of Privacy Practices for Protected Health Information indicated & if you request a copy of your health information, we will charge a reasonable fee for copying &.

A home observation visit for Patient #5 was conducted on 07/12/2022 at 10:00AM. Observed agency folder in home with undated Notice of Privacy Practice for Protected Health Information informing the patient of the charge when requesting a copy of medical record.

During an interview on 07/11/2022 at 11:30AM, when asked for the process taken when a patient requests their medical record, the administrator read the Notice of Privacy Practices for Protected Health Information and indicated it reads a fee is charged.

A home observation visit for Patient #6 was conducted on 07/12/2022 at 12:58PM. Observed agency folder in home with undated Notice of Privacy Practice for Protected Health

clients for copies of health information. We do not charge our clients for clinical records. The Notice of Privacy Practices for Protected Health Information form was revised to indicate there is no charge to the client for copies of their health information. All current active clients will receive an updated and revised Notice of Privacy Practices for Protected Health Information form by 8-12-2022 and all new home folders for future new clients have the revised form in them.

	Information informing the patient of a charge when requesting a copy of medical record. A home observation visit for Patient #5 was conducted on 07/13/2022 at 10:04AM. Observed agency folder in home with undated Notice of Privacy Practice for Protected Health Information informing the patient of a charge when requesting a copy of medical record.			

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

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