STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDER'S JOURNEY HOME CARE LLC	4334 E 3RD STREET , BLOOMINGTON, Indiana, 47401

(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: 06/10/2024-06/14/2024 & 06/17/2024-06/18/2024 Active Census: 434 At this Emergency Preparedness survey, Elder's Journey Home Care LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
E0036	EP Training and Testing CFR(s): 484.102(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an	E0036		

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

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E0036	Continued from page 1 emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to implement a full-scale emergency training and testing program for 1 of 1 Emergency Preparedness Program reviewed. Findings include: A revised policy dated October 2017 titled "Emergency Operations Plan (EOP) Training Program" indicated the agency would provide emergency preparedness testing and training at least annually, to include a full-scale exercise that is community-based or a facility-based exercise; conduct an additional exercise that can be a second full-scale exercise that is community-based or a tabletop exercise led by a faciliatory; Exercises must sufficiently stress agency's plan to identify weaknesses.	E0036		

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E0036	Continued from page 2 During an interview on 06/17/2024 at 1:45 PM, the Performance Improvement Manager indicated she attended the 2023 and 2024 Coalition, where multiple scenarios were conducted in multiple counties. The performance improvement manager indicated she was the only agency person who had attended the Coalition emergency preparedness drill. The performance Improvement Manager indicated she provided information about the Coalition experience to the agency during a Manager's Meeting on 06/01/2023 for the 2023 Coalition and 04/18/2024 Managers Meeting for the 2024 Coalition; the Managers then provided education to the nursing staff during the Nursing Case Conference on 06/13/2023 and 05/14/2024; during the 4th quarter of the year, an ADP training on Preparing for an Emergency was sent out to all aide staff. The Performance Improvement Manager indicated she did not know where to find Emergency Preparedness regulations.	E0036		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 06/10/2024-06/14/2023 & 06/17/2024-06/18/2024 12 Month Unduplicated Skilled Admissions: 626 An Extended Survey was announced on 06/13/2024 at 8:40 AM. An Immediate Jeopardy related to 42 CFR §484.60: Care planning, coordination of services, and quality of care was identified on 06/06/2024 when it was identified that a PSA agency called the agency to report a patient wound. The agency did not coordinate with the physician to obtain an order for a visit and waited to evaluate the wound 6 days later. The agency did not ensure the home health aide followed the aide's plan of care regarding bathing and personal hygiene. The Administrator was notified of an Immediate Jeopardy on 06/17/2024 at 11:15 AM. An unacceptable removal plan for the Immediate Jeopardy was received on 06/18/2024 at 12:54 PM. The Immediate Jeopardy was unremoved at the time of exit on 06/18/2024. During this Federal Recertification Survey, Elder's Journey Home Care LLC was found to be out of compliance with Condition of Participation §484.45 Reporting OASIS information; Condition of Participation §484.50 Patient Rights; Condition of Participation §484.55:	G0000		

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G0000	Continued from page 3 Comprehensive Assessment of Patients; Conditions of Participation §484.60 Care planning, coordination of services, and quality of care; and Condition of Participation §484.80 Home Health Aide Services. QR Completed 06/19/2024 by A4	G0000		
G0372	Encoding and transmitting OASIS CFR(s): 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to encode and electronically transmit each completed OASIS assessment to the CMS system within 30 days of completing the assessment of the patient for 1 of 1 Agency Error Summary Report review. Findings include: A policy titled "Encoding and Reporting OASIS Data" was provided by the Director of Clinical Services (DCS) on 06/10/2024. The policy indicated that the OASIS (Outcome and Assessment Information Set) was to be submitted to CMS within 30 days of completing the assessment of the patient. A review of the Agency Error Summary Report dated 10/01/2023 to 06/10/2024 indicated error -3333 (late assessment submissions). The report evidenced 443 assessments with errors, and the percentage of assessment errors was 37.7%. The agency failed to submit all OASIS assessments within 30 days of completing the patient's assessment. During an interview on 06/11/2024 at 11:30 AM, Quality Assurance 2 was asked to explain why the agency had late assessment submission errors. Quality Assurance 2 stated the late OASIS submission assessments were due to Covid-19 (virus) and the nursing crisis. The Director of Clinical Services stated that the agency was working on hiring more nurses to address the issue. During an interview on 06/18/2024 at 10:47 AM, the Administrator and Performance Improvement Manager stated that they do not track OASIS items such as	G0372		

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G0372	Continued from page 4 potential avoidable events (discharge to community with pressure ulcers, behaviors, and medication errors) or OASIS submissions. They stated that this was information to them and were not previously aware of the number of late OASIS submissions obtained from CMS.	G0372		
G0406	Condition of Participation: Patient rights. CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the agency provided services as ordered on the plan of care (See tag G436); failed to notify the patient or physician before discharge for cause (See tag G464); and failed to provide patients with contact information for providers able to provide care (See tag G448) The cumulative effect of this systemic problem 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 484.50 Patient Rights.	G0406		
G0436	Receive all services in plan of care CFR(s): 484.50(c)(5) Receive all services outlined in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide services as ordered on the plan of care (POC) for 2 of 6 active record reviews. (Patients #5 ,#6) Findings include: 1. An undated document titled "Patient Bill of Rights" indicated that the Patient should receive all services outlined in the plan of care (POC). 2. A review of Patient #5's record for the certification period of 03/23/2023 to 05/21/2023, with	G0436		

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G0436	Continued from page 5 a SOC date of 03/09/2023, included a Home Health Certificate and Plan of Care with orders for home health aide (HHA) services two hours a day two days a week. The agency failed to provide HHA services from 03/09/2023 to 04/24/2023 and failed to provide evidence as to why it did not provide services. During an interview on 06/17/2024 at 2:18 PM, the Quality Assurance (QA) Nurse 2 indicated the Patient would not receive services until the agency received Medicaid authorization. 3. A review of Patient #6's record, certification period 02/15/2023 to 04/15/2023, included a Home Health Certification and Plan of Care with orders for skilled nursing services 1 hour a day, one day a week for the duration of the certification period and home health aide services 4 hours a day, three days a week for the duration of the certification period. The agency failed to provide skilled nursing services from 02/15/2023 to 03/21/2023 and failed to document a reason why it did not. During an interview on 06/17/2024 at 2:18 PM, the QA Nurse 2 indicated the agency process from referral to first scheduled home visit is as follows: A referral is received. A visit is made to the Patient's home, where a hands-off assessment was conducted. The agency creates a Home Health Certification and Plan of Care/485 that was sent to physicians and Medicaid. No visits are provided to patients until Medicaid authorization has been received unless the Patient has an immediate need, such as IV medication or wound care. Once Medicaid authorization is received, the agency will conduct an admission visit to collect the OASIS (Outcome and Assessment Information Set) assessment. A Home Health Plan of Care and Certification (New POC) will be created with a new certification period, and services will start at that time.	G0436		
G0464	Advise the patient of discharge for cause CFR(s): 484.50(d)(5)(i) (i) Advise the patient, representative (if any), the physician(s) or allowed practitioner(s), issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care	G0464		

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G0464	Continued from page 6 and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to notify the patient or physician prior to discharge for cause for 1 of 5 closed records reviewed. (Patient #1). Findings include: A policy titled "Client Discharge Process" indicated, but was not limited to, "Criteria for discharge…The client's care has become such that it is unsafe and medically inappropriate to maintain the client in his/her home". The Clinical Record for Patient #1, certification period 01/14/2023-03/14/2023, Start of Care (SOC) date of 08/11/2022, included a discharge summary dated 03/07/2023 sent to the provider via fax indicating Patient #1's services were terminated due to unsanitary work environment. Patient #1's record included a letter dated 03/07/2023 sent via certified mail to the patient indicating the agency had contacted the wound care center to request they assist the patient with finding another agency to provide care. The record included a Skilled Nursing Visit Note dated 02/13/2023 that indicated patient had deplorable living conditions and unsafe living condition. The record included Skilled Nursing Visit Notes between 02/17/2023-03/06/2023 from RN 6 failed to include documentation of unsafe or unsanitary home conditions. The record failed to evidence notification to the patient and/or physician prior to discharge for cause. During an interview on 06/12/2024 at 9:58 AM, the Director of Clinical Services indicated a discharge order and summary was sent to the wound center and requested this facility assist the patient with finding another home health agency to take over patient care, however, indicated this information was not documented in the patient's record. During a phone interview on 06/13/2024 at 12:24 PM, Patient #1 indicated patient was discharged on	G0464		

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G0464	Continued from page 7 03/07/2024 for unknown reason, never received a list of resources for providers to continue home health care, and the agency suddenly stopped coming to patient's home to provide care. During a phone interview on 06/13/2024 at 1:02 PM, RN 6 indicated Patient #1 had received a visit from RN 7 on 02/13/2023 that indicated patient had unsafe living conditions. RN 6 indicated Patient #1 home conditions had improved and RN 6 had continued patient care from 02/17/23 through 03/06/2023 and RN 6 felt comfortable to continue providing care to patient in patient's home. RN 6 indicated being unsure of who discharged the patient from the agency. RN 6 indicated neither patient nor physician was notified prior to patient being discharged. 410 IAC 17-12-2(i)	G0464		
G0468	Provide contact info other services CFR(s): 484.50(d)(5)(iii) (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide patients with contact information for providers able to provide care for 2 of 5 discharge record reviews (Patient #1, #2). Findings include: 1. A policy titled "Client Discharge Process" indicated, but was not limited to, "The Registered Nurse shall review the clinical record to assure accuracy and completion. A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the client's ongoing care needs and available resources provided to the client and family". 2. The Clinical Record for Patient #1, certification period 01/14/2023-03/14/2023, Start of Care (SOC) date of 08/11/2022, included a discharge summary dated 03/07/2023 indicating Patient #1's services were terminated due to unsanitary work environment. Patient #1 record included a letter dated 03/07/2023 sent via certified mail to the patient indicating the agency had	G0468		

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G0468	Continued from page 8 contacted the wound care center to request they assist the patient with finding another agency to provide care. The record failed to evidence a detailed discharge summary that aligned with the agency discharge summary. The record failed to evidence resources being provided to the patient at the time of discharge. During an interview on 06/12/2024 at 9:58 AM, the Director of Clinical Services indicated a discharge order and summary was sent to Indiana University Health Wound Care Center and requested this facility assist the patient with finding another home health agency to take over patient care, however, indicated all of this information was not documented in the patient's record. During a phone interview on 06/13/2024 at 12:24 PM, Patient #1 indicated the patient was discharged on 03/07/2024 for an unknown reason, never received a list of resources for providers to continue home health care, and the agency suddenly stopped coming to the patient's home to provide care. During a phone interview on 06/13/2024 at 1:02 PM, RN 6 indicated the patient had not been given a list of resources to provide home health care prior to discharge. 4. A record review on Patient # 2, certification period 05/01/2024 to 06/30/2024, included a copy of a mailed letter sent to Patient #2 indicating the agency was discharging the patient but did not provide information on other agencies that could assist the patient with wound care at home. No other documentation of information on other agencies was available in the community found in Patient #2's chart. During an interview on 06/12/2024 at 9:15 AM, the Director of Clinical Services indicated the agency did not assist Patient #2 with getting other agencies to provide care. The Director of Clinical Services indicated she looked in emails and Patient #2's chart but could not locate information that the agency provided a list of other agencies to the patient. 5. A review of Patient #5's record for the certification period of 03/23/2023 to 05/21/2023, with a SOC date of 03/09/2023, included a Home Health Certificate and Plan of Care with orders for home health aide (HHA) services two hours a day two days a week. The agency failed to provide HHA services from 03/09/2023 to 04/24/2023 and failed to provide evidence as to why it did not.	G0468		

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G0468	Continued from page 9 During an interview on 06/17/2024 at 2:18 PM, the Quality Assurance (QA) Nurse 2 indicated the Patient would not receive services until the agency received Medicaid authorization.	G0468		
G0510	Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to complete an initial assessment within 48 hours of a referral (See tag G514) and failed to ensure staff completed an accurate, comprehensive assessment that reflected the patient's health status (See tag G528). The cumulative effect of the deficient practice resulted in the agency's noncompliance with Condition of Participation §484.55: Comprehensive Assessment of Patients. The cumulative effect of the deficient practice resulted in the agency's noncompliance with Condition of Participation §484.55: Comprehensive Assessment of Patients.	G0510		
G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by:	G0514		

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G0514	Continued from page 10 Based on record review and interview, the agency failed to complete an initial assessment within 48 hours of a referral for 3 of 8 full chart reviews with skilled nursing services. (Patient #2, #5, #6) Findings include: 1. An undated Policy titled "Admission Policy" indicated that Home care referrals should, at a minimum, include Client identifying data, medications, treatments required, Physician and reimbursement information, and other pertinent information; the initial assessment will be completed within forty-eight hours of referral. 2. A Document provided by Quality Nurse 2 was a printed email dated 04/14/2024. Next to the date was handwriting that was placed on the document prior to receiving "got referral." The email was sent to multiple Elders Journey employees and was from QA Nurse 2 regarding Patient #2. The agency was unable to provide a Physician referral order. 3. A document provided by Quality Nurse 2 was a printed email with a handwritten circle placed around the date 02/09/2023. The email was sent to multiple Elders Journey employees and was from QA Nurse 2 regarding Patient #6, ready for sign-up and evaluation. The agency was unable to provide a Physician referral order. 4. A review of Patient #2's record included a Home Health Plan of Care & Certification with a certification period of 05/01/2023 to 06/27/2023, a start of care (SOC) date of 05/01/2023 and the Oasis assessment date of 04/29/2023; no referral order from a physician in the patient chart; a Signup attempt 1, dated 04/17/2023. The agency failed to contact the patient for the first visit or complete the initial assessment within 48 hours of the referral. 5. A review of Patient #5's record included a Home Health Plan of Care & Certification, certification period 03/23/2023 to 05/21/2024, SOC date 03/09/2023, and the Oasis assessment date of 03/23/2023. The record failed to evidence a physician referral order. The agency failed to contact the patient for the first visit or complete the initial assessment within 48 hours of the referral. 6. A review of Patient #6's record included a Home Health Plan of Care & Certification with a	G0514		

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ELDER'S JOURNEY HOME CARE LLC	4334 E 3RD STREET , BLOOMINGTON, Indiana, 47401

(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
G0514	Continued from page 11 certification period of 03/14/2023 to 05/12/2023, a start of care (SOC) date of 03/20/2023 and the Oasis assessment date of 03/20/2023; no referral order from a Physician in the patient chart. The agency failed to complete the initial assessment within 48 hours of the referral. During an interview on 06/17/2024 at 2:18 PM, Quality Assurance (QA) Nurse 2 provided copies of emails sent to other Elder Journey employees that were not part of the Patient record and did not clearly identify a referral date. When asked which email was the referral date, QA Nurse 2 pointed to "03/20." 410 IAC 17-14-1 (a)(1)(A)	G0514		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency staff failed to complete an accurate, comprehensive assessment that reflected the patient's health status for 1 of 2 home visit observations. (RN 1) Findings include: A policy titled "Comprehensive Client Assessment" indicated the purpose of the assessment was to determine appropriate care, treatment, and services to meet the patient's changing needs. The comprehensive assessment must accurately reflect the patient's status. A 2014 National Pressure Ulcer Advisory Panel (NPUAP) article titled Prevention and Treatment of Pressure Ulcers: Quick Reference Guide indicated a comprehensive skin assessment should be conducted as soon as possible but within 8 hours of reporting for individuals who are a risk for pressure ulcers. The skin assessment should include skin temperature, edema, and change in tissue consistency in relation to surrounding tissue. The assessment should differentiate whether the skin redness was blanchable or non-blanchable (redness or discoloration disappears when pressure is applied). On 6/6/2024, a Case Conference note indicated that Entity 2, a Personal Service Attendant (PSA) provider,	G0528		

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G0528	Continued from page 12 called to report that Patient #5 had an open area on their buttocks. During a recertification home visit on 06/12/2024 at 10:30 AM, Registered Nurse (RN) 1 failed to assess Patient #5's chest, back, under breast, peri-area, bilateral upper and lower legs, soles of feet, and bottom portion of the buttocks. RN 1 failed to measure an open area surrounded by red/purple discoloration on Patient #5's right buttock and failed to measure red/purple discoloration on the left buttock and tailbone area. Patient #5 stated they lost their dentures. Patient #5 said they do not use the wheelchair because maneuvering is too hard. RN 1 asked the Patient if they could walk to their bed. Patient #5 stated they could but could pivot transfer with help to the seat of the rolling walker. Patient #5 then propelled the rolling walker backward using their feat. RN 1 wrote her notes in a notebook. RN 1 failed to use the OASIS (comprehensive assessment) form during the assessment. RN 1 failed to accurately complete a head-to-toe assessment and record the data on the OASIS. During an interview at the home visit, RN 1 stated that the wound looked like a bedsore and was about 3 cm x 2 cm. RN 1 stated that she thought she was able to walk. Entity 2, the PSA provider, said that she had cared for the Patient for a year and had never seen the Patient walk. At that time, RN 1 stated she was waiting to document her assessment at home on an electronic tablet. RN 1 stated she does not provide hands-on care. A review of Patient #5's record on 06/13/2024 included the OASIS document from the home visit on 06/12/2024. The OASIS indicated measurements of the open area to the right buttock as 3 cm length by 2 cm width with no depth recorded. The OASIS indicated that Patient #5 had dentures, no problems with eating, and was able to transfer to a wheelchair. At the home visit, Patient #5 stated they lost their dentures. During an interview on 06/13/2024 at 1:30 PM, home health aide (HHA) 1 stated that despite being ordered on the plan of care, they do not offer Patient #5 a shower, shampoo, or bath. If Patient #5 wanted a bath, they would have to ask. They only do what the patient tells them to do. HHA 1 stated she was not sure what the other provider does. During an interview on 06/12/2024 at 2:30 PM, the Director of Clinical Services (DCS) stated that the expectation was for the nurse to do a head-to-toe assessment at recertification. Staff are to use a	G0528		

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G0528	Continued from page 13 plastic measuring tool to measure wounds. She stated that they use the OASIS form as the comprehensive assessment. DCS was not able to give a reason why she falsified the OASIS document. 410 IAC 17-4-1(a)(1)(A)	G0528		
G0570	Care planning, coordination, quality of care CFR(s): 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. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to accurately assess, measure, and manage a patient's wound promptly, coordinate care effectively with the provider and PSA agency, and provide immediate care to meet the patient's overall needs (See tag G570); failed to have a signed plan of care (POC) or a verbal POC order from the primary Physician before providing services and treatments to patients (See tag G572); failed to ensure the Plan of Care (POC) included mental status specific to person, place, and time; failed to ensure the POC included all medications; and failed to ensure the POC included a current and complete list of Durable Medical Equipment (DME) and Supplies (See tag G574), failed to ensure the Registered Nurse (RN) provided services as ordered by the physician (See tag G580), and failed to coordinate care with a physician regarding a patient's wound. (See tag G608). An Immediate Jeopardy related to Condition of Participation §484.60: Care planning, coordination of	G0570		

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G0570	Continued from page 14 services, and quality of care was identified on 06/06/2024 and announced on 06/17/2024 at 11:15 AM. An unacceptable removal plan for the Immediate Jeopardy was received on 06/18/2024 at 12:54 PM. The Immediate Jeopardy was unremoved at the time of exit on 06/18/2024. The cumulative effect of this problem resulted in being out of compliance with Condition of Participation §484.60 Care planning, coordination of services, and quality of care of patients and has the likelihood to affect all current patients receiving services from this provider. Findings include:	G0570		
G0572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. This STANDARD is NOT MET as evidenced by: Based on record review and interviews, the agency failed to have a signed plan of care (POC) or a verbal POC order from the primary physician before providing services and treatments to patients for 5 of 9 full record reviews. (Patient #2, #5, #6, #8, #9) Findings include: 1. An undated Policy titled "Admission Policy" indicates a physician order for skilled nursing must be obtained from the Client's Physician before the start of care date. Skilled Nursing and Home Health Aide services must follow a written Plan of Care established and reviewed by a Doctor of Medicine. 2. An undated Policy titled "Plan of Care" indicates that if a physician refers a patient under a Plan that cannot be completed until after an assessment visit, the Physician shall be consulted to approve additions	G0572		

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G0572	Continued from page 15 and modifications to the original plan. The Plan of Care/ 485 will be developed following the initial assessment and sent to the Physician for signature. 3. The record review for Patient #2, certification period 05/01/2024 to 06/30/2024, revealed that patient care was provided to Patient #2 without a verbal or physician-signed order on 05/03/2024, 05/05/2024, 05/08/2024, and 05/10/2024. 4. The record review for Patient #5, certification period 04/18/2024 to 06/16/2024, included a Verbal Order Recertification (VO-Recertification) fax dated 04/16/2024, signed by the physician on 04/23/2024. The VO-Recertification indicated the agency would continue using the expired plan of care (POC) from the prior certification period until the updated POC was signed by the physician. The record evidenced that patient care was provided to Patient #5 without a verbal or physician-signed order on 04/20/2024, 04/23/2024, 04/24/2024, 05/01/2024, 05/02/2024, 05/08/2024, 05/09/2024, 05/16/2024, 05/18/2024, 05/24/2024, 05/30/2024, and 06/01/2024. 5. The record review for Patient #6, certification period 05/13/2024 to 07/11/2024, included a Recertification fax sent to the Physician on 05/08/2024, signed by the Physician on 05/14/2023, indicating the agency will continue using expired POC from the prior certification period until Physician signs updated POC. The agency failed to obtain a verbal order or current signed POC. The record revealed that patient care was provided to Patient #6 without a verbal or physician-signed order on 05/13/2024, 05/14/2024, 05/15/2024, 05/16/2024, 05/17/2024, 05/18/2024, 05/19/2024, 05/20/2024, and 05/21/2024. During an interview on 06/11/2024 at 9:05 AM, RN 3 indicated he did not notify the Physician. QA Nurse 1 or QA Nurse 2 would notify the Physician by email to report the start of care, recertification of care, or resumption of care. He does not communicate with the Physician. 6. The record review for Patient #8, certification period 10/25/2023 to 12/23/2023, revealed that patient care was provided to Patient #8 without a verbal or physician-signed order on 10/26/2023, 10/27/2023, 10/29/2023, 10/30/2023, and 10/31/2023. 7. The record review for Patient #9, certification period 10/28/2023 to 12/26/2023, included a Recertification fax sent to the Physician on 10/28/2023, signed by the Physician on 12/28/2023,	G0572		

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G0572	Continued from page 16 indicating the agency will continue using expired POC from prior certification period until Physician signs updated POC. The agency failed to obtain a verbal order or current signed POC. The record revealed that patient care was provided to Patient #9 without a verbal or physician-signed order on 10/28/2023, 10/29/2023, 10/30/2023, 10/31/2023, 11/01/2023, 11/02/2023, 11/03/2023, 11/04/2023, 11/05/2023, 11/06/2023, 11/07/2023, 11/08/2023, 11/10/2023, 11/11/2023, and 11/12/2023. During an interview on 6/13/2024 at 9:30 AM, the Director of Clinical Services indicated that Patient #9's POC was signed on 11/28/2024 and acknowledged this was after the patient was discharged from service. Services were provided for the entire certification period with no signed POC by the Physician. 8. During an interview on 6/11/2024 at 12:25, Quality Assurance Nurse 2 indicated that the POC is sent to the Physician to get signed, and the Admission nurses should call the Physician to discuss the POC. She indicated that during recertification, a fax is sent to the patient's Physician on the same day as the POC. The fax reads, "Recertification visit completed. Elder's Journey to continue the current plan of care until the updated care plan is signed per MD." 410 IAC 17-131(a)	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted;	G0574		

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G0574	Continued from page 17 (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the Plan of Care (POC) included mental status specific to person, place, and time for 5 of 9 full record reviews (Patient #2, #6, #7, #8, #9), failed to ensure the POC included all medications for 2 of 6 active patients with home visits (Patient #6, #7), and failed to ensure the POC included a current and complete list of Durable Medical Equipment (DME) and Supplies for 2 of 6 active patients with home visits (Patient #6, #7). Findings include: 1. A policy titled "Plan of Care" indicated, but was not limited to, POC will be updated as necessary, including mental status, home medical equipment and assistive devices, and medications. "The Plan of Care shall be completed in full to include…mental status… need for/presence of home medical equipment and assistive devices…medications". 2. A record review for Patient #2, certification period 05/01/2024 to 06/30/2024, included a POC with Oriented checked on POC as Patient #2's mental status but failed to identify if Patient #2 is oriented to Person, Place, or Time. The agency failed to document Patient #2's oriented status on POC accurately.	G0574		

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G0574	Continued from page 18 3. During an observation on 06/11/2024 at 9:05 AM, Patient #6 had a rollator (wheeled walker) and shower chair in the home. The agency failed to accurately list DME supplies on POC. The medications in the home were reviewed with RN 3. Mucinex DM (control for cough, thin and loose mucus) was being used by the patient as needed, but the patient was not on the POC or medication profile. The agency failed to have an accurate medication list on the POC or medication profile. A record review for Patient #6, certification period 05/13/2024 to 07/11/2024, included a POC with a list of DME (Durable Medical Equipment) that Patient #6 had in the home. Neither the shower chair nor the rollator, used by the patient, are listed on the DME and Supplies list on POC. The POC does not list Mucinex on the medication list, which patient #6 takes as needed. Oriented, forgetful is checked on POC as patient's mental status, but fails to identify if Patient #6 is oriented to Person, Place, or Time. The agency failed to have an accurate list of all available DME, medication taken by patients, and patients-oriented status on POC. 4. A Clinical Record for Patient #7, certification period 05/19/2024-07/17/2024, included a Plan of Care (POC) that indicated wound care and medication orders for BLE to include applying Eucerin cream after cleansing the area and a list of DME that patient #7 had in the home. The electric wheelchair used by the patient was not listed on the DME and Supplies list on POC, and there were urinary ostomy supplies on POC. The POC does not list zinc oxide (skin barrier cream) or ammonium lactate(dry skin lotion) 12% on the medication list, which patient #7 has applied to BLE with wound care. The agency failed to have an accurate list of all available DME and medication used by patients on POC. During an interview on 06/12/2024 at 1:33 PM, Patient #7 indicated medications listed on POC for wound care were not current, now uses zinc oxide and ammonium lactate 12%, denies having a history of urinary ostomy supplies, has a powered wheelchair in the home for use. During an interview on 06/12/2024 at 1:50 PM, RN 2 indicated Patient #7 has never had a urinary ostomy to RN 2 knowledge, Patient #7 wound care order with medications is not up to date but RN 2 had previously reached out to the Nurse Practitioner for an updated medication order to incorporate the change. RN 2 indicated this case conference note from RN 2 reaching out to the Nurse Practitioner would be in Patient #7's	G0574		

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G0574	Continued from page 19 medical record. During an interview on 06/12/2024 at 2:46 PM, the Director of Clinical Services indicated that the DME on Patient #7's POC was not correct, as the DME listed a urinary ostomy. This was a clerical error that should not have been on the POC for Patient #7. The RN should follow wound care orders or contact the Nurse Practitioner prior to administering other medications on wounds. During an interview on 06/12/2024 at 3:20 PM, the Director of Clinical Services indicated that the POC contained in Patient #7's record was the most up-to-date order regarding wound care and medications. 5. A record review for Patient #8, certification period 10/25/2023 to 12/23/2023, included a POC with Oriented and Forgetful checked on POC as Patient #8's mental status but fails to identify if Patient #8 is oriented to Person, Place, or Time. The agency failed to document Patient #8's oriented status on POC accurately. 6. A record review for Patient #9, certification period 10/28/2023 to 12/26/2023, included a POC with Oriented, Forgetful, and Disoriented checked on POC as Patient #9's mental status but failed to identify if Patient #9 is oriented to Person, Place or Time. The agency failed to document Patient #9's oriented status on POC accurately. 7. During an interview on 6/12/2024 at 9:15 AM, the Director of Clinical Services indicated the medical record system the agency currently uses has a check box for "orientated" but no option for orientated to "person, place, or time" but indicated there are free text boxes that staff could type in what patient is orientated to. She indicated that nurses should be asking about new or changed medication at each visit, physicians should be notified of new or changed medications, and that new orders should be written. 8. During an interview on 6/12/2024 at 2:45 AM, the Director of Clinical Services indicated that the DME list on POC should be updated at recertification, and medication reconciliation should be done every 60 days and as needed. 410 IAC 17-13-1(a)(1)(D)(i-xiii)	G0574		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1)	G0580		

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G0580	Continued from page 20 Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the Registered Nurse (RN) failed to provide services as ordered by the physician, affecting 2 of 2 observed RN home visits. (Patient #5, #6) Findings include: 1. An undated policy titled "Admission Policy" indicated that skilled nursing and home health aide services must follow a written plan of care established and reviewed by a Doctor of Medicine. 2. During an observation on 06/11/2024 at 9:05 AM, RN 3 did not perform a head-to-toe assessment on Patient #6 to evaluate all systems (Respiratory, Cardiovascular, Integrity, Genitourinary, and Gastrointestinal) as outlined on the POC. The RN failed to provide services as ordered by the physician. The record review for Patient #6, certification period 05/13/2024 to 07/11/2024, included a POC that indicated skilled nursing services should assess respiratory status. During an interview on 06/11/2024 at 9:15 AM, RN 3 indicated the visit was completed at 9:15 AM (the visit started at 9:05 AM) and had the patient sign a tablet. RN 3 indicated he sees the patient every day for insulin administration and once per week on Monday for medication set-up and that no other services are provided by the RN. 3. During an interview on 06/12/24 at 2:00 PM, the Director of Clinical Services indicated that the agency did not have a home visit policy or an assessment policy. She indicated that the home visit assessments should follow the patient's plan of care and that all systems on the plan of care should be assessed during each visit. 4. During a recertification home visit on 06/12/2024 at 10:30 AM, Registered Nurse (RN) 1 failed to assess Patient #5's chest, back, under breast, peri-area, bilateral upper and lower legs, soles of feet, and bottom portion of the buttocks. RN 1 failed to measure an open area surrounded with red/purple discoloration on Patient #5's right buttock and failed to measure red/purple discoloration to the left buttock and	G0580		

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G0580	Continued from page 21 tailbone area. RN 1 stated it looked like a bedsore and was about 3 cm x 2 cm. RN 1 failed to accurately complete a head-to-toe assessment and record the data on the OASIS (comprehensive assessment). During an interview on 06/12/2024 at 2:30 PM, the Director of Clinical Services (DCS) stated that the expectation was for the nurse to do a head-to-toe assessment at recertification. Staff are to use a plastic measuring tool to measure wounds. She stated that they use the OASIS form as the comprehensive assessment. 410 IAC 17-13-1(a)	G0580		
G0608	Coordinate care delivery CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to coordinate care with the physician regarding a patient's wound for 1 of 6 active record reviews. (Patient #5) Findings include: 1. A policy titled "Plan of Care" was provided by the Director of Clinical Services (DCS) on 06/10/2024. The policy indicated that the agency addresses the care, treatment, and services provided. The Patient and other agency staff shall participate in the development of the plan of care and any changes that would alter it. Staff will obtain additional visit orders accompanied by a description of the Patient's needs that could warrant a visit. 2. A policy titled "Wound Measurement" was provided by the Director of Clinical Services (DCS) on 6/10/2024. The policy indicated that nursing staff were to measure wounds at a minimum weekly. 3. A job description titled "Home Health Aide" was provided by the Director of Clinical Services (DCS) on 06/11/2024. The description indicated that the aide was to report patient condition changes to the Registered Nurse (RN), perform personal care activities such as bathing, shampooing, skincare, and other related	G0608		

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G0608	Continued from page 22 duties, and promote a safe patient environment. 4. A 2014 NPUAP article titled Prevention and Treatment of Pressure Ulcers: Quick Reference Guide indicated a comprehensive skin assessment should be conducted as soon as possible but within 8 hours of reporting for individuals who are a risk for pressure ulcers. The skin assessment should include skin temperature, edema, and change in tissue consistency in relation to surrounding tissue. The assessment should differentiate whether the skin redness was blanchable or non-blanchable (redness or discoloration disappears when pressure is applied). 5. On 6/6/2024, a Case Conference note indicated that Entity 2, a Personal Service Attendant (PSA) provider, called to report that Patient #5 had an open area on their buttocks. The Registered Nurse Case Manager (RNCM), physician, and Case Manager (CM) were notified. The nurse advised Patient #5 to contact their physician for an appointment if they felt the area needed attention before the RNCM visit. The next RNCM visit, scheduled for 06/12/2024, was for a recertification visit for home health aide services. The agency failed to evidence documentation that an order was obtained to assess the patient's wound promptly. Surveyors accompanied RN 1 during a home visit on 06/12/2024. During a recertification home visit for Patient #5 on 06/12/2024 at 10:30 AM, RN 1 failed to measure the open area and surrounding deep, purple-redness with a measuring tool on Patient #5's right buttock. RN 1 indicated it resembled a bedsore and estimated it to be about 3 centimeters (cm) X 2cm. RN 1 instructed the Patient to apply Destin (skin barrier cream) or A & D (ointment) over the open area until the Patient called the physician. RN 1 mentioned that she does not provide direct hands-on care. RN 1 failed to assess the wound per professional standards and failed to notify the physician at the home visit. On 06/13/2024, the Case Conference Notes indicated that RN 4 reported a defined stage II pressure ulcer measuring 1 cm x 1 cm on Patient #5's right medial buttock. Zinc paste has been regularly applied to the affected area. A photograph was taken showing open areas on both buttocks with zinc paste. The document failed to evidence a measurement for the second-acquired wound to the left buttock and could not indicate the change in measurements to the previous measurement to the right medial buttock. A review of the wound photo taken on 06/13/2024 and reviewed on 06/14/2024 revealed two open areas, one on	G0608		

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G0608	Continued from page 23 each buttock, surrounded by purple/redness. During an interview on 06/14/2024 at 9:30 AM, the Administrator stated that 90% of their patients are non-compliant and do what they want to do. If Patients had to switch to Medicare for wound treatment, they would lose our services. The RN Education Nurse stated that if the nurse knows about a wound ahead of the visit, they should get a verbal order and initiate TAO (triple antibiotic ointment) and a dry dressing. During an interview on 06/14/2024 at 3:00 PM, the Administrator and QA Nurse 2 stated that the doctor does not want anything done until the Patient comes in to see them. "We asked the MD to call the Patient to schedule an appointment. We do not set up appointments for the Patient." The Administrator indicated that the patient "is just trying to live her life, and health and safety has always been an issue for them." A review of a Wound [Appointment] Note dated 06/17/2024 indicated the Nurse Practitioner stated she was sending Patient #5 to the emergency room (ER) for an evaluation. There was no indication of why the Patient was sent to the ER. The note was signed by QA Nurse 2. 410 IAC 17-14-1(a)(1)(F)	G0608		
G0644	Program data CFR(s): 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed	G0644		

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G0644	Continued from page 24 to include measures derived from OASIS and incorporate them into the QAPI program for 1 of 1 Quality Assessment Performance Improvement (QAPI) reviews. Findings include: A policy titled "Quality Assessment Performance Improvement" was provided by the Administrator on 06/18/2024. The policy indicated the agency should utilize OASIS reports that included the following: Home Health Compare, Potential Avoidable Events and Patient Listings, Outcome-Based Quality Improvement Report, Patient/Agency Characteristics Report, Submission Status by Agency Report, and Error Summary Report by the home health agency. The policy indicated data may be collected from measures derived from the OASIS data. On 06/18/2024 at 10:47 AM, the Performance Improvement Manager and the Administrator reviewed the 2023 and 2024 QAPI programs with the surveyor. The agency failed to provide evidence that it included OASIS reports in the programs. During an interview on 06/18/2024 at 11:00 AM, the Program Improvement Manager was asked why the agency did not include late submission reports and potentially avoidable events in the QAPI program, such as discharging a patient into the community with pressure ulcers, behaviors, or improper medications in the QAPI program. The Performance Improvement Manager and the Administrator stated they were unaware those items needed to be included in the program. 410 IAC 17-12-2(a)	G0644		
G0682	Infection Prevention CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure standard infection control precautions were followed regarding bag technique for 2 of 5 home observations with a Registered Nurse (RN 1, RN 3); failed to ensure gloves were removed and hand hygiene performed throughout the entire home visit or	G0682		

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G0682	Continued from page 25 failed to perform hand hygiene after glove removal for 3 of 5 home visit observations with a nurse (RN 1, RN 2, RN 3): and failed to follow manufacturer's instructions on disinfecting equipment for 3 of 5 home visit observations with a nurse. (RN 1, RN 2, RN 3) Finding include: 1. A policy titled "Hand Washing & Hand Hygiene" was provided by the Director of Clinical Services (DCS) on 06/12/2024. The policy indicated that staff should wash their hands between tasks on the same patient and after glove removal. 2. A document titled "Competency Evaluation, Supply Bag Technique" was provided by DCS on 06/12/2024. The policy indicated that staff should wash their hands before entering the supply bag and clean the equipment before returning to the bag. 3. During an observation on 06/11/2024 at 9:05 AM, RN 3 donned gloves before retrieving equipment from the nursing bag. Patient #6's vitals were taken, and the equipment returned to the bag; medication was prepared and administered, and gloves were removed. RN 3 failed to change gloves after entering the nursing bag, before and after contact with the patient, and before administering medication. RN 3 did not disinfect the equipment (Blood Pressure cuff, Oximeter, and Thermometer) before or after the equipment was used to take patient #6's vitals. RN 3 Failed to follow instructions on disinfecting equipment between patients. During an interview on 6/12/2024 at 2:45 AM, the Director of Clinical Services indicated blood pressure cuffs and other equipment used during home visits should be disinfected between patient use 4. During an observation on 06/12/2024 at 10:30 AM, RN 1 applied gloves and assessed Patient #5's bed sore on their right buttocks. RN 1 kept her soiled gloves while assisting Patient #5 from the bed and documenting on her notepad. RN 1 failed to remove her gloves and perform hand hygiene after assessing the patient's bedsore and before touching her notepad. RN 1 cleaned her vital sign equipment (stethoscope and oxygen saturation device) with an alcohol wipe and placed them directly into her equipment while wet. RN 1 failed to allow the equipment to dry before placing it into the bag. During an interview on 06/12/2024 at 2:00 PM, the Director of Clinical Services (DCS) stated that the	G0682		

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G0682	Continued from page 26 nurse was expected to perform hand hygiene after removing their gloves and before touching clean items. DCS also stated that vital sign equipment should be left to dry after disinfecting and before returning it to its bag. 5. During an observation on 06/12/2024 at 1:04 PM, RN 2 provided wound care for Patient #7 following the completion of the assessment during the home visit. RN 2 failed to properly disinfect the stethoscope and blood pressure cuff for 4 minutes following the completion of Patient #7 vital signs and failed to change gloves and complete hand hygiene between cleaning and applying Zinc barrier cream in the creases of both legs and ammonium lactate lotion 12% on wound sites. During an observation on 06/12/2024 at 1:50 PM, RN 2 provided the Lysol Wipes package that RN 2 used to wipe the stethoscope and blood pressure cuff. The Lysol Wipes package instructions indicated dry times for sanitizing was 10 seconds and for disinfection was 4 minutes. During an interview on 06/12/2024 at 1:50 PM, RN 2 indicated wiping stethoscope and blood pressure cuff with personal Lysol wipes. RN 2 indicated dry time for Lysol wipes to sanitize was 10 seconds, and for disinfection was 4 minutes, according to the Lysol wipes package. RN 2 indicated not allowing the stethoscope and blood pressure cuff to dry for 4 minutes prior to placing the stethoscope around the neck and blood pressure cuff back in the supply bag. RN 2 indicated not changing gloves between cleaning the wound site and application of lotion. During an interview on 06/12/2024 at 2:46 PM, the Director of Clinical Services indicated RN 2 should have changed gloves and completed hand hygiene between cleaning and applying lotion, and again following the application of lotion. The Director of Clinical Services indicated the expectation of RN 2 is to disinfect the stethoscope and blood pressure cuff between patient use, Lysol wipes were permitted for proper disinfection of equipment when following package instructions. 410 IAC 17-12-1(m)	G0682		
G0750	Home health aide services CFR(s): 484.80 Condition of participation: Home health aide services.	G0750		

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G0750	Continued from page 27 All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to follow the Home Health Aide (HHA) Plan of Care (POC) as ordered by the Physician (See tag G800); failed to ensure the home health aide provided hands-on direct patient care (See tag G802); and failed to ensure the home health aide reported changes in the patient's condition and needs to a nurse (See tag G804). The cumulative effect of the deficient practice resulted in the agency's noncompliance with Condition of Participation §484.80 Home Health Aide Services. .	G0750		
G0776	Inservice training supervised by RN CFR(s): 484.80(d)(1) In-service training may be offered by any organization and must be supervised by a registered nurse. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure in-service training for Home Health Aides (HHA) were provided under the supervision of a Registered Nurse (RN) for 1 of 4 HHA personnel records reviewed (HHA 3). Findings include: 1. A policy titled, "In-Service Education and Staff Development" indicated the agency is responsible for maintaining the records of the in-service education programs and the agency will follow Medicaid Conditions of Participation or as states require with in-service HHA education: Training must be provided by or under the direction of a Registered Nurse. 2. A document titled, "Annual TB Education sent out Oct. 2023, 1 hour" failed to evidence annual TB (tuberculosis) in-services an RN supervised training. 3. During an interview on 06/18/2024 at 12:40 PM, a document titled "Elder's Journey Home Care Newsletter",	G0776		

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G0776	Continued from page 28 indicated the newsletter would be counted as in-service and is sent by email each month, no evidence was provided that staff members read email, or newsletter is supervised by RN, per in-service requirements. 4. During an interview with HR Director on 06/18/2024 at 1:00 PM, the HR Director indicated the agency fails to maintain sign-in records of In-Service Training because they are completed online by staff. HR Director stated this was started during COVID and has not resumed in person. HR Director stated the Clinical Director is the RN who "oversees" in-service training. 410 IAC 17-14-1	G0776		
G0800	Services provided by HH aide CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to follow the Home Health Aide (HHA) Plan of Care (POC) as ordered by the Physician, for 5 of 6 patients with HHA services. (Patient #3, #5, #6, #9 #11) Findings include: 1. An undated document titled "Position: Home Health Aide" indicates the Home Health Aide must follow a written POC. 2. A review of Patient #3's record included an Aide Plan of Care dated 12/12/2023 that was electronically signed by Registered Nurse (RN) 6. The Aide Plan of Care indicated a frequency of ten hours a day, five days a week, for HHA services. The section titled "Assignment" indicated the HHA was to do the following tasks at each visit: hair care, skin care, mouth/denture care, foot care, dressing, preparing a meal, encouraging fluids, personal care, bed bath, check for pressure points, toileting/hygiene, and	G0800		

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G0800	Continued from page 29 medication reminders, assist with walker and bedside commode, and reposition in bed. A review of Patient #3's "Aide Visit Note-Daily" dated 12/16/2023, 12/18/2023, 12/22/2023 evidenced skin care, dressing, and personal care was marked as not completed/not needed, and on 12/30/2023 evidenced shampoo, mouth/denture care, nail care, shower, bed bath, linen change was marked not completed/not needed. Additionally, on the following dates: 12/13/2023 12/14/2023, 12/15/2023, 12/19/2023, 12/20/2023, 12/21/2023, 12/23/2023, 12/26/2024, 12/27/2024, 12/28/2024, 12/29/2024, 01/0/2024, 01/03/2024, and 01/04/2024 the aide provided hair care and dressing, but all other tasks were refused without reason. HHA #13, #17, and #18 failed to follow the aide POC, provided a reason why the Patient did not need care and failed to inform the nurse of the Patient's refusal of care. 3. During an interview at the home visit on 06/12/2024 at 10:30 AM, Patient #5 indicated they could not recall the last time they had a shower, bed bath, or shampoo. RN 1, HHA 1, and the PSA provider were present during the interview. A review of Patient #5's record included an Aide Plan of Care dated 04/16/2024, electronically signed by RN 1. The Aide Plan of Care indicated a frequency of two hours a day, two days a week, for HHA services. The section titled "Assignment" indicated the HHA was to do the following tasks at each visit: vital signs (temperature, respirations, blood pressure pulse rate), hair care, shampooing, skin care, mouth/denture care, foot care, dressing, prepare a meal, encourage fluids, personal care, shower, sponge bath (up in a chair), check for pressure points, toileting/hygiene, and medication reminders, assist with walker and wheelchair. A review of Patient #5's "Aide Visit Note-Daily" failed to evidence that HHA 1 and HHA 19 provided care as assigned on the aide plan of care for the following aide visit dates: On 06/14/2024, evidenced vital signs, hair care, skin care, mouth/denture care, foot care, dressing, preparing a meal, encouraged fluids, personal care, shower, sponge bath (up in a chair), check for pressure points, toileting/hygiene, and medication reminders, assist with walker and wheelchair was marked not completed/not needed/or other caregiver did. On 06/12/2024, evidenced vital signs, hair care, skin	G0800		

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G0800	Continued from page 30 care, mouth/denture care, foot care, dressing, personal care, shower, sponge bath (up in a chair), check for pressure points, toileting/hygiene, medication reminders, and assistance with walker and wheelchair were marked not completed/not needed. On 06/04/2024, vital signs were not taken due to not being requested and no equipment. The document also evidenced that shampooing, nail care, personal care, showering, and assistance with a wheelchair were marked as not requested /not needed. On 06/01/2024, evidenced vital signs, hair care, skin care, mouth/denture care, foot care, dressing, preparing a meal, encouraging fluids, personal care, shower, sponge bath (up in a chair), check for pressure points, toileting/hygiene, and wheelchair were marked not completed/not needed. On 05/30/2024, evidenced vital signs, hair care, skin care, mouth/denture care, foot care, nail care, preparing a meal, encouraging fluids, showers, sponge baths (in a chair), and assistance with a wheelchair were marked as not needed. On 05/24/2024, evidenced vital signs, shampooing, mouth/denture care, foot care, dressing, preparing a meal, encouraging fluids, personal care, shower, sponge bath (up in a chair), check for pressure points, toileting/hygiene, and medication reminders, assisted with walkers and wheelchair were marked as not needed. On 05/18/2024, evidenced vital signs, hair care, shampooing, skin care, mouth/denture care, foot care, dressing, preparing a meal, encouraging fluids, personal care, shower, sponge bath (up in a chair), assisting with a wheelchair were marked as not needed. On 05/16/2024, evidenced vital signs, shampooing, mouth/denture care, foot care, preparing a meal, encouraging fluids, showering, sponge bath (up in a chair), checking for pressure points, and assisting with a wheelchair were marked as not needed. On 05/09/2024, evidenced vital signs, hair care, shampooing, mouth/denture care, foot care, preparing a meal, encouraging fluids, showers, sponge baths (up in a chair), checking for pressure points, and assisting with a wheelchair were marked as not needed. On 05/08/2024, evidenced vital signs, hair care, shampooing, mouth/denture care, foot care, preparing a meal, encouraging fluids, showers, sponge baths (up in a chair), preparing meals, assisting with the	G0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDER'S JOURNEY HOME CARE LLC	4334 E 3RD STREET , BLOOMINGTON, Indiana, 47401

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G0800	Continued from page 31 wheelchair were marked as not needed. On 05/02/2024, evidenced vital signs, shampooing, mouth/denture care, foot care, preparing a meal, encouraging fluids, showers, sponge baths (up in a chair), and assistance with a wheelchair were marked as not needed. On 05/01/2024, evidenced vital signs, hair care, shampooing, skin care, mouth/denture care, foot care, dressing, preparing meals, encouraging fluids, personal care, showers, sponge baths (up in a chair), and assistance with a wheelchair were marked as not needed. On 04/24/2024, evidenced vital signs, shampooing, skin care, mouth/denture care, foot care, nail care, preparing a meal, encouraging fluids, showers, sponge baths (up in a chair), and assistance with a wheelchair were marked as not needed. During a phone interview on 06/13/2024 at 1:30 PM, HHA 1 indicated they do not offer a shower or bath to Patient #5 despite it being ordered on the plan of care. She stated that if Patient #5 wanted a bath, they would ask. HHA 1 said they would do what the Patient told them to do, and if the patient refused care, they would mark it as refused and report it to the nurse. The agency HHA failed to follow the Aide POC. 4. During an observation on 06/14/2024 at 10:54 AM, Patient #6 was sitting in a living room chair with a TV on, while HHA 4 was found sitting in the hallway of Patient #6's apartment using a cell phone conducting personal business with phone speaker on from 10:54 AM to 11:06 AM. After HHA 4 completed the phone call, HHA 4 provided a tour of the apartment and pointed out the bathroom was not clean, indicating if she cleaned it today, it would look the same again tomorrow. The bathroom had towels lying on the floor, bowel specimens along the rim of the toilet, and a strong odor of urine. HHA 4 indicated she was not going to get house cleaning done today; she usually mops and takes the trash out if it is full and usually does cleaning between 10:30 AM and 12:00 AM. HHA 4 said three times during the observation visit: make sure to tell them that a lot of housekeeping is done at the end of the visit, but I ran out of time today. (She was referring to notes being taken during the visit). The record review for Patient #6, certification period 05/13/2024 to 07/11/2024, included an Aide Plan of Care with an effective date of 05/13/2024, indicating Patient #6 was to receive the following services: shampoo, skin care, mouth care, dressing, other	G0800		

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G0800	Continued from page 32 (shaving verbal cues), shower, toileting/hygiene, and medication reminders every visit. The Aide Visit Note - Daily indicated all Aide Plan of Care services was not offered on 05/13/2024, 05/22/2024, 05/24/2024, 05/29/2024,05/31/2024, 06/04/2024, 06/07/2024 or 06/12/2024 During an interview on 06/14/2024 at 11:06 AM, Home Health Aide (HHA) 4 indicated her job was to prepare meals, housekeeping, laundry, and grooming. HHA 4 indicated she could not remember the last time she helped Patient #6 with a shower; she did not offer Patient #6 a shower during today's visit. Patient #6 gets showers every week, and the patient has a friend who comes on Saturday to help with showers. HHA 4 indicated she arrived at 8:00 AM today, had coffee with the patient, watched TV, a nurse arrived for a home visit, and then the surveyor arrived. HHA 4 indicated the agency provides a sheet of what HHA 4 should offer patients during visits, but she was unable to locate the paper; she indicated she can see what the patient needs and provides it and can also look at the phone where charting is done. During an interview on 06/14/2024 at 10:35 AM, Patient #6 was asked if they are offered a shower every visit the HHA is there. Patient #6 stated, "I guess I'm offered a shower every day." They indicated they have a buddy who comes on weekends and helps with showering, but they did not take a shower today. They indicated the HHA sometimes cooks and cleans the bathroom. 5. The record review for Patient #9, certification period 10/28/2023 to 12/26/2023, included an Aide Plan of Care with an effective date of 10/28/2023, indicated Patient #9 was to receive the following services: hair care, shampoo, skin care, mouth care, foot care, nail care, dressing, personal care, sponge bath in a chair, assist with walker and cane, prepare meals, encourage fluid intake, and toilet hygiene are ordered each visit. The Aide Visit Note - Daily indicated all Aide Plan of Care services were not offered on 10/29/2023, 10/30/2023, 11/2/2023, 11/02/2023, 11/05/2023, and 11/11/2023. 6. During an observation on 06/14/2024 at 10:30 AM, HHA 12 provided light housekeeping duties for Patient #11 during the home visit. HHA 12 failed to offer Patient #11 hair care, mouth/denture care, and dressing. The Clinical Record for Patient #11, certification period 06/14/2024-08/12/2024, included an Aide Plan of Care (POC) that indicated HHA was to complete hair care, skin care, mouth/denture care, and dressing at	G0800		

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G0800	Continued from page 33 each visit, as well as light housekeeping duties. An Aide visit note dated 06/14/2024 indicated that Patient #11 had received hair care, mouth/denture care, and dressing completed by HHA 12. HHA 12 failed to follow the Aide POC as ordered by the physician. During an interview on 06/14/2024 at 10:35 AM, Patient #11 indicated refusing to shower at this visit due to being too tired, and the HHA would only be doing light housekeeping at this visit. During an interview on 06/14/2024 at 10:50 AM, HHA 12 indicated Patient #11 refused a shower and would only be receiving light housekeeping at this visit. HHA 12 indicated not providing mouth/denture care to Patient #11, as the patient does this independently.	G0800		
G0802	Duties of a HH aide CFR(s): 484.80(g)(3) The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency home health aide (HHA) failed to provide hands-on direct patient care for 3 of 5 record reviews with home health aide services. (HHA 1, HHA 4, HHA 12) Findings include: 1. An undated document titled "Position: Home Health Aide" indicated that the Home Health Aide (HHA) must follow a written plan of care. The HHA was to follow the plan and complete the tasks assigned to it, such as bathing, shampooing, skincare/hair care, oral hygiene, shaving, and dressing. 2. A review of Patient #3's record included an Aide Plan of Care dated 12/12/2023 that was electronically signed by Registered Nurse (RN) 6. The Aide Plan of Care indicated a frequency of ten hours a day, five days a week, for home health aide services. The section	G0802		

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G0802	Continued from page 34 titled "Assignment" indicated the HHA was to do the following tasks at each visit: hair care, skin care, mouth/denture care, foot care, dressing, preparing a meal, encouraging fluids, personal care, bed bath, check for pressure points, toileting/hygiene, and medication reminders, assist with walker and bedside commode, and reposition in bed. A review of the "Aide Visit Note-Daily" dated 12/16/2023, 12/18/2023, 12/22/2023 evidenced skin care, dressing, and personal care was marked as not completed/not needed, and on 12/30/2023 evidenced shampoo, mouth/denture care, nail care, shower, bed bath, linen change were marked not completed/not needed. Additionally, on the following dates: 12/13/2023, 12/14/2023, 12/15/2023, 12/19/2023, 12/20/2023, 12/21/2023, 12/23/2023, 12/26/2023, 12/27/2023, 12/28/2023, 12/29/2023, 01/0/2024, 01/03/2024, and 01/04/2024 the aide failed to provide all direct hands-on care as assigned on the aide plan of care. 3. A review of Patient #5's record included an Aide Plan of Care dated 04/18/2024 that was electronically signed by RN 1. The Aide Plan of Care indicated a frequency of two hours a day, two times a week for home health aide (HHA) services. The section titled “Assignment” indicated the HHA was to do the following each visit: obtain temperature, respirations, blood pressure, pulse rate, hair care, skin care, mouth/denture care, foot care, nail care, dressing, prepare a meal, encourage fluids, personal care, shower, sponge bath in a chair, check for pressure points, toileting/hygiene, and medication reminders, assist with walker and wheelchair. A review of the “Aide Visit Note-Daily” dated 04/20/2024, 04/23/2024, 04/24/2024, 05/01/2024, 05/02/2024, 05/08/2024, 05/09/2024, 05/16/2024, 05/18/2024, 05/24/2024, 05/30/2024, 06/01/2024, 06/04/2024, 06/12/2024, and 06/14/2024, failed to evidence HHA 1 followed the Aide Plan of Care and provided hands-on personal care tasks assigned at each visit. During a phone interview on 06/13/2024 at 1:30 PM, HHA 1 was asked why the aide visit notes indicated the tasks of showering, bathing, mouth/denture care, foot/nail care, shampooing, and preparing meals were marked as not completed and not needed. HHA 1 stated she does not offer a shower or bath to Patient #5 despite it being ordered on the aide plan of care. She stated that if Patient #5 wanted a bath, they would ask. HHA 1 stated they do what the Patient tells them	G0802		

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G0802	Continued from page 35 to do. HHA 1 stated that if the Patient refused care, they would mark it as refused and report it to the nurse. The agency HHA failed to follow the Aide POC. 4. The record review for Patient #6, certification period 05/13/2024 to 07/11/2024, included an Aide Plan of Care with an effective date of 05/13/2024, indicating Patient #6 was to receive the following services: shampoo, skin care, mouth care, dressing, other (shaving verbal cues), shower, toileting/hygiene, and medication reminders every visit. The Aide Visit Note - Daily indicated all Aide Plan of Care services was not offered on 05/13/2024, 05/22/2024, 05/24/2024, 05/29/2024,05/31/2024, 06/04/2024, 06/07/2024 or 06/12/2024 During an observation on 06/14/2024 at 10:54 AM, Patient #6 was sitting in a living room chair with a TV on, while HHA 4 was found sitting in the hallway of Patient #6's apartment using a cell phone conducting personal business with phone speaker on from 10:54 AM to 11:06 AM. After HHA 4 completed the phone call, HHA 4 provided a tour of the apartment and pointed out the bathroom was not clean, indicating if she cleaned it today, it would look the same again tomorrow. The bathroom had towels lying on the floor, bowel specimens along the rim of the toilet, and a strong odor of urine. HHA 4 indicated she was not going to get house cleaning done today; she usually mops and takes the trash out if it is full and usually does cleaning between 10:30 AM and 12:00 AM. HHA said three times during the observation visit: make sure to tell them that a lot of housekeeping is done at the end of the visit, but I ran out of time today. (She was referring to notes being taken during the visit). During an interview on 06/14/2024 at 11:06 AM, Home Health Aide (HHA) 4 indicated her job was to prepare meals, housekeeping, laundry, and grooming. HHA 4 indicated she could not remember the last time she helped Patient #6 with a shower; she did not offer Patient #6 a shower during today's visit. He gets showers every week, and he has a friend who comes on Saturday to help with showers. HHA 4 indicated she arrived at 8:00 AM today, had coffee with the patient, watched TV, a nurse arrived for a home visit, and then the surveyor arrived. HHA 4 indicated the agency provides a sheet of what HHA 4 should offer patients during visits, but she was unable to locate the paper; she indicated she can see what the patient needs and provides it and can also look at the phone where charting is done. During an interview on 06/14/2024 at 10:35 AM, Patient	G0802		

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G0802	Continued from page 36 #6 was asked if they are offered a shower every visit the HHA is there. Patient #6 stated, "I guess I'm offered a shower every day." They indicated they have a buddy who comes on weekends and helps with showering, but they did not take a shower today. They indicated the HHA sometimes cooks and cleans the bathroom. 5. The record review for Patient #11, certification period 06/14/2024-08/12/2024, included an Aide Plan of Care (POC) that indicated HHA was to complete hair care, skin care, mouth/denture care, and dressing at each visit, as well as light housekeeping duties. An Aide visit note dated 06/14/2024 indicated that Patient #11 had received hair care, mouth/denture care, and dressing completed by HHA 12. HHA 12 failed to provide hands-on care to Patient #11 during this home visit. During an observation on 06/14/2024 at 10:30 AM, Home Health Aide (HHA) 12 only provided light housekeeping duties for Patient #11 during the home visit. HHA 12 failed to offer Patient #11 hair care, mouth/denture care, and dressing. During an interview on 06/14/2024 at 10:35 AM, Patient #11 indicated refusing to shower at this visit due to being too tired, and the HHA would only be doing light housekeeping at this visit. During an interview on 06/14/2024 at 10:50 AM, HHA 12 indicated that Patient #11 refused a shower and would only be receiving light housekeeping at this visit. HHA 12 also indicated that it would not provide mouth/denture care to Patient #11, as the patient does this independently. 410 IAC 17-14-1(h)(1)-(14)	G0802		
G0804	Aides are members of interdisciplinary team CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency home health aide (HHA) failed to report changes in the patient's condition and needs to a nurse for 1 of 5 record reviews with HHA services. (HHA 1)	G0804		

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G0804	Continued from page 37 Findings include: A review of a job description titled "Home Health Aide" was provided by the Director of Clinical Services (DCS) on 06/12/2024. The aide job description indicated but was not limited to the home health aide reports to the clinical supervisor or the case manager. The policy indicated the HHA was to report any changes in the patient's condition and needs to the nurse. During an interview at a recertification home visit on 06/12/2024 at 10:30 AM, the Personal Service Attendant (PSA) provider stated Patient #5 refuses showers and bed baths. The PSA provider stated she does not know what the other HHA does while in the home. During the visit, HHA 1 entered the home and was asked about the bathing schedule, to which she stated I don't know when the Patient had a bath last. HHA 1 stated she was off on the 13th but could give the patient a bath on the 14th. At that time, HHA 1 did not offer Patient #5 a bath for the day. Registered Nurse (RN) 1 was not aware the patient was not receiving a bath. HHA 1 failed to ensure bathing and hygiene tasks were performed at each visit and failed to report to the nurse when care was not provided. During a phone interview on 06/13/2024 at 1:30 PM, HHA 1 indicated Patient #5 does not ask for help. HHA 1 said they do not offer a shower or bath to Patient #5 despite it being ordered on the aide plan of care. She stated that if Patient #5 wanted a bath, they would ask. HHA 1 said they do what the Patient tells them to do. HHA 1 stated that if the Patient refused care, they would mark it as refused and report it to the nurse. HHA 1 said they do not know what the PSA provider does but assume they are to give her a bath. HHA 1 was asked how she knows what to do for the Patient while in the home. HHA 1 said the tasks can be found in Alora (electronic medical record). HHA 1 was asked what specifically they do for Patient #5, to which she said she cleans her up, changes her clothes, and if she has the "runs," she wipes the patient's buttocks. HHA 1 stated she has been taking care of Patient #5 for over a year as well as her family. HHA 1 was asked if Patient #5 walks, to which she said, "Not really, I have never seen [patient] walk." HHA 1 said the patient stands, turns, and sits on the seat of a rolling walker, and then I push the walker. The agency HHA failed to follow the Aide POC and document why care was not provided. The HHA failed to report to the nurse why the tasks assigned at each visit, such as bathing and hygiene, were not needed or offered to the patient.	G0804		

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G0804	Continued from page 38 During an interview on 06/14/2024 at 9:30 AM, the Registered Nurse (RN) Educational Nurse stated the aide should report to the nurse or office when the patient was refusing care when care was not completed on the aide plan of care, and if there was a change in condition. She stated it was not appropriate for the nurse or aide to use a rolling walker as a wheelchair and would need re-education. At that time, the Administrator stated that 90% of their patients are non-compliant and do what they want to do. If Patients had to switch to Medicare, they would lose our services. 410 IAC 17-14-1(1)(m)	G0804		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency Administrator failed to ensure that the home health agency met all the rules and regulations for licensure and failed to ensure compliance with Center of Medicare & Medicaid Services (CMS) Conditions of Participation for 1 of 1 home health agency. Findings include: A policy titled "Governing Body" was provided by the Administrator on 06/18/2024. The policy indicated that the Administrator was responsible for the agency's day-to-day operations of the agency in accordance with all state and federal regulations. The Administrator failed to implement full-scale emergency training and testing, which stressed the agency's emergency preparedness program. (See tag E0036) The Administrator failed to ensure agency staff encode and electronically transmit each completed OASIS assessment to the CMS system within 30 days of completing the assessment of the patient. (See tag G372) The Administrator failed to ensure the agency provided services as ordered on the POC, failed to notify the patient or physician before discharge for cause, and failed to provide patients with contact information for	G0948		

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G0948	Continued from page 39 providers able to provide care. (See tag G436) The Administrator failed to ensure staff completed an initial assessment within 48 hours of a referral. (See tag G514) The Administrator failed to ensure agency staff completed an accurate, comprehensive assessment that reflected the patient's health status. (See tag G528) The Administrator failed to ensure staff accurately assess, measure, and manage a patient's wound promptly, coordinate care effectively with the provider and Personal Service Agency (PSA) agency, and provide immediate care to meet the patient's overall needs, failed to ensure the POC included mental status specific to person, place, and time, all medications, a current and complete list of Durable Medical Equipment (DME) and Supplies, and the Registered Nurse (RN) provided services as ordered by the physician. (See tag G570) The Administrator failed to ensure a signed POC or a verbal POC order from the primary Physician before providing services and treatments to patients. (See tag G572) The Administrator failed to ensure standard infection control precautions were followed regarding bag technique, failed to ensure gloves were removed, and hand hygiene was performed throughout the entire home visit, failed to perform hand hygiene after glove removal, and failed to ensure staff followed the manufacturer's instructions on disinfecting equipment. (See tag G682) The Administrator failed to ensure agency staff followed the Home Health Aide (HHA) POC as ordered by the Physician, failed to ensure the home health aide provided hands-on direct patient care, and failed to ensure the home health aide reported changes in the patient's condition and needs to a nurse. (See tag G800, G802, G804) The Administrator failed to ensure agency staff completed accurate clinical record documentation. (See tag G1008) The Administrator failed to ensure staff completed a detailed discharge summary and failed to document all communication with the patient regarding discharge. (See tag G1022) The Administrator failed to ensure the agency's	G0948		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDER'S JOURNEY HOME CARE LLC	4334 E 3RD STREET , BLOOMINGTON, Indiana, 47401

(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
G0948	Continued from page 40 organizational structure, administrative control, and lines of authority and delegation responsibility were down to the patient care level. (See tag N440) 410 IAC 17-12-1(c)(1)	G0948		
G1008	Clinical records CFR(s): 484.110 Condition of participation: Clinical records. The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure staff completed accurate clinical record documentation for 2 of 6 patients with home visits (Patient #6, #11). Findings include: 1. A policy titled "Clinical Documentation" indicated, but was not limited to, "Purpose: To ensure that there is an accurate record of the services provided, client response and ongoing need for care". 2. During an observation on 06/11/2024 at 9:05 AM, Registered Nurse (RN) 3 administered 18 units of Basaglar (long-acting basal insulin used to control high blood sugar) insulin subcutaneously (under the skin) to Patient #6 during a home visit. A record review of Patient #6's certification period from 5/13/2024 to 7/11/2024 included a Plan of Care (POC) that indicated skilled nursing was to administer Basaglar insulin 14 units every morning. The medication list on the POC indicated Basaglar insulin 18 units to be administered every morning. The agency failed to have an accurate POC. An Aide Plan of Care with an effective date of 05/13/2024 indicated Patient #6 was to have a shower every visit. An "Aide Visit Note", dated 06/10/2024, indicated the shower was completed on 06/10/2024; Home Health Aide (HHA) 4 indicated she was	G1008		

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G1008	Continued from page 41 unable to remember the last time she assisted the patient with the shower since a friend helps Patient #6 every weekend with a shower. HHA 4 failed to accurately document home visit services offered/provided on 06/10/2024. An "Aide Visit note" dated 06/14/2024 indicated a shower was offered and refused. HHA 4 indicated no shower was offered on 06/14/2024 to Patient #6. HHA 4 failed to document home visit services offered/provided accurately. During an interview on 6/14/2024 at 10:54 AM, HHA 4 indicated that she did not offer a shower to Patient #6 today because Patient #6 does their showers on Saturdays when a friend comes to help him. HHA 4 indicated she could not remember the last time she helped the patient with a shower. 3. During an observation on 06/14/2024 at 10:30 AM, Home Health Aide (HHA) 12 provided light housekeeping duties for Patient #11 during the home visit; no hands-on services were provided as ordered on the HHA POC. The Clinical Record for Patient #11, certification period 06/14/2024-08/12/2024, included an Aide Plan of Care (POC) that indicated HHA was to complete hair care, skin care, mouth/denture care, and dressing at each visit, as well as light housekeeping duties. An Aide visit note dated 06/14/2024 indicated that Patient #11 had received hair care, mouth/denture care, and dressing completed by HHA 12. The HHA 12 did not provide hands-on care during the home visit on 06/12/2024. HHA 12 failed to accurately document events during the home visit. During an interview on 06/14/2024 at 10:35 AM, Patient #11 indicated refusing to shower at this visit due to being too tired, and the HHA would only be doing light housekeeping at this visit. During an interview on 06/14/2024 at 10:50 AM, HHA 12 indicated Patient #11 refused a shower and would only be receiving light housekeeping at this visit. HHA 12 indicated not providing mouth/denture care to Patient #11, as the patient does this independently.	G1008		
G1012	Required items in clinical record CFR(s): 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders;	G1012		

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G1012	Continued from page 42 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to maintain referral documents in the patient's clinical records for 5 of 8 full record reviews with skilled nursing services (Patient #1, #2, #5, #6, #9) Findings include: 1. An undated policy titled "Clinical Documentation" indicated that communication with physicians will be documented in clinical progress notes or other interagency communication forms. 2. An undated policy titled "Physician/allowed Non-Physician Practitioner (NNP) orders" indicated that the agency must place a copy of the order in the chart. All entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer-secured entries. 3. The clinical record for Patient #1, certification period 01/14/2023-03/14/2023, Start of Care (SOC) date of 08/11/2022, failed to evidence a Physician referral order. A document provided by Quality Assurance (QA) Nurse 2 was a printed email dated 08/09/2022. Next to the date was handwriting placed on the document before receiving "took referral." The email was sent to multiple Elder's Journey employees and was from Quality Nurse 2 regarding Patient #1. The agency could not provide a Physician referral order for Patient #1. 4. The clinical record for Patient #5, certification period 03/23/2023 to 05/21/2024, SOC date 03/09/2023, failed to evidence a referral order from the physician. During an interview on 06/17/2024 at 2:18 PM, QA Nurse 2 provided copies of emails sent to other Elder Journey employees that were not part of the Patient record and did not identify a referral date. QA Nurse 2 was asked to identify which email was the referral date to which she pointed to "03/20". The agency failed to maintain referral information in the clinical record. 410 IAC 17-15-1(a)(1)-(7)	G1012		
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the	G1022		

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G1022	Continued from page 43 primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure staff completed a detailed discharge summary and failed to document all communication with the patient regarding discharge for 5 of 5 closed record reviews. (Patients #1,#2, #3, #8, #9) Findings include: 1. A policy titled "Client Discharge Process" was provided by the Director of Clinical Services (DCS) on 06/10/2024. The policy indicated that the agency should document if goals were met at the time of discharge. The policy indicated all communication with the patient, including a rationale for discharge, must be maintained in the patient's record. Staff are to complete a discharge summary that includes the following: Patient status at the time of admission to the agency, statement of care and interventions provided and outcomes of care, status at discharge/last visit/current medications, and continuing care needs, name of person or organizations assuming responsibility for care, instructions and referrals given to the patient/family/caregiver, reason for discharge and date of discharge. 2. A review of Patient #1's record, certification period 01/14/2023-03/14/2023, Start of Care (SOC) date 08/11/2022, included a discharge summary dated 03/07/2023 indicating Patient #1's services were terminated due to unsanitary work environment. The record failed to evidence a detailed discharge summary that aligned with the agency discharge summary. 3. A review of Patient #2's record included a Home Health Plan of Care & Certification, certification	G1022		

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G1022	Continued from page 44 period 05/01/2023 to 06/30/2023, and a discharge summary dated 06/30/2023, which indicated Patient 2 was discharged from home health services. Per the Wound Care Center, the Patient had been discharged due to behaviors and non-compliance with care. The record failed to evidence a detailed discharge summary aligned with the agency discharge policy. 4. A review of Patient #3's record included a Home Health Plan of Care & Certification, certification period 12/13/2024 to 02/10/2024, SOC date 05/23/2016, included a discharge summary dated 01/23/2024 stating Patient 3 was ineligible for Medicaid and were unable to renew. The record failed to evidence a detailed discharge summary aligned with the agency discharge policy. 5. A review of Patient #8's record included a Home Health Plan of Care & Certification with a certification period of 10/25/2023 to 12/23/2023. The record also included a discharge summary dated 11/13/2023 that indicated Patient 8 was being discharged from skilled nursing services due to the Patient's ability to self-administer insulin. The record failed to evidence a detailed discharge summary that aligned with the agency discharge policy. 6. A review of Patient #9's record included a Home Health Plan of Care & Certification with a certification period of 10/28/2024 to 22/26/2023, included a discharge summary dated 01/23/2023 stating Patient 9 was being discharged from home health due to the patient not being safe to remain in the home and is non-compliant with care, which risks patients' health. The record failed to evidence a detailed discharge summary that aligned with the agency discharge policy. 7. During an interview on 06/11/2024 at 9:15 AM, RN 3 indicated he does not communicate with the physician; all information goes through office QA Nurses, who create reports and notify the physician of findings/events (admission report, missed visit, etc.). 8. During an interview on 6/11/2024 at 11:40 AM, the Director of Clinical Services indicated that the discharge summary should summarize the care provided and explain why the patient is being discharged. 8. During an interview on 6/12/2024 at 9:15 AM, the Director of Clinical Services indicated the discharge summary should include the care the patient received from the agency during the certification period 9. During an interview on 6/12/2024 at 2:00 PM, the	G1022		

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G1022	Continued from page 45 Director of Clinical Service indicated the discharge summary was created by support staff in the office (Quality Assurance Nurses), who send it to the physician, not the Registered Nurse (RN) who performs the discharge visit. 410 IAC 17-15-1-(a)(6)	G1022		