STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K153	A. BUILDING B. WING	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM - PM HOME HEALTH SERVICES LLC	3906 W 86TH STREET, INDIANAPOLIS, IN, 46268

(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
G0000	INITIAL COMMENTS This visit was for a 2nd revisit of a Home Health Provider, to conduct a Post Condition Revisit (PCR) survey. The 1st revisit occurred on 06-08-23. Survey Dates: 07-18-2023, 07-19-2023, and 07-20-2023 Census: 25 Unduplicated Skilled Patients: 4 AM PM Home Health Services continued to be out of compliance with the Condition of Participation: Care Planning, Coordination of Services, and Quality of Care, 484.60. Condition-level deficiencies were first identified during April 24, 2023 survey, in which your agency was subject to a fully extended survey pursuant to section 1891(c)(2)(D) of the	G0000	G000 AM-PM Home Health Services, LLC is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by AM-PM Home Health Services, LLC that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. AM-PM Home Health Services, LLC desires this Plan of Correction to be considered our Allegation of Compliance.	

	Social Security Act, and continued at the first PCR survey on 06-06-2023 and 06-08-2023, Condition-level deficiencies were also cited during this PCR survey on 07-20-2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating or being the site of a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning April 24, 2023, and continuing through April 24, 2025. QR completed by A3 on 07-25-2023 - 7-27-2023			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment reflected the patient's relevant medical history and current health problems; the patient's	G0528	G0528 Director of Nursing will in-service nurses on requirements for comprehensive assessment to include the following - reflect the patient's relevant medical history and current health problems; the patient's psychosocial status, such as ability to participate in care, ability to identify and meet one's needs, and support	2023-08-27

	psychosocial status, such as ability to participate in care, ability to identify and meet one's needs, and support systems available; and education, knowledge level, and ability to understand and learn for 6 of 6 active patients whose records were reviewed. (Patients #1, 2, 3, 4, 5, and 6) Findings include: 1. A Briggs Healthcare policy was provided by the Administrator on 07-18-2023 at 12:55 PM. The "Comprehensive Client Assessment," Policy No. C-145 indicated, but was not limited to, " ... Purpose ... To determine the appropriate care, treatment, and services to meet client needs and his/her changing needs ... Special Instructions ... 3... b. Demographic and client history ... e. Respiratory status f. supportive assistance ... m. Neuro/emotional/behavioral status ... 11. Client needs are assessed and care guidelines established based on assessment data ..." 2. On 07-18-2023 at 11:20 AM, Patient #1's clinical record was reviewed. The clinical record		systems available; and education, knowledge level, and ability to understand and learn. Assessment must have goals for interventions and nurse must document education provided. If there are no new issues to educate on nurse should re-instruct patient on areas of concern from previous certification period. Nurses are to review comprehensive assessment before submitting to ensure all areas of assessment are complete and accurately reflect patient's current status.(8/27/2023) Director of Nursing/designee will review all active patient comprehensive assessments to ensure they are complete and accurately reflect patient's current status, have goals for interventions and there is documentation patient was re-instructed on areas of concern during previous certification period if there are no new issues to educate on. If assessment is not complete and/or accurate the nurse who did assessment in question will revise assessment to accurately reflect patient's status. (8/27/2023)	

	contained a document titled "Assessment Details" and was dated 07-05-2023 and signed by the Administrator. The document evidenced, but was not limited to, the following diagnoses: Blindness in both eyes, dependence on renal dialysis (a treatment where some of the blood was removed from the body to remove waste. It replaces the non-functioning kidneys), above the knee amputation of the right and left leg, Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Neuropathy (nerves were damaged because of the disease), Anemia in chronic kidney disease (a disease where the kidneys are unable to produce enough erythropoietin, causing low red blood cell levels), previous occurrence of sepsis (an infection affecting the entire body), and chronic pain. The assessment failed to indicate how the patient communicated and if there was a speech/language barrier. The assessment failed to indicate how pain effects the patient's activities of daily living. The assessment indicated in integumentary status that there		Director of Nursing/designee will audit all comprehensive assessments submitted weekly to ensure they are complete and accurately reflect patient's status. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service nurses on need for plans of care to be specific to patient's assessed needs and condition. (8/27/2023) Director of Nursing/designee will review all active patient plans of care to ensure they are specific to patient's assessed needs and condition. Any plan that is not specific the nurse will contact MD to obtain verbal order to revise plan to make it specific to patient. (8/27/2023) Director of Nursing/designee will audit all plans of care submitted weekly to ensure they are specific to patient's needs and condition. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring	

	were “no open wounds”, in the section titled “Nutritional Health Screen” they marked “Skin issues: Pressure Ulcers.” The assessment failed to describe the location and the assessment/appearance of the pressure ulcer. The assessment contained a section titled “Respiratory Status” and for the subsection titled “Lung Sounds”, the Administrator marked “Diminished.” The “Lung Sounds” section indicated, but was not limited to, “… Diminished… Left: (sic blank), Upper Left: (sic blank), Lower Left: (sic blank), Right: (sic blank), Upper Right: (sic blank), Lower Right: (sic blank) …”. The assessment failed to indicate the patient’s respiratory status. The assessment contained a section titled “Endocrine”, indicated the blood sugar range was 120-150. The assessment contained a section titled “SN (sic Skilled Nurse) Endocrine Goals,” that indicated the blood sugar goals were 100-150. The section titled “Patient/Caregiver Education Provided this visit:” failed to indicate what education was provided to the patient and if they understood the education and the assessment failed to document		these corrective actions to ensure that this deficiency is corrected and will not recur	

	an accurate description/assessment of Patient #1's current health status. 3. On 07-18-2023 at 1:45 PM, Patient #3's clinical record was reviewed. The clinical record evidenced a document titled "Assessment Details," dated on 07-07-2023 and signed by the Administrator. The document evidenced, but was not limited to, the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD) (a disease that blocks the airway and caused breathing difficulties), sequelae of cerebral infarction (residual symptoms after a disruption of blood to the brain), age-related physical debility (pain and weakness that come with age), Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Neuropathy (nerves were damaged because of the disease), and trochanteric bursitis of the right hip (a condition caused by inflammation in the hip). The assessment evidenced in the section titled "Ear/Nose/Throat/Mouth" and subsection titled "Mouth Condition", the Administrator			

	indicated the mouth condition was normal. The section titled "Nutrition/hydration status" evidenced the patient had dentures. The assessment failed to accurately depict the patient. The assessment contained a section titled "Respiratory Status" and for the subsection titled "Lung Sounds", the Administrator marked "Diminished". The "Lung Sounds" section indicated but was not limited to, "... Diminished... Left: (sic blank), Upper Left: (sic blank), Lower Left: (sic blank), Right: (sic blank), Upper Right: (sic blank), Lower Right: (sic blank) ...". The assessment failed to indicate the patient's respiratory status. The section titled "Patient/Caregiver Education Provided this visit:" failed to indicate what education was provided to the patient and if they understood the education. The assessment failed to evidence this diabetic's feet were assessed. The assessment failed to demonstrate an accurate description/assessment of Patient #3's current health status. 4. On 07-19-2023 at 12:57 PM,			

	Patient #4's clinical record was reviewed. The clinical record evidenced a document titled "Assessment Details," dated 07-06-2023 and signed by the Alternate Administrator. The document evidenced but was not limited to the following diagnoses: Fibromyalgia (a disorder that causes pain throughout the body), Orthostatic hypotension (when an individual stands after sitting or lying down and the blood pressure drops), Type 2 Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Polyneuropathy (the disease effects the nerves in the extremities), Hypertension (high blood pressure), sleep apnea (breathing stops and starts during sleep), chronic fatigue, and Hyperlipidemia (high lipids in the blood). The assessment failed to include blood pressure parameters for when the nurse was to contact the physician or when the patient was to contact the nurse or physician. The assessment failed to include how the patient's pain effected their activities of daily living. The assessment contained a section titled "Respiratory			

	Status" and for the subsection titled "Lung Sounds", the Administrator marked "Wheezes". The "Lung Sounds" section indicated but was not limited to, "... Wheezes... Left: (sic blank), Upper Left: (sic blank), Lower Left: (sic blank), Right: (sic blank), Upper Right: (sic blank), Lower Right: (sic blank) ...". The assessment failed to indicate the patient's respiratory status. The assessment failed to document an accurate description/assessment of Patient #4's current health status. 5. During an interview with the Administrator on 07-18-2023 at 2:55 PM, the Administrator indicated the electronic medical record system would alert the nurse if a section of the assessment was incomplete. The Administrator and Alternate Administrator indicated they were able to fill out goals for each intervention and removed the blank goals. When queried regarding education taught to patients during the recertification, the Administrator indicated it depended on who the patient			

	was. The Administrator indicated that their patients were well-versed in their diseases. 6. During an interview with the Administrator, Owner, and Scheduler on 07-19-2023 at 2:45 PM, the Administrator indicated they were working on making the plans of care more specific, and removing the duplicates that are pulled from the assessment from their electronic medical record. The Administrator indicated that if a finding for respiratory was abnormal, clinicians were to indicate why it was abnormal in the assessment. 7. A review of the comprehensive assessment for Patient #2, dated 07-13-2023, evidenced diagnoses, but not limited to, Underweight, Other specified congenital malformations (birth defects), unspecified intellectual disabilities (a disability that affects the acquisition of knowledge and skills), blindness, one eye, and unspecified sensorineural hearing loss (hearing loss caused by damage to the inner			

	the brain). The assessment indicated the patient's caregiver able/willing to provide care, then indicated the caregiver was not able/willing to assist with ADL's (activities of daily living), failed to: provide patient weight monitoring, indicate any communication, speech/language barriers, identify nutritional status/needs, identify hearing loss, identify unsteady gait, identify assistance for ambulation/use of assistive device, visual or auditory impairment, and indicated the patient was not a fall risk. On page 3 of 23 of the assessment, Patient #2 weight was documented as 92 versus page 12 of 23, indicated Patient #2's weight was 130. Under the Nursing assessment and Evaluation page 4 of 23, Patient weight monitoring was not documented. The comprehensive assessment for Patient #2 failed to reflect Patient #2's relevant medical history and current health problems and support systems available. 8. A review of the comprehensive assessment for Patient #5 dated 07-13-2023,			

	limited to, Cerebral Palsy (a congenital disorder of movement, muscle tone, or posture. Cerebral palsy is due to abnormal brain development, often before birth), autistic disorder (neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures, and moderate intellectual disabilities). The comprehensive assessment section titled, "Communication" was left bland, indicated the patient had a surgical incision, but did not indicate where, and ADL's (activities of daily living) functional limitations failed to indicate difficulty with ambulation. The comprehensive assessment for Patient #5 failed to identify communication level and ADL's functional limitations and relevant medical history. 9. A review of the comprehensive assessment for Patient #6 dated 07-12-2023, evidenced diagnoses, but not limited to, cerebral infarction (occurs as a result of disrupted blood flow to the brain due to			

	the problems with the blood vessels that supply it. A lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and a history of falling. The assessment indicated family was supportive, caregiver not able/willing to provide care, caregiver not able to receive/follow instructions, caregiver not able/willing to assist with ADL's and needed care, and caregiver is able to safely care for patient, Respiratory status indicated lung sounds were diminished, all other respiratory assessments were bland, failed to indicate: respiratory care plan, interventions/order skilled nursing assessment, evaluation, and treatment, gastrointestinal status, who prepared their meals, and their ability to plan an prepare light meals. The comprehensive assessment failed to identify support systems, medical history, current health problems, and ADL's.			

	10. On 07-20-2023 at 10:28 AM, during an interview the Administrator indicated the home health agency expected a head to toe assessment to be completed, indicated that Patient #5 did not have a surgical wound and didn't know why that was marked on the assessment, and expected all areas on the comprehensive assessment to be completed. The Administrator further indicated they have had difficulties with their electronic medical records system, and they were attempting to address the problem areas. 410 IAC 17-14-1(a)(1)(B)			
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes	G0530	G0530 Director of Nursing will in-service nurses that the comprehensive assessment is to have patient-specific goals that reflect patient's current assessed needs and health	2023-08-27

	identified by the HHA; Based on record review and interview, the agency failed to ensure the patients' comprehensive assessment had patient-specific goals with measurable outcomes for 5 of 6 clinical records reviewed. (Patient: 1, 2, 3, 4, and 6) Findings Include: 1. A Briggs Healthcare policy was provided by the Administrator on 07-18-2023 at 12:55 PM. The "Comprehensive Client Assessment" Policy No. C-145 indicated but was not limited to, " ... Special Instructions ... 7 ... goals are identified, and/or continuing care needs are recognized ... 11. Client needs are assessed and care guidelines established based on assessment data ... " 2. On 07-18-2023 at 11:20 AM, Patient #1's clinical record was reviewed. The clinical record contained a document titled "Assessment Details" and was dated 07-05-2023 and signed by the Administrator. The document evidenced but was not limited to the following diagnoses: Blindness in both eyes, dependence on renal		status and have measurable outcomes, indicate what education was provided and if patient verbalized understanding of that education and if goals from previous certification period were effective. Assessment is to be complete, accurate and based on patient'scurrent assessed needs. (8/27/23) Director of Nursing/designee will audit all current patient comprehensive assessments to ensure they have patient-specific goals that reflect patient's current assessed needs and health status and have measurable outcomes, indicate what education was provided and if patient verbalized understanding of that education and were goals from previous certification period were effective. (8/27/2023) Director of Nursing/designee will audit all comprehensive assessments submitted weekly to ensure they have patient-specific goals that reflect patient's current assessed needs and health status and have measurable	

	dialysis (a treatment where some of the blood was removed from the body to remove waste. It replaces the non-functioning kidneys), above the knee amputation of the right and left leg, Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Neuropathy (nerves were damaged because of the disease), Anemia in chronic kidney disease (a disease where the kidneys are unable to produce enough erythropoietin, causing low red blood cell levels), previous occurrence of sepsis (an infection affecting the entire body), and chronic pain. The assessment failed to evidence communication goals or interventions. The assessment failed to evidence respiratory goals for the patient. The assessment failed to evidence Skilled Nursing (SN) instructions and Teaching under the section titled “Renal/Genitourinary Status” The section titled “Digestive/Gastro” failed to evidence SN instructions and teaching. The section titled “Endocrine” failed to indicate when the nurse should report the blood sugar level to the physician, no boxes were		education was provided and if patient verbalized understanding of that education and were goals from previous certification period were effective. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service nurses on requirements for comprehensive assessment to include the following - reflect the patient's relevant medical history and current health problems; the patient's psychosocial status, such as ability to participate in care, ability to identify and meet one's needs, and support systems available; and education, knowledge level, and ability to understand and learn. Assessment must have goals for interventions and nurse must document education provided. If there are no new issues to educate on nurse should re-instruct patient on areas of concern from previous certification period. Nurses are to review comprehensive assessment before submitting to ensure all areas of	

	selected for educating the patient regarding the disease process and complications, signs of low/high blood sugar, following the diet prescribed by the physician, monitoring glucose levels and maintaining a log, what signs and symptoms to report to the nurse or physician, reporting blood sugar levels, complying with medication, and using aseptic technique. The section titled "Patient/Caregiver Education Provided this visit:" failed to indicate what education was provided to the patient and if they understood the education. The assessment failed to ensure the assessment, treatment, teaching, and goals were effective and individualized to Patient #1's needs. 3. On 07-18-2023 at 1:45 PM, Patient #3's clinical record was reviewed. The clinical record evidenced a document titled "Assessment Details" dated on 07-07-2023 and signed by the Administrator. The document evidenced but was not limited to the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD) (a disease that blocks the airway and caused		assessment are complete and accurately reflect patient's current status. (8/27/23) Director of Nursing/designee will review all active patient comprehensive assessments to ensure they are complete and accurately reflect patient's current status, have goals for interventions and there is documentation patient was re-instructed on areas of concern during previous certification period if there are no new issues to educate on. If assessment is not complete and/or accurate the nurse who did assessment in question will revise assessment to accurately reflect patient's status. (8/27/23) Director of Nursing/designee will audit all comprehensive assessments submitted weekly to ensure they are complete and accurately reflect patient's status. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service nurses on need for plans of care to be specific to patient's assessed needs and condition. (8/27/23)	

	breathing difficulties), sequelae of cerebral infarction (residual symptoms after a disruption of blood to the brain), age-related physical debility (pain and weakness that come with age), Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Neuropathy (nerves were damaged because of the disease), and trochanteric bursitis of the right hip (a condition caused by inflammation in the hip). The assessment failed to include Cardiac teaching and instructions to the patient and failed to indicate cardiac goals of the patient. The assessment failed to indicate pain goals. The assessment failed to indicate under the section titled "Integumentary Status" assessments, treatments, evaluations, instruction and teaching, and integumentary goals for the patient. The assessment failed to include respiratory goals for the patient. The section titled "Digestive/Gastro – Care Plan/Interventions/Orders", it failed to indicate how Skilled Nursing would assess, evaluate, treat, and instruct/teach the patient regarding the digestive		Director of Nursing/designee will review all active patient plans of care to ensure they are specific to patient's assessed needs and condition. Any plan that is not specific the nurse will contact MD to obtain verbal order to revise plan to make it specific to patient. (8/27/23) Director of Nursing/designee will audit all plans of care submitted weekly to ensure they are specific to patient's needs and condition. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	system. The assessment failed to include goals for the digestive system for the patient. The assessment failed to indicate in the section titled "Endocrine" what parameters the nurse was to inform the physician of blood sugar levels. The assessment failed to include what parameters the patient should inform the physician or nurse of the blood sugar levels. The assessment failed to include Endocrine goals for the patient. The assessment failed to ensure the patient was assessed for their use with their assistive device as evidenced in the "Musculoskeletal Care Plan/Intervention/Orders" section. The box labeled "Patient's need/use of assistive device" was unchecked. The goals failed to indicate that the patient would use their assistive device effectively. The 60-day clinical summary indicated the patient was ambulating with a cane. On page 19, for Skilled Nursing Care Plan/Orders, the assessment, evaluation, and goals were blank. The section titled "Patient/Caregiver Education Provided this visit:" failed to indicate what education was provided to the patient and if they understood			

	the education. The assessment failed to ensure the assessment, treatment, teaching, and goals were effective and individualized to Patient #3's needs. 4. On 07-19-2023 at 12:57 PM, Patient #4's clinical record was reviewed. The clinical record evidenced a document titled "Assessment Details" dated 07-06-2023 and signed by the Alternate Administrator. The document evidenced but was not limited to the following diagnoses: Fibromyalgia (a disorder that causes pain throughout the body), Orthostatic hypotension (when an individual stands after sitting or lying down and the blood pressure drops), Type 2 Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Polyneuropathy (the disease effects the nerves in the extremities), Hypertension (high blood pressure), sleep apnea (breathing stops and starts during sleep), chronic fatigue, and Hyperlipidemia (high lipids in the blood). The assessment failed to include blood pressure			

	parameters for when the nurse was to contact the physician or when the patient was to contact the nurse or physician. The assessment failed to include the Skilled Nurse would assess and evaluate the effectiveness of the pain management for the patient. The assessment failed to indicate how the Skilled Nurse would assess, evaluate and treat the integumentary status of the patient. The assessment failed to include integumentary education and goals for the patient. The assessment failed to include goals for the patient's respiratory status and renal status. The assessment failed to include an in the Digestive/Gastro Care plan Assessment and Evaluation that they would assess the gastrointestinal status. The assessment failed to include teaching and instructions for the patient's digestive care plan. The Neuro care plan/interventions/orders failed to include the Skilled Nurse would educate the patient on fall precautions, and safe transfers. The assessment failed to ensure			

	teaching, and goals were effective and individualized to Patient #4's needs. 5. During an interview with the Administrator on 07-18-2023 at 2:55 PM, the Administrator indicated the electronic medical record system would alert the nurse if a section of the assessment was incomplete. The Administrator and Alternate Administrator indicated they were able to fill out goals for each intervention and removed the blank goals. When queried regarding education taught to the patients during the recertification, the Administrator indicated it depended on who the patient was and what their main focus was. The Administrator indicated that their patients were well-versed in their diseases. 6. During an interview with the Administrator, Owner, and Scheduler on 07-19-2023 at 2:45 PM, the Administrator indicated they were working on making the plans of care more specific, and removing the duplicates that are pulled from the assessment from their			

	Administrator indicated that if a finding for respiratory was abnormal, they were to indicate why it was abnormal. 7. A review of the clinical record for Patient #2 revealed an Assessment Details document, dated 07-13-2023, evidenced diagnoses but not limited to Underweight, Other specified congenital malformations (birth defects), unspecified intellectual disabilities9a disability that affects the acquisition of knowledge and skills), blindness, one eye, and unspecified sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain). The document failed to evidence effective communication interventions or goals, failed to evidence a goal for nutrition/hydration status, and failed to evidence interventions and goals for the need/use of assistive devices, 8. A review of the clinical record for Patient #6 revealed an Assessment Details document dated 07-12-2023, evidenced diagnoses but not			

	(occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it.), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and history of falling. The document failed to evidence cardiac interventions or goals, and failed to evidence respiratory interventions and goals.			
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.	G0570	Director of Nursing will in-service nurses all the requirements of a plan of care to include patient-specific goals, patient-specific interventions, education. (8/27/23) Director of Nursing/designee will audit all current patient plan of care to ensure they include all the required elements including patient specific goals, patient-specific interventions, education. Nurse will contact MD to obtain verbal order for any plan of care that is missing any required elements including specific goals or services being provided. (8/27/23) Director of Nursing/designee will audit all plans of care submitted weekly to ensure they contain all required elements including patient specific goals, patient-specific interventions, education. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure	2023-08-27

	Based on record review and interview, the agency failed to ensure patients had an individualized plan of care as noted in 6 of 6 active clinical records reviewed. The records failed to provide patient-specific interventions, education, and measurable outcomes and goals (G574). (Patients #1, 2, 3, 4, 5, and 6) The cumulative effects of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.60, Care Planning, Coordination of Care, and Quality of Care. 410 IAC 17-13-1 (a) *		that this deficiency is corrected and will not recur.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her	G0572	Director of Nursing in-serviced nurses on the need for persons receiving attendant care to have MD orders for attendant care. Those patients are to be treated like patients receiving home health aide services. (8/17/23)	2023-08-27

	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 agency failed to obtain orders for Attendant Care Services (ATTC) from the physician for 1 of 1 patient who received Home Health Aide and Attendant Care Services out of a sample of 6. (Patient #3) Findings Include: 1. A Briggs Healthcare policy was provided by the Administrator on 07-18-2023 at 12:55 PM. The "Clinical Documentation" Policy No. C-680 indicated but was not limited to, " ... Purpose ... To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement ... 4. Telephone or other communication with clients, physicians ... or members of the health care team will be documented in clinical progress notes or other interagency communication form ..." 2. On 07-18-2023 at 1:45 PM, Patient #3's clinical record was reviewed and evidenced a plan		Director of Nursing will instruct nurses they are to obtain orders, to include frequency, duration and tasks to be provided, for attendant care services being provided to patients currently receiving attendant care. (8/17/23) Director of Nursing/designee will obtain discharge orders for patients cited for attendant care services. Once an order is received from MD and area on aging case manager has obtained a personal service agency to take over attendant care services the patient's attendant care services will be discharged. (8/27/23) Director of Nursing will in-service staff that patients who also need attendant care services need to be referred to a personal service agency. (8/17/23) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	of care signed by the Administrator, with a start of care date of 01-10-2023 and a certification period from 07-09-2023 to 09-06-2023. The plan of care indicated Patient #3 was to receive Home Health Aide (HHA) services 6 hours a day, 7 days a week. The plan of care failed to evidence orders for Attendant care services (ATTC) with this home health agency. The agency failed to provide communication notes or a plan of care to the physician that indicated the patient received ATTC services from the agency. 3. During an interview with the Administrator and the Scheduler on 07-19-2023 at 12:15, they indicated Patient #3 received waiver hours through the agency for Attendant Care Services. The Administrator indicated they do not list Attendant Care services on the plan of care because ATTC was billed separately. The Administrator indicated they had never sent an order for Attendant care services from the agency to the physician. During an interview with the			

	Scheduler on 07-19-2023 at 12:43 PM, they confirmed Patient #3 received waiver services for Attendant care with this home health agency. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and	G0574	Director of Nursing will in-service nurses all the requirements of a plan of care to include patient-specific goals, include all services provided by agency. (8/27/23) Director of Nursing/designee will audit all current patient plan of care to ensure they include all the required elements including patient specific goals and all services being provided by agency. Nurse will contact MD to obtain verbal order for any plan of care that is missing any required elements including specific goals or services being provided. (8/27/23) Director of Nursing/designee will audit all plans of care submitted weekly to ensure they contain all required elements including patient specific goals and all services being provided by agency.	2023-08-27

	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 agency failed to ensure the patients' plans of care had patient-specific goals for 5 of 6 (Patient #1, 2, 3, 4, and 6) clinical records reviewed and failed to ensure all services the agency provided were listed on the plan of care for the physician's review for 1 of 1 (Patient #3) patient who received both home health aide and attendant care services from the home health agency for a total of 6 patient records reviewed. Findings Include: 1. A Briggs Healthcare policy was provided by the Administrator on 07-18-2023 at 12:55 PM. The "Plan of Care" Policy No. C-580 indicated but was not limited to, " ... 2. The Plan of Care shall be completed in full to include ... c. Type, frequency, and duration of all visits/services ... e. Need for/presence of home medical equipment and assistive devices ... j. Functional limitations and		Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	precautions … l. Specific dietary or nutritional requirements or restrictions … n. Medical supplies and equipment required … q. Treatment goals … ” 2. On 07-18-2023 at 11:20 AM, Patient #1’s clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 08-02-2018 and a certification period of 07-07-2023 to 09-04-2023. The plan of care included but was not limited to the following diagnoses: Blindness in both eyes, dependence on renal dialysis (a treatment where some of the blood was removed from the body to remove waste. It replaces the non-functioning kidneys), above the knee amputation of the right and left leg, Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Neuropathy (nerves were damaged because of the disease), Anemia in chronic kidney disease (a disease where the kidneys are unable to produce enough erythropoietin, causing low red blood cell levels), previous occurrence of sepsis (an infection affecting the entire			

	body), and chronic pain. The plan of care failed to include Home Health Aide frequency and duration. The plan of care indicated but was not limited to, "... Orders and Goals... Home Health Aide Orders... Order: Home Health Aide to provide/assist with personal care and assistance with ADLs (sic Activities of Daily Living) ...". The plan of care failed to include blood glucose parameters for the patient and when the physician was to be notified. The plan of care failed to include goals related to the patient's diagnosis of Diabetes. 3. On 07-18-2023 at 1:45 PM, Patient #3's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 01-10-2023 and a certification period of 07-09-2023 to 09-06-2023. The plan of care indicated but was limited to the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD) (a disease that blocks the airway and caused breathing difficulties), sequelae of cerebral infarction (residual symptoms after a disruption of blood to the brain), age-related physical			

	come with age), Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Neuropathy (nerves were damaged because of the disease), and trochanteric bursitis of the right hip (a condition caused by inflammation in the hip). The plan of care indicated but was not limited to, "... Clinical Summary... grab bars in shower... ambulating with cane...". The plan of care failed to include all necessary Diabetic supplies on the plan of care, including chemstrips. The plan of care failed to include all durable medical equipment the patient had or would need for ongoing care. The plan of care indicated in the section titled "Orders and Goals" but was not limited to, "... Order: Skilled Nursing to teach and instruct: Emergency Preparedness Planning. Goal: Patient/Caregiver will remain safe at home during plan of care... Order... Ambulation safety, fall precautions... Goal: Patient will remain safe at home during plan of care. Patient/Caregiver will demonstrate correct safety techniques related to care			

	within ... Order ... Cardiovascular/Pulmonary status. Goal: stable cardiopulmonary status ... Order: Skilled nursing Frequency and Duration every 28-30 days for supervised visits, every 60 days for recertification. Goal: (sic blank) ... Home Health Aide Orders ... Order: Frequency and Duration: 6 hrs (sic hours) / daily. Goal: HHA (sic Home Health Aide) will provide safe and effective care ..." The plan of care indicated Patient #3 was to receive Home Health Aide (HHA) services 6 hours a day, 7 days a week. The plan of care failed to evidence orders from the physician for the patient to receive Attendant care services (ATTC) with this home health agency. The agency failed to provide communication notes or a plan of care to the physician that indicated the patient received ATTC. During an interview with the Administrator and the Scheduler on 07-19-2023 at 12:15 PM, they indicated Patient #3 received waiver hours			

	agency for Attendant Care Services. The Administrator indicated they do not list Attendant Care services on the plan of care because of billing. During an interview with the Scheduler on 07-19-2023 at 12:43 PM, they confirmed Patient #3 received waiver services for Attendant care with this home health agency. 4. On 07-19-2023 at 12:57 PM, Patient #4's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 07-23-2023 and a certification period of 07-08-2023 to 9-5-2023. The plan of care indicated but was not limited to the following diagnoses: Fibromyalgia (a disorder that causes pain throughout the body), Orthostatic hypotension (when an individual stands after sitting or lying down and the blood pressure drops), Type 2 Diabetes Mellitus (a disease where the body was unable to control blood glucose levels) with Diabetic Polyneuropathy (the disease effects the nerves in the extremities), Hypertension (high blood pressure), sleep apnea			

	(breathing stops and starts during sleep), chronic fatigue, and Hyperlipidemia (high lipids in the blood). The plan of care indicated but was not limited to, "... Clinical Summary... wears CPAP (sic Continuous Positive Airway Pressure) ...". The durable medical equipment list failed to include the patient's CPAP machine. The plan of care indicated but was not limited to, "... Orders and Goals... Order: Skilled nursing to assess and evaluate: Neurological, Emotional, Behavioral status. Goal: Patient/Caregiver will verbalize understanding of signs and symptoms to report to nurse or physician within cert period... Order... Respiratory status. Goal: Patient/Caregiver will verbalize understanding of signs and symptoms to report to nurse or physician within cert period... Order... Cardiovascular and Pulmonary Status. Goal: Patient/Caregiver will verbalize understanding of signs and symptoms to report to nurse or physician within cert period... Order... Musculoskeletal, mobility status. Goal: Patient/Caregiver will verbalize understanding of signs and symptoms to report to nurse or physician within cert period...".			

	The plan of care failed to indicate patient specific goals. 5. During an interview with the Administrator on 07-18-2023 at 2:55 PM, the Administrator and Alternate Administrator indicated they were able to fill out goals for each intervention and removed the blank goals. 6. During an interview with the Administrator, Owner, and Scheduler on 07-19-2023 at 2:45 PM, the Administrator indicated they were working on making the plans of care more specific, and removing the duplicates that are pulled from the assessment from their electronic medical record. 7. On 07-18-2023, the record review of Patient #2 evidenced a plan of care (POC) with a start of care (SOC) date of 09-30-2020 for the certification period of 07-17-2023 to 09-14-2023. The POC evidenced diagnoses but not limited to underweight, other specified congenital malformations (birth defects), unspecified intellectual disabilities (a disability that affects the acquisitions of knowledge and skills), blindness, one eye, and			

	unspecified sensorineural hearing loss (hearing loss caused by damage to the inner ear or the nerve from the ear to the brain). The POC contained an orders and goals section that indicated but was not limited to, "... Order: Skilled nursing to assess and evaluate: Nutrition/Hydration Status", which failed to identify a goal. The record failed to identify communication orders and goals. 8. On 07-18-2023, the record review of Patient #6 evidenced a POC with a SOC date 07-29-2020 for the certification period of 07-14-2023 to 09-11-2023. The POC evidenced diagnoses but not limited to cerebral palsy (a congenital disorder of movement, muscle tone, or posture. Cerebral palsy is due to abnormal brain development, often before birth), autistic disorder (neurological and developmental disorder that affects how people interact with others, communicate, learn, and behave), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and moderate intellectual disabilities. The			

	Assessment Details document dated 07-13-2023 evidenced skilled nursing assessment and evaluation included but not limited to Nutrition and Hydration status, Therapeutic Diet/Education, and Neurological, Emotional, Behavioral status. The POC contained an orders and goals section which failed to identify orders and goals for Nutrition and Hydration status, Therapeutic Diet/Education, and Neurological, Emotional, Behavioral status. 410 IAC 17-13-1(a)(1)(D)(ii, iii, and xiii)			
G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on record review and interview the agency failed to ensure the admitting clinician collaborated with the ordering physician after home health admission visits or recertifications were performed, to ensure the plan of care was established with the ordering	G0602	Director of Nursing will in-service nurses they are to contact MD after admission/recertification visit to collaborate with MD on the plan of care as a result of admission/recertification assessment. This collaboration is to be documented in patient chart. (8/27/23) Director of Nursing/designee will audit all current patient charts to ensure there is documented collaboration with	2023-08-27

	provider in 4 of 6 active clinical records reviewed. (Patients 1, 2, 4, and 5) Findings include: 1. A Briggs Healthcare policy was provided by the Administrator on 07-18-2023 at 12:55 PM. The "Clinical Documentation" Policy No. C-680 indicated but was not limited to, "... Purpose... To document conformance with the Plan of Care, modifications to the plan, and interdisciplinary involvement... 4. Telephone or other communication with clients, physicians... or members of the health care team will be documented in clinical progress notes or other interagency communication form...". 2. On 07-18-2023 at 11:20 AM, Patient #1's clinical record was reviewed. The clinical record evidenced a plan of care with Person 9 as the signing physician from Entity 8, the physician's office. During an interview with Person 10, a Medical Assistant for Patient #1's physician, Person 9, on 07-20-2023 at 1:15 PM, Person 10 indicated the agency		MD regarding recent admission/recertification and the plan of care established as a result of that assessment. (8/27/23) Director of Nursing/designee will audit all admissions/recertifications submitted weekly to ensure there is documentation of collaboration with MD to establish the plan of care as a result of that assessment. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	9's physician office, in January 2023. Person 10 indicated the agency only faxed information to Person 9. 3. On 07-19-2023 at 12:57 PM, Patient #4's clinical record was reviewed. The clinical record evidenced a plan of care with Person 3 as the signing physician from Entity 2, the physician's office. During an interview with Person 4, an Intake Coordinator at Entity 2, on 07-20-2023 at 9:49 AM, Person 4 indicated there were no coordination notes from the agency to the physician, Person 3, regarding the care for Patient #4. 4. A review of the comprehensive assessment for Patient #2, dated 07-13-2023, evidenced that care coordination occurred between the skilled nurse and the ordering physician. The POC (Plan of Care) dated 07-15-23 indicated Person 13 of Entity 2 was the ordering physician. The POC for Patient #2, dated 05-19-2023 for the certification period of 05-18-2023 to 07-16-2023 had been signed by Person 11 on 05-22-2023 of			

	Entity 2. During an interview on 07-20-2023 at 1:45 PM with Person 12 of Entity 2 indicated Person 13 left Entity 2 a few months ago, Patient #2 transferred to Person 11 of Entity 2, effective 03-10-2023. Person 12 further indicated that they never receive phone calls from the agency for collaboration and development of the POC, indicated the agency always faxes any documents for the physician's signature. 5. A review of the Clinical Record for Patient #5 evidenced Person 14 is the ordering physician. During an interview on 07-19-2023 at 1:46 PM with Person 15 of Entity 16 for Person 14, the ordering physician for Patient #5, indicated the agency doesn't phone the physician office for collaboration and development of the POC. 410 IAC 17-14-1(a)(1)(G)			
G0604	Integrate all orders	G0604		2023-08-27

	484.60(d)(2) Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient. Based on record review and interview, the agency failed to ensure all orders were integrated into the Plan of Care 1 of 6 active record reviews. (Patient #6) Findings Include: 1. A review of an agency's undated policy titled, 'Plan of Care C-580' revealed, " ... The plan will be consistently reviewed to ensure client needs are met, and will be updated as necessary ... 2. The plan of care shall be completed in full to include :.. c. Type, frequency, and duration of all visits/services ... " 2. A review of clinical record #6 evidenced a Home Health Plan of Care & Certification dated 07-12-2023 for the certification period of 07-14-2023 to 09-11-2023. The record revealed Patient #6 was to received HHA (Home Health Aide) services 7 days a week, 6 hours per day. Further review		Director of Nursing will in-service nurses on requirement to integrate all orders into the plan of care. (8/27/23) Director of Nursing/designee will audit all current patient plans of care to ensure all orders have been integrated into the plan of care. (8/27/23) Director of Nursing/designee will audit all plans of care submitted weekly to ensure all orders have been integrated into the plan of care. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	of the record evidenced an order that was written on 04-11-2023 by the administrator, and signed by the attending physician on 05-11-2023, for HHA services to be decreased to "4 days/week 6 hours a day per patient request". 3. During an interview with the administrator on 07-19-2023 at 11:30 AM, the administrator indicated the order should be on the Plan of Care. 410 IAC 17-12-2(h)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to ensure patient's had a written visit schedule in their home in 2 of 2 home visits. (Patients #7 and 8) Findings Include: 1. A Briggs Healthcare policy	G0614	Director of Nursing will in-service nurses on requirement for all patients to have a visit schedule in their home folder. (8/27/23) Director of Nursing will instruct nurses to check all current patient home folders for current visit schedule. If one is not present nurse will ensure one is provided to patient. This is to be documented in patient chart. (8/27/23)	2023-08-27

	was provided by the Administrator on 07-18-2023 at 12:55 PM. The "Plan of Care" Policy No. C-580 indicated but was not limited to, "... include ... c. Type, frequency, and duration of all visits/services ..." 2. During a home visit at Patient #8's residence on 07-19-2023 at 07:58 AM, the admission packet was reviewed and failed to evidence a visit schedule for the patient. 3. During an interview with the Administrator on 07-20-2023 at 2:33 PM, the Administrator indicated the patients never had physical schedules in the home. The Administrator indicated the patients were seen typically around the same time every week and the patient's knew when staff were coming. 4. During a home visit on 07-19-2023 at 9:10 AM, a review was conducted of Patient #7's home health agency binder, which failed to contain a visit schedule.		Director of Nursing/designee will audit all admissions/recertifications done weekly to ensure there is documentation a visit schedule has been provided to patient and placed in home folder. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	
G0684	Infection control 484.70(b)(1)(2)	G0684	G0684 Director of Nursing will in-service all field staff on	2023-08-27

	Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review, observation, and interview, the agency failed to ensure field staff followed appropriate infection control practices per agency policy while providing patient care in 2 of 2 home visits conducted. (Patients #7 and 8) Findings include: 1. A review of an agency's undated policy titled, 'OSHA INFECTION CONTROL/EXPOSURE PLAN B-405' revealed, " ... wearing and changing gloves as necessary during the delivery of client care ... "		proper infection control practices including when providing patient care. This includes proper hand hygiene, proper gloving protocols and providing a safe clean environment. (8/27/23) Director of Nursing/designee will ensure staff receives annual training on proper infection control practices including when providing patient care. This includes proper hand hygiene, proper gloving protocols and providing a safe clean environment. (8/27/23) Director of Nursing will make a shared visit with each nurse/aide to ensure they follow proper infection control practices. (8/27/23) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	A review of an agency's undated policy titled, 'HANDWASHING/HAND HYGIENE D-330' revealed, "... d. Between tasks on the same client ... f. After removing gloves. g. After touching objects that are potentially contaminated ... 2. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by manufacture to hands and rub hands together vigorously for at least 20 (twenty) seconds, covering all services of hand and fingers ... " 2. A home visit for Patient #7 was conducted on 07-19-2023, at 9:00 AM, to observe HHA (home health aide) 2 perform personal care. HHA 2 initiated the visit by assisting Patient #7 upstairs. When in the bathroom, HHA 2 donned a pair of gloves, turned the water on in the shower to warm up, assisted Patient #7 with undressing and into the shower. Once Patient #7 was in the shower, HHA 2 left the bathroom, to retrieve Patient #7 clothing and returned. While Patient #7 was in the shower,			

	HHA 2 to clean, HHA 2 placed them in the sink under running water. When Patient #7 was finished with their shower, HHA 2 assisted them out of the shower onto a shower chair next to the sink, dried Patient #7 off, towel drying their hair. HHA 2 poured mouthwash into a cup for Patient #7 to rinse their mouth, when Patient #7 was ready to expel the mouthwash into the sink, they indicated by pointing to their dentures, HHA 2 picked the dentures up and placed them on the towel HHA 2 used to dry Patient #7 off, that was on the edge of the sink, then assisted with putting their bra and underpants on and brushed their hair. HHA 2 doffed their gloves, escorted Patient #7 into their bedroom, HHA 2 assisted with completing dressing, putting deodorant on and applying lotion on patient's #7 lower extremities. Once completely dressed, HHA 2 went to the bathroom, used the patient's bar soap, wash their hands approximated 8 seconds, used toilet paper to dry their hands, and turned the water off. HHA 2 failed to change their			

	at appropriate intervals during the home visit, and failed to provide a safe clean environment for the patient. 3. During an interview on 07-19-2023 at 9:10 AM, HHA 2 indicated they had received Home Health Aide competency training upon hire and yearly, and felt that the training had been adequate. The further indicated that a nurse comes to evaluate them around 1 time a month. 4. During an interview on 07-20-2023 at 15:15 AM, the administrator indicated HHA's should never use the patient's bar soap, and should wash their hands for at least a minute, they should change their gloves frequently when providing personal care, and shook their head no when this writer described the situation with Patient #7's dentures. 5. During a home visit at Patient #8's residence on 07-19-2023 at 08:33 AM, Home Health Aide (HHA) 1 was observed performing personal care. When HHA 1 entered Patient #8's residence, the HHA failed to perform hand hygiene. HHA 1			

	proceeded to sort through the patient's dirty laundry without gloves, left the residence to do the laundry and returned to the residence and failed to perform hand hygiene when they reentered Patient #8's residence. HHA 1 had swept the floor, cleaned the toilet, mopped the floor, vacuumed the floor, and then replaced the trash bag. HHA 1 failed to don gloves or perform hand hygiene before, during, and after performing the light housekeeping. HHA 1 proceeded to assist the patient in taking a shower and wiping the patient's back, the back of the legs, and bottom. Hand hygiene was not performed by HHA 1 before, during, or after the shower. HHA 1 helped the patient dry their back, legs, and bottom. Hand hygiene was not performed by HHA 1 before, during, or after drying the patient. HHA 1 failed to perform hand hygiene or don gloves for the entirety of the home observation. 6. During an interview with the Administrator on 07-20-2023 at 2:33 PM, the Administrator			

	indicated hand hygiene was to be performed during a visit upon entering the patient's residence, when assisting the patient, in between making meals and personal care, in-between housekeeping, and personal care. The Administrator indicated gloves were to be donned when providing personal care, when cleaning, and if there was a potential for bodily fluids.			
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.	G0800	Director of Nursing will in-service aides on requirement to provide services ordered on the aide plan of care. If a task is not performed aide to mark "refused" or "R" or document why task was not performed as ordered. If task is not performed for reason other than refused aide must notify nurse/Director of Nursing and document they were notified. (8/27/23) Director of Nursing/designee will audit all aide visit notes submitted weekly by comparing aide care plan to visit note to ensure aide care is followed. If	2023-08-27

	Based on record review and interview, the agency failed to ensure the HHA's (Home Health Aides) provided services delegated in the home health aide plan of care in 6 (Patients #1, 2, 3, 4, 5, and 6) of 6 patients' whose clinical records were reviewed. The findings include: 1. A review of an agency's undated policy titled, 'HOME HEALTH AIDE: DOCUMENTATION C-800,' revealed, "POLICY ... Home Health Aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan ... 3. The designated Registered Nurse ...is responsible for reviewing the Home Health Aide's charting before it is placed in the chart ... " 2. On 07-18-2023 a Clinical Record Review of Patient #2 evidenced a 'AIDE Plan of Care' dated 07-17-2023, which revealed the following tasks for the HHA to perform each visit: skin care, mouth/denture care,		completed it must be marked as refused or documentation present stating why it wasn't completed. If task is not performed for reason other than refused there must be documentation aide notified nurse/Director of Nursing. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	nail care, dressing, make bed, light housekeeping, sweep, vacuum, take out trash, prepare meal, encourage fluids, assist with medication reminders, personal care, shower, check for pressure points, toileting/hygiene, and assist with ambulation, provide supervision. Further record review revealed the following HHA 8's visit notes: on 07-10-2023 failed to evidence: a shower, encourage fluid intake, and medication reminder was completed and a note indicating why tasks were not completed; on 07-11-2023 failed to evidence a shower, encourage fluid intake, and medication reminder was completed and a note indicating why tasks were not completed; on 07-12-2023 failed to evidence a shower, light housekeeping, sweep, vacuum, and medication reminder was completed and a note indicating why tasks were not completed; on 07-14-2023 failed to evidence: a shower, encourage fluid intake, light housekeeping, sweep, vacuum, and medication reminder was completed and a note indicating why tasks were not completed; on 07-15-2023			

	failed to evidence, a shower, encourage fluid intake, light housekeeping, and medication reminder was completed and a note indicating why tasks were not completed; on 07-16-2023 failed to evidence: a shower, encourage fluid intake, sweep, vacuum, and medication reminder were completed and a note indicating why tasks were not completed; and on 07-17-2023 failed to evidence a shower, encourage fluid intake, assistance with feeding, light housekeeping, vacuum, and medication reminder were completed or a note indicating why tasks were not completed. HHA 8 failed to follow the Aide Plan of Care. 3. On 07-18-2023 a Clinical Record Review of Patient #5 evidenced a 'AIDE Plan of Care,' dated 07-13-2023 which revealed the following tasks for the HHA to perform each visit: hair care, skin care, mouth/denture care, foot care, nail care, dressing, light laundry, make bed, light housekeeping, sweep, prepare meal, encourage fluids, assist with feeding, personal care, shower, check for pressure points, toileting/hygiene, and			

medication reminders. Further record review revealed the following HHA 9's visit notes: on 07-07-2023 failed to evidence light laundry was completed or a note indicating why the task was not completed; on 07-08-2023 failed to evidence light laundry was completed or a note indicating why the task was not completed; on 07-10-2023 failed to evidence light laundry was completed or a note indicating why the task was not completed; on 07-11-2023 failed to evidence light laundry was completed or a note indicating why the task was not completed; on 07-13-2023 failed to evidence light laundry was completed or a note indicating why the task was not completed; on 07-14-2023 failed to evidence light laundry was provided or a note indicating why the task was not completed; on 07-15-2023 failed to evidence light laundry was completed or a note indicating why the task was not completed; and on 07-17-2023 failed to evidence light laundry was completed or a note indicating why the task was not completed. HHA 9 failed to follow the Aide Plan of Care.

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; (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 agency failed to ensure the accuracy of supervisor visits for HHA's (Home Health Aides) providing services according to the plan of care for 6 of 6 active clinical records reviewed. (Patients 1, 2, 3, 4, 5, and 6) Findings include: 1. A review of an agency's undated policy titled, 'HOME HEALTH AIDE: DOCUMENTATION C-800' revealed, "... 3. The designated	G0818	Director of Nursing will in-service nurses on requirement to accurately complete the aide supervisory visit note. If the aide plan of care isn't being followed then RN is not to mark aide follows aide plan of care. (8/23/27) Director of Nursing/designee will review all aide supervisory visit notes submitted weekly to ensure they are completed accurately. Aide notes will be reviewed by comparing to aide care plan to ensure plan is being followed if nurse marks aide follows plan of care. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going)¿ The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	2023-08-27

	Registered Nurse ... is responsible for reviewing the Home Health Aide's charting before it is placed in the chart ... " A review of an agency's undated policy titled, 'HOME HEALTH AIDE SUPERVISION C-340' revealed, " ... 8. The aide visit record is reviewed by the supervising nurses ... to assure services are being provided according to the care plan." 2. On 07-18-2023 a Clinical Record Review of Patient #2 evidenced a 'AIDE Plan of Care' dated 07-17-2023 which revealed the following tasks for the HHA to perform each visit: skin care, mouth/denture care, nail care, dressing, make bed, light housekeeping, sweep, vacuum, take out trash, prepare meal, encourage fluids, assist with medication reminders, personal care, shower, check for pressure points, toileting/hygiene, and assist with ambulation, provide supervision. Further record review revealed the following HHA 8's daily visit notes: on 07-10-2023 failed to evidence: a shower, encourage fluid intake, and medication reminder was			

	completed and a note indicating why tasks were not completed; on 07-11-2023 failed to evidence a shower, encourage fluid intake, and medication reminder was completed and a note indicating why tasks were not completed; on 07-12-2023 failed to evidence a shower, light housekeeping, sweep, vacuum, and medication reminder was completed and a note indicating why tasks were not completed; on 07-14-2023 failed to evidence: a shower, encourage fluid intake, light housekeeping, sweep, vacuum, and medication reminder was completed and a note indicating why tasks were not completed; on 07-15-2023 failed to evidence, a shower, encourage fluid intake, light housekeeping, and medication reminder was completed and a note indicating why tasks were not completed; on 07-16-2023 failed to evidence: a shower, encourage fluid intake, sweep, vacuum, and medication reminder was completed and a note indicating why tasks were not completed; and on 07-17-2023 failed to evidence a shower, encourage fluid intake, assistance with feeding, light			

	housekeeping, vacuum, and medication reminder was completed and a note indicating why tasks were not completed. The HHA failed to follow the Aide Plan of Care. A Supervisory Visit Note dated 07-13-2023 and signed by Administrative Staff 3 at 11:58 AM, indicated HHA 8 followed the client's Care Plan. 3. On 07-18-2023 a Clinical Record Review of Patient #5 evidenced a 'AIDE Plan of Care' dated 07-13-2023 which revealed the following tasks for the HHA to perform each visit: hair care, skin care, mouth/denture care, foot care, nail care, dressing, light laundry, make bed, light housekeeping, sweep, prepare meal, encourage fluids, assist with feeding, personal care, shower, check for pressure points, toileting/hygiene, and medication reminders. Further record review revealed the following HHA 9's visit notes: on 07-07-2023 failed to evidence light laundry was completed and a note indicating why the task was not completed; on 07-08-2023 failed to evidence light laundry			

	was completed and a note indicating why the task was not completed; on 07-10-2023 failed to evidence light laundry was completed and a note indicating why the task was not completed; on 07-11-2023 failed to evidence light laundry was completed and a note indicating why the task was not completed; on 07-13-2023 failed to evidence light laundry was completed and a note indicating why the task was not completed; on 07-14-2023 failed to evidence light laundry was provided and a note indicating why the task was not completed; on 07-15-2023 failed to evidence light laundry was completed and a note indicating why the task was not completed; and on 07-17-2023 failed to evidence light laundry was completed and a note indicating why the task was not completed. HHA 9 failed to follow the Aide Plan of Care. A Supervisory Visit Note signed and dated by Administrative Staff 3 on 07-13-2023 at 10:00 AM, indicated HHA 9 followed the client's Care Plan. 4. On 07-18-2023 a Clinical			

	evidenced a 'AIDE Plan of Care' dated 07-14-2023 which revealed the following tasks for the HHA to perform each visit: skin care, mouth/denture care, dressing, prepare meal, personal care, check for pressure points, medications reminder, and assist with ambulation with use of walker/cane. Further record review revealed the following HHA 10's visit notes: on 07-07-2023 failed to evidence mouth/denture care, check for pressure points was completed and a note indicating why tasks were not completed; on 07-11-2023 failed to evidence mouth/denture care and check for pressure points was completed and a note indicating why tasks were not completed ; on 07-12-2023 failed to evidence mouth/denture care was completed and a note indicating why tasks were not completed , on 07-13-2023 failed to evidence mouth/denture care was completed and a note indicating why tasks were not completed ; on 07-14-2023 failed to evidence mouth/denture care and check for pressure points was			

	completed and a note indicating why tasks were not completed ; on 07-18-2023 failed to evidence mouth/denture care and check for pressure points was completed and a note indicating why tasks were not completed; and on 07-19-2023 failed to evidence mouth/denture care and check for pressure points was completed and a note indicating why tasks were not completed . HHA 10 failed to follow the Aide Plan of Care. A Supervisory Visit Note signed and dated by Administrative Staff 3 on 07-12-2023 at 11:18 AM, indicated HHA 10 followed the client's Care Plan. 5. On 07-18-2023 at 11:20 AM, Patient #1's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 08-02-2018 and a certification period of 07-07-2023 to 09-04-2023. The plan of care failed to include Home Health Aide frequency and duration. The plan of care indicated but was not limited to, " ... Orders and Goals ... Home Health Aide Orders ... Order:			

	provide/assist with personal care and assistance with ADLs (sic Activities of Daily Living) ..." The clinical record contained an Aide Plan of Care dated 07-07-2023. The aide plan of care indicated the patient was to receive for each visit skin care, mouth/denture care, dressing, light laundry, bed made, light housekeeping in the bedroom, bathroom, and kitchen, dusting, sweeping, vacuuming, take out trash, prepare meal, assist with feeding, personal care, sponge bath up in chair, check for pressure points, toileting/hygiene, medications reminder, and reposition in bed. The aide plan of care indicated the patient was to receive weekly shampooing, bed linen change and as needed, and clean equipment. On the aide visit note dated 07-09-2023, Home Health Aide (HHA) 3 indicated the tasks checking pressure points, toileting/hygiene, and medication reminder were not applicable. The aide visit note indicated these tasks were to be performed each visit.			

	On the aide visit note dated 07-11-2023, HHA 4 indicated the tasks reposition in bed, make bed, dust, and vacuum were not completed during the visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-12-2023, HHA 4 indicated the tasks reposition in bed, light laundry, dust, sweep, vacuum, and check pressure points were not completed during the visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-13-2023, HHA 4 indicated the tasks reposition in bed and vacuum were not completed during the visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-14-2023, HHA 4 indicated the tasks reposition in bed and dust were not completed during the visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit notes dated 07-11, 07-12, 07-13, and 07-14-2023, it failed to evidence			

	Patient #1 received shampoo care. The aide visit note indicated this task was to be performed weekly. On the aide visit note dated 07-17-2023, HHA 3 indicated the tasks sponge bath in chair, wheelchair assistance, checking for pressure points, toileting/hygiene, and medication reminder were not applicable. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-18-2023, HHA 3 indicated the tasks wheelchair assistance, assisting with feeding, checking for pressure points, and medication reminder were not applicable. The aide visit note indicated these tasks were to be performed each visit. The aide visit notes failed to evidence the HHA followed the plan of care. The clinical record evidenced a document titled "Supervisory Visit Note" signed by the Administrator and dated 07-05-2023. The document indicated that the aide followed Patient #1's plan of care.			

	6. On 07-18-2023 at 1:45 PM, Patient #3's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 01-10-2023 and a certification period of 07-09-2023 to 09-06-2023. The plan of care indicated the patient was to receive HHA services 6 hours a day, 7 days a week. The clinical record contained an Aide Plan of Care dated 07-09-2023 that indicated Patient #3 was to receive HHA services 6 hours a day, 7 days a week. The aide plan of care indicated the patient was to receive for each visit hair care, skin care, mouth/denture care, dressing, light laundry, bed made, light housekeeping in the bedroom, bathroom, and kitchen, clean equipment, dusting, sweeping, vacuuming, take out trash, water plants, prepare meal, encourage fluids, personal care, shower, check for pressure points, toileting/hygiene, medications reminder, walker, Home program exercise, and reposition in bed. The aide plan of care indicated the patient was to receive weekly shampooing and bed linen			

	change. On the aide visit note dated 07-08-2023, HHA 5 indicated the tasks reposition in bed and dust were not applicable. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-09-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, bed linen change, make bed, light housekeeping: bed/bath/kitchen, sweep, vacuum, take out trash, transport for errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated 07-10-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, bed linen change, make bed, light housekeeping: bed/bath/kitchen, dust, sweep, vacuum, take out trash, transport for errands and other home activities. The note failed			

	5 failed to follow the aide plan of care. On the aide visit note dated 07-11-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, make bed, light housekeeping: bed/bath/kitchen, sweep, vacuum, take out trash, transport for doctor's appointment, errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated 07-12-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, bed linen change, make bed, light housekeeping: bed/bath/kitchen, dust, sweep, vacuum, take out trash, transport for doctor's appointment, errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated			

	07-13-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, bed linen change, make bed, light housekeeping: bed/bath/kitchen, sweep, vacuum, take out trash, transport for errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated 07-14-2023, HHA5 indicated the following tasks were completed during the visit: personal care, prepare meals, bed linen change, make bed, light housekeeping: bed/bath/kitchen, dust, sweep, vacuum, take out trash, transport for errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated 07-15-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, make bed, light housekeeping: bed/bath/kitchen, sweep,			

	transport for errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated 07-16-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, make bed, light housekeeping: bed/bath/kitchen, sweep, vacuum, take out trash, transport for errands and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated 07-17-2023, HHA 5 indicated the following tasks were completed during the visit: personal care, prepare meals, bed linen change, make bed, light housekeeping: bed/bath/kitchen, dust, sweep, vacuum, take out trash, transport for errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. On the aide visit note dated 07-18-2023, HHA 5 indicated			

	the following tasks were completed during the visit: personal care, prepare meals, bed linen change, make bed, light housekeeping: bed/bath/kitchen, dust, sweep, vacuum, take out trash, transport for errands, shopping, and other home activities. The note failed to evidence hands on care. HHA 5 failed to follow the aide plan of care. The aide visit notes failed to evidence the HHA followed the plan of care. The clinical record evidenced a document titled "Supervisory Visit Note" signed by the Administrator and dated 07-07-2023. The document indicated that the aide followed the Patient #3's plan of care. 7. On 07-19-2023 at 12:57 PM, Patient #4's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 07-23-2023 and a certification period of 07-08-2023. The clinical record evidenced an Aide Plan of Care dated 07-08-2023. The aide plan of care indicated the patient was			

	care, skin care, dressing, light laundry, bed linen change, bed made, light housekeeping in the bedroom, bathroom, and kitchen, clean equipment, sweeping, vacuuming, take out trash, prepare meal, encourage fluids, assist with feeding, personal care, shower, toileting/hygiene, medications reminder, and assistance with cane. The aide plan of care indicated the patient was to receive weekly shampooing, foot care, nail care, dusting, tub bath with an indication that the patient was able to determine if they wanted a bath or shower. On the aide visit note dated 07-07-2023, HHA 6 indicated personal care, cleaning equipment, vacuuming, taking out the trash, toileting/hygiene were not applicable during the home visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-10-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning equipment, vacuuming, taking out the trash, and toileting/hygiene were not			

	visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-11-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning equipment, vacuuming, taking out the trash, and toileting/hygiene were not applicable during the home visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-12-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning the equipment, vacuuming, taking out the trash, and toileting/hygiene were not applicable during the home visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-13-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning the equipment, vacuuming, taking out the trash, and toileting/hygiene were not applicable during the home visit. The aide visit note			

	indicated these tasks were to be performed each visit. On the aide visit note dated 07-14-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning the equipment, vacuuming, taking out the trash, and toileting/hygiene were not applicable during the home visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-16-2023, HHA 7 indicated they did not complete light laundry for the patient. The aide visit note indicated this task was to be performed each visit. On the aide visit note dated 07-17-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning the equipment, vacuuming, taking out the trash, and toileting/hygiene were not applicable during the home visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-18-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning the			

	equipment, sweeping, vacuuming, taking out the trash, and toileting/hygiene were not applicable during the home visit. The aide visit note indicated these tasks were to be performed each visit. On the aide visit note dated 07-19-2023, HHA 6 indicated personal care, bed linen change, making the bed, cleaning the equipment, vacuuming, taking out the trash, and toileting/hygiene were not applicable during the home visit. The aide visit note indicated these tasks were to be performed each visit. The aide visit notes failed to evidence the HHA followed the plan of care. The clinical record evidenced a document titled "Supervisory Visit Note" signed by the Administrator and dated 07-06-2023. The document indicated that the aide followed the Patient #4's plan of care.			

	8. During an interview with the Administrator on 07-18-2023 at 2:55 PM, they indicated the HHAs were to document the tasks they performed and follow the aide plan of care. 410 IAC 17-14-1(n)			
G1010	Contents of clinical record 484.110(a) Standard: Contents of clinical record. The record must include: Based on record review and interview, the agency failed to provide separate Home Health Aide (HHA) notes from Attendant Care (ATTC) Notes for 1 of 1 active patient records reviewed with ATTC services from the agency out of a sample of 6. (Patient #3) Findings Include: 1. A Briggs Healthcare policy titled "Clinical Documentation" was provided by the on 07-18-2023 at 12:55 PM. The "Clinical Documentation" Policy No. C-680 indicated but was not limited to, "... Purpose... To ensure that there is an accurate record of the services provided... Special Instructions...	G1010	Director of Nursing will in-service aides they are to document attendant care services on separate notes from the home health aide notes. (8/17/23) **Clients with Attendant care services have had those services transferred to a personal care agency** Director of Nursing will audit all aide/attendant care notes to ensure attendant care and home health services are documented on separate notes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	2023-08-17

	2. A separate note shall be completed for each visit/shift and signed and dated by the appropriate professional...". 2. On 07-18-2023 at 1:45 PM, Patient #3's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 01-10-2023 and a certification period of 07-09-2023 to 09-06-2023. The plan of care indicated the patient was to receive Skilled Nursing (SN) services every 28-30 days for supervisory visits and every 60 days for recertification and HHA services 6 hours a day, 7 days a week. The plan of care failed to indicate the patient also received ATTC services from the agency. A review of the documents titled "Aide Visit Note – Daily" dated from 07-09-2023 to 07-18-2023 evidenced the notes failed to include all the tasks HHA 5 was to perform according to the plan of care. During an interview with the Administrator and the Scheduler on 07-19-2023 at 12:15 PM, they indicated Patient			

	through the agency for ATTC. The Administrator indicated the aide visit notes on the dates 07-09-2023 to 07-18-2023 were for the ATTC services the patient received and not for the HHA services the patient was to receive according to the plan of care.			
N9999	Final Observations *	N9999	NA	2023-08-22

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
Tonisha Harrington	RN Administrator	8/22/2023 1:50:36 PM