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	07/11/2023

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: 7/7/2023, 7/10/2023, and 7/11/2023 Facility ID: 12812	E0000		
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: 7/7/2023, 7/10/2023, and 7/11/2023 Current Census: 12 Unduplicated admissions for the last 12 months: 16	G0000		

	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 CFR §484.60 Care Planning, Coordination of Care and Quality of Care, and 42 CFR §484.65 Quality Assessment and Performance Improvement. During the 7/11/2023 survey 2 condition-level deficiencies were resolved: 42 CFR §484.80 Home health aide services and 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. Also during this survey, 8 standards were corrected, 7 standards were re-cited, and 1 new standards were cited. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed 07/18/2023			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary	G0564	**G0564** **Clinical recordreview patient #1,** the agencyimmediately reviewed its policy on Discharge	2023-07-24

	content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge 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 transfer/discharge summaries included all the required information in 1 of 1 transfer record reviewed. (Patient #1) The findings include: Record review on 7/12/2023, 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 ...." Clinical record review for Patient #1 was completed on 7/11/2023, for certification period 5/12/2023 - 7/10/2023. Record review evidenced a transfer summary dated		TreatmentPreferences and other pertinent information related to discharge summaryincluding but not limited to the reason for admission, significant findings,diagnosis, medications, client condition at discharge, follow-up instructions,etc. when a patient is discharged from home health agency. Agency reviewed other client's charts who maybe likely affected by this deficiency and initiated corrections on these likelyaffected clients to ensure compliance with the state/federal regulations. The agency will audit 50% of the patient'sclinical records quarterly and during the discharge of a patient to ensure itcontains pertinent information needed on discharge. This will prevent thisdeficiency from reoccurring again and ensure 100% compliance. The Director of Nursing is responsiblefor monitoring this corrective action scheduled to be implemented on 8/31/23and to abide by state/federal regulations.	

	7/3/2023, which failed to include information regarding the patient's treatment preferences. During an interview on 7/11/2023, at 10:50 AM, the Clinical Manager indicated the system auto generated the transfer summary, and whatever information was generated goes on the transfer summary. The Clinical Manager indicated the transfer summary should have the treatment preferences on it.			
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 ordered in the plan of care in 4 of 4 clinical	G0572	**G0572** For clinical record reviewof patient #1, the agency immediatelyidentified patient affected with this deficiency and reviewed the patient'shome health aide Plan of Care. The director ofnursing called the aide assigned to care for the patient with this deficiencyand Re-in-serviced aide again on the importance of documenting in their notes thehands-on care rendered to the client including but not limited to bathing,wearing briefs, meal preparation, and feeding, dressing, brushing client'steeth, comb hair, etc. and staying to the duration of their scheduled hours ofcare to address patient needs and toensure that this deficiency does not reoccur. The director of nursing instructed officestaff to	2023-07-24

	records reviewed. (Patient #1, 2, 3, 4) 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 7/11/2023. Record review evidenced a plan of care for certification period 5/12/2023 - 7/10/2023, which indicated the patient was to receive 6 hours of home health aide services 5 days per week, Monday through Friday. The plan of care indicated the home health aide would assist/prepare daily meals and set up, assist the patient with feeding, assist patient with dressing, change bed linens, empty catheter bag, and remind patient to take their medications. Record review evidenced a home health aide visit note		printing them out forfiling to ensure all hands-on care rendered to the client assigned to them isproperly documented in their aide's note prior to printing them out for filing.The director of nursing further instructed office staff to **reject** anyhome health aide's notes without proper documentation. This will ensure homehealth aides' accountability and compliance with the regulatory requirements. The director of nursing will audit 50% of all clients'charts quarterly ensuring proper documentation of home health aide care asoutlined in the client's individualized plan of care. Homehealth aides will receive phone calls on a regular basis reminding them todocument the hands-on care rendered to their clients. Thedirector of nursing will be responsible for monitoring this corrective actionscheduled to be completed on 8/31/2023 to ensure 100% compliance and avoid itsreoccurrence. **Forclinical record review for patient #2,** the agency immediately identifiedpatient affected by this deficiency and reviewed the patient's home health aidePlan of Care. The director ofnursing called the aide assigned to care for the patient with this deficiencyand Re-in-serviced aide again on the importance of documenting in their notes thehands-on care	

	dated 7/1/2023, which indicated the home health aide failed to assist with meals, assist with feeding, assist with dressing, change bed linens, and remind the patient to take their medications. Record review evidenced a visit note dated 7/5/2023, which indicated the patient received a home health aide visit from 7:00 AM until 12:00 PM (5 hours). During an interview on 7/10/2023, at 9:35 AM, the Clinical Manager indicated the home health aide was only able to complete 5 hours of a visit on 7/5/2023. The Clinical Manager indicated the patient should receive the hours as ordered on the plan of care. At 11:08 AM, the Clinical Manager indicated the home health aide should have performed all the tasks on the plan of care. 3. Clinical record review for Patient #2 was completed on 7/11/2023. Record review evidenced a plan of care for certification period 5/13/2023 - 7/11/2023, which indicated the home health aide was to take vital signs during visits, ensure the patient had a brief on prior		rendered to the client including but not limited to bathing,ensuring the patient wears briefs prior to getting on the bus, mealpreparation, and feeding, medication reminders, dressing, brushing client'steeth, comb hair, etc. toaddress patient needs and to ensure that this deficiency does not reoccur. The director of nursing has reached out to the patient'sfamilies and in-serviced home health aides that **vital signs will No longerbe taken daily** on all stable patients except if there's an immediatemedical necessity and it's ordered by their physicians with reporting notificationparameters. The director of nursing instructed office staff to go through allhome health aide notes prior to printing them out for filing to ensure allhands-on care rendered to the client assigned to them is properly documented intheir aide's note prior to printing them out for filing. The director ofnursing further instructed office staff to **reject** any home health aide'snotes without proper documentation. This will ensure	

	to getting on the bus, assist patient with bathing, and give verbal medication reminders each visit. The plan of care indicated the home health aide was to call the office if the temperature was below 96 degrees. Record review evidenced home health aide visit notes dated 6/30/2023, 7/3/2023, and 7/5/2023, which all failed to evidence the home health aide ensured the patient had a brief on prior to getting on the bus, assisted with bathing, and gave verbal medication reminders. These visit notes all had the following vital signs: pulse - 80, blood pressure -123/80, and temperature - 95. Record review failed to evidence any communication notes or documentation which indicated the home health aide called the office to notify of the temperature of 95 degrees as ordered on the plan of care. During an interview on 7/11/2023, at 11:34 AM, the Clinical Manager indicated the home health aides should have been performing tasks as were ordered on the plan of care. The		home health aides'accountability and compliance with the regulatory requirements. The director of nursing will audit 50% of all clients'charts quarterly ensuring proper documentation of home health aide care asoutlined in the client's individualized plan of care. Home health aides willreceive phone calls on a regular basis reminding them to document the hands-oncare rendered to their clients. Thedirector of nursing will be responsible for monitoring this corrective actionscheduled to be completed on 8/31/2023 to ensure 100% compliance and avoid itsreoccurrence. **For clinical record reviewfor patient #3,** the agency immediatelyidentified patient affected with this deficiency and reviewed the patient'shome health aide Plan of Care. The director of nursing called the aideassigned to care for the patient with this deficiency and Re-in-serviced aideagain on the importance of documenting in	

	Clinical Manager indicated the home health aide was probably not checking the vital signs during visits, and copied the vitals from their assessment. 4. Clinical record review for Patient #3 was completed on 7/11/2023. Record review evidenced a plan of care for certification period 7/1/2023 - 8/29/2023, which indicated the home health aide was to assist the patient to turn every 2 hours, assist with meals and feeding, perform grooming assistance, change bed linens, wash dishes, and give verbal medication reminders. Record review evidenced a home health aide visit note dated 7/1/2023, which failed to evidence the home health aide turned the patient every 2 hours, assisted with meals and feeding, performed grooming assistance, changed bed linens, washed dishes, and gave verbal medication reminders as ordered on the plan of care. During an interview on 7/11/2023, at 1:19 PM, the Clinical Manager indicated if the home health aide did not perform the tasks on the plan of		carerendered to the client including but not limited to bathing, Turning PatientEvery 2 Hours, meal preparation, and feeding, Perform Grooming assistance, washdishes, medication reminders, dressing, brushing client's teeth, comb hair,etc. to address patient needs and to ensure that this deficiency does notreoccur. The director of nursing has reachedout to the patient's families and in-serviced home health aides that **vitalsigns will No longer be taken daily** on all stable patients except ifthere's an immediate medical necessity and it's ordered by their physicianswith reporting notification parameters. The director of nursing instructed officestaff to go through all home health aide notes prior to printing them out forfiling to ensure all hands-on care rendered to the client assigned to them isproperly documented in their aide's note prior to printing them out for filing.The director of nursing further instructed office staff to reject any homehealth aide's notes without proper documentation. This will ensure home healthaides' accountability and	

	care they would be blank on the visit note. The Clinical Manager indicated maybe the patient did not want the home health aide to perform these tasks. 5. Clinical record review for Patient #4 was completed on 7/11/2023. Record review evidenced a plan of care for certification period 5/27/2023 - 7/25/2023, which indicated the home health aide was to assist with dinner, encourage use of cane, assist with bath/shower, dressing, shampoo hair, comb hair, take vital signs and give verbal medication reminders. Record review evidenced home health aide visit notes dated 6/30/2023, and 7/3/2023, which failed to evidence the home health aide performed a temperature, bath/shower, dressing, shampooed hair, combed hair, gave verbal medication reminders, encouraged the use of cane, and assisted with dinner. During an interview on 7/11/2023, at 1:30 PM, the Clinical Manager indicated the home health aide should have been performing all the tasks on the plan of care.		compliance with the regulatory requirements. The director of nursing will audit 50%of all clients' charts quarterly ensuring proper documentation of home healthaide care as outlined in the client's individualized plan of care. Home healthaides will receive phone calls on a regular basis reminding them to documentthe hands-on care rendered to their clients. The director of nursing will be responsiblefor monitoring this corrective action scheduled to be completed on 8/31/2023 toensure 100% compliance and avoid its reoccurrence. **Forclinical record review for patient #4,** the agency immediately identifiedpatient affected with this deficiency and reviewed the patient's home healthaide Plan of Care. The director ofnursing called the aide assigned to care for the patient with this deficiencyand Re-in-serviced aide again on the importance of documenting in their notes thehands-on care rendered to the client including but not limited to bathing,Assist	

	410 IAC 17-13-1(a)		with Dinner, encouraging use of Cane, wash patient dishes only afterdinner, medication reminders, dressing, brushing client's teeth, comb hair,etc. toaddress patient needs and to ensure that this deficiency does not reoccur.	

			The director of nursing has reached out to thepatient's families and in-serviced home health aides that **vital signs willNo longer be taken daily** on all stable patients except if there's animmediate medical necessity and it's ordered by their physicians with reportingnotification parameters. The director of nursing instructed office staff to gothrough all home health aide notes prior to printing them out for filing toensure all hands-on care rendered to the client assigned to them is properlydocumented in their aide's note prior to printing them out for filing. Thedirector of nursing further instructed office staff to **reject** any homehealth aide's notes without proper documentation. This will ensure home healthaides' accountability and compliance with the regulatory requirements. The director of nursing will audit 50% of all clients'charts quarterly ensuring proper documentation of home health aide care asoutlined in the client's individualized plan of care. Home health aides willreceive phone calls on a	

			regular basis reminding them to document the hands-oncare rendered to their clients. Thedirector of nursing will be responsible for monitoring this corrective action scheduled to becompleted on 8/31/2023 to ensure 100% compliance and avoid its reoccurrence.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and	G0574	**G0574** **For clinical record review of patient #1,** the director of nursing reviewed the client affected by thisdeficiency plan of care and included Entity #1 home health agency provision ofPT, OT SN Wound Care in the plan of care. The director of nursing furtherupdated the patient plan of care to include Risk forHospitalization/Interventions, and Psychosocial information with the patientplan of care to ensure this deficiency will not reoccur again. Thedirector of nursing further reviewed other patients' charts likely to beimpacted by this deficiency and Initiated corrections to include pertinentinformation about another home health agency care provision, the risk forhospitalization/intervention, and psychosocial information in their plan ofcare reflecting their care interventions. This will be faxed to theirrespective physicians for	2023-07-24

	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. Based on record review and interview, the home health agency failed to ensure plans of care contained all the required elements in 4 of 4 clinical records reviewed. (Patient #1, 2, 3, 4) 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, treatments ... Medical supplies and equipment required ... Any safety measures to protect against injury ... Instructions to client/caregiver ...." 2. Clinical record review for Patient #1 was completed on 7/11/2023, for certification		medicalcharts. The director of nursingwill review and update clients' plan of care every sixty days to include allpertinent information regarding their care interventions and provisions fromanother home health agency. The director will randomly callpatients/caregivers, and during supervisory visits to inquire about any changesin patient status to be included in their plan of care and fax to theirphysician for signature. 50% of the client's records will be quarterly audited by thedirector of nursing that is responsible for monitoring this corrective actionto be completed by 8/31/2023to ensure 100% compliance and avoid its reoccurrence. **For clinicalrecord review of patient #2,** the director of nursing reviewed the clientaffected by this deficiency plan of care and updated the patient's Psychosocialinformation of whom the patient lives with, the caregiver, and	

	period 5/12/2023 - 7/10/2023. Record review evidenced a resumption of care assessment dated 7/5/2023, which indicated the patient was receiving home health services from Entity #1 (home health agency) for skilled nursing, physical therapy, and occupational therapy. This assessment identified the following risks for hospitalization: history of falls, unintentional weight loss of 10 pounds or more in the past 12 months, multiple hospitalizations, multiple emergency department visits, decline in mental, emotional, or behavioral status, reported or observed history of difficulty complying with medical instructions, taking 5 or more medications, and currently reports exhaustion. The resumption of care assessment included the following psychosocial information: unable to participate in own care, lack of willing and able caregiver, social isolation, and transportation needs. The resumption of care assessment indicated the patient lived with someone in the home, but they were not able or willing to provide the patient with assistance.		patientinformation on functional status in the community with the patient plan of careto ensure this deficiency will not reoccur again. Thedirector of nursing further reviewed other patients' charts likely to beimpacted by this deficiency and Initiated corrections to include pertinentinformation about psychosocial information in their plan of care reflectingtheir care interventions and faxed to their respective physicians for signatureand will be logged in the client's medical charts. The director of nursing will reviewand update clients' plan of care every sixty days to include all pertinentinformation regarding their care interventions. The director will randomly callpatients/caregivers, and during supervisory visits to inquire about any changesin patient status to be included in their plan of care and fax to theirphysician for signature. 50% ofthe client's records will be quarterly audited by the director of nursing thatis responsible for monitoring this corrective action to be completed by 8/31/2023 to ensure 100%compliance and	

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 revised and updated in 1 of 1 transfer records reviewed. (Patient #1) The findings include: Record review evidenced an undated agency policy obtained 7/12/2023, titled "Coordination of Client Services" which stated, "... Each 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 ..."	G0586	**G0586** The agency immediately reviewed itspolicy on patient medication administration and update the identified patientaffected with the deficiency plan of care and faxed it to the physician forsignature. The clinical manager audited other patients' charts likelyto be affected by this deficiency and updated their medication records toinclude any medication on hold/new and faxed it to their physicians forsignature and record purposes.	2023-07-24

	Clinical record review for Patient #1 was completed on 7/11/2023, for certification period 5/12/2023 - 7/10/2023. Record review evidenced a resumption of care assessment dated 7/5/2023, which indicated the patient discharged from the hospital on 7/5/2023, and was to hold the following medications for 1 week following hospital discharge: plavix (to prevent stroke and heart attack) and Xarelto (blood thinner). Record review evidenced a plan of care for certification period 5/12/2023 - 7/10/2023, which included orders for patient to take plavix and Xarelto. Record review failed to evidence the plan of care was updated after the hospital discharge to reflect the medications on hold. During an interview on 7/11/2023, at 10:42 AM, the Clinical Manager indicated they did not update the plan of care for 5/12/2023 - 7/10/2023, but they updated the plan of care for 7/11/2023 - 9/8/2023. At 11:01 AM, the Clinical Manager indicated they did not update the plan of care with the medication holds, because it		The clinical manager will subsequentlyreview all clients' charts every sixty days ensuring medications are updatedaccording to their physician's order and documented in their plan of care. Theclinical manager will randomly call patients, and during supervisory visits inquireabout any changes in their medications to be updated and faxed to theirphysician for signature and logged in their various charts. 50% ofclient medical records will be reviewed quarterly to ensure all client'smedications are monitored and updated per their individual specific physicianorder and to abide by regulatory standards of practice. The director of nursingis responsible for monitoring this corrective action to be completed by8/31/2023	

	would look like the order was discontinued.			
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 failed to provide a patient-specific home health aide care plan in 4 of 4 clinical records reviewed. (#1, 2, 3, 4) The findings include: 1. Record review evidenced an undated agency policy obtained 7/11/2023, 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	G0798	**G0798** For clinical record review patent#1, the director of nursing identified the client affected by thisdeficiency and updated the patient plan of care to include meal preparation ofBreakfast and Lunch, changing patient briefs when soiled /every 2 hours, Emptyfoley bag prior to the end of scheduled shift, Bathe client when in bed orsitting on bedside commode, Lotion body, and comb hair. A copy of the updatedplan of care was faxed to the physician for signature. The director ofnursing further reviewed other client charts likely to be impacted by thisdeficiency and updated/corrected their plan of care to include requiredspecific care interventions and faxed them to their various physicians forsignature and documented in their charts. The director of nursingwill audit all client charts every sixty days. The director of nursing willreach	2023-07-24

	related to the physical care needs of the client ….” 2. Clinical record review for Patient #1 was completed on 7/11/2023. Record review evidenced a home health aide plan of care for certification period 5/12/2023 - 7/10/2023, which indicated the home health aide was to encourage the use of assistive devices, but failed to specify which assistive devices. The plan of care indicated the home health aide was to assist/prepare daily meals, but failed to specify which meals the aide was to prepare/assist with. The plan of care indicated the patient wore briefs/diapers, but failed to include any directions to change the patient's briefs/diapers. The plan of care indicated the home health aide was to empty the urinary catheter bag, but failed to indicate the frequency or indication for when the home health aide was to empty the catheter. This plan of care indicated the home health aide was to assist with bathing, but failed to specify what kind of assistance the patient required while bathing. The plan of care indicated the home health aide		out to clients via phone calls and during supervisory visits to inquireabout any updated changes related to their health status. Any changes will bedocumented in their plan of care and faxed to their physician for signature toensure this deficiency doesn’t recur. Thedirector of nursing is responsible for quarterly chart audits of 50% of clientmedical records to ensure all client’s plans of care are monitored and updatedper their individual specific needs and to abide by the regulatory standard ofpractice compliance scheduled to be completed on 8/31/2023. **For clinical record review patent#2**, the director ofnursing identified the client affected by this deficiency and updated thepatient plan of care to include meal preparation of Breakfast, changing patientbriefs every 2 hours as needed, Bathe patient in the Tub or shower per patient/caregiverpreference, Lotion body, and comb hair, and verbally remind the patient to takemedication as scheduled. A copy of the updated plan of care was faxed to thephysician for signature. Thedirector of nursing further reviewed other client charts likely to be impactedby this deficiency and	

	was to assist with grooming, but failed to specify what type of grooming the patient required assistance with. During an interview on 7/11/2023, at 10:26 AM, the Clinical Manager indicated the home health aide was supposed to empty the catheter bag when it was full. The Clinical Manager indicated the plan of care should have specified the assistive device was a walker and wheelchair. At 10:29 AM, the Clinical Manager indicated the home health aide should have assisted the patient with whatever meals the family prepared for them that day. The Clinical Manager indicated the patient received meals on wheels, so the home health aide was supposed to assist with setting up the meals on wheels meals. The Clinical Manager indicated the home health aide was expected to change the patient's diaper/briefs when soiled. At 11:09 AM, the Clinical Manager indicated the patient was chair bound, so required a bed bath or chair bath. The Clinical Manager indicated this information should have been included in the plan of care.		updated/corrected their plan of care to include requiredspecific care interventions and faxed them to their various physicians forsignature and documented in their charts. Thedirector of nursing will audit all client charts every sixty days. The directorof nursing will reach out to clients via phone calls and during supervisoryvisits to inquire about any updated changes related to their health status. Anychanges will be documented in their plan of care and faxed to their physicianfor signature to ensure this deficiency doesn't recur. Thedirector of nursing is responsible for quarterly chart audits of 50% of clientmedical records to ensure all client's plans of care are monitored and updatedper their individual specific needs and to abide by the regulatory standard ofpractice compliance scheduled to be completed on 8/31/2023. **For clinical record review patent#3**, the director ofnursing identified the client affected by this deficiency and updated thepatient plan of care	

	3. Clinical record review for Patient #2 was completed on 7/11/2023. Record review evidenced a home health aide plan of care for certification period 5/13/2023 - 7/11/2023, which indicated the home health aide was to assist with bathing, but failed to specify if the patient required a bed bath, chair bath, or shower. The plan of care indicated the home health aide was to give verbal medication reminders, but failed to specify when the aide was to give the medication reminders. During an interview on 7/11/2023, at 11:34 AM, the Clinical Manager indicated the plan of care should have specified the patient was a shower assist. The Clinical Manager indicated the frequency of medication reminders should have been included on the plan of care. 4. Clinical record review for Patient #3 was completed on 7/11/2023. Record review evidenced a home health aide plan of care for certification period 7/1/2023 - 8/29/2023, which indicated the patient wore diapers at all times, but		to include meal preparation of Breakfast and Lunch, changingpatient briefs every 2 hours and as needed during scheduled shifts, Batheclient in bed/sitting on bath bench, Lotion body, Brush Teeth, and comb hair,and make the bed and change Linens every 2 days or as needed during Aide'sscheduled shift. A copy of the updated plan of care was faxed to the physicianfor signature. Thedirector of nursing further reviewed other client charts likely to be impactedby this deficiency and updated/corrected their plan of care to include requiredspecific care interventions and faxed them to their various physicians forsignature and documented in their charts. Thedirector of nursing will audit all client charts every sixty days. The directorof nursing will reach out to clients via phone calls and during supervisoryvisits to inquire about any updated changes related to their health status. Anychanges will be documented in their plan of care and faxed to their physicianfor signature to ensure	

	failed to include instructions for the home health aide to change the diapers when soiled. The home health aide plan of care indicated the aide was to assist the patient with meals, but failed to indicate which meals the patient required assistance with. The home health aide plan of care indicated the aide was to bathe the patient, but failed to specify what kind of assistance the patient required for bathing. The home health aide plan of care indicated the aide was to assist the patient with grooming, but failed to specify which grooming tasks the aide was to complete. The home health aide plan of care indicated the home health aide was to change the bed linens, but failed to specify when the home health aide was to change the bed linens. During an interview on 7/11/2023, at 1:00 PM, the Clinical Manager indicated the plan of care should have specified which meals the aide was to assist the patient with. At 1:16 PM, the Clinical Manager indicated the plan of care should have specified the home health aide was to change the patient's diapers when soiled.		this deficiency doesn't recur. Thedirector of nursing is responsible for quarterly chart audits of 50% of clientmedical records to ensure all client's plans of care are monitored and updatedper their individual specific needs and to abide by the regulatory standard ofpractice compliance scheduled to be completed on 8/31/2023. **For clinical record review patent#4**, the director ofnursing identified the client affected by this deficiency and updated thepatient plan of care to include meal preparation of dinner, changing patientbriefs every 2 hours and as needed during scheduled shifts, Bathe client in bed/sitting on bath bench, Lotion body, Brush Teeth, and comb hair, and make thebed and change Linens every 2 days or as needed during Aide's scheduled shift.A copy of the updated plan of care was faxed to the physician for signature. Thedirector of nursing further reviewed other client charts likely to be impactedby this	

	The Clinical Manager indicated the plan of care should have specified what kind of bathing assistance the patient required. The Clinical Manager indicated the plan of care should have specified which grooming tasks the home health aide was expected to perform. The Clinical Manager indicated the home health aide should have changed bed linens when soiled.		deficiency and updated/corrected their plan of care to include requiredspecific care interventions and faxed them to their various physicians forsignature and documented in their charts. Thedirector of nursing will audit all client charts every sixty days. The directorof nursing will reach out to clients via phone calls and during supervisoryvisits to inquire about any updated changes related to their health status. Anychanges will be documented in their plan of care and faxed to their physicianfor signature to ensure this deficiency doesn't recur. Thedirector of nursing is responsible for quarterly chart audits of 50% of clientmedical records to ensure all client's plans of care are monitored and updatedper their individual specific needs and to abide by the regulatory standard ofpractice compliance scheduled to be completed on 8/31/2023.	

	5. Clinical record review for Patient #4 was completed on 7/11/2023. Record review evidenced a home health aide plan of care for certification period 5/27/2023 - 7/25/2023, which indicated the patient was incontinent and used briefs at all times, but failed to include instructions for the home health aide to change the patient's briefs if soiled. The plan of care indicated the home health aide was to assist the patient with a bath/shower, but failed to specify what kind of bath/shower assistance the patient required. The plan of care indicated the home health aide was to change the patient's linens, but failed to specify when the bed linens should have been changed. During an interview on 7/11/2023, at 1:25 PM, the Clinical Manager indicated the plan of care should have specified when to change the bed linens, when to change the briefs, and what kind of shower assistance was required. 410 IAC 17-13-2(a)			

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 provided services which were ordered on the plan of care; and/or provided home health aide services which were not covered under the Indiana Health Coverage Programs (IHCP) home health benefit, in 2 of 4 clinical records reviewed. (Patient #1, 2) The findings include: 1. Review of the Indiana Health Coverage Programs policies and procedures manual, effective date May 1, 2022, titled "Home Health Services", stated, "... the Indiana Health Coverage Programs [IHCP] defines 'home health services' as services provided on a part-time and	G0800	**G0800** **For clinical record review for patients #1,2,** the director ofnursing immediately reviewed the affected patient's plan of care and their homehealth Aides' notes and instructed the supporting staff to call the aidesassigned to these patients to the office for in-service. The director of nursing instructedsupporting staff to Re-in-service the home health aides assigned to thesepatients and reiterated the importance of not rendering services not indicatedin the patient's plan of care such as mouth care, foot care, catheter care,nail care, and no longer approved by IHCP such as housekeeping, laundry, wipingdown surfaces, cleaning bathroom, kitchen, vacuuming and washing dishes toensure 100% compliance with the state. The agency staff will randomly callhome health aides assigned to their client's homes to remind them not to renderservices not indicated in their patients' plan of care and not approved by the IHCP.The director of nursing will reiterate	2023-07-24

	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) ...." 2. Record review evidenced an undated agency policy obtained 7/12/2023, 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 in writing 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 ...." 3. Clinical record review for Patient #1 was completed on 7/11/2023. Record review evidenced a home health aide plan of care for certification period 5/12/2023 - 7/10/2023, which indicated the home		that performingservices no longer approved by the IHCP will not be accepted in their homehealth aide notes. The office staff will audit 50% of home healthaides' records quarterly to ensure all home health aides' documentationreflects the client's plan of care to abide by the regulatory standard ofpractice compliance scheduled to be completed on 8/31/2023. The director ofnursing is responsible for monitoring this corrective action.	

	health aide was to perform housekeeping, vacuuming, washing dishes, dusting, laundry, and wiping down of surfaces, which were not covered services under the IHCP benefit. The plan of care indicated the home health aide was not to perform catheter care. Record review evidenced home health aide visit notes dated 6/30/2023, 7/2/2023, 7/3/2023, 7/5/2023, 7/6/2023, and 7/7/2023, which all indicated the aide performed the following tasks, which were not covered services under the IHCP benefit: laundry, cleaned the bathroom, bedroom, and kitchen, washed dishes, and went grocery shopping. These visit notes also indicated the home health aides performed the following tasks which were not included on the plan of care: catheter care, mouth care, shave, nail care, and foot care. During an interview on 7/11/2023, at 11:08 AM, the Clinical Manager indicated the home health aides couldn't do catheter care, grocery shopping, or housekeeping tasks. The Clinical Manager indicated the			

	home health aide should have been performing only tasks ordered on the plan of care. 4. Clinical record review for Patient #2 was completed on 7/11/2023, for certification period 5/13/2023 - 7/11/2023. Record review evidenced home health aide visit notes dated 6/30/2023, 7/3/2023, and 7/5/2023, which all indicated the home health aide cleaned the bathroom, bedroom, kitchen, and did dishes, which was not covered services under the IHCP benefit. During an interview on 7/11/2023, at 11:35 AM, the Clinical Manager indicated the home health aides should not have been performing any housekeeping.			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;	G0818	**G0818** **For clinical record review of patient #1,** the agency reviewed its care plan policyand identified the client affected by this deficiency, and reviewed the patient'shome health aide Plan of Care. The director of nursing called the aideassigned to care for the patient affected by this deficiency and	2023-07-24

	(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and interview, the home health agency failed to ensure home health aides provided care which was ordered on the plan of care in 4 of 4 clinical records reviewed. (Patient #1, 2, 3, 4) The findings include: 1. Record review evidenced an agency policy revised 10/26/2011, titled "Home Health Aide Supervision" which stated, "... The aide visit record is reviewed by the supervising nurse/therapist to assure services are being provided according to the care plan ...." 2. Clinical record review for Patient #1 was completed on 7/11/2023. Record review evidenced a plan of care for certification period 5/12/2023 - 7/10/2023, which indicated the patient was to receive 6 hours of home health aide services 5		importance of performing tasks as outlined in the patientplan of care including but not limited to assisting with meals-breakfast andlunch, dressing both upper and lower body, linen change when soiled and asneeded, and medication reminder only, and not rendering services not indicatedin the client plan of care such as mouth care, foot care, nail care cathetercare, etc, and other services no longer approved by IHCP such as laundry,housekeeping, grocery shopping, etc. The director ofnursing has instructed office staff to go through all home health aide notesprior to printing them out for filing to ensure all hands-on care rendered tothe client assigned to them is properly documented in their aide's note priorto printing them out for filing. The director of nursing further instructedoffice staff to **reject** any home health aide's notes without properdocumentation. This will ensure home health aides' accountability andcompliance with the regulatory requirements. Homehealth aides will receive phone calls on a regular basis reminding them not to renderany services not indicated in the client's plan of care, and to	

	days per week, Monday through Friday. The plan of care indicated the home health aide would assist/prepare daily meals and set up, assist the patient with feeding, assist patient with dressing, change bed linens, empty catheter bag, and remind patient to take their medications. The home health aide plan of care indicated the home health aide was to perform housekeeping, vacuuming, washing dishes, dusting, laundry, and wiping down of surfaces, which were not covered services under the IHCP benefit. The plan of care indicated the home health aide was not to perform catheter care. Record review evidenced home health aide visit notes dated 6/30/2023, 7/2/2023, 7/3/2023, 7/5/2023, 7/6/2023, and 7/7/2023, which all indicated the aide performed the following tasks, which were not covered services under the IHCP benefit: laundry, cleaned the bathroom, bedroom, and kitchen, washed dishes, and went grocery shopping. These visit notes also indicated the		document thehands-on care rendered to their clients appropriately in their aide's notes. Theoffice staff will audit 50% of home health aides' records quarterly to ensureall home health aides' documentation reflects the client's plan of care toabide by the regulatory standard of practice compliance scheduled to be completedon 8/31/2023. The director of nursing is responsible for monitoring thiscorrective action. **For clinicalrecord review of patient #2**, the agencyreviewed its care plan policy and identified the client affected by thisdeficiency, and reviewed thepatient's home health aide Plan of Care.	

	home health aides performed the following tasks which were not included on the plan of care: catheter care, mouth care, shave, nail care, and foot care. Record review evidenced a home health aide visit note dated 7/1/2023, which indicated the home health aide failed to assist with meals, assist with feeding, assist with dressing, change bed linens, and remind the patient to take their medications. Record review evidenced a home health aide supervisory visit note dated 6/23/2023, which indicated the home health aide followed and implemented the plan of care. During an interview on 7/11/2023, at 1:40 PM, the Clinical Manager indicated home health aide supervisory visits were conducted every 30 days, by observing the home health aide provide care. The Clinical Manager indicated they did not review the home health aides previous documentation to ensure they were following the plan of care. 3. Clinical record review for		The director ofnursing called the aide assigned to care for the patient affected by thisdeficiency and Re-in-serviced aide again on the importance of performing tasksas outlined in the patient plan of care including but not limited to bathing,assisting with breakfast, ensuring the client has brief on prior to getting onthe bus, dressing and medication reminder only, and not rendering services notindicated in the client plan of care and no longer approved by IHCP such as laundry,housekeeping, grocery shopping, vacuuming, dishes, etc. The director of nursinghas reached out to the patient's families and in-serviced home health aidesthat **vital signs will No longer be taken daily** on all stable patientsexcept if there's an immediate medical necessity and it's ordered by theirphysicians with reporting notification parameters. The director of nursing instructedoffice staff to go through all home health aide notes prior to printing themout for filing to ensure all hands-on care rendered to the client	

	7/11/2023. Record review evidenced a plan of care for certification period 5/13/2023 - 7/11/2023, which indicated the home health aide was to take vital signs during visits, ensure the patient had a brief on prior to getting on the bus, assist patient with bathing, and give verbal medication reminders each visit. The plan of care indicated the home health aide was to call the office if the temperature was below 96 degrees. Record review evidenced home health aide visit notes dated 6/30/2023, 7/3/2023, and 7/5/2023, which all indicated the home health aide cleaned the bathroom, bedroom, kitchen, and did dishes, which was not covered services under the IHCP benefit, or ordered on the plan of care. Record review evidenced home health aide visit notes dated 6/30/2023, 7/3/2023, and 7/5/2023, which all failed to evidence the home health aide ensured the patient had a brief on prior to getting on the bus, assisted with bathing, and gave verbal medication reminders. These visit notes all had the		assigned tothem is properly documented in their aide's note prior to printing them out forfiling. The director of nursing further instructed office staff to **reject** anyhome health aide's notes without proper documentation. This will ensure homehealth aides' accountability and compliance with the regulatory requirements. Homehealth aides will receive phone calls on a regular basis reminding them not to renderany services not indicated in the client's plan of care, and to document thehands-on care rendered to their clients appropriately in their aide's notes. The office staff will audit 50% of home health aides' recordsquarterly to ensure all home health aides' documentation reflects the client'splan of care to abide by the regulatory standard of practice complianceschedule to be completed on 8/31/2023. The director of nursing is responsiblefor monitoring this corrective action. **For clinicalrecord review of patient #3**, the agencyreviewed its care plan policy and	

	following vital signs: pulse - 80, blood pressure -123/80, and temperature - 95. Record review failed to evidence any communication notes or documentation which indicated the home health aide called the office to notify of the temperature of 95 degrees as ordered on the plan of care. Record review evidenced a home health aide supervisory visit dated 6/16/2023, which indicated the home health aide was following and implementing the plan of care. During an interview on 7/11/2023, at 11:34 AM, the Clinical Manager indicated the home health aides should have been performing tasks as were ordered on the plan of care. The Clinical Manager indicated the home health aide was probably not checking the vital signs during visits, and copied the vitals from their assessment. 4. Clinical record review for Patient #3 was completed on 7/11/2023. Record review evidenced a plan of care for certification period 7/1/2023 - 8/29/2023, which indicated the home health aide was to assist		identified the client affected by thisdeficiency, and reviewed thepatient's home health aide Plan of Care. The director ofnursing called the aide assigned to care for the patient affected by thisdeficiency and Re-in-serviced aide again on the importance of performing tasksas outlined in the patient plan of care including but not limited to assistingwith bathing, turn every 2 hours, meals-breakfast and lunch, dressing bothupper and lower body, linen change when soiled and as needed, wash only clientdishes after each meal, brush teeth, comb hair, and medication reminder only, andnot rendering services not indicated in the client plan of care and no longerapproved by IHCP such as laundry, housekeeping, grocery shopping, etc. The director of nursing has instructed officestaff to go through all home health aide notes prior to printing them out forfiling to ensure all hands-on care rendered to the client assigned to them isproperly documented in their aide's note	

	the patient to turn every 2 hours, assist with meals and feeding, perform grooming assistance, change bed linens, wash dishes, and give verbal medication reminders. Record review evidenced a home health aide visit note dated 7/1/2023, which failed to evidence the home health aide turned the patient every 2 hours, assisted with meals and feeding, performed grooming assistance, changed bed linens, washed dishes, and gave verbal medication reminders as ordered on the plan of care. Record review evidenced a home health aide supervisory visit dated 7/3/2023, which indicated the home health aide was following and implementing the plan of care. During an interview on 7/11/2023, at 1:19 PM, the Clinical Manager indicated if the home health aide did not perform the tasks on the plan of care they would be blank on the visit note. The Clinical Manager indicated maybe the patient did not want the home health aide to perform these tasks. The Clinical Manager indicated they		prior to printing them out for filing.The director of nursing further instructed office staff to **reject** anyhome health aide's notes without proper documentation. This will ensure homehealth aides' accountability and compliance with the regulatory requirements. Homehealth aides will receive phone calls on a regular basis reminding them not to renderany services not indicated in the client's plan of care, and to document thehands-on care rendered to their clients appropriately in their aide's notes. The office staff will audit 50% of home health aides' recordsquarterly to ensure all home health aides' documentation reflects the client'splan of care to abide by the regulatory standard of practice compliancescheduled to be completed on 8/31/2023. The director of nursing is responsiblefor monitoring this corrective action. **For clinicalrecord review of patient #4**, the agencyreviewed its care plan policy and identified the client affected by thisdeficiency, and reviewed	

	did not review the visit notes during supervisory visits. 5. Clinical record review for Patient #4 was completed on 7/11/2023. Record review evidenced a plan of care for certification period 5/27/2023 - 7/25/2023, which indicated the home health aide was to assist with dinner, encourage use of cane, assist with bath/shower, dressing, shampoo hair, comb hair, take vital signs and give verbal medication reminders. Record review evidenced home health aide visit notes dated 6/30/2023, and 7/3/2023, which failed to evidence the home health aide performed a temperature, bath/shower, dressing, shampooed hair, combed hair, gave verbal medication reminders, encouraged the use of cane, and assisted with dinner. Record review evidenced a home health aide supervisory visit dated 6/23/2023, which indicated the home health aide was implementing and following the plan of care. During an interview on 7/11/2023, at 1:30 PM, the Clinical Manager indicated the		thepatient's home health aide Plan of Care. The director ofnursing called the aide assigned to care for the patient affected by thisdeficiency and Re-in-serviced aide again on the importance of performing tasksas outlined in the patient plan of care including but not limited to bathing,assisting with dinner, dressing, comb hair, brush teeth, and medicationreminder only, and not rendering services not indicated in the client plan ofcare and no longer approved by IHCP such as laundry, housekeeping, groceryshopping, vacuuming, dishes, etc. The director of nursinghas reached out to the patient's families and in-serviced home health aidesthat **vital signs will No longer be taken daily** on all stable patientsexcept if there's an immediate medical necessity and it's ordered by theirphysicians with reporting notification parameters. The director of nursing instructedoffice staff to go through all home health aide notes prior to printing themout	

	home health aide should have been performing all the tasks on the plan of care. 410 IAC 17-14-1(n)		for filing to ensure all hands-on care rendered to the client assigned tothem is properly documented in their aide's note prior to printing them out forfiling. The director of nursing further instructed office staff to **reject** anyhome health aide's notes without proper documentation. This will ensure homehealth aides' accountability and compliance with the regulatory requirements. Homehealth aides will receive phone calls on a regular basis reminding them not to renderany services not indicated in the client's plan of care, and to document thehands-on care rendered to their clients appropriately in their aide's notes. The office staff will audit 50% of home health aides' recordsquarterly to ensure all home health aides' documentation reflects the client'splan of care to abide by the regulatory standard of practice complianceschedule to be completed on 8/31/2023. The director of nursing is responsiblefor monitoring this corrective action.	

N0000	Initial Comments This visit was revisit for a State relicensure	N0000		

	survey. Survey Dates: 7/7/2023, 7/10/2023, and 7/11/2023 Facility ID: 012812 Census: 12 Unduplicated admissions for past 12 months: 16			

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	7/24/2023 2:03:40 PM