STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K110	A. BUILDING B. WING	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST OPTION ADULT DAY SERVICES & HOME HEALTH INC	6111 HARRISON STREET SUITE 225, MERRILLVILLE, IN, 46411

(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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 2/13/2023 and 2/14/2023 Facility ID: 012812	E0000		
E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-(§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must	E0006	**E0006** The administratorimmediately reviewed and updated its policy on emergency preparedness toinclude facility and community-based risk assessment, and all hazards likely tooccur in this region including but not limited to fire,power outages, floods and winter storms, tornadoes, disease outbreaks/pandemic,	2023-06-30

	develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an		earthquake, Land Slide,blizzard, etc. Theagency has initiated and updated in-service training of all employees via phonetree on emergency preparedness that is likely to occur in this region. Agencyhas reached out to the federal, state, and regional emergency agencies in theregion and has obtained the contact information for constant communication,collaborating and cooperating with them in all events likely to impact ourpatients in this region. Theagency will attend meetings and workshops organized by regional/local emergencypreparedness agencies to be abreast of events likely to occur in the region. The agency willdevelop and maintain contact information for these agencies' phone numbers ande-mails for emergency preparedness alerts. The administrator isresponsible for the implementation of this corrective action scheduled to becompleted o 6/30/2023 to ensure 100% compliance, and to prevent this deficiencyfrom	

	emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the home health agency failed ensure the emergency preparedness plan was based on and included a documented, facility and community-based all hazards risk assessment, and included strategies for addressing emergency events identified by the risk assessment. The findings include: Record review on 2/13/2023, evidenced an emergency preparedness policy update, dated 11/2022, which stated, "... 1st Option Adult Day Services & Home Health updated its policy on Emergency Preparedness to include all hazards likely to be experienced in its areas of operation to include the following events: ... Earthquake		recurring again.	

	...." Record review on 2/13/2023, evidenced a document dated 11/2022, titled "Emergency Preparedness All Hazard Risk Assessment" which included the following risks, which were not likely to occur in the area served: hurricane, land/mudslide, and earthquake. Review of the agency's emergency preparedness plan on 2/13/2023, failed to evidence the agency had conducted and documented a facility based and community-based risk assessment utilizing an all-hazards approach. The emergency preparedness plan failed to use objective data to identify only the risks which were likely to occur in the facility and the community served. The emergency preparedness plan failed to include strategies to address the identified facility and community-based risks. During an interview on			

	2/14/2023, at 10:05 AM, administrator #2 indicated the identified risks for the facility and community would be winter storm, blizzard, and possibly fire. Administrator #2 indicated the risk assessment included all possible hazards such as earthquake, hurricane, and land/mudslide because nobody could predict what emergencies would happen. Administrator #2 indicated the risk assessment was completed by including hazards they knew could possibly happen in the area, like winter storms. Administrator #2 indicated the agency did not use any objective data during the risk assessment.			
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(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 be reviewed and updated at least every 2 years.	E0017	**E0017** **For clinical record review patients #6,1,2,3, &4:** theagency immediately reviewed and updated its emergency preparedness plan toinclude specific evacuation/safe locations and addresses nearer to the clientand documented it in their home folders. Agency educated patient/familycaregiver regarding the addresses to safe	2023-06-30

	At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on observation, record review, and interview, the home health agency failed to ensure patients had individualized emergency preparedness plans, which were included as part of the comprehensive assessment in 6 of 7 active clinical records reviewed. (Patient #1, 2, 3, 4, 5, 6) The findings include: 3. Clinical record review for Patient #1 was completed on 2/14/2023. Record review evidenced a recertification comprehensive assessment dated 1/13/2023, which included an emergency preparedness plan. This plan included 5 possible evacuation locations, but failed to include any addresses for these locations. 4. Clinical record review for Patient #2 was completed on 2/14/2023. Record review evidenced a recertification		locations including but not limitedto the salvation army, American red cross, etc in the events of stormy weather,blizzard, tornadoes, and extreme cold weather condition and updated patients'contact person information. Agency reviewed other clientcharts likely to be affected by this deficiency and ensured that the emergencypreparedness plan is specifically documented for each client and evacuationlocations addresses are included in their various home folders. All clientswill be assessed and emergency preparedness plans established specifically tomeet their needs. The agency will annually review all patients' clinical records to ensure thattheir emergency preparedness plan has evacuation locations addresses andcurrent contact persons. This will ensure that the deficiency is corrected andwill not recur.The administrator is responsible for the implementation of thiscorrective action scheduled to be completed on 6/30/2023	

	comprehensive assessment dated 1/04/2023, which included an emergency preparedness plan. This plan included evacuation plan to triage to an immediate safe location, but failed to evidence the patient's primary alternate "safe location", or an address for the location. 5. Clinical record review for Patient #3 was completed on 2/14/2023. Record review evidenced a recertification comprehensive assessment dated 2/02/2023, which included an emergency preparedness plan. This plan included 5 possible evacuation locations, but failed to include any addresses for these locations. 6. Clinical record review for Patient #4 was completed on 2/14/2023. Record review evidenced a recertification comprehensive assessment dated 2/06/2023, which included an emergency preparedness plan. This plan included 5 possible evacuation locations, but failed to include any addresses for these locations.		to ensure 100%compliance.	

	1. Observation of a home visit for Patient #5 was completed on 2/14/2023, at 9:00 AM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which contained an emergency preparedness plan. The emergency preparedness plan failed to include an evacuation location. During an interview on 2/14/2023, at 10:15 AM, clinical manager #1 indicated the individual emergency preparedness plans should have included evacuation locations. Clinical manager #1 indicated the individual emergency preparedness plans included several locations such as hospitals which were near the patient based on the city they lived in, and in case of emergency, the patients would call the locations to obtain the address to evacuate to. Clinical manager #1 indicated if there was an emergency and the patients evacuated, they would call the patient's family member to find out where the patients were located, because the family was responsible for the			

	patient in case of emergency. Clinical manager #1 indicated they could also call all of the evacuation locations listed to find out where the patient was at in case of emergency. 2. Clinical record review for Patient #6 was completed on 2/14/2023, for certification period 2/5/2023 – 4/5/2023. Record review evidenced a recertification comprehensive assessment dated 1/31/2023, which included an emergency preparedness plan. This plan included 7 possible evacuation locations for Patient #6 based on the city they lived in, but failed to include any addresses for these locations.			
E0021	HHA- Procedures for Follow up Staff/Pts. 484.102(b)(3) §484.102(b)(3) Condition of Participation: [(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 be reviewed and updated at least every 2 years.	E0021	**E0021** Effective immediately, the administrator updated its emergencypreparedness policy and procedure to include notification of state and local officialsof any on-duty staff or patient not reachable in the event of an emergency andtheir emergency contact person and phone numbers where to reach	2023-06-30

	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 home health agency failed to develop and implement policies and procedures which included informing State and local officials of any on duty staff or patients who were unable to be contacted. The findings include: Record review on 2/13/2023, of the emergency preparedness plan and policies failed to include the need to inform State and local officials of any on duty staff or patients who were unable to be contacted in an emergency. During an interview on 2/14/2023, at 10:27 AM, The Clinical Manager indicated the emergency preparedness policies should have included		and connectwith agency employees and patients during emergencies. The director of nursing has initiated in-service for all field employeesabout the appropriate procedures to follow when informing the state and localofficials regarding their locations addresses during emergency events The agency will periodically review its emergency preparedness policy andprocedure ensuring contact information for state and local emergencyorganizations are updated as required. This will enable the agency to reportemergencies and communicate with state and local officials in a timely mannerregarding patient and on-duty staff not being reachable during emergencies. The administrator is responsible for the implementation of thiscorrective action scheduled to be completed on 6/30/2023 to ensure 100%compliance.	

	informing State and local officials of on duty staff or patients who could not be reached.			
E0032	Primary/Alternate Means for Communication 403.748(c)(3),482.15(c)(3),485.625(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the home health	E0032	**E0032** The agency has reviewed and revised its policy on emergency preparednessto include contact information of these emergency organizations but not limitedto Region 5 Federal Emergency (FEMA), Department of Health and Human Services EmergencyCoordinator, District 1 Hospital Emergency Planning Committee contactinformation, and Regional Emergency Preparedness Coalition. The agency includedRadio communication as alternate means of communication with the stateemergency preparedness staff. The agency obtained emails/phone numbers of local, federal, state, orregional emergency preparedness staff; other healthcare institutions, and stateprotection and advocacy agencies in the region	2023-06-30

	agency failed to ensure the emergency communication plan included primary and alternate contact information for regional and state emergency preparedness staff. The findings include: Review on 2/13/2023, of the agency's emergency preparedness communication plan failed to include contact information for regional emergency preparedness officials such as the region 5, Department of Health and Human Services emergency coordinator, the District 1 Hospital Emergency Planning Committee contact information, or regional emergency preparedness coalition contact information. The communication plan failed to include an alternate means of communicating with State and regional emergency preparedness officials, such as radio communications. During an interview on 2/14/2023, at 10:30 AM, administrator #2 indicated the agency would call or text the regional and State emergency preparedness officials if the phone system was down.		andupdated home folder in the event of emergencies. The agency will annually review all patients' clinical records to ensurethat their emergency preparedness communication plan is current and up to date.This will ensure that the deficiency is corrected and will not recur. The Administrator is responsible for the implementation of this correctiveaction scheduled to be completed on 6/30/2023 to ensure 100% compliance. TheAdministrator will monitor this corrective action to ensure that thisdeficiency is corrected and will not recur.	

	Administrator #2 indicated the primary and alternate contact information for regional and State emergency preparedness officials should have been included in the communication plan.			
G0000	INITIAL COMMENTS This visit was for a Post Condition Revisit survey for a Federal Recertification and State Re-licensure survey. Facility ID: 012812 Survey Dates: 2/13/2023 and 2/14/2023 Census: 11 Unduplicated admissions: 12 1st Option Adult Day Services and Home Health INC., was precluded from providing its own home health aide training and competency evaluation for a period of two years from 12/14/2022 - 12/13/2024, due to being found out of compliance with Conditions of Participation: 42 CFR §484.102 Emergency preparedness, 42	G0000		

	Coordination of Care and Quality of Care, and 42 CFR §484.65 Quality Assessment and Performance Improvement. One new condition-level deficiency was cited during the 2/14/2023 survey: 42 CFR §484.80 Home health aide services; 2 condition-level deficiencies were resolved: 42 CFR §484.102 Emergency preparedness, and 42 CFR §484.65 Quality Assessment and Performance Improvement; and 1 condition-level deficiency was re-cited: 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. Also during this survey, 21 standards were corrected, 13 standards were re-cited, and 4 new standards were cited. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review completed 2/24/2023.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review, and interview, the home health agency failed to ensure the comprehensive assessment included a review of all	G0536	**G0536**	2023-06-30

	medications the patient was currently using in 1 of 3 active clinical records reviewed, in which a comprehensive assessment was conducted after 1/31/2023. (Patient #6) The findings include: Record review evidenced an undated agency policy obtained 2/14/2023, titled "Comprehensive Client Assessment" which stated, "… The Comprehensive Assessment will include a review of all medications the client is using … This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with therapy …." Clinical record review for Patient #6 was completed on 2/14/2023, for certification period 2/5/2023 – 4/5/2023. Record review evidenced a recertification assessment dated 1/31/2023, which indicated a review of all medications had been completed. This document		Theaffected clients' medication profile was reviewed and identified medicationprofile deficiencies were corrected to ensure medication profile reflects the currentclient's medication-Asper creme Ointment topical for pain as needed, andPropranolol frequency for blood pressure is updated to the client's medicationprofile ensuring this deficiency does not recur. The directorof nursing reviewed all client charts likely to be affected by this deficiencyand corrected them in a timely manner. 50% ofpatient's clinical records will be audited quarterly and during admissions andrecertification of care to reflect patient's current medication profile status.This will prevent this deficiency from reoccurring again and ensure 100%compliance. TheDirector of Nursing will be responsible for monitoring this corrective action scheduledto be completed 6/30/ 2023 to ensure compliance. This will ensure this deficiencywill not recur.	

	aspercreme (ointment for pain), but failed to include this on the medication profile. Clinical record review evidenced a medication profile dated 2/1/2023, which included an order for propranolol (to lower heart rate and blood pressure) as needed for high blood pressure. The medication profile failed to include a frequency to take propranolol. During an interview on 2/14/2023, at 3:51 PM, The Clinical Manager indicated the order should have included a frequency of every 4 hours as needed for high blood pressure. At 3:55 PM, the Clinical Manager indicated the aspercreme should have been included on the medication profile. 410 IAC 17-14-1(a)(1)(B)			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge	G0564	**G0564** The agency reviewed its policy on Dischargesummary to ensure that patient discharge summary contains the reason foradmission, significant findings, diagnosis, procedures performed if any,medications	2023-06-30

	goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the home health agency failed to ensure the discharge/transfer summary and policy contained all necessary information pertaining to the current course of illness and treatment, post-discharge goals, and treatment preferences. The findings include: Record review on 2/13/2023, evidenced an undated agency policy titled "Policy and Procedure on Discharge" which stated, "... The discharge summary shall contain: The reason for admission, significant findings, any diagnosis, procedures performed, significant medications administered, condition at discharge, discharge medications, and follow-up instructions ...." During an interview on 2/14/2023, at 4:21 PM, the Clinical Manager indicated the		administered, client condition at discharge, follow-upinstructions, and discharged medications accurately reflect the patient'scurrent health status. The agency reviewed all discharged clients'records and identified charts likely to be affected by this deficiency andupdated their records to ensure compliance with the state/federal regulations. 50% of the patient's clinical recordswill be audited quarterly and during discharge of a patient ensuring itcontains necessary information per policy and procedure on discharge. This willprevent this deficiency from reoccurring again and ensure 100% compliance. The Director of Nursing is responsiblefor monitoring this corrective action to ensure this deficiency does notreoccur again. This corrective action was implemented on 6/30/2023.	

	discharge or transfer summary included the reason the patient went to the hospital or discharged, and mostly the reason behind discharge or transfer. The Clinical Manager indicated they would send the medications with the discharge or transfer summary. The Clinical Manager indicated they did not currently include post-discharge goals, or treatment preferences in the transfer/discharge summary.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record	G0570	**G0570** The director of nursing immediatelyrevised all active patients' plans of care to meet their individualized needsand included all pertinent diagnoses, psychosocial status, types of suppliesand equipment required, frequency and duration of visit to be made, nutritionalrequirements, all medications and treatments, patient-specific education, thepatient's personal goals, information related to any advanced directives, andor description of the patient's risk for emergency department visit/hospital readmission,and all necessary interventions to	2023-06-30

	review, and interview, the home health agency failed to: ensure the patients received the services written in a plan of care, and/or failed to ensure the patients had an individualized plan of care (See tag G572); ensure the plan of care included one or more of the following: all pertinent diagnoses, psychosocial status, the types of supplies and equipment required, frequency and duration of visits to be made, nutritional requirements, all medications and treatments, patient-specific education, the patient's personal goal(s), information related to any advanced directives, and/or a description of the patient's risk for emergency department visits/hospital re-admission and all necessary interventions to address the underlying risk factors (See tag G574); ensure services and/or treatments were provided only as ordered by a physician (See tag G580); and ensure the plan of care was reviewed and revised (See tag G586). This practice had the potential to affect all agency patients.		address the underlying risk factors asordered, and all other missing information was included and faxed to thepatient's physician for signature. This will ensure a patient-centered plan ofcare for all active patients and as well improve the delivery of qualityhealthcare services to all patients. On 5/8/2023, the director of nursing reviewed other patients' chartlikely to be affected by this deficiency and ensured written individualized planof care with patients' centered goals are signed by their physicians anddocumented. The director of nursing will audit every patient's chart bimonthly ensuringthat plan of care is individualized according to the client's need and orderedby the physician. The director of nursing will further encourage patientparticipation in their plan of care to enable patient centered goals of plan oftreatment are met. The director of nursing will audit 50% client's chart	

	The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care.		documentation of care plan. The director of nursing will be responsiblefor monitoring this corrective action scheduled to be completed 6/30/ 2023 to ensure this deficiency does not recur.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure patients received all services written in the plan of care, and/or failed to ensure the plans of care were individualized in 7 of 7 active clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7)	G0572	**G0572** **For patient clinicalrecord #1,** the agency reviewed itsPlan of Care policy and identified likely affected patients with thisdeficiency. Agency individualized the affected client'splan of care and updated client's achievable measurable goals and sent it to thephysician for signature. The director of nursing in-serviced aideassigned to care for the client to document in their notes any hands-on carerendered to the client including but not limited to bathing, wearing briefs,dressing, brush teeth, comb hair as outlined to address patientindividualized needs and interventions in their plan of care and to ensure thatthis deficiency does not reoccur. The director of nursing in-serviced	2023-06-30

	The findings include: 1. Record review evidenced an agency policy dated 10/26/2011, titled "Plan of Treatment" which stated, "... services are furnished under the ... direction of the ... physician ... An individualized Plan of Care ... signed by a physician shall be required for each [patient] receiving home health and personal care services ...." 2. Clinical record review for Patient #1 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023, which evidenced the home health aide (HHA) orders included to assist with bathing, dressing, and personal care, such as grooming, hair care, shampoo, and oral care, ensure the patient had an adult brief on prior to getting on the bus (in the morning), and apply lotion to buttocks after each episode of incontinence; and the patient was unable to care for him/herself due to mental retardation. The plan of care stated, "... Goals/Rehabilitation Potential/Discharge Plans: ... When patient knowledgeable about when to notify physician		officestaff to ensure all home health aides are documenting in their aide's noteshands-on care rendered to the client assigned to them prior to printing theirnotes for filing. This will ensure home health aides' accountability andcompliance with the regulatory requirements. 50% of all clients' charts will beaudited quarterly by the director of nursing, and findings of refusal/noncompliance as outlined in their individualized plan of care will be reportedto their physician. Home health aides will receivephone calls on a regular basis reminding them to document their hands on care renderedto their clients. The director of nursing will beresponsible for monitoring this corrective action scheduled to be completed on 6/30/2023to ensure 100% compliance and avoid its reoccurrence. **For patient clinical record #2,** the agency reviewed itsPlan of Care policy and identified likely affected patients with	

	... Able to understand medication regime and care related to diagnoses ... Medical condition stabilizes ... When maximum functional potential reached ... Discharge at the end of the episode if the patient is hospitalized ...." The plan of care failed to include individualized measurable goals or discharge plans. Clinical record review evidenced a HHA visit note (5:00 AM - 7:00 AM), dated 1/31/2023, which failed to evidence the patient received assist with grooming, oral care, incontinence care, lotion to buttocks, or the patient had an adult brief on prior to getting on the bus. Clinical record review evidenced a HHA visit note (5:00 AM - 7:00 AM), dated 2/01/2023, which failed to evidence the patient received assist with grooming, incontinence care, lotion to buttocks, or the patient had an adult brief on prior to getting on the bus. Clinical record review evidenced HHA visit notes (5:00 AM - 7:00 AM), dated 2/02/2023 and 2/03/2023, which failed to		individualized the affected client's plan of care andupdated client's achievable measurable goals and sent it to the physician forsignature. The director of nursing in-serviced aideassigned to care for the client to document in their notes any hands-on carerendered to the client including but not limited to empty foley catheter, usegait belt to help client transfer patient, bathing, wearing briefs, dressing, brushteeth, comb hair as outlined to address patient individualized needs andinterventions in their plan of care and to ensure that this deficiency does notreoccur. The director of nursingin-serviced supporting staff to ensure all home health aides are documenting intheir aide's notes the hands-on care rendered to the client assigned to themand completing a shift work assigned to ensure the client receives all servicesaccording to the client's individualized plan of care. 50% of all clients' chartswill be audited quarterly by the director of nursing, and findings	

	assist with grooming, lotion to buttocks, or the patient had an adult brief on prior to getting on the bus. Clinical record review evidenced a HHA visit note (5:00 AM - 7:00 AM), dated 2/04/2023, which failed to evidence the patient received assist with grooming, oral care, incontinence care, lotion to buttocks, or the patient had an adult brief on prior to getting on the bus. Clinical record review evidenced a HHA visit note (5:00 AM - 7:00 AM), dated 2/06/2023, evidenced the patient received a shower, and failed to evidence the patient received any other personal care, or the patient had an adult brief on prior to getting on the bus. Clinical record review evidenced a HHA visit notes (5:00 AM - 7:00 AM), dated 2/07/2023, 2/08/2023, 2/09/2023, and 2/10/2023, which all failed to evidence the patient received lotion to buttocks, or the patient had an adult brief on prior to getting on the bus. During an interview on 2/14/2023 at 3:30 PM, the Clinical Manager indicated the		of refusal/noncompliance as outlined in their individualized plan of care will be reportedto their physician. Home health aides will receive phone calls on a regularbasis reminding them to document their hands on care rendered to their clients. The director of nursingwill be responsible for monitoring this corrective action scheduled to becompleted on 6/30/2023 to ensure 100% compliance and avoid itsreoccurrence. **For patient clinical record#3** the agency reviewed its Plan of Care policy andidentified likely affected patients with this deficiency. Agency individualizedthe affected client's plan of care and updated client's achievable measurablegoals and sent it to the physician for signature. Thedirector of nursing in-serviced aide assigned to care for the client todocument in their notes any hands-on care rendered to the client including butnot limited to bathing/shower, wearing briefs, dressing, brush teeth,comb hair as outlined to address patient individualized needs and interventions intheir plan of care and to ensure that this deficiency does not reoccur.	

	HHA should do what's ordered on the plan of care, and the plan of care wasn't individualized to this patient. 3. Clinical record review for Patient #2 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/09/2023 – 3/09/2023, which evidenced the HHA was ordered 7 days per week, orders included to secure the foley catheter (a tube inserted into the bladder to drain urine) bag (a bag attached to the catheter to collect urine) prior to transferring the patient out of bed or to the restroom, empty urine from urinary drainage bag, and to use a gait belt (belt applied to patient's trunk for safe transfers) for transferring the patient. The plan of care stated, "… Goals/Rehabilitation Potential/Discharge Plans: … Demonstrates compliance with medication by ... [no further information provided] ... Verbalizes pain controlled at acceptable level by ... [no further information provided] ... Discharge Plans ... Return to an independent level of care (self-care) ... When patient knowledgeable about when to		The director of nursing in-serviced supportingstaff to ensure all home health aides are documenting in their aide's notes anyhands-on care rendered to the client assigned to them to ensure the clientreceives all services according to the client's individualized plan of care. 50% of all clients' charts will beaudited quarterly by the director of nursing, and findings of refusal/noncompliance as outlined in their individualized plan of care will be reportedto their physician. The director of nursing will be responsible for monitoringthis corrective action scheduled to be completed on 6/30/2023 to ensure 100%compliance and avoid its reoccurrence. **For patient clinical record#4**, the agency reviewed its "Plan of Care" policy andidentified likely affected patients with this deficiency. Agency individualizedthe affected client's plan of care and updated client's achievable measurablegoals and sent it to the physician for signature. The director of nursing	

	notify physician ... Able to understand medication regime and care related to diagnoses ... Medical condition stabilizes ... When maximum functional potential reached ... Discharge at the end of the episode if the patient is hospitalized ....” The plan of care failed to include any individualized measurable goals or discharge plans. Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/04/2023, 2/05/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, 2/10/2023, 2/11/2023, and 2/12/2023 all failed to evidence the HHA secured the foley catheter, emptied urine from the urinary drainage bag, or used a gait belt to transfer the patient. During an interview on 2/14/2023 at 3:20 PM, the Clinical Manager indicated the plan of care wasn't individualized, and didn't indicate specific orders on how to secure the foley catheter; and confirmed the HHA visit notes failed to evidence the HHA secured the foley catheter, emptied urine from the urinary		in-serviced aideassigned to care for the client to document in their notes any hands-on carerendered to the client including but not limited to bathing/shower, wearingbriefs, dressing, brush teeth, comb hair as outlined to address patientindividualized needs and interventions in their plan of care and to ensure thatthis deficiency does not reoccur. The director of nursing in-servicedsupporting staff to ensure all home health aides are documenting in theiraide’s notes the hands-on care rendered to the client assigned to them andcompleting a shift work assigned to ensure the client receives all servicesaccording to the client’s individualized plan of care. 50% of all clients’ charts will beaudited quarterly by the director of nursing that is responsible for monitoringthis corrective action to ensure 100% compliance and avoid itsreoccurrence. **For patientclinical record#5**, the agency reviewed its“Plan of	

	drainage bag, or used a gait belt to transfer the patient. 4. Clinical record review for Patient #3 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023, which evidenced the home health aide (HHA) orders included to assist with bathing, dressing, and personal care, such as grooming, hair care, shampoo, and oral care. The plan of care stated, "… Goals/Rehabilitation Potential/Discharge Plans: … Able to understand medication regime and care related to diagnoses … Medical condition stabilizes … When maximum functional potential reached … Discharge at the end of the episode if the patient is hospitalized … Demonstrates compliance with medication by … [no further information provided] ... Stabilization of cardiovascular [heart and circulatory system] pulmonary [lung] condition by [no further information provided] ... Verbalizes pain controlled at acceptable level by ... [no further information provided] ... Verbalizes/Demonstrates independence with care by ...		affected patients with this deficiency.Agency individualized the affected patient's plan of care and updated patient'sachievable measurable goals outcomes, and discharge plans and faxed it to thephysician for signature. The director of nursing in-servicedaide assigned to care for the client to document in their notes any hands-oncare rendered to the client including but not limited to bathing/shower,wearing briefs, dressing, brush teeth, comb hair asoutlined to address patient individualized needs and interventions in theirplan of care and to ensure that this deficiency does not reoccur. The director of nursing in-servicedsupporting staff to ensure all home health aides are documenting in theiraide's notes the hands-on care rendered to the client assigned to them andcompleting a shift work assigned to ensure the client receives all servicesaccording to the client's individualized plan of care. 50% of all clients' charts will beaudited quarterly by the director of nursing that is responsible for monitoringthis corrective action to ensure 100% compliance and avoid its reoccurrence. **For patient clinical record #6,** theagency reviewed its "Plan of Care" policy and identified likely affectedpatients with this deficiency. Agency individualized the affected	

	[no further information provided] ...." The plan of care failed to include individualized measurable goals or discharge plans. Clinical record review evidenced HHA visits dated 2/02/2023, 2/06/2023, and 2/08/2023 all failed to evidence the HHA provided any personal care. Clinical record review evidenced HHA visits dated 2/07/2023 and 2/09/2023 evidenced the HHA provided shower assistance, but failed to evidence the HHA provided any other personal care. During an interview on 2/14/2023 at 3:35 PM, the Clinical Manager indicated the home health aides were previously told they have to provide personal care every visit, and she needed to re-educate them. Person #10 (agency Secretary) indicated the home health aides knew they had to do personal care. The clinical Manager indicated the plan of care was not individualized. 5. Clinical record review for Patient #4 was completed on 2/14/2023. Record review		updated patient's hours of service to be 5 hours/day,5 days/week as outline in the patient's plan of care. Agency updated patent'sachievable measurable goals outcomes, teachings, and discharge plans and faxedit to the physician for signature. The director of nursing in-servicedaide assigned to care for the client to document in their notes any hands-oncare rendered to the client including but not limited to bathing/shower, wearingbriefs, dressing, brush teeth, comb hair as outlined to address patientindividualized needs and interventions in their plan of care and to ensure thatthis deficiency does not reoccur. The director of nursing in-servicedsupporting staff to ensure all home health aides are documenting in theiraide's notes the hands-on care rendered to the client assigned to them andcompleting a shift work assigned to ensure the client receives all servicesaccording to the client's individualized plan of care. 50% of all clients' charts will be	

	evidenced a plan of care for certification period 2/07/2023 – 4/07/2023, which evidenced the HHA orders included to assist with bathing, dressing, and personal care, such as grooming, hair care, shampoo, and oral care. The plan of care stated, "… Goals/Rehabilitation Potential/Discharge Plans: … Demonstrates compliance with medication by ... [no further information provided] ... Verbalizes pain controlled at acceptable level by ... [no further information provided] ... Verbalizes/Demonstrates independence with care by ... [no further information provided] ... Return to an independent level of care (self-care) ... When patient knowledgeable about when to notify physician ... Able to understand medication regime and care related to diagnoses … Medical condition stabilizes … When maximum functional potential reached … Discharge at the end of the episode if the patient is hospitalized … …." The plan of care failed to include individualized measurable goals or discharge plans. Clinical record review evidenced		audited quarterly bythe director of nursing that is responsible for monitoring this correctiveaction to ensure100% compliance and avoid its reoccurrence. **For patient clinical record #7,** Agency unable to correct this deficiency becausepatient expired.	

	HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, and 2/10/2023, all failed to evidence the HHA provided any personal care. During an interview on 2/14/2023, the Clinical Manager indicated the plan of care was also the HHA care plan. During an interview on 2/14/2023 at 2:44 PM, the Clinical Manager indicated all the patients' plans of care looked the same because all the patients wanted the same things, they wanted basic ADL's (activities of daily living), all the current patients were HHA only, and none received skilled nursing services. The Clinical Manager confirmed "such as" meant it was an example, not an actual order specific to the patient. When queried if each patient's plan of care included patient-specific interventions, goals, or discharge plans, the Clinical Manager stated, "... Probably not ....", and indicated the plans of care were generic because they were all HHA only patients.			

	410 IAC 17-13-1(a) 6. Clinical record review for Patient #5 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023, which included the following generic home health aide orders: encourage use of assistive device whenever possible, ensure well-lit, clutter free walkway such as keeping cords secure and out of walkway, removing throw rugs, eliminating tripping hazards, assist/prepare daily meals, assist with bathing, dressing, personal care such as grooming, hair care, shampoo, oral care, report any skin tears, abrasions, rashes, and/or discolorations to the skin, assist patient with light housekeeping for the patient only such as vacuuming, changing bedding/linens, dishes, dusting, wiping down of surfaces, laundry, etc.. The plan of care included the following generic skilled nursing orders: teach disease process, teach signs and symptoms of infection and standard precautions, teach diet, and teach home safety/falls prevention. The plan of care included the following generic			

	discharge plans/goals: return to an independent level of care, able to remain in residence with assistance of primary caregiver/support from community agencies, able to understand medication regime and care related to diagnoses, when maximum functional potential reached, discharge at the end of the episode if the patient is hospitalized. Clinical record review failed to evidence the patient received the education about disease process, signs and symptoms of infection, diet, and home safety/fall prevention, as ordered on the plan of care. Clinical record review evidenced skilled nurse visit notes for the following dates, during which the patient failed to receive assistive device reminders or monitoring of the patient's skin as ordered on the plan of care: 1/31/2023, 2/1/2023, 2/2/2023, 2/3/2023, 2/6/2023, 2/7/2023, 2/8/2023, 2/9/2023, and 2/10/2023.			

During an interview on 2/14/2023, at 2:46 PM, clinical manager #1 indicated all the patient's had the same interventions on the plans of care because all the patient's wanted the same interventions. Clinical manager #1 indicated the plans of care were all generic. At 3:50 PM, clinical manager #1 indicated the nurse and the home health aide should have completed the interventions ordered on the plan of care.

7. Clinical record review for Patient #6 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/5/2023 – 4/5/2023, which included the following generic home health aide orders: encourage use of assistive device whenever possible, ensure well-lit, clutter free walkway such as keeping cords secure and out of walkway, removing throw rugs, eliminating tripping hazards, assist/prepare daily meals, assist with bathing, dressing, personal

	care, shampoo, oral care, report any skin tears, abrasions, rashes, and/or discolorations to the skin, assist patient with light housekeeping for the patient only such as vacuuming, changing bedding/linens, dishes, dusting, wiping down of surfaces, laundry, etc.. The plan of care included the following generic skilled nursing orders: teach disease process, teach signs and symptoms of infection and standard precautions, teach diet, and teach home safety/falls prevention. The plan of care included the following generic discharge plans/goals: return to an independent level of care, able to remain in residence with assistance of primary caregiver/support from community agencies, able to understand medication regime and care related to diagnoses, when maximum functional potential reached, discharge at the end of the episode if the patient is hospitalized. The plan of care indicated the patient was to receive home health aide visits 5 hours per day 5 days per week.			

	Clinical record review evidenced home health aide visit notes for the week of 2/5/2023, which indicated the patient was receiving home health aide visits 6 hours per day 5 days per week, instead of 5 as ordered on the plan of care. Clinical record review evidenced home health aide visit notes dated 1/31/2023, 2/1/2023, 2/2/2023, 2/6/2023, 2/7/2023, 2/8/2023, 2/9/2023, and 2/10/2023, during which, the home health aide failed to perform any bathing, dressing, hair care, or oral care, as ordered on the plan of care. Clinical record review failed to evidence the patient received teaching from the skilled nurse regarding disease process, signs and symptoms of infection, diet, and home safety/fall prevention as ordered on the plan of care. During an interview on 2/14/2023, at 3:54 PM, clinical manager #1 indicated the			

	a different number of hours because they were making up missed hours. 8. Clinical record review for Patient #7 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023, which indicated the patient was to receive home health aide services 7 hours on Thursdays and 6 hours on Tuesdays. The plan of care included the following generic home health aide orders: encourage use of assistive device whenever possible, ensure well-lit, clutter free walkway such as keeping cords secure and out of walkway, removing throw rugs, eliminating tripping hazards, assist/prepare daily meals, assist with bathing, dressing, personal care such as grooming, hair care, shampoo, oral care, report any skin tears, abrasions, rashes, and/or discolorations to the skin, assist patient with light housekeeping for the patient only such as vacuuming, changing bedding/linens, dishes, dusting, wiping down of surfaces, laundry, etc.. The plan			

	of care included the following generic skilled nursing orders: teach disease process, teach signs and symptoms of infection and standard precautions, teach diet, and teach home safety/falls prevention. The plan of care included the following generic discharge plans/goals: return to an independent level of care, able to remain in residence with assistance of primary caregiver/support from community agencies, able to understand medication regime and care related to diagnoses, when maximum functional potential reached, discharge at the end of the episode if the patient is hospitalized. Clinical record review evidenced home health aide visit notes dated 1/31/2023, and 2/2/2023, which indicated the patient received 8 hours of home health aide services on Tuesday and Thursday, instead of the ordered hours. Clinical record review evidenced home health aide visit note dated 2/7/2023, which indicated			

	the patient received 7 hours of home health aide hours on Tuesday instead of 6 as ordered. Clinical record review failed to evidence the patient received teaching from the skilled nurse regarding disease process, signs and symptoms of infection, diet, and home safety/fall prevention as ordered on the plan of care.			
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;	G0574	**G0574** Agencyreviewed its policy on plan of care to ensure an individualized plan of careincludes all pertinent diagnoses, types, frequency, and duration ofvisits/services, specific dietary or nutritional requirements or restrictions,medications, treatments, medical supplies and equipment required, safetymeasures to protect against injury, and instructions to caregiver education,and other necessary interventions were identified and included in	2023-06-30

	(ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.		the affectedclient's plan of care. Agencyreviewed all patients' plan of care likely to be impacted by this deficiencyand updated their individualized care plan per patient needs, sent to thephysician for signature, and logged in the client's medical charts. Thedirector of nursing will review all patients' plan of care bimonthly to ensureall necessary interventions are identified and updated. 50% ofclient's records will be audited quarterly by the director of nursing, andfindings reported to the administrator that is responsible for monitoring thiscorrective action to ensure 100% compliance and avoid its reoccurrence. **For clinicalrecord review patient # 1,** the director of nursing updated patient'splan of care to include the current hours of service provided to the client,vital signs, basic ADLs the client is receiving not limited to incontinentbowel and bladder care, briefs, and education to the caregiver to prevent skinbreak down, and other necessary interventions pertinent to the clientdiagnoses. This was documented and sent to the patient's physician forsignature. The director ofnursing reviewed other clients' charts on	

	Based on record review and interview, the home health agency failed to ensure the plan of care included one or more of the following: all pertinent diagnoses, psychosocial status, the types of supplies and equipment required, frequency and duration of visits to be made, nutritional requirements, all medications and treatments, patient-specific education, the patient's personal goal(s), information related to any advanced directives, and/or a description of the patient's risk for emergency department visits/hospital re-admission and all necessary interventions to address the underlying risk factors in 7 of 7 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7). The findings include: 1. Record review evidenced an agency policy dated 10/26/2011, titled "Plan of Treatment" which stated, "... The Plan of Care shall be completed in full to include: ... All pertinent diagnoses[es] ... Type, frequency, and duration of all visits/services ... Specific dietary or nutritional requirements or restrictions ... Medications,		affectedby this deficiency and updated their charts to reflect their pertinent careinterventions. The updated care plans were faxed to their respective physiciansfor signature and will be documented and logged in the client's medical charts. The administratorhas in-serviced the director of nursing and support staff to ensure that the planof care is individualized, pertinent care interventions are documented,accurate, up to date, and signed by the physician. All home health aides havebeen in-serviced to perform services only as ordered in the client's plan ofcare. 50% of theclient's records will be audited quarterly by the director of nursing that isresponsible for monitoring this corrective action to ensure 100% compliance andavoid its reoccurrence **For clinicalrecord review patient #2,** the director of nursing identified the client affected with thisdeficiency and revised the patient's plan of	

	and equipment required ... Any safety measures to protect against injury ... Instructions to client/caregiver ...." 2. Clinical record review for Patient #1 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023. The document evidenced Home Health Aide (HHA) services were ordered 6 hours per day, 5 days per week, but failed to evidence the duration of the services; Skilled Nursing (SN) was ordered, but failed to evidence frequency or duration of the service; nutritional requirements stated, "... No Problem ....", but failed to evidence the patients prescribed diet; the patient required 24 hour supervision, but failed to evidence how the 24 hour supervision was provided; provided evidenced the patient was incontinent of bowel and bladder, and wore a brief, but failed to evidence patient/caregiver education to prevent skin breakdown due to incontinence and use of a brief; stated, "... Caregiver ... to constantly check daily blood sugar and call [physician] ... if the reading is out of range ....",		care to include frequency andduration of home health aide service to the client, patient personal achievablegoals, and client/caregiver education. This was documented and sent to thepatient's physician for signature. The directorof nursing audited other clients' medical records likely to be impacted by thisdeficiency and updated their plan of care reflecting their care interventionsand faxed them to their respective physicians for signature. The plan of carewill be documented and logged in the client's medical charts. The director of nursing in-servicedaide assigned to care for the client to document in their notes any hands-oncare rendered to the client including but not limited to emptying foleycatheter, using gait belt to help transfer patient, bathing, wearing briefs,dressing, brushing teeth, comb hair as outlined to address patientindividualized needs and interventions in their plan of care and to ensure thatthis deficiency does not reoccur. 50% ofthe client's records will	

	but failed to evidence blood sugar parameters to notify the physician; failed to evidence equipment included a glucometer (machine to check blood sugar levels) and lancets (needles for glucometer use); and failed to evidence the patient's personal goal(s), any information on advance directives, or a description of the patient's risk for emergency department visits/hospital re-admission and all necessary interventions to address the underlying risk factors. Clinical record review evidenced an initial comprehensive assessment (start of care) dated 1/13/2023. The document evidenced the patient was disoriented and constantly confused; psychosocial findings included the patient was unable to read or write, had difficulty interacting with other persons, inability to function within the community, lived with another person in the home, but only had regular nighttime assistance, and medications must be stored out of reach of patient secondary to current health problems of mental retardation/autism; the patient		be audited quarterly by the director of nursing thatis responsible for monitoring this corrective action to ensure 100% complianceand avoid its reoccurrence. The director of nursing will be responsible for monitoring thiscorrective action scheduled to be completed on 6/30/2023 to ensure 100%compliance and avoid its reoccurrence. **For clinicalrecord review patient #3**, the agency reviewed its care plan policyand identified the client affected by this deficiency. The director of nursingrevised the patient's plan of care to include frequency and duration of homehealth aide service, incontinent care, psychosocial needs, vital signs,hospitalization risk, diet, patient personal achievable goals, andclient/caregiver education. This was documented and sent to the patient'sphysician for signature. The director of nursing audited other clients' medical recordslikely to be impacted by this deficiency and updated their plan of carereflecting their care interventions and faxed them to their respectivephysicians for signature. The plan of care will be documented and logged in theclient's medical charts. The director of nursingin-serviced aide assigned to care for the client to	

	was a high nutritional risk. The plan of care failed to evidence the patient's psychosocial status/needs, or patient/caregiver education for fall risk or high nutritional risk. Clinical record review evidenced a physician office progress note (Person #1, the patient's certifying physician) dated 9/19/2022, which evidenced the patient's diagnoses included constipation, and the patient used a daily stool softener (to prevent exacerbation of constipation). The plan of care failed to evidence the diagnosis of constipation, or patient/caregiver education to mitigate constipation. Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/04/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, and 2/10/2023 all evidenced the HHA took the patient's temperature, pulse, and blood pressure. The plan of care failed to evidence orders for the HHA to obtain the vital signs, or parameters to notify the Clinical Manager. During an interview on		document in their notes anyhands-on care rendered to the client including but not limited, bathing,wearing briefs, dressing, brushing teeth, comb hair asoutlined to address patient individualized needs and interventions in theirplan of care and to ensure that this deficiency does not reoccur. 50% of the client’s records will be audited quarterly by thedirector of nursing that is responsible for monitoring this corrective actionto ensure 100% compliance and avoid its reoccurrence. The director of nursing will be responsible formonitoring this corrective action scheduled to be completed on 6/30/2023 toensure 100% compliance and avoid its reoccurrence. **For clinical review patient #4,** the agency reviewed its policy on theplan of care, identified the client affected with this deficiency and revisedthe client’s plan of care to specifically include frequency and duration ofservice hours provided to the client, patient/caregiver education, psychosocialneeds, pain	

	2/14/2023 at 2:04 PM, the Clinical Manager indicated orders for the HHA to take vital signs should be on the plan of care, and the patients' advance directives weren't included on the plans of care. When queried how the agency ensured patient safety when a plan of care indicated the patient needed 24 hour supervision, the Clinical Manager indicated the agency was only there according to hours approved (on the plan of care), and stated, "... after we leave, we don't know what goes on ...." When queried if she would expect to see specific nutritional requirements on the plan of care, the Clinical Manager stated, "... If there's any allergy of food, or tube feeding [administration of nutrition/fluids via a tube inserted into the stomach], we don't do that ... The family does that ... Aide is there to feed the client [patient] according to instructions from doctor ...." When queried how she determined the patient's risk(s) for emergent care/hospitalizations, interventions to address them, and where it was documented, the Clinical Manager stated, "...		hospitalization, and sent to the physician forsignature and documented in the client chart. Thedirector of nursing audited other clients' medical records likely to beimpacted by this deficiency and updated their plan of care reflecting theircare interventions and faxed them to their respective physicians for signature.The plan of care will be documented and logged in the client's medical charts. The director of nursing in-servicedaide assigned to care for the client to document in their notes any hands-oncare rendered to the client including but not limited, bathing, wearing briefs,dressing, brushing teeth, comb hair as outlined to address patientindividualized needs and interventions in their plan of care and to ensure thatthis deficiency does not reoccur. 50% ofthe client's records will be audited quarterly by the director of nursing thatis responsible for monitoring this corrective action to ensure 100% complianceand avoid its reoccurrence. The director of nursing will be responsible for monitoring thiscorrective action	

	If there is a need for it ... every patient is different ...." When queried if the patient's personal goal(s) were assessed, and where they were documented, the Clinical Manager stated, "... I go by the assessment ...." 3. Clinical record review for Patient #2 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/09/2023 – 3/09/2023, which evidenced the HHA was ordered 7 days per week, but failed to evidence the duration of the services; SN was ordered, but failed to evidence frequency or duration of the service; orders included to secure the foley catheter (a tube inserted into the bladder to drain urine) bag (a bag attached to the catheter to collect urine) prior to transferring the patient out of bed or to the restroom, but failed to evidence how the foley catheter bag was secured; the patient required 24 hour supervision, but failed to evidence how the 24 hour supervision was provided; the patient was incontinent of bowel and/or bladder, but failed to evidence patient/caregiver education to prevent skin		scheduled to be completed on 6/30/2023 to ensure 100%compliance and avoid its reoccurrence. **For clinicalrecord review patient #5,** the director of nursing updated patient's plan of care to includethe current hours of service provided to the client, vital signs, basic ADLsthe client is receiving not limited to incontinent bowel and bladder care,briefs, and education to the caregiver/patient to prevent skin break down,psychosocial needs, nutritional requirements, hospitalization risk, and othernecessary interventions pertinent to the client diagnoses. This was documentedand sent to the patient's physician for signature. Thedirector of nursing reviewed other clients' charts on 5/8/2023 who may likelybe affected by this deficiency and updated their charts to reflect theirpertinent care interventions. The updated care plans were faxed to theirrespective physicians for signature and will be documented and logged in theclient's medical charts.	

	breakdown due to incontinence; a goal for patient to verbalize pain controlled at an acceptable level, but failed to evidence a diagnosis or location of pain, or patient/caregiver education to mitigate pain; a diagnosis of urinary tract infection (UTI), but failed to evidence patient/caregiver education to mitigate UTI; and failed to evidence the patient's personal goal(s), any information on advance directives, or a description of the patient's risk for emergency department visits/hospital re-admission and all necessary interventions to address the underlying risk factors.		Theadministrator has in-serviced the director of nursing and support staff toensure that the plan of care is individualized, pertinent care interventionsare documented, accurate, up to date, and signed by the physician. All homehealth aides have been in-serviced to perform services only as ordered in theclient's plan of care. 50% ofthe client's records will be audited quarterly by the director of nursing thatis responsible for monitoring this corrective action scheduled to be completed on6/30/2023 to ensure 100% compliance and avoid its reoccurrence. The director ofnursing is responsible for monitoring this corrective action. **For clinical record review patient#6,** the director ofnursing updated patient's plan of care to include the frequency and duration ofcurrent hours of service provided to the client, vital signs, interventions tofall prevention/risk, pain mitigation, and education to the caregiver/patientto prevent skin	

	Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/04/2023, 2/05/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, 2/10/2023, 2/11/2023, and 2/12/2023, which all evidenced the HHA took the patient's vital signs (temperature, pulse, respirations, and blood pressure). The plan of care failed to evidence orders for the HHA to obtain the vital signs, or parameters to notify the Clinical Manager. During an interview on 2/14/2023 at 3:20 PM, the Clinical Manager indicated the plan of care didn't indicate specific orders on how to secure the foley catheter; psychosocial needs should be on the plan of care, there were no interventions for pain, and all interventions should be on the plan of care. 4. Clinical record review for Patient #3 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023, which evidenced the HHA was ordered Monday -		needs, nutritional requirements,hospitalization risk, and other necessary interventions pertinent to the clientdiagnoses. This was documented and sent to the patient’s physician forsignature. Thedirector of nursing reviewed other clients’ charts on 5/8/2023 who may likelybe affected by this deficiency and updated their charts to reflect theirpertinent care interventions. The updated care plans were faxed to theirrespective physicians for signature and will be documented and logged in theclient’s medical charts. Theadministrator has in-serviced the director of nursing and support staff toensure that the plan of care is individualized, pertinent care interventionsare documented, accurate, up to date, and signed by the physician. All homehealth aides have been in-serviced to perform services only as ordered in theclient’s plan of care. 50% ofthe client’s records will be audited quarterly by the director of nursing thatis responsible for monitoring this	

	the duration of the services; SN was ordered, but failed to evidence frequency or duration of the service; evidenced primary diagnosis of obstructive sleep apnea (occurs when the muscles in the back of your throat relax too much to allow normal breathing), other diagnoses included dyspnea (difficulty breathing), but failed to evidence patient/caregiver education to mitigate obstructive sleep apnea or dyspnea; and failed to evidence the patient's personal goal(s), any information on advance directives, or a description of the patient's risk for emergency department visits/hospital re-admission and all necessary interventions to address the underlying risk factors. Clinical record review evidenced a comprehensive reassessment (recertification of services) dated 2/02/2023. The document evidenced the patient's psychosocial assessment findings included the patient lived alone, had an inability to cope with altered health status, had homemaker/household needs, family dynamic issues (not further clarified), had transportation needs, and family		be completedon 6/30/2023 to ensure 100% compliance and avoid its reoccurrence. The directorof nursing is responsible for monitoring this corrective action. **For clinical record review patient#7,** Agency was unableto correct this deficiency because patient expired.	

	was primary caregiver and was not willing or available to assist the patient; had multiple risks for hospitalization; had pain in the right lower leg and back; had swelling to both lower legs; the patient checked his blood sugar levels twice daily; and was a high nutritional risk. The plan of care failed to evidence the patient's psychosocial status/needs, or patient/caregiver education to mitigate pain or swelling; the patient checked his blood sugar levels twice daily, or parameters to notify the physician; or patient/caregiver education on high nutritional risk. Clinical record review evidenced a HHA visit dated 2/02/2023, which evidenced the HHA took the patient's temperature and blood pressure. The plan of care failed to evidence orders for the HHA to obtain the patient's temperature and blood pressure. The plan of care failed to evidence orders for the HHA to obtain the patient's temperature and blood pressure, or parameters to notify the Clinical Manager. Clinical record review evidenced HHA visits dated 2/06/2023,			

	2/07/2023, 2/08/2023, and 2/09/2023, which all evidenced the HHA took the patient's blood pressure. The plan of care failed to evidence orders for the HHA to obtain the patient's blood pressure, or parameters to notify the Clinical Manager. During an interview on 2/14/2023, the Clinical Manager confirmed the plan of care failed to evidence the HHA was tasked to obtain vital signs, information on advance directives, the patient's psychosocial status/needs, patient/caregiver education to mitigate pain or swelling; failed to evidence the patient checked his blood sugar levels twice daily, or parameters to notify the physician; or patient/caregiver education on high nutritional risk. 5. Clinical record review for Patient #4 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023, which evidenced the HHA was ordered 5 days per week, but failed to evidence the duration of the services; SN was ordered, but failed to evidence frequency or duration of the			

	service; evidenced primary diagnosis of stroke, other diagnoses included hypertension (high blood pressure), but failed to evidence patient/caregiver education for signs/symptoms of stroke, or mitigation of high blood pressure; and failed to evidence the patient's personal goal(s), any information on advance directives, or a description of the patient's risk for emergency department visits/hospital re-admission and all necessary interventions to address the underlying risk factors. Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, and 2/10/2023, which all evidenced the HHA took the patient's vital signs (temperature, pulse, respirations, and blood pressure). The plan of care failed to evidence orders for the HHA to obtain the vital signs, or parameters to notify the Clinical Manager. During an interview on 2/14/2023 at 2:04 PM, the Clinical Manager indicated the			

	care plan (the same document). During an interview on 2/14/2023 at 2:44 PM, the Clinical Manager indicated all the patients' plans of care looked the same because all the patients wanted the same things, they wanted basic ADL's (activities of daily living), all the current patients were HHA only, and none received skilled nursing services. The Clinical Manager confirmed "such as" meant it was an example, not an actual order specific to the patient. When queried if each patient's plan of care included patient-specific interventions, goals, or discharge plans, the Clinical Manager stated, "... Probably not ....", and indicated the plans of care were generic, because they were all HHA only patients. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(ii, ix, xiii) 6. Clinical record review for Patient #5 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023, which indicated the			

	patient was to receive skilled nursing services but failed to include the frequency or duration of skilled nurse visits to be made. The plan of care included the following goals which were not measurable: Able to remain in residence with assistance of primary caregiver/support from community agencies, able to understand medication regime and care related to diagnoses, and when maximum functional potential reached. The plan of care failed to include any information regarding the patient's psychosocial status, nutritional requirements, information related to advanced directives, and a description of the patient's risk for emergency department visits and hospital re-admission, and necessary interventions to address the risk factors. The plan of care failed to include any patient-specific interventions. The plan of care indicated the home health aide was to visit 5 hour per day Monday through Thursday, and 8 hours on Fridays, but failed to include a duration of home health aide visits.			

	Clinical record review evidenced a do not resuscitate order signed on 4/19/2016, which failed to be included in the plan of care. During an interview on 2/14/2023, at 3:13 PM, clinical manager #1 indicated the frequency and duration of skilled nurse visits and home health aide visits should have been included on plans of care. At 3:16 PM, clinical manager #1 indicated the patient stated goals should have been included on the plan of care. Clinical manager #1 indicated the goals on the plans of care were not patient-specific or measurable. Clinical manager #1 indicated diet requirements should have been included on the plans of care. Clinical manager #1 indicated information regarding advanced directives should have been included in the plans of care as well as interventions to address hospitalization risk factors. At 3:25 PM, clinical manager #1 indicated the patient's psychosocial status should have been included in the plans of care. Clinical manager #1			

	indicated Patient #5 had a current do not resuscitate order which should have been included in the plan of care.			

	7. Clinical record review for Patient #6 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/5/2023 – 4/5/2023, which indicated the patient was to receive skilled nurse visits but failed to include the frequency or duration of visits. The plan of care indicated the patient was to receive home health aide visits 5 hours per day 5 days per week but failed to include the duration of home health aide visits. The plan of care failed to include any patient-specific interventions regarding falls or pain. The plan of care failed to include nutritional information such as diet, psychosocial information such as who patient lived with or support systems, information related to advanced directives, and a description of the patient's risk for emergency department visits and hospital re-admission, and necessary interventions to address the risk factors. Clinical record review evidenced a recertification comprehensive assessment dated 1/31/2023,			

	a willing and able caregiver but had family dynamic issues. The assessment included the following risks for hospitalization: history of falls, unintentional weight loss, currently taking 5 or more medications, and reports exhaustion. The assessment indicated the patient had daily pain and was a high fall risk. This assessment indicated the patient used a leg brace, which was not included on the plan of care. During an interview on 2/14/2023, at 3:55 PM, clinical manager #1 indicated the leg brace should have been on the plan of care and was on the recertification assessment. 8. Clinical record review for Patient #7 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023, which included an order for bisacodyl (laxative) daily as needed but failed to include an indication for use. The plan of care indicated the patient was to receive skilled			

	nurse visits but failed to include the frequency or duration of visits. The plan of care indicated the patient was to receive home health aide visits 6 hours on Tuesdays and 7 hours on Thursdays but failed to include a duration of home health aide treatment. The plan of care failed to include nutritional information such as diet, psychosocial information such as who patient lived with or support systems, information related to advanced directives, and a description of the patient's risk for emergency department visits and hospital re-admission, and necessary interventions to address the risk factors. The plan of care failed to include any patient-specific interventions regarding falls or pain. Clinical record review evidenced a resumption of care comprehensive assessment dated 1/26/2023, which indicated the patient had pain which interfered with completing tasks, was a high fall risk, lived with her daughter, and had the following risks for hospitalization: multiple			

	hospitalizations, multiple emergency department visits, currently taking 5 or more medications, and exhaustion. During an interview on 2/14/2023, at 4:09 PM, clinical manager #1 indicated the plan of care should have had an indication for use for bisacodyl.			
G0586	Review and revision of the plan of care 484.60(c) Standard: Review and revision of the plan of care. Based on record review and interview, the home health agency failed to ensure the plan of care was reviewed and revised in 1 of 1 clinical records in which a resumption of care assessment was conducted. (#7) The findings include: Record review evidenced an undated agency policy obtained 12/14/2022, titled "Coordination of Client Services" which stated, "... Each	G0586	**G0586** Theagency is unable to correct this deficiency because the patient expired and noservices were rendered. The clinical manager immediately reviewed other patient's charts likely tobe affected by this deficiency and updated their medication records to include anynew /discontinued medication and faxed it to their physicians for signature andrecord purposes. The clinical manager will subsequentlyreview all clients' charts bimonthly to ensure all pertinent patient medicationrecords are updated according to their physician's	2023-06-30

	staff Registered Nurse shall meet with the Nursing Supervisor/Team Leader weekly or as necessary to review all areas of client needs, including: … The physician's Plan of Care … The primary care Nurse or Therapist will assume responsibility for updating/changing the Care Plan and communicating changes to caregivers within 24 hours following the conference or changes … the physician will be contacted when his/her approval for that change is necessary …" Clinical record review for Patient #7 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023, which was dated and signed by clinical manager on 1/10/2023. The plan of care included an order for Norco (pain medication).		theirplan of care accordingly and faxed to their physician for signature and logged intheir various charts. 50% ofclient medical records will be quarterly reviewed to ensure all client's medicationsare monitored and updated per their individual specific physician order and touphold 100% regulatory standard of practice compliance scheduled to becompleted on 6/30/2023. The director of nursing is responsible for monitoringthis corrective action.	

	Clinical record review evidenced a medication profile dated 1/27/2023, which included an order for hydromorphone (pain medication), and not Norco. Clinical record review indicated the patient was hospitalized on 1/13/2023 and resumed home health services on 1/26/2023. Record review failed to evidence the plan of care was updated after hospitalization to accurately reflect the medications the patient was taking. During an interview on 2/14/2023, at 4:09 PM, the Clinical Manager indicated the hydromorphone should have been included in the updated plan of care.			
G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph	G0750	**G0750** Theadministrator immediately reviewed the agency's policy on care plan and identifiedthe deficiency. The administrator instructed the support staff to schedulein-service with all active Aides regarding following	2023-06-30

	(a) of this section. Based on record review and interview, the home health agency failed to: provide a patient-specific Home Health Aide (HHA) care plan (See tag G798); and ensure home health aides provided services which were ordered on the plan of care and/or permitted by State law (See tag G800). This practice had the potential to affect all home health agency patients. The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.80 Home health aide services.		the client's care plan as it'shanded to them upon arriving at the client's house. Theadministrator instructed the director of nursing to strictly conduct 30/60-daysupervisory visits ensuring home health aides are following patient care plangiven to them upon acceptance of patient's care. Agencywill review weekly aides' notes ensuring patients' plans of care are followedas ordered. Patients will be asked periodically and during supervisory visitsregarding aides following their plan of care as ordered. 50% of Aides' records will be quarterly reviewedto ensure home health aides are following the patient care plan handed to themupon caring for the patient. This will prevent this deficiency from happeningagain and ensure compliance with the state law. The director of nursing is responsiblefor monitoring this corrective action. The director of nursing will be responsiblefor monitoring this corrective action scheduled to be	

			toensure 100% compliance and avoid its reoccurrence.	
G0798	Home health aide assignments and duties 484.80(g)(1) 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 (RN) failed to provide a patient-specific Home Health Aide (HHA) care plan in 7 of 7 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7). The findings include: 2. Clinical record review for Patient #1 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023. The document evidenced the patient received HHA services, diagnoses included diabetes, and nutritional requirements stated, "... No Problem ...." The	G0798	**G0798** **For clinical record review patent#1**, the director ofnursing immediately identified client affected by this deficiency and updatedclient plan of care to include specific personal care task, and how often toprovide them, diet/nutritional requirements ordered by the client physician, whenand how to perform to perform client task, and assistance with patient specifichousehold task. Copy of the updated plan of care faxed to their physician forsignature. Thedirector of nursing reviewed other client charts likely to impacted withdeficiency and updated/corrected their plan of to include required specificcare interventions and faxed to their various physicians for signature anddocumented in their charts. Thedirector of nursing will audit all client charts every 60-day recertificationperiod to ensure updated client health status and specific	2023-06-30

	document also stated, "... Aide: Monitor patient at all times ... encourage use of assistive devices whenever possible ... ensure well-lit, clutter free walkway such as keeping cords secure ... removing throw rugs ... prepare meals and assist with set up/feed ... assist with bathing, dressing, personal care such as grooming, hair care, shampoo, oral care ... assist patient with light housekeeping ... such as ... vacuuming, changing bedding/linens, dishes, wiping down of surfaces, laundry, etc. ...." The plan of care/Aide care plan failed to evidence patient specific instructions/tasks for how often or what the HHA was to monitor for; what diet the patient required due to diabetes, how often, or what type of assistance was needed; patient specific personal care tasks, or how often to provide them; or patient specific household tasks, or how often to perform them. Clinical record review evidenced a comprehensive assessment (start of care) dated 1/12/2023. The document evidenced the patient was incontinent of		tasks/interventionsneeded are well documented and fax to their physician for signature to ensurethis deficiency doesn't not recur. 50% of client medical records will bequarterly reviewed to ensure all clients plan of cares are monitored andupdated per their individual specific needs and to uphold 100% regulatorystandard of practice compliance scheduled to be completed on 6/30/2023. Thedirector of nursing is responsible for monitoring this corrective action. **For clinical record review patent#2**, the director ofnursing immediately identified client affected by this deficiency and updatedclient plan of care to include patient use of assistive device (walker, cane),specific task/instructions, diet/nutritional requirements ordered by the clientphysician, when and how to perform client task, and assistance with patientspecific household task. Copy of the updated plan of care faxed to theirphysician for signature	

	care failed to evidence HHA orders for incontinence care. During an interview on 2/14/2023 at 3:30 PM, the Clinical Manager stated, "... It's not a skilled patient, so the plan of care is generic for all of them ... The patients tell them [aides] what they need ...." 3. Clinical record review for Patient #2 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023. The document evidenced the patient received HHA services. The document stated, "... Aide: Monitor patient at all times ... encourage use of assistive devices whenever possible ... ensure well-lit, clutter free walkway such as keeping cords secure ... removing throw rugs ... assist/prepare daily meals and set up ... assist with feeding whenever possible ... assist with bathing, dressing, personal care such as grooming, hair care, shampoo, oral care ... assist patient with light housekeeping ... such as ... vacuuming, changing bedding/linens, dishes, wiping down of surfaces, laundry, etc. ...." The plan of		Thedirector of nursing reviewed other client charts likely to impacted withdeficiency and updated/corrected their plan of to include required specificcare interventions and faxed to their various physicians for signature anddocumented in their charts. Thedirector of nursing will audit all client charts every 60-day recertificationperiod to ensure updated client health status and specific tasks/interventionsneeded are well documented and fax to their physician for signature to ensurethis deficiency doesn't not recur. 50% ofclient medical records will be quarterly reviewed to ensure all clients plan ofcares are monitored and updated per their individual specific needs and touphold 100% regulatory standard of practice compliance scheduled to becompleted on 6/30/2023. The director of nursing is responsible for monitoringthis corrective action. **For clinical record review patent#3**, the director ofnursing immediately identified client affected by this deficiency and updatedclient plan of care to include when	

	care/Aide care plan failed to evidence patient specific instructions/tasks for how often or what the HHA was to monitor for; what assistive devices or when the HHA should encourage the patient to use them; which meals to prepare, how often, or what type of assistance was needed; patient specific personal care tasks, or how often to provide them; or patient specific household tasks, or how often to perform them. Clinical record review evidenced a comprehensive reassessment (recertification of services) dated 1/04/2023. The document evidenced the patient was dependent for toileting needs (ability to maintain personal hygiene, adjust clothes before and after using the toilet), and use of a shower chair to prevent falls. The plan of care/Aide care plan failed to evidence patient specific instructions/tasks for provision of toileting needs, or use of a shower chair during personal care. During an interview on 2/14/2023 at 2:04 PM, the Clinical Manager indicated the		appropriate to encourage patient use ofassistive device (walker, cane, wheelchair), move from sitting to standingposition with assistance, specific task/instructions, diet/nutritionalrequirements ordered by the client physician, when and how to perform client task,and assistance with patient specific household task. Copy of the updated planof care faxed to their physician for signature. Thedirector of nursing reviewed other client charts likely to impacted withdeficiency and updated/corrected their plan of to include required specificcare interventions and faxed to their various physicians for signature anddocumented in their charts. Thedirector of nursing will audit all client charts every 60-day recertificationperiod to ensure updated client health status and specific tasks/interventionsneeded are well documented and fax to their physician for signature to ensurethis deficiency doesn’t not recur. 50% ofclient medical records will be quarterly reviewed to ensure all clients plan ofcares	

	Aide Care Plan were the same thing (one document). During an interview on 2/14/2023 at 3:20 PM, the Clinical Manager stated, "... like I said, all plans of care are the same because it's just ADLs [activities of daily living] ...." 4. Clinical record review for Patient #3 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023. The document evidenced the patient received HHA services. The document stated, "... Home Health Aide Care Plan: ... Patient recently diagnoses with disorientation ... Redirect client [patient] appropriately such as bathroom door, kitchen entrance, food choices, etc. ... constantly remind patient to slowly rise from chair/bed to minimize fall risk ... encourage use of assistive device, whenever possible ... ensure well-lit, clutter free walkway such as keeping cords secure ... removing throw rugs ... assist/prepare daily meals and assist with set up ... assist with bathing, dressing, personal care such as grooming, hair care,		are monitored and updated per their individual specific needs and touphold 100% regulatory standard of practice compliance scheduled to becompleted on 6/30/2023. The director of nursing is responsible for monitoringthis corrective action. **For clinical record review patent#4**, the director ofnursing immediately identified client affected by this deficiency and updatedclient plan of care to include when appropriate to encourage patient use ofassistive device (walker, cane, wheelchair), move from sitting to standing positionwith assistance, specific task/instructions, diet/nutritional requirementsordered by the client physician, when and how to perform client task andassistance with patient specific household task. Copy of the updated plan ofcare faxed to their physician for signature. Thedirector of nursing reviewed other client charts likely to impacted withdeficiency and updated/corrected their plan of to include required specificcare interventions and faxed to their	

	patient with light housekeeping ... such as ... vacuuming, changing bedding/linens, dishes, wiping down of surfaces, laundry, etc. ... [patient] is on 1500 cc [cubic centimeters] fluid restriction ... [patient] self-monitors ...." The plan of care/Aide care plan failed to evidence patient specific instructions/tasks for when it was appropriate for the HHA to redirect the patient; if the patient needed contact assistance or an assistive device when transferring from sitting to standing; what assistive device or when the HHA should encourage the patient to use it; which meals to prepare, how often, or what type of assistance was needed; patient specific personal care tasks, or how often to provide them; patient specific household tasks, or how often to perform them; or HHA to monitor fluid intake due to recent diagnosis of disorientation. Clinical record review evidenced a comprehensive reassessment (recertification of services) dated 2/02/2023. The document evidenced the patient lived alone, had tooth or mouth problems that made it hard to		various physicians for signature anddocumented in their charts. Thedirector of nursing will audit all client charts every 60-day recertificationperiod to ensure updated client health status and specific tasks/interventionsneeded are well documented and fax to their physician for signature to ensurethis deficiency doesn't not recur. 50% ofclient medical records will be quarterly reviewed to ensure all clients plan ofcares are monitored and updated per their individual specific needs and touphold 100% regulatory standard of practice compliance scheduled to becompleted on 6/30/2023. The director of nursing is responsible for monitoringthis corrective action. **For clinical record review patent#5**, the director ofnursing immediately identified client affected by this deficiency and updatedclient plan of care to include when appropriate to encourage patient use ofassistive device (walker, cane, wheelchair), move from sitting to standingposition	

	eat, ate fewer than 2 meals per day, ate few fruits, vegetables, or milk products, ate alone most of the time, and was a high nutritional risk. The plan of care/Aide care plan evidenced HHA provided services for 4 hours on Mondays, 8 hours on Tuesdays/Thursdays, and 6 hours on Wednesdays/Fridays; but failed to evidence patient specific instructions/tasks to encourage the patient to increase nutritional intake, encourage a well balanced diet to include fruits, vegetables and dairy products, or if the patient required a mechanically altered diet (chopped, pureed) due to tooth or mouth problems that made it hard to eat. During an interview on 2/14/2023 at 3:35 PM, the Clinical Manager indicated the plan of care/Aide care plan was not patient specific. 5. Clinical record review for Patient #4 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023. The document evidenced the patient received HHA services. The document		with assistance, specific task/instructions, diet/nutritionalrequirements ordered by the client physician, when and how to perform clienttask(provision for toileting), and assistance with patient specific householdtask. Copy of the updated plan of care faxed to their physician for signature. Thedirector of nursing reviewed other client charts likely to impacted withdeficiency and updated/corrected their plan of to include required specificcare interventions and faxed to their various physicians for signature anddocumented in their charts. Thedirector of nursing will audit all client charts every 60-day recertificationperiod to ensure updated client health status and specific tasks/interventionsneeded are well documented and fax to their physician for signature to ensurethis deficiency doesn't not recur. 50% ofclient medical records will be quarterly reviewed to ensure all clients plan ofcares are monitored and updated per their individual specific needs	

	Care Plan: ... Encourage [patient] to participate in his care at all times ... encourage use of assistive device, whenever possible ... ensure well-lit, clutter free walkway such as keeping cords secure ... removing throw rugs ... assist/prepare daily meals and set up ... assist with bathing, dressing, personal care such as grooming, hair care, shampoo, oral care ... assist patient with light housekeeping ... such as ... vacuuming, changing bedding/linens, dishes, wiping down of surfaces, laundry, etc. ...." The plan of care/Aide care plan failed to evidence patient specific instructions/tasks for what specific care the HHA was to encourage the patient to participate; what assistive device or when the HHA should encourage the patient to use it; which meals to prepare, how often, or what type of assistance was needed; patient specific personal care tasks, or how often to provide them; or patient specific household tasks, or how often to perform them. Clinical record review evidenced a comprehensive reassessment (recertification of services)		and touphold 100% regulatory standard of practice compliance scheduled to becompleted on 6/30/2023. The director of nursing is responsible for monitoringthis corrective action. **For clinical record review patent#6**, the director ofnursing immediately identified client affected by this deficiency and updatedclient plan of care to include when appropriate to encourage patient use ofassistive device (walker, cane, wheelchair), move from sitting to standingposition with assistance, specific task/instructions, diet/nutritionalrequirements ordered by the client physician, when and how to perform clienttask(provision for toileting), and assistance with patient specific householdtask. Copy of the updated plan of care faxed to their physician for signature. Thedirector of nursing reviewed other client charts likely to impacted withdeficiency and updated/corrected their plan of to include required specificcare interventions and faxed to their various physicians for signature	

	evidenced the patient lived alone, ate fewer than 2 meals per day, ate few fruits, vegetables, or milk products, ate alone most of the time, and was a high nutritional risk. The plan of care/Aide care plan evidenced HHA provided services for 3 hours per day, 5 days per week; but failed to evidence patient specific instructions/tasks to encourage the patient to increase nutritional intake, or encourage a well balanced diet to include fruits, vegetables and dairy products. During an interview on 2/14/2023 at 2:44 PM, the Clinical Manager indicated all the patients' plans of care looked the same because all the patients wanted basic ADL's (activities of daily living). The Clinical Manager confirmed "such as" meant it was an example, not an actual order specific to the patient. When queried if each patient's plan of care included patient-specific interventions, the Clinical Manager stated, "... Probably not ....", and indicated the plans of care were generic because they were all HHA only patients.		anddocumented in their charts. Thedirector of nursing will audit all client charts every 60-day recertificationperiod to ensure updated client health status and specific tasks/interventionsneeded are well documented and fax to their physician for signature to ensurethis deficiency doesn't not recur. 50% ofclient medical records will be quarterly reviewed to ensure all clients plan ofcares are monitored and updated per their individual specific needs and touphold 100% regulatory standard of practice compliance scheduled to becompleted on 6/30/2023. The director nursing is responsible for monitoring thiscorrective action. **For clinical record review patent#7,** Agency unable tocorrect this deficiency because patient expired.	

	1. Record review evidenced an undated agency policy obtained 2/14/2023, titled “Home Health Aide Plan of Care” which stated, “… The home health aide cannot be responsible for performing any procedure that is not assigned to him/her inwriting by the registered nurse/therapist or that is beyond his/her ability … The home health aide tasks must be related to the physical care needs of the client ….” 6. Clinical record review for Patient #5 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023. The document evidenced the patient received HHA services. The document stated, "... Aide: Monitor patient at all times ... encourage use of assistive devices whenever possible ... ensure well-lit, clutter free walkway such as keeping cords secure ... removing throw rugs ... assist/prepare daily meals and set up ... assist with feeding whenever possible ... assist with bathing, dressing, personal care such as grooming, hair care, shampoo, oral care ... assist patient with light housekeeping			

	... such as ... vacuuming, changing bedding/linens, dishes, wiping down of surfaces, laundry, etc. ...." The plan of care/Aide care plan failed to evidence patient specific instructions/tasks for how often or what the HHA was to monitor for; what assistive devices or when the HHA should encourage the patient to use them; which meals to prepare, how often, or what type of assistance was needed; patient specific personal care tasks, or how often to provide them; or patient specific household tasks, or how often to perform them. Clinical record review evidenced a comprehensive reassessment (recertification of services) dated 1/9/2023. The document evidenced the patient was dependent for toileting, grooming, and showering. The plan of care/Aide care plan failed to evidence patient specific instructions/tasks for provision of toileting, grooming, or showering needs. 7. Clinical record review for Patient #6 was completed on 2/14/2023. Record review			

	certification period 2/5/2023 – 4/5/2023. The document evidenced the patient received HHA services. The document stated, "... Aide: Monitor patient at all times ... encourage use of assistive devices whenever possible ... ensure well-lit, clutter free walkway such as keeping cords secure ... removing throw rugs ... assist/prepare daily meals and set up ... assist with feeding whenever possible ... assist with bathing, dressing, personal care such as grooming, hair care, shampoo, oral care ... assist patient with light housekeeping ... such as ... vacuuming, changing bedding/linens, dishes, wiping down of surfaces, laundry, etc. ...." The plan of care/Aide care plan failed to evidence patient specific instructions/tasks for how often or what the HHA was to monitor for; what assistive devices or when the HHA should encourage the patient to use them; which meals to prepare, how often, or what type of assistance was needed; patient specific personal care tasks, or how often to provide them; or patient specific household tasks, or how often to perform them.			

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 and interview, the home health agency failed to ensure home health aides (HHA) provided services which were ordered on the plan of care; and/or provided HHA services which were not covered under the Indiana Health Coverage Programs (IHCP) home health benefit, in 6 of 7 clinical records reviewed. (#1, 2, 3, 4, 5, 6) The findings include: 4. Clinical record review for Patient #1 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023, which evidenced Home Health Aide (HHA)	G0800	**G0800** **Forclinical record review patients #5,6,2,4:** The director ofnursing immediately revised plan of care of the affected clients Not to includemedication pick up from the pharmacy, grocery shopping, and transportation todoctor's appointments, bank, running errands for the patients and faxed totheir physicians for signature and logged them in their various charts. The director of nursing reviewed allclients charts likely to impacted with this deficiency and corrected them. Thedirector of nursing reached out to all the clients vis phone calls, and directmessages through their assigned aides that services of grocery shopping, pharmacypick-up, and transportation to doctors appointment will no longer be providedper Indiana health coverage programs policy with immediate effect. The administrator instructedsupporting staff to in-service all active home health aides not to renderservices no longer approved by IHCP to ensure 100% compliance with the state. The agency supporting staff will calland email active aides assigned to their clients' homes not to render servicesnot approved by the state. The	2023-06-30

	included the HHA Care Plan. The document failed to evidence the HHA tasks included obtaining vital signs (one or more: temperature, pulse, breaths per minute, blood pressure). Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/04/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, and 2/10/2023 all evidenced the HHA took the patient's temperature, pulse, and blood pressure. The home health aide provided services not included on the plan of care. During an interview on 2/14/2023 at 2:04 PM, the Clinical Manager indicated orders for the HHA to take vital signs should be on the plan of care. 5. Clinical record review for Patient #2 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023. The document evidenced the patient received home health aide (HHA) services, primary diagnosis was		director of nursing will reiterate during30/60-day supervisory visits that pharmacy pick-up, grocery shopping, andtransportation to the doctor's office, banks, and running errands for thepatient must not be rendered as it is no longer approved by the state. 50% ofclient medical records will be quarterly reviewed to ensure all client's plansof care are monitored and updated and services discontinued are not rendered touphold 100% regulatory standard of practice compliance scheduled to becompleted on 6/30/2023. The director of nursing is responsible for monitoringthis corrective action. **For clinicalrecord review patients # 1,3:** Thedirector of nursing reviewed these patients' charts and revised their plan ofcare to include vital signs. The director of nursing faxed the revised plan ofcare to the patient's physicians for signature and logged them in their charts. The director of nursing reviewed all clients'charts likely to be impacted by this	

	diabetes, had a urinary catheter (a tube inserted into the bladder to drain urine), and the HHA was to assist with grocery shopping and pharmacy pick up, which was not permitted to be performed under Indiana State law; failed to evidence the HHA tasks included obtaining vital signs, shave the patient, or perform nail and foot care, and stated, "... Aide: Do not perform catheter care at all ...." Clinical record review evidenced a HHA visit dated 2/04/2023, which evidenced the HHA took the patient's vital signs (temperature, pulse, respirations, and blood pressure). The home health aide provided services not included on the plan of care. Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/04/2023, 2/05/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, 2/10/2023, 2/11/2023, and 2/12/2023, which all evidenced the HHA took the patient's vital signs, provided catheter care, shaved the patient, and performed nail and foot care. The home health aide provided		deficiency, and revised their plan of careto include vital signs and faxed them to their various physician for signatureand d logged them in their charts. Thedirector of nursing will subsequently review all client s charts every 60 daysto ensure all pertinent patient care interventions are documented accordinglyand faxed to their physician for signature and logged them in their variouscharts. Quarterlyreview of 50% of client medical records will be implemented to ensure 100%compliance, and to avoid this deficiency from happening again. The director ofnursing is responsible for monitoring this corrective action schedule to becompleted on 6/30/2023.	

	services not included on the plan of care. Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/05/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, 2/10/2023, all evidenced the home health aide grocery shopped for the patient. The home health aide provided services not permitted under Indiana State law. 6. Clinical record review for Patient #3 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023. The document evidenced the patient received HHA services, and the HHA was to assist with grocery shopping and pharmacy pick up, which was not permitted to be performed under Indiana State law; and failed to evidence the HHA tasks included obtaining vital signs. Clinical record review evidenced a HHA visit dated 2/02/2023, which evidenced the HHA grocery shopped for the patient, and took the patient's temperature and blood			

	pressure. The home health aide provided services not included on the plan of care, and provided services not permitted under Indiana State law. Clinical record review evidenced HHA visits dated 2/06/2023, 2/07/2023, and 2/09/2023, which all evidenced the HHA took the patient's blood pressure. The home health aide provided services not included on the plan of care. Clinical record review evidenced a HHA visit dated 2/08/2023, which evidenced the HHA grocery shopped for the patient, and obtained the patient's blood pressure. The home health aide provided services not included on the plan of care, and provided services not permitted under Indiana State law. During an interview on 2/14/2023, the Clinical Manager confirmed the plan of care failed to evidence the HHA was tasked to obtain vital signs. 7. Clinical record review for Patient #4 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/11/2023 –			

	4/11/2023. The document evidenced the patient received HHA services, the HHA was to assist with grocery shopping and pharmacy pick up, which was not permitted to be performed under Indiana State law; and failed to evidence the HHA tasks included obtaining vital signs. Clinical record review evidenced HHA visits dated 2/01/2023, 2/02/2023, 2/03/2023, 2/06/2023, 2/07/2023, 2/08/2023, 2/09/2023, and 2/10/2023, which all evidenced the HHA took the patient's vital signs (temperature, pulse, respirations, and blood pressure). The home health aide provided services not included on the plan of care. Clinical record review evidenced HHA visits dated 2/02/2023 and 2/09/2023, which evidenced the HHA grocery shopped for the patient. The home health aide provided services not permitted under Indiana State law. 8. During an interview on 2/14/2023 at 2:04 PM, the Clinical Manager indicated the plan of care was also the HHA care plan (the same document).			

	9. During an interview on 2/14/2023 at 2:44 PM, the Clinical Manager indicated home health aides were allowed to run errands for the patients, if groceries were needed, the patient would call ahead (to the store) and get the exact amount due, and would write a check for the aide to take to the store. 1. Record review evidenced an undated agency policy obtained 2/14/2023, titled "Home Health Aide Plan of Care" which stated, "... The home health aide cannot be responsible for performing any procedure that is not assigned to him/her inwriting by the registered nurse/therapist or that is beyond his/her ability ... The home health aide tasks must be related to the physical care needs of the client ...." 2. Clinical record review for Patient #5 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 1/13/2023 –			

	3/13/2023, which indicated the home health aide was to assist with grocery shopping, and pharmacy pick up, which was not permitted o be performed under Indiana State law. 3. Clinical record review for Patient #6 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/5/2023 – 4/5/2023, which indicated the home health aide was to assist with grocery shopping, and pharmacy pick up, which was not permitted to be performed under Indiana State law. During an interview on 2/14/2023, at 2:50 PM, clinical manager #1 indicated the home health aides were allowed to and encouraged to pick up groceries and pharmaceuticals for patients who lived alone.			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations	G0948	**G0948** The Administrator reviewed the job descriptionof an administrator and immediately	2023-06-30

	of the HHA; Based on record review and interview, the Administrator failed to be responsible for all day-to-day operations of the home health agency. The findings include: Record review of an undated agency policy obtained on 2/14/2023, titled "Job Description of Administrator", evidenced the Administrator oversaw all aspects of the agency, ensured compliance with federal and state regulations, and ensured all departments complied with the current healthcare laws and regulations. The home health agency failed to ensure the plan of care was reviewed and revised when a resumption of care assessment was conducted (Please see tag G0586). The Administrator failed to ensure the Registered Nurse (RN) provided a patient-specific Home Health Aide (HHA) care plan (Please see tag G0798). The home health agency failed to ensure home health aides provided services which were		Nursing to briefhim daily on the overall clinical activities regarding patient care services,coordination of patient care, revision of plan of care, patient-specific homehealth aide care plan, and ensuring aides are providing services as ordered intheir plan of care to adhere to the state law and ensuring this deficiency doesnot recur. On 5/9/2023, the administratorinstructed support staff to compile updated lists of all active patients,assigned aides, and services provided and other agencies providing services tothe same agency’s patients, physicians, and other health care professionalsinvolved in the patient’s care and forward them to him to ensure services arerendered as ordered. The Administrator will develop and maintaina comprehensive patient census list, and 50% of chart reviews will be conductedquarterly by the administrator detailing all the services the patients arereceiving as ordered by their physicians. The administrator is responsible forthis corrective action to	

	ordered on the plan of care and/or permitted by State law (Please see tag G0800). The Administrator failed to ensure the Clinical Manager provided oversight of all patient care services (Please see tag G0958). The home health agency failed to ensure the Clinical Manager coordinated patient care (Please see tag G0962). During an interview on 2/13/2023 at 9:45 AM, the Administrator indicated he was also a member of the Governing Body. During an interview on 2/14/2023 at 2:00 PM, the Administrator indicated the agency's policies weren't updated to include current state and federal regulations; he was unaware the regulations were changed/revised, and his policies were from 2011 when he bought them. During an interview on 2/14/2023 at 3:52 PM, the Administrator indicated he was unaware Home Health Aide's weren't allowed to run errands		ensure 100% compliance. The administrator willmonitor this corrective action scheduled to be completed on 6/30/2023 to ensurethat this deficiency is corrected and will not recur.	

	shopping needs.			
G0958	Clinical manager 484.105(c) Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following-- Based on record review and interview, the Clinical Manager failed to provide oversight of all patient care services. The findings include: Record review of an undated job description obtained 2/14/2023, titled "Job Description for Director of Nursing [Clinical Manager]", evidenced the Clinical Manager was was responsible to ensure services were delivered in compliance with State and Federal regulations, and assignment of agency personnel. Review of Indiana Health Coverage Programs policies and procedures manual, effective date May 1, 2022, stated, "... the Indiana Health Coverage	G0958	**G0958** A copy of the clinical manager jobdescription was reviewed for a better understanding of what it entails. TheAdministrator in-serviced the clinical manager in adhering to the jobdescription related to overseeing all patient care services. The clinicalmanager immediately revised the plan of care for the affected clients Not includingmedication pick up from the pharmacy, grocery shopping, transportation todoctor's appointments, bank, running errands for the patients to meet IHCPregulatory standards, and faxed to their physicians for signature and loggedthem in their various charts. The clinical manager further reviewedall clients' charts likely to be impacted by this deficiency and corrected themper her job description. The clinical manager reached out to all the clients viaphone calls, and direct messages through their assigned aides and educated themthat services	2023-06-30

	Programs [IHCP] defines 'home health services' as services provided on a part-time and intermittent basis to Medicaid members of any age in the member's place of residence ... The following services are not covered under the home health benefit ... Transporting the member to grocery stores, pharmacies, banks and so forth ... Homemaker services (including shopping, laundry, cleaning, meal preparation and so on) ... Chores (including picking up prescriptions and running other errands) ...." During an interview on 2/14/2023 at 2:44 PM, the Clinical Manager indicated home health aides were allowed to run errands for the agency's patients as part of the visit. Running errands for patients is not covered under the Indiana Health Coverage Programs (IHCP) home health benefit. During an interview on 2/13/2023 at 2:39 PM, the Clinical Manager indicated she didn't make staff/patient schedules, Person #10 (agency Secretary) made patient schedules, if changes to		of grocery shopping, pharmacy pick-up, and transportation to doctor'sappointments, bank, and running errands will no longer be provided per IHCP regulatorystandard effective immediately. The clinical manager will periodicallyreview her job description to ensure oversight of all patient services. Theadministrator will periodically conduct a performance evaluation for all staff bytheir respective job description. This will ensure 100% compliance. The Administrator will be responsiblefor and monitor this corrective action scheduled to be completed on 6/30/2023 to ensure thatthis deficiency is corrected and will not recur.	

	#10 approved them, and Person #10 confirmed she approved any scheduling changes. The Clinical Manager indicated any changes to the schedule were between the aide and the patient.			
G0962	Coordinate patient care 484.105(c)(2) Coordinating patient care, Based on record review and interview, the home health agency failed to ensure the clinical manager coordinated patient care in 1 of 1 clinical records reviewed with a referral for services. (#7) The findings include: Record review on 12/13/2022, evidenced a director of nursing job description signed by clinical manager #2 on 8/18/2011, which stated, "... The director of nursing coordinates care with the interdisciplinary team, patient/family and	G0962	**G0962** Agency unable to correct thisdeficiency because the patient passed away. Agencyimmediately reviewed other patient's charts likely to be affected by thisdeficiency and updated their charts to include services/therapy received fromother agencies providing care for the same client. The clinical manager further called the patient'sfamily/agency to ensure referrals from the hospital/physician's office arefollowed up and initial contact/SOC for the services ordered for the patientare being provided. The clinical manager will fax care coordination to the agencyproviding services to the client as ordered. This will ensure both agencies areaware of the services patient is receiving as ordered by the physician.	2023-06-30

	coordinates clinical departments; assumes responsibility for continuity, quality, and safety of services delivered in compliance with State and Federal regulations…." Clinical record review for Patient #7 was completed on 2/14/2023, for certification period 1/13/2023 – 3/13/2023. Record review evidenced a resumption of care assessment dated 1/26/2023, which indicated the patient was a high fall risk and should have received a referral to physical and/or occupational therapy. Clinical record review failed to evidence the patient ever received a referral or consult for therapy services. During an interview on 2/14/2023, at 4:27 PM, the Clinical Manager indicated the patient had received a therapy referral after hospital discharge. The Clinical Manager indicated they were unsure if the patient		The clinical manager will subsequentlyreview client's charts every 60 days and during supervisory visits from patient/familyto ensure patient is receiving services as ordered. This will be documented inthe client chart and reported to the client physician for signature for recordpurposes. Quarterly review of 50% of clientmedical records will be implemented to ensure 100% compliance, and to avoidthis deficiency from happening again. The clinical manager is responsible formonitoring this corrective action schedule to be completed on 6/30/2023.	

	services yet, or what the plan was for therapy. The Clinical Manager indicated they did not document any communication with the patient about therapy services. The Clinical Manager did not know what company was supposed to provide the therapy services.			
N0000	Initial Comments This visit was revisit for a State relicensure survey. Survey Dates: 2/13/2023 and 2/14/2023 Facility ID: 012812 Census: 11 Unduplicated admissions: 12	N0000		
N0533	Nursing Plan of Care 410 IAC 17-13-2 Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health	N0533	**N0533** For clinical records review **# 5, 6, 1, 2, 3& 4,**the director of nursing immediately reviewed affected clients' records, and 60-daysummaries and duration of services provided to the client were corrected tomeet the regulatory requirements of the client's Plan of care. The Director of Nursing immediately reviewedall active	2023-06-30

	aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. Based on record review and interview, the home health agency failed to ensure the clinical record for home health aide only patients included 60 day summaries, and/or frequency or duration of services to be provided in 6 of 7 active clinical records reviewed (#1, 2, 3, 4, 5, 6). The findings include: 3. Clinical record review for		patients' charts ensuring 60-day summaries and duration of servicesprovidedreflect the patient's current plan of care(485) and faxed them to their physicians. TheDirector of Nursing will review all patient's charts quarterly to ensure 100%compliance with the 60-day summary and duration of service standards are met. TheDirector of Nursing will be responsible for monitoring this corrective action scheduledto be completed 6/30/2023 to ensure compliance. This will ensure thisdeficiency will not recur.	

	2/14/2023 (start of care date 1/13/2023). Record review evidenced a plan of care for certification period 1/13/2023 – 3/13/2023. The document evidenced Home Health Aide (HHA) services were ordered 6 hours per day, 5 days per week, but failed to evidence the duration of the services; and Skilled Nursing (SN) was ordered, but failed to evidence frequency or duration of the service. 4. Clinical record review for Patient #2 was completed on 2/14/2023 (start of care date 7/29/2019). Record review evidenced a plan of care for certification period 1/09/2023 – 3/09/2023, which evidenced the HHA was ordered 7 days per week, but failed to evidence the duration of the services; SN was ordered, but failed to evidence frequency or duration of the service; and failed to evidence a 60 day summary. 5. Clinical record review for Patient #3 was completed on 2/14/2023 (start of care date 12/14/2021). Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023, which evidenced the			

	HHA was ordered Monday - Friday, but failed to evidence the duration of the services; SN was ordered, but failed to evidence frequency or duration of the service; and failed to evidence a 60 day summary. 6. Clinical record review for Patient #4 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/07/2023 – 4/07/2023, which evidenced the HHA was ordered 5 days per week, but failed to evidence the duration of the services; SN was ordered, but failed to evidence frequency or duration of the service; and failed to evidence a 60 day summary.			

1. Clinical record review for Patient #5 was completed on 2/14/2023. Record review evidenced a home health aide nursing care plan for certification period 1/13/2023 – 3/13/2023, which failed to include a 60-day summary. This document failed to include the frequency of home health aide interventions including assisting with meal preparation, bathing, dressing, grooming, housekeeping, and medication reminders.

During an interview on 2/14/2023, at 2:27 PM, clinical manager #1 indicated the agency only did 60-day summaries for skilled nursing patients, and it would have been documented under the care plan. Clinical manager #1 indicated at 3:17 PM, home health aides were supposed to complete every intervention on the plan of care every visit.

2. Clinical record review for Patient #6 was completed on 2/14/2023. Record review evidenced a plan of care for certification period 2/5/2023 – 4/5/2023, which indicated the home health aide was to

	bathing, dressing, grooming, housekeeping, and medication reminders, but failed to specify how frequently these tasks were to be performed.			

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
Willy Okwara	Administrator	6/16/2023 12:53:59 PM