STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K060	A. BUILDING B. WING	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY CARES, INC	3637 S SR 3, NEW CASTLE, IN, 47362

(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: January 31, February 1, 2, 3, 6, 7. 8. 9; 2023 Unduplicated skilled admissions for past 12 months: 19 Active patients: 80 At this Emergency Preparedness survey, Bethany Cares Home Health Care, was found to not be in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic at 42 CFR 484.102.	E0000		2023-03-24

	QR: Area 2 02/22/23			
E0006	Plan Based on All Hazards Risk Assessment 483.73(a)(1)-(2) §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), §485.542(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 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	E0006	**E 0006 CFR 484.102(a)(1)-(2) Plan Basedon All Hazards Risk Assessment** 1. Administrator immediately identified and completed the current missing risk assessment form from the Emergency preparedness planbinder that is required to meet CFR 484.102(a)(1)-(2) and informed alternateadministrator to insert the current assessment into binder. 2. Administrator In-serviced alternateadministrator on the requirement of the facility based and community-based riskassessment, using the all-hazards approach and that includes strategies foraddressing emergency events identified by the risk assessment to meetrequirement CFR 484.102(a)(1)-(2). 3. Admin/Alternate Admin to audit 100%Emergency preparedness plan and all components to be reviewed and updatedannually to meet requirement to meet CFR 484.102(a)(1)-(2).	2023-02-10

	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 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 to maintain an emergency preparedness plan which included a facility-based and community-based risk assessment completed biennially, which had the potential to affect all agency patients and employees. Findings include: Agency policy #B-400A titled		4. Administrator is responsible formonitoring these actions to ensure this deficiency is corrected & will notrecur. 5. Completed Date 2-10-2023.	

	"Hazard Vulnerability Analysis" (HVA) indicated but was not limited to "... The HVA will be conducted initially when developing the Emergency Preparedness Plan, upon identification of any new external risk factor, when beginning a new service, and annually ...." Review of the agency's Emergency Preparedness Plan failed to evidence a facility-based and community-based risk assessment was completed since October 2019. During an interview, conducted on 02/09/2023 beginning at 4:10 PM, the Alternate Administrator / Alternate Clinical Manager confirmed the agency had not completed a facility - based and community - based risk assessment since 2019.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home Health Provider. Survey Dates: January 31,	G0000		2023-03-24

	February 1, 2, 3, 6, 7. 8. 9; 2023 The survey was announced as fully extended on February 3, 2023, at 3:54 PM. Unduplicated skilled admissions for past 12 months: 19 Active patients: 80 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Recertification Survey, Bethany Cares Home Health Agency was found to be out of compliance with Conditions of Participation 484.60 Care planning, coordination of services, and quality of care. Based on the Condition-level deficiencies during the survey completed on 02/09/2023, Bethany Cares Home Health Agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on February 3, 2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, the agency is precluded			

	of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning February 9. 2023, and continuing through February 8, 2025. QR: Area 2 02/22/23			
G0460	Patient refuses services 484.50(d)(4) The patient refuses services, or elects to be transferred or discharged; Based on record review and interview, the home health agency failed to follow its policy of documenting its communication with the responsible physician regarding the need to discharge a patient for noncompliance with the plan of care, the measures the agency took to investigate the patient's refusal of services, and the interventions the agency attempted in order to obtain patient participation with the plan of care, for 3 of 3 records reviewed of patients who were discharged for noncompliance with the plan of care (Patients #7, 9, 10).	G0460	**G 0460 CFR 484.50(d)(4) Patient RefusesServices** 1. 1.) Administratorimmediately identified the discharged clients that appeared like they weredischarged without notice. Their homehealth aide services were discharged but we continued with waiver services,which was more appropriate for their needs. They were not just Discharged, we continued attendant and homemakingcare due to their refusal of personal care needs through HHA. We could have hadbetter charting on what happened. 2. 2.) Administratorin-serviced management staff on the discharge policy & procedure in place(including a 15-day notice)	2023-03-11

	Findings include: 1. Agency policy #C-620 indicated but was not limited to "... Discharge Procedure: ... 2 ... Clients are told in a timely manner of the need to plan for discharge ... 3. The physician will be involved in the discharge plan ... 9. To avoid charges of 'abandonment' at the time of discharge agency documentation will include the following: a. Evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge client from the agency ... d. Documentation of all communication with the client ... Discharge Criteria: 1. Criteria for discharge may include ... c. Client is non-compliant with the established plan of care ...." 3. The clinical record of Patient #9 (start of care 06/29/2022, discharge date 08/23/2022) included a plan of care for the initial certification period of 06/29/2022-08/27/2022, which indicated the patient was to receive home health aide services. The record included a Journal Note, documented by Registered Nurse (RN) #4 on		that is utilized according to interpretiveguidelines 484.50(d)(4). Agency to Continue current policy & procedures tomeet CFR(s): 484.50(d)(4) to prevent a deficiency from happening in the future. 3. 3.)Administratorin-serviced CM on their responsibilities to educate the patients/family membersof the necessity to comply with physician orders and the home health plan ofcare in order to improve their health and meet their care needs. The Administrator stressed the necessity thatthis education and the patient's response to the education be clearlydocumented in the patient's clinical record. 4. 4.)Administratorin-serviced management staff and CM to document efforts; and make efforts toresolve the problems presented by the patient's behaviors, behaviors of otherpersons in the patient's home, non-compliance, or other situations. (Includingverbal aggressive behaviors & Threats) to meet requirement CFR(s):484.50(d)(4).	

	07/07/2023, which indicated an unnamed home health aide (HHA) reported the patient "never needs any assistance with any personal care." The note also indicated RN #4 spoke with Patient #9 "about HHA and what it consists of … [RN #4] explained to [patient] that … her aide is there for personal care." The record included a Journal Note, documented by RN #4 on 08/03/2022, which indicated an unnamed HHA reported Patient #9 called the aide a "housekeeper" and "when [the HHA] tries to talk to [the patient] about her job duties [the patient] does not accept [the aide's] explanation for … [being] there for [the patient's] personal care …." The record failed to evidence the RN #4 nor any other administrative staff spoke with the patient regarding the possibility of discharge if the patient repeatedly refused personal care. The record included a skilled nurse visit for a post-outpatient procedure completed on 07/15/2022 and a HHA supervisory visit completed via		5. 5.)Administratorin-serviced management staff on interpretive guidelines 484.50(d)(4) andclarifying DC reasons, notices, and cause for imminent DC to meet requirementCFR(s): 484.50(d)(4). 6. 6.) Administratorin-serviced CM on being very clear in their documentation and notification tothe patients & physicians when discharging from HHA services and continuing PSA attendant and/or homemaking services under the waiver program to better meet the patients' needs tomeet requirement CFR(s): 484.50(d)(4). 7. 7.) Administratorin-serviced CM to document MD notifications of any issues in care, behaviors,staffing issues, & reasons agency may discharge the pt to prevent adeficiency from happening in the future to meet to meet CFR(s): 484.50(d)(4). 8. 8.)Administratoris responsible for monitoring these actions to ensure this element is corrected& will not recur.	

	telephone on 08/17/2022, both by RN #4. The visit notes failed to evidence the nurse spoke with the patient regarding the possibility of discharge if the patient repeatedly refused personal care. The record included a Journal Note, documented by RN #4 on 08/23/2022 at 8:41 AM, which indicated an unnamed HHA reported Patient #9 was rude, ordered the aide around, and made comments about the aide being a "housekeeper" and "servant." The record included a second Journal Note, documented by RN #4 on 08/23/2022 at 11:09 AM, which indicated the nurse discussed via email with Patient #9's case manager the patient's "behavior issues" and the patient repeatedly refusing personal care. The note indicated the patient's case manager replied "I [the case manager] was not aware that [Patient #9] was receiving [Medicaid PA] hours and [the patient] has not informed me of having any caregivers in the home … Please discharge [Patient #9] from HHA immediately …." The record included a third Journal Note, documented by RN #4 on		9. 9.)CompleteDate 3-11-23.	

	08/23/2022 at 2:45 PM, which indicated the nurse spoke with Patient #9 "to notify [the patient they] do not meet the criteria for HHA services [due to] no personal care …." During an interview conducted with RN #4 on 02/09/2023 starting at 2:25 PM, the nurse reported Patient #9 was discharged due to no longer qualifying for home health aide services since the patient had frequently refused personal care during HHA services. The nurse reported while speaking with Patient #9 on 07/07/2023, they did inform Patient #9 that if they continued to refuse personal care then the patient would no longer qualify for home health aide services. RN #4 could not recall any other specific occasions where they informed Patient #9 and/or the patient's provider of the potential for discharge due to frequent refusal of personal care tasks. 4. The clinical record of Patient #10 (start of care 10/04/2021, discharge date 12/03/2021) included a plan of care for initial certification period 10/04/2021-12/02/2021 which			

	indicated the patient was to receive home health aide services. The record included a HHA supervisory visit completed by RN #4 on 11/17/2021 and recertification comprehensive assessment completed by RN #4 on 12/01/2021. The visit notes failed to evidence RN #4 spoke with Patient #10 regarding the possibility of discharge if the patient repeatedly refused visits and/or personal care tasks. The record included a Journal Note, documented on 12/03/2021 by RN #4, which indicated Patient #10 was discharged from the agency that day due to "multiple missed visits [related to the patient] sending aides away. During HHA hours, [Patient #10] has not been wanting assistance with ADLs, only homemaking tasks …." During an interview conducted with RN #4 on 02/09/2023 starting at 2:25 PM, the nurse reported Patient #9 was discharged due to no longer qualifying for home health aide services since the patient had multiple missed visits and frequently refused personal care			

	during HHA services. The nurse also reported they did remember speaking with Patient #10 regarding the potential for discharge if the patient continued to repeatedly refuse visits and/or personal care tasks but could not recall exactly when the conversation(s) occurred. 2. Review of Patient #7's clinical record included a plan of care for certification period 10/23/2022 – 12/21/2022 with orders for HHA (home health aide) services 1 hour per day, 3 days per week for 9 weeks for tasks included but not limited to shower assist, check pressure areas, skin care/ apply lotion, and standby assist. The record evidenced a Discharge Summary dated 11/22/2022 and signed by RN #2 which indicated "Reason for Discharge…Agency/Organizatio n decision Explain: discharged due to non-compliance with home health aide tasks…" The record evidenced a Discharge Order dated 11/22/2022 and signed by RN #2 which indicated "Order Description…Patient discharged from…Home Health Services on 11/22/2022 due to			

	non-compliance of letting aide perform home health aide tasks…" The record failed to evidence RN #2 or administrative staff communicated with Patient #7 or the responsible physician about the possibility of discharge if the patient repeatedly refused personal care. 5. During an interview on 02/07/2023 at 09:36 AM, Patient #7 indicated they were discharged from the agency with approximately 1 day of notice because they take their bath in the evening and indicated the patient was not included in the decision for discharge. Patient #7 also indicated the agency did not offer to provide HHA services at the patient's preferred bath time in the evening. 6. During an interview on 02/07/2023 at 02:45 PM, the Administrator indicated prior to discharge for non-compliance the agency would try to work with and educate the patient on the risks of non-compliance and notify the physician of non-compliance.			

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 review and interview, the agency failed to notify the patient's provider, per agency policy, of a change in wound status, abnormal urinary symptoms, and abnormal bowel movement color and consistency (See G590) and failed to ensure staff coordinated care with the patient's primary caregiver regarding missing a supply of an emergency seizure medication (See G608). The cumulative effect of the noncompliance resulted in the agency being found out of	G0570	**G 0570 CFR484.60 Care Planning, Coordination, Quality of Care** **REQUEST IDR –**	2023-03-11

	compliance with Condition of Participation 484.60 Care planning, coordination of services, and quality of care.		1.) Administratorimmediately identified the patient with wounds, urinary issues, and bowelprogram. The patient is non-compliant at times and has been for many years. Thispatient wants to be left alone and at times very grouchy and hateful to others.He will only let his 1 aide come to do care, refuses any alternates and this isthe same for his nurse. No alternates! The MD, CM, wound center, hospital and staffare all aware of this patient's ongoing noncompliance & refusing services/otherstaff, and care at times. He is a verydifficult patient and a difficult case. Refusing care and/or beingnon-compliant can be interchangeable words. This patient has been discharged tohospice since survey due to him not wanting any care, no wound care anymore, hewants to be left alone. We havecontinued care under waiver- attendant care. I am asking that this condition be changed to standarddeficiency. I understand we could havebetter documentation, but all parties have been aware of this client's issues,attitude and	

			non-compliance for years-ongoing. When the dischargeassessment/order was sent to PCP/MD the PCP, became upset that we sent all 50+pages and the Dr. asked to not receive additional info on him anymore, told usto send to wound center. This PCP/MD is aware of the patient's condition, wounds,etc. and is now upset with us. All parties have been aware of this patient'scondition and care for many years. Nothing we could have done would change any outcomes for this particularpatient. There was no patient harm and nothing we can do wouldhave made the patient change his ways. Hehas been discharged to hospice because he wants to be left alone to die. Patient states" he only kept services because heliked his aide and thought he would lose her if he went to hospice". 2.) In regards to the school agepatient in southern Indiana where the nurse attends school with the patient, theemergency medication had never been used, not warranted, and was discontinuedfrom med sheet immediately by the MD when we called and the med sheet has beenupdated. I am requesting this element	

			beremoved or changed to a standard tag instead of condition. This patientwas never in any harm. The medication had never been used and neverwarranted to be used. The patient does not haveseizures. CG states no seizures for over 10 yrs and maybe from CP whenyounger. CG had removed medication bag from the back pack that is takento the school with the nurse. The MD was called ASAP and the medication forrectal use was DC'd immediately 2-3-23. This DC order was given to thesurveyors. I feel this is a matter of not updating the med list and removingunused/unneeded meds. The Nurses have been counseled and in-serviced regardingthis issue. Med list updated. COC sent to all providers. In thisparticular situation I do not feel this element at condition level tag iswarranted.3.) Seeattached documents Pleasereconsider this tag to be changed to a standard tag instead of a condition. Thankyou.	

G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to notify the patient's provider according to agency policy of a change in wound status, abnormal urinary symptoms, and abnormal bowel movement color and consistency, for 1 of 1 clinical records reviewed which evidenced a change in patient condition (Patient #4). Findings include: Agency policy #C-360 titled "Coordination of Client Services" indicated but was not limited to "... Special Instructions ... 7. The primary care Nurse ... will assume responsibility for updating/changing the Care plan and communicating changes to caregivers within twenty-four (24) hours following the conference or changes. The physician will be contacted when his/her approval for that	G0590	**G 0590 CFR 484.60(c)(1) Promptly AlertRelevant Physician of Changes** 1. Administratorin-serviced all CM on promptly alerting the MD on all patient changes,including changes in wound measurements, patient refusal or non-compliance withordered care, changes in bowel program, and any all-other pertinent changes tomeet CFR 484.60(c)(1) so this element will not recur. 2. Administratorin-serviced CM and field nurses to call the CM with changes and not just sendan email, that may not get read until the next week by the CM to meet CFR484.60(c)(1) so this element will not recur. 3. 100% of wound care patient records was reviewed immediately to ensure accuracy of coordination ofcare documents, to ensure this element does not recur to meet CFR 484.60. 4. Administratoris responsible for monitoring these actions to ensure this element is corrected& will not recur. 5. CompletedDate 3-11-23.	2023-03-11

	physician to changes in client condition ….” During an interview conducted on 02/08/2023 starting at 12:39 PM with the Administrator/Clinical Manager and Alternate Administrator/Alternate Clinical Manager, the Administrator/Clinical Manager indicated the “primary care nurse” noted in policy C-360 was the patient’s RN Case Manager. The clinical record of Patient #4 included plans of care for the recertification periods 10/19/2022 - 12/17/2022 and 12/18/2022 - 02/15/2023 which indicated patient diagnoses included but were not limited to paraplegia, Type 2 diabetes mellitus, Stage 4 pressure ulcer (type of wound caused by prolonged pressure on an area of the body, classified as stages between 1 through 4 based on wound severity, with Stage 4 the worst) of right buttock, Stage 3 pressure ulcer of right ankle, and Stage 4 pressure ulcer of left buttock. The plans of care included orders for skilled nursing visits to be conducted 3 hours per day, 2			

	days a week for 9 weeks, with nursing interventions which included but were not limited to "evaluate for [signs and symptoms] of infections ... evaluate/monitor wounds/healing ... Complete weekly wound measurements ...." The plans of care were signed by Patient #4's primary care provider (PCP) and indicated the patient's wounds were "assessed and treated" by a local wound clinic. The plan of care for the recertification period 10/19/2022 - 12/17/2022 indicated the patient was tested for C.diff (a bacterial infection of the intestines which results in severe diarrhea and inflammation of the colon) and the test was negative. The record included a recertification comprehensive assessment completed on 10/14/2022 by RN #2. The assessment note indicated the patient had two wounds – one Stage 4 to the right hip and one Stage 4 to the left sacrum/gluteal cleft. The record included a skilled nurse visit conducted on 10/22/2022 by RN #1. The visit			

	note indicated the patient's wound to the left sacrum/gluteal cleft increased by 1 centimeter (cm) in length. The record failed to evidence the patient's wound clinic was notified of the increase in wound size. The record included a skilled nurse visit conducted on 11/11/2022 by RN #1. The visit note indicated the patient's wound to the right hip increased by 1.5 cm in width and 2 cm in depth and indicated the patient's urine was cloudy with sediment noted. The record failed to evidence the patient's wound clinic was notified of the increase in wound size nor was the PCP notified of the abnormal urine symptoms. The record included a skilled nurse visit was conducted on 11/18/2022 by RN #1. The visit note indicated the patient's wound to the right hip increased by 1 cm in length and 1 cm in width and the wound to the left sacrum/gluteal cleft had increased by 1.5 cm in width and had "deteriorated." The note indicated a large amount			

	urine. The record failed to evidence the patient's wound clinic was notified of the increases in wound size nor was the PCP notified of the abnormal urinary symptom. The record included a skilled nurse visit conducted on 11/21/2022 by RN #1. The nurse visit note indicated a new Stage 2 pressure ulcer to the left hip was observed and noted the patient's wound clinic had not seen the patient since the development of the wound and indicated the patient's urine was cloudy and had a large amount of sediment which had clogged the patient's urinary catheter and required a change in catheter systems. The record failed to evidence the patient's wound clinic was notified of the newly developed wound nor were wound care orders were obtained. The record included a skilled nurse visit conducted on 11/25/2022 by RN #1. The visit note indicated the wound to Patient #4's left hip had deteriorated to a Stage III pressure ulcer and had developed slough in the wound bed, the right hip wound had			

	increased by 1 cm in width, and the wound to the left sacrum/gluteal cleft had increased in size by 2 cm in length and had "deteriorated." The note also indicated the patient reported abdominal pain, their urine had sediment in it, and the patient's stool had a mucus-like consistency and was blood tinged. The record failed to evidence the patient's wound clinic was notified of the increases in wound size nor was the PCP notified of the patient's abnormal urinary symptoms and bowel movement. The record included a skilled nurse visit conducted on 12/05/2022 by RN #1. The visit note indicated the wound to Patient #4's right hip had increased by 2 cm in width and 1.5 cm in depth and the wound to the left hip had increased by 1 cm in width. The note also indicated the patient's urine was amber colored and had sediment. The record failed to evidence the patient's wound clinic was notified of the increases in wound size nor was the PCP notified of the patient's abnormal urinary symptoms. The record included a skilled			

	nurse visit conducted on 12/09/2023 by RN #1. The visit note indicated the patient had sediment in their urine. The visit note failed to evidence the PCP was notified of the patient's abnormal urinary symptom. The record included a skilled nurse visit conducted on 12/12/2023 by RN #1. The visit note indicated the patient had sediment in their urine. The visit note failed to evidence the PCP was notified of the patient's abnormal urinary symptom. The record included a recertification comprehensive assessment completed on 12/13/2022 by RN #2. The assessment note indicated the patient had 3 wounds – one Stage 4 to the right hip, one Stage 4 to the left sacrum/gluteal cleft, and one Stage 3 to the left hip. The record included a skilled nurse visit was conducted on 12/30/2022 by RN #1. The visit note indicated the wound to the left sacrum/gluteal cleft had increased by 1 cm in length and indicated the patient's urine was amber colored, had an odor, and sediment was noted. The			

	record failed to evidence the patient's wound clinic was notified of the increase in wound size nor was the PCP notified of the patient's abnormal urinary symptoms. The record included a skilled nurse visit was conducted on 01/03/2023 by RN #1. The visit note indicated the patient had a large amount of sediment in their urine which was blocking their catheter and required a change in catheter systems. The record failed to evidence the patient's PCP was notified of the patient's abnormal urinary symptoms. The record included a skilled nurse visit was conducted on 01/06/2023 by RN #1. The visit note indicated the wound to the left hip had increased by 1 cm in length and 1 cm in depth. The record failed to evidence the patient's wound clinic was notified of the increase in wound size. The record included a skilled nurse visit conducted on 01/13/2023 by RN #1. The visit note indicated the wound to the left hip had increased by 1 cm in length and the wound to the			

	left sacrum/gluteal cleft had increased by 2 cm in width and extended to the patient's right coccyx and gluteal cleft. The record failed to evidence the patient's wound clinic was notified of the increases in wound size. The record included a skilled nurse visit conducted on 01/30/2023 by RN #1. The visit note indicated two new wounds were observed –one Stage 2 pressure ulcer to the right heel and one Stage 2 pressure ulcer to the right ankle. The record failed to evidence the patient's wound clinic was notified of the newly developed wounds nor were wound care orders obtained until the next skilled nurse visit on 02/03/2023. An interview was conducted on 02/06/2023 starting at 3:40 PM with the Administrator/Clinical Manager and Alternate Administrator/Alternate Clinical Manager. During the interview, the Administrator/Clinical Manager reported the RN case manager was responsible for coordinating all care for the patient. The Administrator/Clinical Manager confirmed the RN case manager			

	should notify the treating provider of a newly developed wound and if the patient was exhibiting signs or symptoms of infection. An interview was conducted on 02/07/2023 beginning at 4:02 PM with RN #2, who was Patient #4's RN Case Manager. During the interview, the nurse reported Patient #4's wound clinic did not have any protocols for when the home health agency was to notify the clinic of changes in the patient's wounds. The nurse stated they would notify Patient #4's wound clinic for changes which would indicate an infection such as change in wound bed color, wound drainage which was more viscous, and/or wound odor. 17-13-1(a)(2)			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on observation, record	G0608	**G 0608 CFR 484.60(d)(4) Coordinate CareDelivery** REQUEST IDR - I am requesting this element be removed or changed to astandard tag instead of condition. This patient was never in anyharm. The medication had never been used and never warranted to beused. The patient does not have seizures. CG states noseizures for over 10 yrs and maybe from CP when younger. CG had removedmedication bag from the back pack that is taken to the	2023-02-10

	review, and interview, the home health agency failed to ensure staff coordinated care with the patient's primary caregiver regarding missing a supply of an emergency seizure medication for 1 of 1 nurse visit observations with a patient with emergency seizure medications (Patient #2). Findings include: The clinical record of Patient #2 included a plan of care for the recertification period 01/02/2023 - 03/02/2023 which indicated the patient's diagnoses included but were not limited to cerebral palsy and epilepsy. The plan of care indicated the patient's current medications included but were not limited to Diazepam (Diastat, given to treat seizures) 10 milligram rectal kit to be given as needed for seizures lasting more than 5 minutes. The record included a "Seizure Management Plan," reviewed and signed by Registered Nurse (RN) #4, the patient's RN case manager, on 01/01/2023. The patient's seizure management plan indicated seizure interventions included, but were not limited to, administer the as needed Diastat medication for seizures lasting longer than 5		school with the nurse.The MD was called ASAP and the medication for rectal use was DC'd immediately2-3-23. This DC order was given to the surveyors. I feel this is a matterof not updating the med list and removing unused/unneeded meds. The Nurses havebeen counseled and in-serviced regarding this issue. Med listupdated. COC sent to all providers. In this particular situation I do notfeel this element at condition level tag is warranted. 1. Administratorimmediately identified and in-serviced the employee who was providing care outof the home, at school, without the ordered emergency medications, and spoke topatient's mother for coordination of care on emergency meds to meet requirementCFR 484.60(d)(4). 2. Administratorimmediately on 2-3-23 contacted the patient CM & MD and had the rectalmedication discontinued due to med list not updated, and medication has neverbeen used or needed. 3. Administratorin-serviced CM and LPN on following the POC and medication orders to meetrequirement CFR 484.60(d)(4). 4. Administratorin-serviced CM and LPN to discontinue medications that are not used and updatethe med list as needed to meet requirement CFR 484.60(d)(4) to ensure this doesnot recur. 5. Administratorin-serviced CM and LPN to communicate and coordinate care with primary CG toensure patients have emergency meds/supplies as ordered with them out of thehome to meet requirement CFR 484.60(d)(4), to ensure this does not recur. 6. CM immediately reviewed 100% all patient care plans & medlists for any similar concerns, and found no other similar concerns. 7. 100% of patient care plans & medication lists will be reviewed with each recertification or other assessments to ensure this element does not recur.	

	minutes. A visit observation was conducted with Patient #2 and Licensed Practical Nurse (LPN) #1 starting at 11:16 AM outside of the patient's home. During the visit LPN reported the patient's supply of emergency Diastat was typically kept in the patient's backpack, however they did not currently have a supply of the medication. LPN #1 reported they had not discussed the missing medication with the patient's primary caregiver. The nurse estimated the medication had been missing from their backpack for approximately 1 week. An interview was conducted on 02/02/2023 starting at 3:36 PM with Patient #2's primary caregiver. During the interview the primary caregiver reported LPN #1 was responsible for preparing the patient's backpack and the caregiver was not aware the Diastat was missing from the patient's backpack. An interview was conducted on 02/02/2023 starting at 3:55 PM with the Alternate		8. Administratoris responsible for monitoring these actions to ensure this element is corrected& will not recur. 9. Completedon 2-10-2023.	

	Administrator/Alternate Clinical Manager. During the interview, the Alternate Administrator/Alternate Clinical Manager confirmed the nurse should ensure all patient emergency medications were available at all times and should coordinate with the patient's and/or caregiver if the medication(s) was/were not available. 17-12-2(g)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure all staff followed standard precautions and infection control policies and procedures for 3 of 3 home visit observations (Licensed Practical Nurse (LPN) #1, Registered Nurse (RN) #2, Home Health Aide (HHA) #3). Findings include: 1. Agency policy titled "Hand	G0682	**G 682 CFR 484.70(a) InfectionPrevention** 1. Administrator in-serviced staff on requirementof CFR 484.70(a) Infection Prevention. 2. Management staff immediatelyidentified employees who were not following hand washing protocol via CMobservation. 3. Administrator in-serviced all staffon agency's hand washing policy to meet requirement CFR 484.70(a). 4. Administrator in-servicedall staff on donning gloves (before & after patient contact) per policy& procedures to meet	2023-03-11

	Washing" indicated but was not limited to "… The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: … After caring for a client … Procedure … 11. Wash hands, using plenty of lather and friction for at least 30 seconds …." 2. Agency in-service document titled "Bag Technique In-Service" indicated but was not limited to "… The CDC recommends that each home care agency implement policies that define that the equipment of the nursing bag be cleaned on a 'regular' basis … 'regular' basis to mean 'after each use on a patient and before replacing the item in the nursing bag' …." 3. A home visit observation was conducted on 02/01/2023 beginning at 11:16 AM with Patient #2 (start of care 09/14/2020) and LPN #1. During the visit, the nurse was observed cleaning the patient's gluteal cleft (groove between the buttocks) by wiping from the patient's lower back towards the vagina. After completing perineal care, LPN #2 removed their gloves but		requirement CFR 484.70(a). 5. Administrator in-serviced staff onfollowing infection control policies, cross contamination, and standardprecautions to meet requirement CFR 484.70(a). 6. Administrator in-serviced CM to doadditional home visits to observe hand hygiene and glove practices &provide any additional education/training to meet requirement CFR 484.70(a). 7. 100% of staff will be observed by CMquarterly on hand hygiene and glove practices to ensure accuracy so deficiencydoes not recur. 8. Administrator is responsible formonitoring these actions to ensure this standard is corrected & will notrecur. 9. Completed on 3-11-23.	

	failed to perform hand hygiene prior to completing further patient care. 4. A home visit observation was conducted on 02/02/2023 beginning at 10:00 AM with Patient #3 (start of care 06/24/2019) and RN #2. During the visit, the nurse was observed and failed to perform hand hygiene in between glove changes. RN #2 was observed removing a clipboard from their nursing bag, placed the clipboard on the patient's table and wrote notes, then returned the clipboard to their nursing bag, and failed to clean the clipboard prior to returning it to the bag. 5. A home visit observation was conducted on 02/03/2023 beginning at 10:15 AM with Patient #6 (start of care 08/24/2021) and HHA #3. During the home visit, the aide was observed failing to perform hand hygiene in between glove changes on 2 occasions and was observed and to wash their hands for 17 seconds. 6. An interview was conducted on 02/03/2023 beginning at 3:47 PM with the Alternate			

	Administrator/Alternate Clinical Manager. During the interview, the Alternate Administrator/Alternate Clinical Manager confirmed staff should wash their hands for a minimum of 30 seconds, staff should perform hand hygiene in between glove changes, and staff should not place dirty equipment into their nursing bag. The Alternate Administrator stated when performing perineal care on female patients, staff should clean the patient from the front of the gluteal cleft (closest to the vagina) to the back of the cleft (closest to the spine). 17-12-1(m)			
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 home health agency	G0798	**G 0798 CFR 484.80(g)(1) Home HealthAide Assignments & Duties** 1. Administrator immediately identifiedand in-serviced staff that was not completing aide tasks on the mobile appcorrectly. 2. Administrator in-serviced all staff onnot marking all of the tasks on every visit on the same day if they are notbeing	2023-03-11

	failed to ensure the aide care plan was detailed and specific to the individual patient for 4 of 4 records reviewed of patients receiving home health aide services (Patients #1, 3, 4 and 6). 3. Review of Patient #3's clinical record included a Plan of Care for the recertification period 12/05/2022 – 02/02/2023 which indicated the patient was to receive HHA services for 7 hours per day, 5 days per week for 9 weeks. The record also included an aide care plan which indicated aide tasks included "check pressure areas … clean under fingernails … clear pathways … dressing/clothing assist … file fingernails … incontinent urine assist … make bed and straighten client area … meal prep … mobility assist … peri care … re-positioning bed/chair … shower assist 1x [one time] weekly … Skin care/apply lotion 1x weekly … toileting assist … transfer assist … wheelchair assist." The aide care plan failed to evidence the frequency all tasks, except showering and skin care, were to be completed. The aide visit notes for Patient #3 were reviewed and indicated the patient either declined or		completed, mark completed or declined and note the reason to meetrequirements CFR 484.80(g)(1) Home Health Aide Assignments & Duties. 3. Administrator in-serviced CM on beingspecific to each individual patients' needs, including but not limited to nailcare: Diabetics will have "NO CLIPPING" added to all care plans to meetrequirement CFR 484.80(g)(1). 4. Administrator in-serviced CM on beingspecific with patient's shower/bath requests, includes making care plan specificfor am or pm shower/bath assist to meet requirement CFR 484.80(g)(1). 5. Administrator submitted a ticket(BCI-357) to Kantime EMR system to try to get care plans section to be able tohave am or pm separate care plans to meet requirement CFR 484.80(g)(1). 6. Administratorin-serviced all CM on reviewing the aide visit notes monthly with ASV & duringeach recertification assessment for accuracy to correct this standard andensure this does not recur to meet requirements CFR 484.80(g)(1). 7. 100% of agency care plans will be audited by CM immediately for accuracy, as needed with any changes and withevery recertification assessment to prevent a standard from	

	was "noncompliant" with the tasks clean under fingernails, file fingernails, and showering during all aide visits for the certification period 12/05/2022 – 02/02/2023. An interview was conducted with RN #3, RN Case Manager for Patient #3, on 02/08/2023 starting at 3:15 PM. During the interview, the nurse reported they did not regularly review aide visit notes unless there was a "concern" and was unaware Patient #3 was refusing or "noncompliant" with showering and nail care related tasks. The nurse also reported they did not review specific tasks with the patient and/or aide during recertification or supervisory visits to ensure the tasks were still needed and/or appropriate for the patient. 4. Review of Patient #4's clinical record included a Plan of Care for the recertification period 12/18/2022-02/15/2023 which indicated the patient was to receive HHA services for 5 hours per day, 7 days per week for 9 weeks. The record also included an aide care plan which indicated the aide tasks included "bed bath assist …		happening in thefuture to meet requirements CFR 484.80(g)(1). 8. 100% of care plans, POC will be audited quarterly with chart audits to ensure this does not recur to meet requirements CFR 484.80(g)(1). 9. Administrator is responsible formonitoring these actions to ensure this standard is corrected & will notrecur. 10. Completed Date 3-11-23.	

	catheter care … check pressure areas … dressing/clothing assist … hair care … incontinent bowel assist [inability to control bowel movements] … incontinent urine assist … make bed and straighten client area … medication reminders … mobility assist … re-positioning bed/chair … skin care/apply lotion … transfer assist … wheelchair assist." The aide care plan failed to evidence the frequency the above tasks were to be completed. 5. Review of Patient #6's clinical record included a Plan of Care for the recertification period 12/17/2022-02/14/2023 which indicated the patient was to receive HHA services for 1 hour per day, 7 days per week for 9 weeks. The record also included an aide care plan which indicated the aide tasks included "ambulation assist … brush teeth/oral care … check pressure areas … clean client area … clear pathways … document seizure frequency and duration … dressing/clothing assist … incontinent urine [inability to control urination] assist … make bed and straighten client area … mobility assist … nail care … peri			

	care [perineal, cleaning of genital and buttocks areas] … shaving (no blood thinners) … shower assist … skin care/apply lotion … standby assist … transfer assist." The aide care plan failed to evidence the frequency all tasks were to be completed. Findings include: 1. Policy C-751 "Home Health Aide Care Plan" indicated "… A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse… Purpose… To provide a means of assigning duties to the Home Health Aide that are clear to the… Home Health Aide…The Care Plan shall be developed in plain, non-technical lay terms, and identify the duties to be performed… The Home Health Aide Care Plan shall be reviewed and updated by the Registered Nurse minimally every 60 days…" 2. Review of Patient #1's clinical record evidenced a Plan of Care for certification period 01/17/2023 – 03/17/2023 which			

	multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves) and type 2 diabetes mellitus without complications (a chronic condition that affects the way the body processes blood sugar) and included orders for HHA (home health aide) services for 6 hours per day, 5 days per week for 9 weeks. The record also included an aide care plan which included the following tasks: blood sugar reminders, check pressure areas, clean client area, clear pathways, dressing/ clothing assist, hair care, incontinent bowel assist, incontinent urine assist, make bed and straighten client area, meal prep, medication reminders, mobility assist, nail care, pericare, re-positioning bed/ chair, shower assist, skin care/ apply lotion, stand by assist, toileting assist, transfer assist, and did you wear a face mask during your shift. The record indicated the HHA services are scheduled in 2-hour shifts, three times per day, 5 days per week. The aide care plan failed to include a frequency for each task, failed to specify which tasks were to be performed on each of the 3			

	shifts, and failed to specify not to cut nails under nail care for this diabetic patient. 6. During an interview on 02/07/2023 at 02:45 PM, the Administrator indicated they had just noticed the previous day that the EMR software had added the option to include frequency on the aide care plan and admitted could have put "shower in AM," etc., to clarify when to have performed a task on the aide care plan. The Administrator also indicated the aide care plan for a diabetic patient should have said no clipping of the nails under nail care.			
G0804	Aides are members of interdisciplinary team 484.80(g)(4) Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. Based on record review and interview, the home health agency failed to ensure the home health aide completed appropriate documentation of care in compliance with the home health	G0804	**G 0804 CFR 484.80(g)(4) Aides AreMembers of Interdisciplinary Team** 1. Administratorimmediately identified and in-serviced all CMs & aides that was notcompleting aide tasks on the mobile app correctly that meets requirement CFR484.80(g)(4). 2. Administratorin-serviced all CMs & Aides on not marking all of the tasks on every visiton the same day if they are not being completed, mark completed or declined andnote the reason the patient declined the specific service. This is toensure the agency is meeting the requirements CFR 484.80(g)(4) Home Health AideAssignments & Duties. 3. Administratorin-serviced CMs on being specific with patient's shower/bath requests,	2023-03-11

	agency's policies and procedures for 1 of 4 active patients who received home health aide services (Patient #1.) Findings include: 1. Review of Policy C-140 "Position: Home Health Aide" indicated "...Completes the appropriate records to document care given..." 2. Review of Policy C-220 "Home Health Aide Service" indicated "...Home health aides must document each visit at the time care is provided...All services provided by the Home Health Aide shall be documented in the clinical record..." 3. Review of C-800 "Home Health Aide: Documentation" indicated "...Home health aides will document care/ services provided on the home health aide charting form..." 4. Review of Patient #1's clinical record evidenced a Plan of Care for certification period 01/17/2023 – 03/17/2023 which indicated diagnoses including multiple sclerosis (a disease in which the immune system eats away at the protective covering		includesmaking care plan specific for am or pm shower/bath assist to meetrequirement CFR 484.80(g)(4). 4. Administratorin-serviced all aides on reporting changes or needed updates on patients careplans to the CM so the care plan can be changed immediately to meet patientneeds to meet requirement CFR 484.80(g)(4). 5. 100 % ofagency care plans will be reviewed by management/CM immediately & every 60days with recertification assessments for accuracy & compliance to prevent thiselement from happening in the future to meet requirements CFR 484.80(g)(4). 6. Administratorsubmitted a ticket (BCI-357) to Kantime EMR system to try to get care planssection updated to be able to have an am & pm separate care plan to meetrequirement CFR 484.80(g)(4). 7. All care plans were reviewed immediately foraccuracy and updates made to meet compliance. 8. Administrator in-servicedall CM on reviewing the aide visit notes monthly with ASV & during eachrecertification assessment for accuracy to correct this standard and ensurethis does not recur to meet requirements CFR 484.80(g)(1). 9. Administratoris responsible for monitoring these actions to ensure this deficiency iscorrected & will not recur. 10. CompletedDate 3-11-23.	

	of the nerves) and type 2 diabetes mellitus without complications (a chronic condition that affects the way the body processes blood sugar) and included orders for HHA (home health aide) services for 6 hours per day, 5 days per week for 9 weeks. The record included an aide care plan which included the following tasks: blood sugar reminders, check pressure areas, clean client area, clear pathways, dressing/ clothing assist, hair care, incontinent bowel assist, incontinent urine assist, make bed and straighten client area, meal prep, medication reminders, mobility assist, nail care, pericare, re-positioning bed/ chair, shower assist, skin care/ apply lotion, stand by assist, toileting assist, transfer assist, and did you wear a face mask during your shift. The record indicated the HHA services are scheduled in 2-hour shifts, three times per day, 5 days per week. The record evidenced HHA #1 marked every task on the aide care plan as completed all 3 shifts on 01/18/2023, 01/19/2023, 01/20/2023, 01/23/2023, 01/24/2023, 01/25/2023, 01/26/2023,			

	01/27/2023, 01/30/2023, 01/31/2023, 02/01/2023, 02/02/2023, and 02/03/2023. 5. During an interview on 02/02/2023 at 01:39 PM, Patient #1 indicated they normally took a shower during the afternoon shift once per week and indicated they had not taken a shower on 02/01/2023 and had not had plans to shower on 02/02/2023 because of pain. Patient #1 indicated they had not received nail care but had recently purchased an emery board. 6. During an interview on 02/03/2023 at 03:34 PM, HHA #1 indicated they documented their visits and check off the tasks completed in the agency's app and indicated if the patient declined the task, they checked the declination and have a list of reasons to choose. When asked whether they did every task on the task list during each shift for Patient #1, HHA #1 indicated they tried, indicated Patient #1 usually had 1-2 showers per week and that he / she marked a task as completed on each shift if the task was completed at any time during			

	they had not yet assisted Patient #1 with a shower during any shift on 01/31/2023, 02/01/2023, 02/02/2023, nor on 02/03/2023. HHA #1 indicated they did not touch Patient #1's toenails because the patient was a diabetic though had filed and sometimes painted Patient #1's fingernails if Patient requested. 7. During an interview on 02/07/2023 at 02:45 PM, the Administrator indicated the HHA should not have marked each task as completed every shift of the day if the task was only completed on one shift of the day and indicated the HHA should document tasks as completed that were not completed.			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: January 31, February 1, 2, 3, 6, 7, 8, and 9, 2023	N0000		2023-03-24

	Unduplicated skilled admissions for past 12 months: 19 Active patients: 80 QR: Area 2 02/22/23			
N0506	Patient Rights 410 IAC 17-12-3(b)(2)(D)(iii) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on record review and interview, the home health agency failed to provide notice of discharge at least 15 days prior to the date of discharge for 3 of 3 discharge records reviewed of a patient discharged due to noncompliance with the aide care plan (Patients #7, 9, 10). Findings include: Agency policy #C-620 indicated but was not limited to "…	N0506	**N 0506 CFR 410 IAC17-12-3(b)(2)(D)(iii) Patient Rights** 1. 1.) Administrator immediately identifiedthe discharged clients that appeared like they were discharged withoutnotice. Their home health aide services weredischarged but we continued with waiver services, which was more appropriatefor their needs. They were not justDischarged, we continued attendant and homemaking care due to their refusal ofpersonal care needs through HHA. We could have had better charting on whathappened. 2. 2.) Administrator in-serviced managementstaff on the discharge policy & procedure in place (including a 15-daynotice) that is utilized according to interpretive guidelines 484.50(d)(4).Agency to Continue current policy & procedures to meet CFR(s):	2023-03-11

	Discharge Procedure: ... 10. Discharge Notice (15 days' [sic] notice) will be given to all patients of routine discharge ... Discharge Criteria: 1. Criteria for discharge may include ... c. Client is non-compliant with the established plan of care ...." The clinical record of Patient #9 (start of care 06/29/2022, discharge date 08/23/2022) included a plan of care for the initial certification period of 06/29/2022-08/27/2022, which indicated the patient was to receive home health aide services. The record included a Journal Note, documented by Registered Nurse (RN) #4 on 08/23/2022 at 2:45 PM, which indicated the nurse spoke with Patient #9 "to notify [the patient they] do not meet the criteria for HHA services [due to] no personal care ...." During an interview conducted with RN #4 on 02/09/2023 starting at 2:25 PM, the nurse reported Patient #9 was discharged due to no longer qualifying for home health aide services since the patient had frequently refused personal care during home health aide visits. The nurse denied the patient		484.50(d)(4)to prevent a deficiency from happening in the future. 3. 3.) Administrator in-serviced managementstaff to document efforts; and make efforts to resolve the problems presentedby the patient's behaviors, behaviors of other persons in the patient's home,noncompliance or other situations. (Including verbal aggressive behaviors &Threats) to meet requirement CFR(s): 484.50(d)(4). 4. 4.) Administrator in-serviced managementstaff on interpretive guidelines 484.50(d)(4) and clarifying DC reasons,notices, and cause for imminent DC to meet requirement CFR(s): 484.50(d)(4). 5. 5.) Administrator in-serviced CM on beingvery clear in their documentation and notification to the physicians whendischarging home health aide hours and switching them to attendant care underthe waiver program to better meet the patients' needs to meet requirementCFR(s): 484.50(d)(4).	

	was notified of the discharge prior to 08/23/2022. The clinical record of Patient #10 (start of care 10/04/2021, discharge date 12/03/2021) included a plan of care for initial certification period 10/04/2021-12/02/2021 which indicated the patient was to receive home health aide services. The record included a Journal Note, documented on 12/03/2021 by RN #4, which indicated Patient #10 was discharged from the agency that day due to "multiple missed visits [related to the patient] sending aides away. During HHA hours, [Patient #10] has not been wanting assistance with ADLs, only homemaking tasks …." During an interview conducted with RN #4 on 02/09/2023 starting at 2:25 PM, the nurse reported Patient #9 was discharged due to no longer qualifying for home health aide services since the patient had multiple missed visits and frequently refused personal care during HHA services. 2. Review of Patient #7's clinical		6. 6.) Administrator in-serviced CM todocument MD notifications of any issues in care, behaviors, staffing issues,& reasons agency may discharge the pt to prevent a deficiency fromhappening in the future to meet to meet CFR(s): 484.50(d)(4). 7. 7.) Administrator is responsible formonitoring these actions to ensure this deficiency is corrected & will notrecur. 8. 8.) Complete Date 3-11-23.	

	for certification period 10/23/2022 – 12/21/2022 with orders for HHA (home health aide) services 1 hour per day, 3 days per week for 9 weeks for tasks included but not limited to shower assist, check pressure areas, skin care/ apply lotion, and standby assist. The record evidenced a Discharge Summary dated 11/22/2022 and signed by RN #2 which indicated "Reason for Discharge…Agency/Organization decision Explain: discharged due to non-compliance with home health aide tasks…" The record failed to evidence the home health agency provided Patient #7 with any notice of discharge. 5. During an interview on 02/07/2023 at 09:36 AM, Patient #7 indicated they were discharged from the agency by phone with approximately 1 day of notice. 6. During an interview on 02/07/2023 at 02:45 PM, the Administrator indicated the agency did not have to give patients 15 days notice of discharge if the patient was not following the care plan.			

N0597	Scope of Services 410 IAC 17-14-1(l)(1)(B) Rule 14 Sec. (1)(l)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on record review and interview, the home health agency failed to ensure new home health aide [HHA] applicants were submitted to the state aide registry, and / or were identified on the state aide registry and in good standing, prior to the provision of independent unsupervised direct patient care for 25 of 25 active HHA files reviewed with a date of hire date after 7/01/2022 (HHA's #5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 31, and 32). Findings include: Findings include: 1. Review of Policy C-140 "Position: Home Health Aide" indicated "Qualifications... successful completion of a formal certification training program and/or a written skills	N0597	**N 0597 CFR 410 IAC 17-14-1(l)(1)(B)Scope of Service**1.)Administrator immediately identified employees that were not submitted on theregistry at this time and immediately submitted the employees to the registryto meet CFR 410 IAC 17-14-1(l)(1)(B) Scope of Service. 2.) Administrator immediatelyidentified HHA #5 who is an office employee and did not want to become HHAafter her competency, administrator ensured her new job description was alreadyin her employee file. Administrator unsure to submit to registry since she wasnot working as an HHA. Administrator immediately submitted HHA#5 to registry2-6-23 to meet requirement CFR 410 IAC 17-14-1(l)(1)(B). 3.) Administrator will ensureall new home health aides are submitted to HHA registry timely after completionof the HHA competency program before their first patient contact to meet requirement CFR410 IAC 17-14-1(l)(1)(B). 4.) Administratorin-serviced office staff (HR, RN's) that all CNA's who are already licensed withthe state will complete a competency skills assessment to meet 484.80. / an d requirement CFR410 IAC 17-14-1(l)(1)(B). 5.) Administratorimmediately identified the miscommunication between surveyor & staff inregards to the HHA certification program and the HHA competency programrequirements. Administrator immediately in-serviced office staff on thedifferences and to make sure we are using correct terminology and the requirementsfor each program to meet requirement CFR 410 IAC 17-14-1(l)(1)(B). 6.)Administrator is responsible for monitoring these actions to ensure this licenserequirement	2023-03-11

	test and competency evaluation..." 2. Review of the employee record of HHA (Home Health Aide) #5 evidenced a start date of 11/21/2022 and a first patient contact date of 12/07/2022. The record evidenced an application for HHA #5 was submitted to the aide registry on 02/06/2023. The agency failed to evidence an application to the aide registry was submitted for HHA #5 prior to the HHA providing patient care without direct supervision. 3. Review of the employee record of HHA #7 evidenced a start date of 09/21/2022 and a first patient contact date of 10/05/2022. The record evidenced an application for HHA #7 was submitted to the aide registry on 10/17/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #7 prior to the HHA providing patient care without direct supervision. 4. Review of the employee record of HHA #8 evidenced a start date of 08/26/2022 and a		is corrected & will not recur. 7.) Completed Date3-11-23. **REQUESTIDR** -I believe I have misspoken or we have causedconfusion on our home health Aide competency program. Agency has alwaysfollowed regulations on competency of our home health aides. This has never been an issue on any survey inthe past 13 years that I have had my agency. We have completed IAHHC trainingas well for our competency program for aides. And we use IAHHC tests and formsfor our program. Aides get a combination of class and practical supervised hoursto determine their competency. All aides take written and skills check offs andhands on care with a patient in the home to determine if the aide is competent ornot. If further training or competencies are needed then the agency providesmore training. Sometimes this takesweeks because we are working around the new hire's schedules, and when they are available to come in to train. We are in a pandemic –hiring crisis- staffing shortages. So,we try to	

	first patient contact date of 09/06/2022. The record evidenced an application for HHA #8 was submitted to the aide registry on 09/22/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #8 prior to the HHA providing patient care without direct supervision. 5. Review of the employee record of HHA #9 evidenced a start date of 10/13/2022 and a first patient contact date of 10/17/2022. The record evidenced an application for HHA #9 was submitted to the aide registry on 12/14/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #9 prior to the HHA providing patient care without direct supervision. 6. Review of the employee record of HHA #10 evidenced a start date of 07/06/2022 and a first patient contact date of 07/11/2022. The record evidenced an application for HHA #10 was submitted to the aide registry on 08/04/2022. The agency failed to evidence an application to the aide		employees to meet their demands so we canget them hired. You cannot go by hiredate and expect it done in 2 wks from hire date. We do supervise training. · Whenwe have an employee hired that is already a licensed CNA, why are we now havingto make them go through HHA class? Theyare already licensed and have completed school. We do not make nurses retrain on hire, whyare we doing this with CNAs now? The CNAs renew their license on the registrythemselves, not the agency hiring them. TheCNA's are already licensed before hire and they maintain this. These staff (CNA) are observed& skills reviewed to determine competency.	

registry was submitted for HHA #10 prior to the HHA providing patient care without direct supervision.

7. Review of the employee record of HHA #11 evidenced a start date of 08/11/2022 and a first patient contact date of 08/23/2022. The record evidenced an application for HHA #11 was submitted to the aide registry on 09/22/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #11 prior to the HHA providing patient care without direct supervision.

8. Review of the employee record of HHA #12 evidenced a start date of 10/04/2022 and a first patient contact date of 10/11/2022. The record evidenced an application for HHA #12 was submitted to the aide registry on 02/09/2023. The agency failed to evidence an application to the aide registry was submitted for HHA #12 prior to the HHA providing patient care without direct supervision.

9. Review of the employee

· Wehired an office scheduler, not HHA, (HHA #5) who decided to be receptionistinstead of in the staffing department. She was not required to be an HHA. Shewas not required to complete home health aide training due to job position& change that we decided was a better fit for HHA #5.

· Allnew home health aides take written test, skills check offs and required competencyto determine if they are competent to start working. All information is in their files. I submit their certifications according to pay periods and I verifyhours worked.

· Weare also trying to work with new programs that hire family to care forfamily. A Large percentage of theseemployees fall under the waiver agency as attendant care or homemakers. Not HHA's.

· UsingKantime EMR we enter the new home health aides in the computer so we can teachthem how to use the Kantime mobile app for their tasks and aide visits,

start date of 10/31/2022 and a first patient contact date of 11/21/2022. The record evidenced an application for HHA #13 was submitted to the aide registry on 12/14/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #13 prior to the HHA providing patient care without direct supervision.

10. Review of the employee record of HHA #14 evidenced a start date of 11/11/2022 and a first patient contact date of 11/17/2022. The record evidenced an application for HHA #14 was submitted to the aide registry on 02/06/2023. The agency failed to evidence an application to the aide registry was submitted for HHA #14 prior to the HHA providing patient care without direct supervision.

11. Review of the employee record of HHA #15 evidenced a start date of 01/09/2023 and a first patient contact date of 01/20/2023. The record did not evidence an application for HHA #15 was submitted to the aide registry. The agency failed to evidence an application to the

showing them how to use the app. The surveyor cannotcount the scheduled visits in Kantime as their first day alone working, we haveto do training. So, if they look at hiredate and the first date that the employee shows on the schedule, it is notaccurate to count that as their first work day unsupervised alone. This would be a day or first day of patientcontact but not an unsupervised visit.

· Also, some employees charts that were reviewed were brand new hires and not on the registry yet, so no datewould be on the registry for the surveyor to see if not submitted yet.

· Thesurveyors were unclear on this issue as well when they were here, they saidthey needed to get clarification from their supervisors.

· Ourstaff is determined competent before they work on their own.

I do not agree with this licenserequirement not being met. I am askingfor this to be

	aide registry was submitted for HHA #15 prior to the HHA providing patient care without direct supervision. 12. Review of the employee record of HHA #16 evidenced a start date of 11/21/2022 and a first patient contact date of 12/14/2022. The record evidenced an application for HHA #16 was submitted to the aide registry on 02/06/2023. The agency failed to evidence an application to the aide registry was submitted for HHA #16 prior to the HHA providing patient care without direct supervision. 13. Review of the employee record of HHA #17 evidenced a start date of 08/02/2022 and a first patient contact date of 08/12/2022. The record evidenced an application for HHA #17 was submitted to the aide registry on 09/22/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #17 prior to the HHA providing patient care without direct supervision. 14. Review of the employee		follow our competency program to meet CFR 410 IAC 17-14-1(I)(1)(B). See attached docs	

start date of 09/13/2022 and a first patient contact date of 09/19/2022. The record evidenced an application for HHA #18 was submitted to the aide registry on 10/17/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #18 prior to the HHA providing patient care without direct supervision.

15. Review of the employee record of HHA #19 evidenced a start date of 11/11/2022 and a first patient contact date of 11/22/2022. The record evidenced an application for HHA #19 was submitted to the aide registry on 12/14/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #19 prior to the HHA providing patient care without direct supervision.

16. Review of the employee record of HHA #20 evidenced a start date of 11/07/2022 and a first patient contact date of 11/18/2022. The record evidenced an application for HHA #20 was submitted to the aide registry on 02/06/2023. The agency failed to evidence

an application to the aide registry was submitted for HHA #20 prior to the HHA providing patient care without direct supervision.

17. Review of the employee record of HHA #21 evidenced a start date of 09/21/2022 and a first patient contact date of 10/11/2022. The record evidenced an application for HHA #21 was submitted to the aide registry on 02/06/2023. The agency failed to evidence an application to the aide registry was submitted for HHA #21 prior to the HHA providing patient care without direct supervision.

18. Review of the employee record of HHA #22 evidenced a start date of 10/21/2022 and a first patient contact date of 10/31/2022. The record evidenced an application for HHA #22 was submitted to the aide registry on 12/14/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #22 prior to the HHA providing patient care without direct supervision.

19. Review of the employee

record of HHA #23 evidenced a start date of 10/17/2022 and a first patient contact date of 10/27/2022. The record evidenced an application for HHA #23 was submitted to the aide registry on 12/14/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #23 prior to the HHA providing patient care without direct supervision.

20. Review of the employee record of HHA #24 evidenced a start date of 08/22/2022 and a first patient contact date of 09/08/2022. The record evidenced an application for HHA #24 was submitted to the aide registry on 09/22/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #24 prior to the HHA providing patient care without direct supervision.

21. Review of the employee record of HHA #25 evidenced a start date of 08/01/2022 and a first patient contact date of 08/02/2022. The record evidenced an application for HHA #25 was submitted to the

The agency failed to evidence an application to the aide registry was submitted for HHA #25 prior to the HHA providing patient care without direct supervision.

22. Review of the employee record of HHA #26 evidenced a start date of 09/02/2022 and a first patient contact date of 09/12/2022. The record evidenced an application for HHA #26 was submitted to the aide registry on 10/17/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #26 prior to the HHA providing patient care without direct supervision.

23. Review of the employee record of HHA #27 evidenced a start date of 01/24/2023 and a first patient contact date of 01/30/2023. The record did not evidence an application for HHA #27 was submitted to the aide registry. The agency failed to evidence an application to the aide registry was submitted for HHA #27 prior to the HHA providing patient care without direct supervision.

24. Review of the employee

record of HHA #28 evidenced a start date of 11/16/2022 and a first patient contact date of 12/01/2022. The record did not evidence an application for HHA #27 was submitted to the aide registry. The agency failed to evidence an application to the aide registry was submitted for HHA #28 prior to the HHA providing patient care without direct supervision.

25. Review of the employee record of HHA (Home Health Aide) #31 evidenced a start date of 11/17/2022 and a first patient contact date of 11/23/2022. The record evidenced an application for HHA #31 was submitted to the aide registry on 12/14/2022. The agency failed to evidence an application to the aide registry was submitted for HHA #31 prior to the HHA providing patient care without direct supervision.

26. Review of the employee record of HHA (Home Health Aide) #32 evidenced a start date of 12/12/2022 and a first patient contact date of 12/23/2022. The record evidenced an application for

aide registry on 02/06/2023. The agency failed to evidence an application to the aide registry was submitted for HHA #32 prior to the HHA providing patient care without direct supervision.

27. During an interview on 02/08/2023 at 02:25 PM, the Administrator indicated HHA #5 had only provided services for one (1) patient for the home health agency and was then transitioned into an office position.

28. During an interview on 02/08/2023 at 03:30 PM, the Administrator indicated they usually hold HHA registry applications until they "have 75 hours in." The Administrator also indicated as long as HHAs have finished testing and skills check off they can staff patients on their own.

29. During an interview on 02/09/2023 at 12:23 PM, the Administrator indicated the agency did not submit an application to the aide registry for HHA #27 because the aide was already "licensed" as a CNA and indicated CNAs did not need to have applications

submitted to the aide registry to work as HHAs. The Administrator also indicated during the interview once the HHAs passed the 16 class hours and 16 competency hours and skills check off they put them on the schedule. The Administrator also indicated "we aren't staring at them" but indicated they did surprise visits and called patients to see how the aide was doing in order to supervise.

30. During an interview on 02/09/2023 at 03:21 PM, the Administrator indicated if an HHA was not listed on the aide registry submission list received during the interview there had not been an application submitted to the registry for that HHA. When asked for the first date each HHA provided care to a patient without direct supervision, the Administrator indicated they did not know how they would know that information and indicated the surveyors had to use the first patient contact date from the list provided by the Director of Nursing on 02/02/2023 at 11:07 AM.

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
Bethany Whybrew RN	Owner	3/16/2023 3:49:17 PM