STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K165	A. BUILDING 00 B. WING	05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VISITING ANGELS HOME HEALTHCARE	3197 S US HWY 231 GREENCASTLE, IN 46135

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G 0000 Bldg. 00		G 0000		

This visit was for a Federal Post Condition revisit and a follow-up to a State Relicensure survey of a Medicaid Home Health Agency that was conducted on 11/7/2020.

Survey Dates: 5/10/2021 thru 5/18/2021

Facility #: 014225

CCN: 15K165

Medicaid#: 300012386

During this survey, 4 Condition level deficiencies were corrected; 3 Condition level deficiencies were recited; 19 standard level deficiencies were corrected; 23 standard level deficiencies were recited.

Visiting Angels Home Healthcare continues to be out of compliance with Conditions of Participation 484.55 Comprehensive Assessments of Patients; 484.60 Care Planning, Coordination of Services, and 484.80 Home Health Aide Services.

Based on the Condition-level deficiencies during the November 17, 2020 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on November 10, 2020. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning November 17, 2020 and continuing through

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	November 16, 2022. The deficiencies cited in this survey are reflected in findings cited pursuant to 410 IAC 17. Quality Review Completed on 6/15/2021 by Area 3			
G 0436 Bldg. 00	484.50(c)(5) Receive all services in plan of care Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure they adhered to patient rights and provide all services as outlined on the patient's plan of care in 4 of 4 active records (Patients #1, 2, 3, 5,). Findings include: 1. A review of undated agency policy "C-660 Care Plans" revealed "Each client will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs." The policy also stated the purpose of the care plan included providing an "updated, coordinated document that reflects the current home care services. 2. A review of the clinical record for patient #2, included a plan of care for the certification period of 4/10/21 - 6/8/21, which revealed orders for skilled nurse 1 hour biweekly for med box (medication box) set up, medication compliance, education and assessment, and home health aide 8 hrs/day x 5 days/week x 7 weeks and 8 hours/day x 2 days per week x 1 week.	G 0436	**G436** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1-** Visits monitored daily/weekly with physician notification if visits are missed **Patient #2-** Visits monitored daily/weekly with physician notification if visits are missed **Patient #3-** Visits monitored daily/weekly with physician notification if visits are missed **Patient #4-** Visits monitored daily/weekly with physician notification if visits are missed **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical	06/25/2021

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	Review of the home health aide visit notes revealed patient #2 received no home health aide visits on week 1; 8 hours/day x 4 days/week x week 2-3; 8 hours/day x 4 days/week x week 4; 6 hours/day x 1 day/week x week 4; 2 hours/day x 1 day/week x week 4; and 8 hours/day x 5 day/week x week 5. The agency failed to provide home health aide services as ordered on the plan of care. 3. A review of the clinical record for patient #3, start of care 8/13/20, included a plan of care for the certification period of 4/10/21 - 6/8/21, which revealed orders for home health aide services 8 hours/day x 5 days/week for weeks 1-7 and 8 hours/day x 2 days/week during week 8, but failed to include orders for weeks 9 and 10. A review of the home health aide visit notes revealed no aide visits week 1; 1 aide visit week 2; and 5 aide visits weeks 3-5. The agency failed to provide home health aide services as ordered on the plan of care. 4. Review of the clinical record for patient #5 included a plan of care for the certification period of 5/3/21 - 7/1/21, which revealed orders for home health aide services 8 hours/day x 5 days per week x weeks 1-7; 8 hours/day x 4 days/week x week 8. A review of the home health aide visit notes from 5/3/21 - 5/11/21 revealed the patient received home health aide services 7.75 hours/day x 1 day per week x week 1; 6 hours/day x 1 day/week x week 2; and 8 hours/day x 1 day/week x week 2. The agency failed to provide home health aide services as ordered on the plan of care. On 5/17/21 at 4:08 PM, patient #5 was queried concerning what services the home health aides		Services/designee has audited 100% of all active patients to assess for any missed visits. Identified missed visits will be investigated to determine whether the Agency missed the visit or the client cancelled the visit. Patients cancelling or decreasing the number of hours/visits will be contacted to ascertain the reason for the modification of the visit times and frequency. All missed visits will be reported to the MD on a weekly basis. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services has in-serviced all clinical staff (nurses and home health aides) on their responsibilities to provide the patient home visits as ordered by the physician/designee. This includes meeting the required frequency of visits/week, staying the required length of time/visit, and completing the tasks as ordered by the physician/designee on the Plan of Care. Field staff are instructed to immediately report incidents of refused services to the Clinical Manager/designee. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator will audit 100% of all SN and Hha visit notes on a weekly basis X 60 days to assess	

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	provided during the visits. Patient #5 stated the home health aide "swept, mopped, and dusted." The surveyor asked if the aide provided assistance with bathing, toileting, or dressing. Patient #5 stated, "She [home health aide] cleans and talks with me. I shower in the evening when my husband helps me. Sometimes I have a little trouble getting up off the toilet so I like to have someone here in case I need help, but I'm usually ok since my husband helps with that too." Patient #5 stated she did not know who was coming tomorrow and stated, "But I should be fine. The house is already clean so there is nothing I need." On 5/18/21 at 2:30 PM the administrator and clinical manager were queried concerning services provided to patient #5. Both individuals agreed that patient #5's plan of care stated she was to receive home health aide services for hands on personal care that included bathing and dressing, and they were unaware that the patient was not receiving any personal care services as outlined on the plan of care. 5. On 5/18/21 at 2:15 PM the administrator and clinical manager were interviewed and the findings were reviewed. They stated they do not report missed visits to the physician. No further information was available at that time. 6. The clinical record of patient #1 contained a of plan of care for initial certification period of 2/24/21 to 4/24/21, the order for discipline and treatment indicated," HHA (home health aide) x 2 hours/day x 3 days/week x 1 week, HHA x 2 hours/day x 5 days/week x 8 weeks...HHA to assist with ADLs (Activities of Daily Living), Bathing MWF (Monday, Wednesday, Friday) and prn (as needed), bathroom clean up, bed care, change linens, conversation, dressing, encourage fluids, fall risk, grooming, hygiene assistance,		ongoing compliance. Identified gaps in service will investigated and addressed. The physician will be notified weekly of any missed visits. Once the agency achieves a 90% compliance rating the agency will decrease the percentage of audits to 30% of all active patients on a weekly basis. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator is responsible for ensuring ongoing compliance with G436. **6. Date of Compliance:** **6/25/21**	

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	medication reminders, and skin care..." Review of a visit note dated 2/25/21 (Thursday), a partial visit was made clock in 9:55 AM to 11:34 AM. Review of visit noted dated 3/4/21(Thursday), a partial visit was made clock in 9:55 AM to 11:32 AM. On week two of eight, home health aide visits were completed on 3/9/21, 3/10/21, 3/11/21, and 3/12/21, the home health aide failed to make a 5th visit for the week. Review of visit note dated 3/19/21 (Friday), a partial visit was made clock in 9:56 AM to 11:00 AM. On week five of eight, home health aide visits were completed on 3/29/21, 3/31/21, 4/1/21, and 4/2/21, the home health aide failed to make a 5th visit for the week. Further review partial visits were made visit note dated 3/29/21 (Monday) clock in 10:04 to 11:02 AM and visit note dated 4/1/21 (Thursday) clock in 9:56 AM to 11:38 AM. On week six of eight, home health aide visits were completed on 4/5/21, 4/6/21, 4/8/21, 4/9/21, the home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/5/21 (Monday) clock in 9:55 AM to 11:28 AM. On week seven of eight, home health aide visits were completed on 4/12/21, 4/13/21, 4/15/21, 4/16/21, the home health aide failed to make a 5th visit for the week. On week eight of eight home health aide visits were completed on 4/19/21, 4/20/21, 4/22/21,			

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	4/23/21, the home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/20/21 (Tuesday) clock in 10:44 AM to 12:12 PM. The home health aide failed to provide 2 hour visits, 5 days a week as ordered on the plan of care. During an interview on 5/11/21 at 3:31 PM, when queried about missing home health aide visits, the administrator and clinical manager indicated they do not have a set rule for missed visits. The Administrator stated, "We do not notify the physician unless we see trends of missed visits."			
G 0510 Bldg. 00	484.55 Comprehensive Assessment of Patients 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. Based on record review, and interview the agency failed to ensure the comprehensive assessments were completely filled out, accurately reflected the patient's current health status and past medical history, failed to ensure assessments included patient's strengths, goals, and care preferences, failed to ensure assessments included the patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with the patient, health care representative, outside	G 0510	**CREDIBLE ALLEGATION OF COMPLIANCE FOR G510:** The Governing Body met and approved the following: additional training, oversight, and QAPI activities to ensure agency operations are in compliance with CFR 484.55: Comprehensive Assessment of Patients. Clinicians will be retrained on the performance and documentation of all aspects of the Comprehensive	06/25/2021

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	agencies and ordering physicians to ensure drug interactions and duplication is identified, failed to ensure assessments identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, and failed to ensure the assessment included information concerning a patient selected representative in 4 out 4 active records reviewed (Patients #1, 2, 3, 5). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality health care, thus being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment. Findings Include: 1. The agency failed to evidence the comprehensive assessments were complete and accurately reflected the patients status, including current health, psychosocial, functional, and cognitive status. (See G528) 2. The agency failed to ensure a complete and accurate assessment of the patient's strengths, goals, and care preferences. (See G530) 3. The agency failed to ensure a complete and accurate assessment of the patient's medical, nursing, rehabilitative, social, and discharge planning needs. (See G534) 4. The agency failed to ensure a complete drug regimen review was completed on all patients, failed to ensure the correct name, dose/strength, frequency, route, time, any significant side effects and/or interactions, any duplicate drug therapy,		Assessment, proper and timely notification of the MD/designee of assessment findings, and any concerns. The Agency has increased their audit activity to include a 100% audit of all certification assessment documentation. The Governing Body has also approved random unannounced supervisory visits of RN Case Managers to evaluate their ability to perform and document the comprehensive assessment process and ensure appropriate timely reporting of all findings to the physician. The Governing Body has approved the following QAPI Project to ensure ongoing oversight and auditing of the comprehensive assessment process to demonstrate compliance with CFR 484.55: “Documentation of the Comprehensive Assessment”. The QAPI Project requires a 100% audit of all comprehensive assessment documentation at all certification time points. In addition, there is a “Supervisory Visit” tool to be used to evaluate RN Case Manager compliance with the comprehensive assessment process. **G510** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** The Governing Body has	

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	and failed to ensure that PRN (as needed) medications contained indications . (See G536) 5. The agency failed to ensure the comprehensive assessment identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule. (See G538)		instructed the Administrator and Director of Clinical Services to retrain the clinicians on the required assessment process and documentation of the assessment, to continue the ongoing Comprehensive Assessment audit process, and perform the random unannounced supervisory visits of the RN Case Managers to evaluate their performance of the assessment process. In addition, new patient assessment forms are being utilized by RN Case Managers to provide more complete documentation of unskilled patients. **Patient #1:** Audits will be conducted after each skilled visit to ensure assessment documentation is complete. New unskilled assessment form has been put in place. **Patient #2:** Audits will be conducted after each skilled visit to ensure assessment documentation is complete. New unskilled assessment form has been put in place. **Patient #3:** Audits will be conducted after each skilled visit to ensure assessment documentation is complete. New unskilled assessment form has been put in place. **Patient #5:** Audits will be conducted after each skilled visit to ensure assessment documentation is complete. New	

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			unskilled assessment form has been put in place. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Service/designee audited 100% of comprehensive assessments for all active patients. Any identified gaps were addressed through staff re-training and new assessment forms being utilized for the latest visits to each patient. Physicians were notified of any additional concerns relevant to the newest assessments. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee has retrained the RN Case Managers r/t completing all components of the comprehensive assessment and their responsibilities to ensure the physician is notified of all findings and concerns. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit 100% of all comprehensive assessments	

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			utilizing the Home Health Comprehensive Assessment Audit Tool. This will be an ongoing process that is to be completed at all certification timepoints. The Director of Clinical Services/designee will perform random unannounced supervisory visits of the RN Case Managers as they perform comprehensive assessments of patients in the home setting. The QAPI Committee will receive monthly reports of compliance and areas of concern. The Administrator is responsible for reporting compliance and any areas of concern to the Governing Body. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator and Director of Clinical Services/designee is responsible for ensuring ongoing compliance with G510. **6. Date of Compliance: 6/25/2021**	
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure all patients received a complete and accurate comprehensive assessment that included health, psychosocial, functional, and cognitive assessments in 4 of 4 active records reviewed. (patients 1, 2, 3, 5)	G 0528	**G528** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** RN Case Manager has re-assessed the patient and provided more thorough	06/25/2021

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	Findings include: 1. Review of agency policy titled "Comprehensive Patient Assessment", approved by the governing body on 2/19/21, revealed "A thorough, well-organized, accurate, comprehensive assessment, that is consistent with the patient's immediate needs will be completed for all patients in a timely manner ... The assessment will identify facilitating factors and potential barriers to the patient reaching his or her goals ...." The purpose of the comprehensive assessment included "to determine the appropriate care, treatment, and services; To collect data about the patient's health history, (physical, functional, and psychological) and his/her needs as appropriate ...; To make care, treatment, or service decisions based on information developed about each patient's needs and the individual's response to care and goals ... ; To identify the patient's medical, nursing, rehabilitative, social, and discharge planning needs." Special instructions revealed "5. The Comprehensive Assessment includes an assessment and documentation of the following areas; Assessment of cognitive, behavioral, and psychiatric symptoms;Assessment of the patient's mental status; Assessment of the patient's psychosocial status; Assessment of the patient's functional abilities ang [sic] goals; Assessment of the patient's functional limitations; Assessment of the patient's functional abilities and goals." The policy also revealed the comprehensive assessment was to include multiple health items to be assessed, including but not limited to patient's history and reason for home health admission, list of all pertinent diagnoses, all surgical procedures, height, weight, vital signs, head-to-toe visual assessment, assessment of all body systems, nutritional status, medications, allergies, and risks for		documentation of their health, psychosocial, functional, and cognitive status. **Patient #2:** RN Case Manager has re-assessed the patient and provided more thorough documentation of their health, psychosocial, functional, and cognitive status. **Patient #3:** RN Case Manager has re-assessed the patient and provided more thorough documentation of their health, psychosocial, functional, and cognitive status. **Patient #5:** RN Case Manager has re-assessed the patient and provided more thorough documentation of their health, psychosocial, functional, and cognitive status. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Service/designee audited 100% of all comprehensive assessments for all active patients for compliance with documentation of health, psychosocial, functional, and cognitive assessments. Any identified gaps in documentation will be returned to the RN Case Managers for re-assessment and	

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	hospitalization, falls, and skin breakdown. 2. Review of the clinical record for patient #2, start of care 8/13/20, revealed a comprehensive recertification assessment dated 4/5/21, which evidenced patient #2 had a primary diagnosis of intellectual disability and a secondary diagnosis of cerebral palsy, but failed to include other pertinent diagnoses including decreased mobility, incontinence, constipation, anxiety/difficulty sleeping, and heartburn. The risk assessment for hospitalization failed to evidenced a complete assessment, including infection control risks, as well as intellectual limitations, history of medication non-compliance, risk for skin breakdown, and high fall risk. The assessment failed to identify if the patient received a pneumonia, tetanus, shingles, hepatitis C, or Covid 19 vaccine, and identified the patient's mother as her primary caregiver and emergency contact but failed to include a contact number where her mother could be reached. The patient's sensory status evidenced no impairment, and in the same section evidenced the patient needed help with ADLs (Activities of Daily Living), bathing safety" due to sensory impairment. Patient #2 had a pain level of 0/10, however M1242 evidenced "1 - Patient has pain that does not interfere with activity or movement". Further pain assessment evidenced "No Problem" but showed activities affected by pain were "hygiene and ambulation." The document evidenced "NA" (not applicable) as to "How does the pain interfere/impact the patient's functional ability and/or safety?" The remainder of the pain assessment was blank, including location of pain, what makes pain worse/ better and what medication or intervention is used. During a home visit on 5/11/21 at 1 PM (see below) the patient complained of a headache and the clinician stated,		completion of appropriate documentation. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee has retrained the RN Case Managers r/t completing all components of the comprehensive assessment including the patient's health, psychosocial, functional, and cognitive condition and documenting these results. Any identified concerns are to be reported to the patient's physician and there is to be documentation of this notification in the clinical record. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit 100% of all comprehensive assessments utilizing the Home Health Comprehensive Assessment Audit Tool. This will be an ongoing process that is to be completed at all certification timepoints. The Director of Clinical Services/designee will perform random unannounced supervisory visits of the RN Case Managers as they perform comprehensive assessments of patients in the home setting to assess their	

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	"She has a headache at every visit and always says it is 8/10. I ask her if she wants her ibuprofen and she always says no" however, review of the neurological assessment failed to include headaches. The assessment failed to include a height or weight, and evidenced a temporal temperature of 100.0, but failed to evidence the clinician assessed for signs/ symptoms of Covid 19, urinary tract infection, or other possible infections, verified the results by repeating the temperature or using an alternate thermometer, or reported findings to the clinical manager and physician. Elimination status revealed patient was incontinent and wore briefs but identified the genitalia assessment as "No Problem". The assessment failed to include menstruation, sexual activity, birth control, or last gynecological exam, and failed to assess the patient's related physical and psychosocial development related to sexuality and menstruation. Neurological assessment revealed patient #2 used a wheelchair due to decreased mobility, but failed to include the patient's walker and failed to include that the new wheelchair was too large for the patient's doorways, which required her to use 2 wheelchairs and her walker inside the house. The neurological assessment failed to include daily headaches as reported by the clinician (see home visit on 5/11/21). The assessment evidenced "no sudden/acute changes" since the last assessment, followed by "mental status changes reported by patient." Musculoskeletal status evidenced cerebral palsy and weakness in the lower extremities affecting bladder incontinence, endurance, ambulation, but failed to include intellectual disability, forgetfulness, delayed speech, ability to prepare meals, and self care ability. The MAHC 10 (Missouri Alliance for Home Care) fall risk assessment tool failed to include all pertinent diagnoses, the size of the new		clinical skills regarding all aspects of the assessment process and documentation of the comprehensive assessment. The QAPI Committee will receive monthly reports of compliance and areas of concerns. The Administrator is responsible for reporting compliance and any areas of concern to the Governing Body. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator and Director of Clinical Services/designee is responsible for ensuring ongoing compliance with G528. **6. Date of Compliance:** **----------6/25/21**	

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	wheelchair, and a complete and accurate pain assessment. The assessment evidenced "HHA (home health aide) assists with transfers" but failed to address transfers when the aide was not present, which would evidence a greater fall risk. The assessment evidenced patient #2 used no injectable and received "setup by SN (skilled nurse) biweekly, but failed to include an assessment on compliance, knowledge, and reconciliation of medications for this certification. Activities permitted failed to include use of a shower bench, use of weekly medication containers, transfers with 2 wheelchairs in the home, Safety measures failed to include infection control and home safety, including locking doors at night, keep wheelchair accessible. The assessment evidenced patient #2 "did not want personal goals" despite evidencing health care and medication compliance needs, and was educated and independent on pressure reduction, nutrition, pain, use of medical devices, emergency preparedness plan, infection control, when to report to the agency, and patient rights but failed to evidence specific information provided, return demonstration, verbal understanding, or goals met. Medication administration evidenced the patient needed additional education, but failed to evidence what was needed or a plan to address compliance. The assessment evidenced skilled instruction /intervention this visit included skilled observation and assessment, and education of fall and safety factors, but failed to evidence the specific education provided and the patient's response. The assessment evidenced "NA" concerning improvements noted with the desired functional tasks and continues to have difficulty/no gains with medication compliance with continued nursing care needed to "conti [sic] current goal." The assessment evidenced "no d/c (discharge) plan at this time as case is continuous			

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	and failed to provide specific information concerning what/how patient #2 is non-compliant with medications and what individualized and specific goals and interventions were implemented and failed to address the patient's medical, nursing, rehabilitative, social, and discharge planning needs. 3. Review of the clinical record for patient #3, revealed a comprehensive recertification and resumption of care assessment dated 4/19/21, for certification period 4/10/21 - 6/8/21, which evidenced "Patient History and Diagnoses" as TBI (traumatic brain injury) and the section for "Prior Hospitalizations Reasons/ Dates - 1 - 3/30/21 - 4/18/21" revealed the patient was hospitalized for pneumonia and seizures. No further history or diagnosis was documented. The assessment evidenced a primary diagnosis of TBI with no secondary diagnosis (seizures). Risk for hospitalizations failed to include other risks not listed including immobility, risk for compromised skin integrity, gastrostomy status, aspiration risk, weakened respiratory status, high risk for infection, high risk for bacterial, viral, and aspiration pneumonia, fall risk, seizures. The assessment failed to include the patient's previous weight, failed to document the presence of a personal services agency. Sensory status evidenced "No Problem" and failed to include the need for dim lighting and sunglasses. Communication evidenced the patient was aphasic and unable to express basic needs. Pain assessment evidenced the Wong-Baker Faces Rating Scale was used and pain was rated 0/10. Question M1242 evidenced patient had pain daily but not constantly, affecting care and mobility/ transfer. Integumentary status failed evidenced no problem but failed to include assessment for risk of problems related to immobility, incontinence,			

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	impaired sensory status, nutritional status, and risk of pressure sores/ shear. Respiratory status failed to include use of oral suction, and nutritional status failed to include a description of the gastrostomy (G-tube) site, g-tube size/balloon, when last replaced, who replaces it, feeding type, volume, flush, aspirate, and evidenced both bolus and pump. Dressings note care failed to include the type of dressing or how to clean the site. Nutritional risk assessment evidenced assessment compared to oral intake prior to patient #3's accident, which occurred in 2016, and was not based on intake within normal limits over the previous 5 years. Elimination status evidenced incontinence, pads, and briefs, but failed to include a bowel program and who assists. Neuro/ emotional/ behavioral status evidenced the patient was totally dependent due to constant disorientation, coma, vegetative state, or delirium, however M1710 evidenced the patient was confused during the day and evening, but not constantly. M1720 evidenced the patient was anxious daily, which is contrary to his inability to communicate and express basic needs. The assessment evidenced a history of seizures, last on 4/16/21, but failed to include a seizure diagnosis, or the type, quality, and duration or the treatment and safety plan and who to notify. The clinician failed to screen for depression and reported "NA" concerning feelings/ emotions patient reports when asked, however the clinician previously documented the patient could not make basic needs known and was aphasic. Psychosocial evidenced "NA", single, no vehicle/ doesn't drive but failed to address Psychosocial needs including need for friendship, loss of companions, loss of ability to hunt, loss of dignity, etc. G0110 failed to include all devices, including leg braces, stander, hoyer lift, suction, g-tube, ramp, handicap equipped vehicle, chair			

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	cushion, hospital bed, shower chair. Functional limitations failed to include endurance, communication (other than speech), toileting, eating, mobility, foot drop. Musculoskeletal revealed the patient had past injuries, but failed to state where, when, why. Patient #3's fall risk assessment failed to include all pertinent diagnoses, failed to include light sensitivity, failed to include pain affecting function. ADL/IADL (activities of daily living/ instrumental activities of daily living assessment revealed "6" in M1820, however it is not an answer option. M1830 evidenced the patient was unable to use the shower or tub, but able to bathe self independently ... at the sink ... which is contrary to the assessment of paralysis and total dependence for all care. Activities permitted failed to include range of motion, up as tolerated. The clinician failed to complete an accurate drug regimen review, including comparison to hospital medication profile and physician profiles. The clinician failed to assess that patient #3 had a Baclofen pump, including when, where, and who filled it and when it is due again, and failed to assess the patient's VP (ventricular-peritoneal) shunt. The assessment failed to include infection control measures, lock wheelchair with transfers, use of a hoyer, use of suction, gastrostomy status, pressure sore prevention, and specific seizure precautions/plan, and need for low level lights/sunglasses. The assessment evidenced care coordination concerning all pertinent secondary diagnoses and followed-up which was contrary to assessment findings showing no secondary diagnoses. Care coordination revealed the patient returned home from hospital, verbal order to do resumption of care assessment obtained from the physician's office but failed to include evidence of detailed care coordination with the patient's hospital, all physicians,			

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	community councel on aging, and personal services agency. Current DME (durable medical equipment) information remained blank, except for gloves, bath bench, and wheelchair. 4. Review of the clinical record for patient #5, start of care 3/4/21, revealed a comprehensive recertification assessment dated 4/29/21 revealed a primary diagnosis of COPD (Chronic Obstructive Pulmonary Disease) and a secondary diagnoses of fibromyalgia. The assessment failed to evidence whether patient #5 received pneumonia, shingles, tetanus, hepatitis C, or Covid 19 vaccinations. The OASIS evidenced a pain level of 0/10 using the Wong-Baker Faces, M1242 evidenced the patient has pain that "does not interfere with activity or movement." Continuing pain assessment revealed the patient was not experiencing pain, but activities affected by pain were ambulation, and that ambulation made pain worse. The pain was located in the legs, was chronic, and is 6/10 at it's worst. The assessment failed to evidence follow up with the physician related to pain levels of 6/10. The patient had non-pitting edema and the assessment failed to identify further assessment or follow up related to pedal edema. Patient #5's height was blank and weight evidenced 62 inches, and she was short of breath with minimal exertion, but it failed to evidence follow up with the physician concerning possible fluid overload or additional diagnoses. M1610 stated no incontinence which was contrary to the elimination assessment which stated patient uses pads for incontinence. The musculoskeletal evidenced no problem, followed by assessment of bilateral weakness to the lower extremity with decreased mobility. The patient's MACH 10 failed to include incontinence, pain affecting function, and cognitive impairment, previously assessed as required prompting when			

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	stressed, confused during the day and evening but not consistently, and memory deficit. The patient experienced a fall but the assessment failed to evidence details including the time and date of the fall. The patient was not assessed for walking 50 feet with 2 turns or 10 feet on uneven surfaces, but failed to identify what medical condition the patient had that prevented her from being assessed. The assessment failed to update goals, setbacks, and summary of care. The assessment failed to be consistent with the patient current health status. 5. On 5/11/21 at 2 PM, the administrator and clinical manager were interviewed concerning the use of a skilled OASIS assessment for non-skilled patients as well as content of the OASIS/comprehensive assessment. They agreed that content was missing from the comprehensive assessments and stated the consultant was insistent they complete a full OASIS assessment on all patients, regardless of services needed. They planned to review OASIS completion with the consultant and review the use of a skilled OASIS on all patients. No further information was provided. 6. The clinical record of patient #1 was reviewed on 5/11/21 and indicated a start of care date of 2/24/21. The record contained a recertification comprehensive assessment that was completed by the alternate clinical manager, dated 4/20/21 for recertification period 4/25/21 to 6/23/21, which indicated diagnoses of Congestive heart failure, Diabetes Melitus II, and Spinal Stenosis. The recertification assessment had multiple sections that were incomplete, such as the section titled "Cardiopulmonary subsection Disorders" and "Disease Management Problems" which both were left blank. The assessment failed to be completed.			

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G 0530 Bldg. 00	410 IAC 17-14-1(a)(1)(B) 484.55(c)(2) Strengths, goals, and care preferences The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview the agency failed to ensure a complete and accurate assessment of the patient's strengths, goals, and care preferences in 4 of 4 active records reviewed (Patients #1, 2, 3, 5). Findings Include: 1. Review of an undated agency policy titled "COMPREHENSIVE CLIENT ASSESSMENT" C-145 stated, " POLICY...The assessment identified facilitating factors and possible barriers to client reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals, and the care treatment and services provided, but will be done at least once in every sixty (60) day period...SPECIAL INSTRUCTIONS...a. The Comprehensive Assessment must accurately reflect the client's status, and must include at a minimum, the following information: .. 2. The assessment will identify the client's primary caregiver (s), if any and other available supports, including their willingness and ability to provide care, and availability and schedules. If there is an identified client representative, that will also be documented..."	G 0530	**G530** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Patient's strengths, goals, and care preferences have been revised with further attention to detail and updates will be made to patient's goals at each recertification. **Patient #2:** Patient's strengths, goals, and care preferences have been revised with further attention to detail and updates will be made to patient's goals at each recertification. **Patient #3:** Patient's strengths, goals, and care preferences have been revised with further attention to detail and updates will be made to patient's goals at each recertification. **Patient #5:** Patient's strengths, goals, and care preferences have been revised with further attention to detail and updates will be made to patient's goals at each recertification.	06/25/2021

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	2. Review of an undated policy titled "CLIENT REASSESSMENT/ UPDATE OF COMPREHENSIVE ASSESSMENT CLIENT REASSESSMENT" C-155 stated, "POLICY...Assessment will include OASIS (Outcome and Assessment Information Set) data collection for all Medicare and Medicaid skilled clients. Clients who are not receiving skilled services under the Medicare or Medicaid program will be assessed using the OASIS tool or an alternative ... 7. Special attention will be paid to client-centered goal setting, clarifying the client's and his/her expectations of the home care services ...8. The assessment will identify the problems, needs, and strengths of the client and the care the family can provide. The initial and ongoing assessments include consideration of the following: a. Specific individualized client needs ... b. description of any applicable strength the client has including physical, psychosocial... f. Progress toward goals since previous assessment ...." 3. During a home visit observation on 5/12/21 at 1:00 PM patient #1 introduced her caregiver who lives there to the surveyor and stated, "This is my night nurse my grandson who lives here and takes care of me at night." The clinical record of patient #1 was reviewed on 5/11/21, start of care date of 2/24/21, contained an initial comprehensive assessment dated 2/24/21, which revealed diagnoses of CHF (Congestive Heart Failure), DM II (Diabetes Mellitus Type 2), and Spinal Stenosis (narrowing of the spinal canal which can cause pain, numbness, muscle weakness, and impaired bladder and/ or bowel). The "Care Preferences/ Patient's Personal Goals" section of the assessment was left blank. The		**2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Service/designee audited 100% of all comprehensive assessments for all active patients for compliance with documentation of the patient's strengths, goals, and care preferences. Any identified gaps in documentation were returned to the RN Case Managers for re-assessment and completion of appropriate documentation. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee has retrained the RN Case Managers r/t completing all components of the comprehensive assessment to include assessment of the patients' strengths, goals, and care preferences, and documenting the results of the assessment. Any identified concerns are to be reported to the patient's physician and there is to be documentation of this notification in the clinical record.	

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	comprehensive assessment failed to list patient personal care preferences, personal goals, and failed to evidence goals with measurable outcomes related to diagnoses. A review of the recertification comprehensive assessment dated 4/20/21, revealed diagnoses of CHF, DM II, and Spinal Stenosis. The recertification assessment indicated under a section titled "Living Arrangements/ Supportive Assistance: Primary Caregiver NA (not applicable)" documented by the RN, Alternate Clinical Manager. The recertification assessment had multiple sections that were incomplete: the section titled "Cardiopulmonary subsection Disorders,and Disease Management Problems" both were left blank. The section titled "Strengths/ Limitations" indicated "participates in all care, obesity, spinal stenosis, weakness and SOB (shortness of breath)". The recertification assessment failed to list: the patient's progress towards both personal and HHA measurable goals since the prior assessment, failed to evidence patient specific measurable goals outcomes, failed to list specific goals related to patient diagnoses, and failed to list the patient caregiver representative information, and failed to address CHF in cardiopulmonary assessment. During an interview on 5/12/21 at 12:55 PM when queried about Entity L, Alternate Clinical Manager indicated that the caregiver lives there and cares for patient #1 at night. 4. The findings were reviewed with the Administrator, Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, in which they had no further information or documentation to provide at this time.		The Director of Clinical Services/designee reinforced the requirement to document patient progress to goals on all recertification comprehensive assessments. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit 100% of all comprehensive assessments utilizing the Home Health Comprehensive Assessment Audit Tool. This will be an ongoing process that is to be completed at all certification timepoints. The Director of Clinical Services/designee will perform random unannounced supervisory visits of the RN Case Managers as they perform comprehensive assessments of patients in the home setting to assess their clinical skills regarding all aspects of the assessment process including the assessment of the patient's strengths, goals, and care preferences. The QAPI Committee will receive monthly reports of compliance and areas of concerns. The Administrator is responsible for reporting compliance and any areas of concern to the Governing Body. **5. Agency staff responsible for**	

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	5. Review of the clinical record for patient #2 revealed a comprehensive assessment/ OASIS recertification dated 4/5/21, which revealed patient #2 had a primary diagnosis of intellectual disability and a secondary diagnosis of cerebral palsy. The assessment failed to include accurate and complete assessment for caregiver status and patient care preferences and goals, and failed to include patient specific goals and interventions. 6. Review of the clinical record for patient #3, OASIS recertification and resumption of care assessment dated 4/19/21, which revealed a diagnosis of TBI (traumatic brain injury). The assessment failed to include accurate and complete assessment for caregiver status and patient care preferences and goals, and failed to include patient specific goals and interventions. 7. Review of the clinical record for patient #5, start of care 3/4/21, revealed a comprehensive assessment OASIS recertification dated 4/29/21, which revealed a primary diagnosis of COPD (Chronic Obstructive Pulmonary Disease) and a secondary diagnoses of fibromyalgia. The assessment evidenced a primary caregiver of "NA" and failed to evidence the patient's husband was her active caregiver. The assessment failed to include accurate and complete assessment for caregiver status and patient care preferences and goals, and failed to include patient specific goals and interventions.		**ensuring ongoing compliance:** The Administrator and Director of Clinical Services/designee is responsible for ensuring ongoing compliance with G530. **6. Date of Compliance:** **----------6/25/21**	
G 0534 Bldg. 00	484.55(c)(4) Patient's needs The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the agency failed to ensure a complete and accurate	G 0534	**G534** **1. Actions the Agency took to correct the deficient practice**	06/25/2021

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	15K165	A. BUILDING 00 B. WING	05/18/2021

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VISITING ANGELS HOME HEALTHCARE	3197 S US HWY 231 GREENCASTLE, IN 46135

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	assessment of the patient's medical, nursing, rehabilitative, social, and discharge planning needs in 4 of 4 active records reviewed (Patients #1, 2, 3, 5). Findings include: 1. A review of an undated policy C-155 titled "CLIENT REASSESSMENT/UPDATE OF COMPREHENSIVE ASSESSMENT" evidenced "Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients. Clients who are not receiving skilled services under the Medicare or Medicaid program will be assessed using the OASIS tool or an alternative ...The initial and ongoing assessments include consideration of the following: Specific individualized client needs pertinent to the care or service being provided; ... Need for continuing home care services; Ability/willingness of the client/family to assume responsibility for healthcare needs. 2. Review of an undated agency policy titled "DISCHARGE PROCESS" C-500, indicated "Discharge Planning is initiated for every home care client at the time of the client's admission for home care. ... Discharge Procedure: 1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected are outcomes. The client/ family will participate in this process beginning with the initial assessment visit .... " 3. The clinical record of patient #1 was reviewed on 5/11/21, start of care date of 2/24/21, which contained an initial comprehensive assessment dated 2/24/21, indicating diagnoses of CHF (Congestive Heart Failure), DM II (Diabetes Mellitus Type 2), and Spinal Stenosis. The		**for each client cited in the deficiency:** **Patient #1:** Patient's assessment documentation has been revised as needed to include medical, nursing, rehabilitative, social, and discharge planning needs. **Patient #2:** Patient's assessment documentation has been revised as needed to include medical, nursing, rehabilitative, social, and discharge planning needs. **Patient #3:** Patient's assessment documentation has been revised as needed to include medical, nursing, rehabilitative, social, and discharge planning needs. **Patient #5:** Patient's assessment documentation has been revised as needed to include medical, nursing, rehabilitative, social, and discharge planning needs. **2. Actions the Agency to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as affected:** The Director of Clinical Service/designee audited 100% of all comprehensive assessments for all active patients for compliance with documentation of the patients' medical, nursing, rehabilitative, social, and discharge planning needs. Any identified gaps in documentation	

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	section titled "Rehabilitation Potential for Anticipated Discharge Planning: Discussed with patient No DC (Discharge) plan as case is ongoing." The comprehensive assessment failed to list patient discharge planning. Review of the recertification comprehensive assessment that was completed by the alternate clinical manager, dated 4/20/21, revealed diagnoses of CHF, DM II, and Spinal Stenosis. The recertification assessment had multiple sections that were incomplete: the section titled "Cardiopulmonary subsection Disorders, and Disease Management Problems" both were left blank. The assessment failed to evidence the patient's specific needs for continued home health care and failed to evidence a plan for discharge and/or obstacles to prevent discharge, and failed to evidence the meaning of "ongoing". During an interview on 5/12/21 at 3:25 PM when queried about discharge planning and clinicians marking NA the Clinical Manager indicated that they were instructed to mark NA from Entity E, the agency consultant, due to ongoing care needs. 4. The findings were reviewed with the Administrator, Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provide at this time. 5. A review of the clinical record for patient #2 revealed a comprehensive assessment/OASIS (Outcome and Assessment Information Set) recertification dated 4/5/21, which revealed patient #2 had a primary diagnosis of intellectual disability and a secondary diagnosis of cerebral palsy. A section titled "Rehabilitation Potential/Anticipated Discharge for Plan of Care" evidenced "No d/c (discharge) plan at this time		will be returned to the RN Case Managers for re-assessment and completion of appropriate documentation. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee has retrained the RN Case Managers r/t completing all components of the comprehensive assessment to include assessment of the patients medical, nursing, rehabilitative, social, and discharge planning needs and documenting the results of the assessment. Any identified concerns are to be reported to the patient's physician and there is to be documentation of this notification in the clinical record. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit 100% of all comprehensive assessments utilizing the Home Health Comprehensive Assessment Audit Tool. This will be an ongoing process that is to be completed at all certification timepoints. The Director of Clinical	

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	due to ongoing case and care needed." The record failed to evidence a plan for discharge and/or obstacles to prevent discharge, failed to evidence the meaning of "ongoing", and failed to evidence the patient's specific needs for continued home health care. 6. A review of the clinical record for patient #3 revealed an OASIS recertification and resumption of care assessment dated 4/19/21, revealed a primary diagnosis of TBI (Traumatic Brain Injury) A section titled "Rehabilitation Potential for Anticipated Discharge Planning" evidenced "No discharge planned at this time." The assessment failed to evidence a plan for discharge and/or obstacles to prevent discharge and failed to evidence the patient's specific needs for continued home health care. . 8. A review of the clinical record for patient #5, start of care 3/4/21, revealed a comprehensive assessment/OASIS dated 4/29/21, which revealed a primary diagnosis of COPD (Chronic Obstructive Pulmonary Disease) and a secondary diagnoses of fibromyalgia. A section titled "Rehabilitation Potential/Anticipated Discharge for Plan of Care" evidenced "Not at this time, due to case [illegible] ongoing at this time. The assessment failed to evidence the meaning of "ongoing", failed to evidence a plan for the patient's discharge and/or obstacles to prevent discharge, and failed to evidence the patient's specific needs for continued home health care. . 401 IAC 17-14-1(a)(1)(B)		Services/designee will perform random unannounced supervisory visits of the RN Case Managers as they perform comprehensive assessments of patients in the home setting to assess their clinical skills regarding all aspects of the assessment process including the assessment of the patient's rehabilitative, social, and discharge planning needs. The QAPI Committee will receive monthly reports of compliance and areas of concern. The Administrator is responsible for reporting compliance and any areas of concern to the Governing Body. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator and Director of Clinical Services/designee is responsible for ensuring ongoing compliance with G534. **6. Date of Compliance:** **----------6/25/21**	
G 0536 Bldg. 00	484.55(c)(5) A review of all current medications A review of all medications the patient is			

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	currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure a complete drug regimen review was completed on all patients, failed to ensure the correct name, dose/strength, frequency, route, time, any significant side effects and/or interactions, any duplicate drug therapy, and failed to ensure that PRN (as needed) medications contained indications of use in 5 of 6 records reviewed. (Patients #1, 2, 3, 5, 6) Findings include: 1. Review of an undated agency policy titled, "MEDICATION PROFILE" C-700 stated, "POLICY The Nurse ... will complete a medication profile for each client at the time of admission; The medication profile shall include all prescriptions and nonprescription drugs .... The profile will be reviewed and updated as needed to reflect current medication the client is taking. PURPOSE To provide a complete list of ALL medications and an evaluation of the client's knowledge of these medications. To provide documentation of the comprehensive assessment of all medications and identify discrepancies between client profile and the physician and/or agency profile. To identify possible ineffective drug therapy, adverse reactions, significant side effects, drug allergies, and contraindicated medication. To provide documentation of changes ... identify the effect of medications ... SPECIAL INSTRUCTIONS 1. At the time of admission, the admission professional shall check all medications .... The clinician shall	G 0536	**G536** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Patient's file has been audited to ensure that medication list is accurate, up to date, and includes indications for PRN medications. **Patient #2:** Patient's file has been audited to ensure that medication list is accurate, up to date, and includes indications for PRN medications. **Patient #3:** Patient's file has been audited to ensure that medication list is accurate, up to date, and includes indications for PRN medications. **Patient #5:** Patient's file has been audited to ensure that medication list is accurate, up to date, and includes indications for PRN medications. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical	06/25/2021

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	promptly report any identified problems to the physician. 2. The Nurse/Therapist shall record on the Medication Profile all prescribed and over the counter (OTC) medications the client is currently taking. 3. The Medication Profile shall document: a. Allergies. b. Date medication ordered or care initiated c. Medication name (full name with no abbreviations). d. Medication dosage (using only accepted abbreviations). e. Route and frequency of administration. f. Contraindications or special precautions. g. Medication actions and side effect. h. Discontinuation date. i. Appropriate storage directions. j. Drug or food-drug interactions. ... 5. If the physician changes the medication orders, the Nurse must add newly ordered drugs or medication changes to the Medication Profile... 8. The Nurse/Therapist shall review all medications with the client and/or caregiver .... 9. The Nurse shall review all medication effectiveness and interactions to ensure appropriateness and effectiveness and interactions to ensure appropriateness and identify potential complications. 10. The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication. 11...A copy shall be ... placed in the client's home chart when extended hours ... are being provided." 2. A review of an undated agency policy titled, "MEDICATION SET UP POLICY" C-701 stated, "...SPECIAL INSTRUCTIONS 1. A medication administration record (MAR) or other medication documentation method should be used to set up medication. 2. The 485/plan of care is the nurse's which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors. 3. The medication list is current and updated ... as changes occur. The		Service/designee audited 100% of all comprehensive assessments of all active patients to ensure documentation of a complete drug regimen review was completed on all patients, and to ensure all aspects of this task are listed in the clinical record including the following: · Correct name of medication · Correct dose/strength, frequency, route, and time of administration, · Listing of any significant side effects and/or interactions, · Listing of any duplicate drug therapy, · Ensuring that PRN medications include documentation of indications of use. Any identified gaps or errors in documentation will be returned to the RN Case Managers for re-assessment, completion of appropriate documentation, and appropriate notification of the MD as warranted. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee has retrained the RN Case Managers r/t completing all components of the drug regimen review ensuring the RN lists the correct drug name, dose/strength, frequency, route,	

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	medications are reviewed at each visit ... 4. The nurse should then compare the medication labels to the 485, checklist, and/or MAR before ... filling the med-planner. 5. The nurse ensures that he/she is filling the med-planner correctly 3. A review of an undated agency policy titled, "MEDICATION MANAGEMENT" C-705 stated " POLICY The agency has a medication management system that supports client safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications...MEDICATION ORDERS...a. The full name of the drug...b. Dose and time drug is to be given and any time limitations...c. Indication for the drug...e. Parameters for using PRN medications including amount and frequency..." 4. The clinical record of patient #1 was reviewed on 5/11/21 and indicated a start of care date of 2/24/21. The record contained a plan of care for the certification period of 2/24/21 to 4/24/21 which indicated, "Medications: Dose/ Frequency/ Route...Acetaminophen 325 mg (milligrams) 2 PO (by mouth) Q4h (every 4 hours) prn..." The medication list failed to evidence an indication for the use of the as needed medications 5. Review of a closed clinical record patient #4 on 5/11/21 indicated a discharge date of 4/6/21. The record contained a plan of care for the recertification period of 2/7/21 to 4/7/21 that indicated, "Medications: Dose/ Frequency/ Route...Immodium AD 2 mg po prn...Colace 100 mg on po prn..methylprednisone 4 mg po..." The medication list failed to evidence an indication for the use of the as needed medications and failed to give a frequency of the methylprednisone.		time, any significant side effects and/or interactions, any duplicate drug therapy, and that PRN medications include documentation of their indications for use. Any identified concerns are to be reported to the patient's physician and there is to be documentation of this notification in the clinical record. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit 100% of all comprehensive assessments utilizing the Home Health Comprehensive Assessment Audit Tool, and audit 100% of the medication profiles, and drug interaction reports. This will be an ongoing process that is to be completed at all certification timepoints. The Director of Clinical Services/designee will perform random unannounced supervisory visits of the RN Case Managers as they perform comprehensive assessments of patients in the home setting to assess their clinical skills regarding all aspects of the assessment process including the review of the patient's medications, assessing for patient knowledge,	

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	6. Review of a closed clinical record patient #6 on 5/11/21 contained a plan of care for the certification period 3/8/21 to 5/6/21. The initial plan of care indicated, "Medications: Dose/ Frequency/ Route...Tylenol 500 mg 2 po Q6h (every 6 hours) prn, Ibuprofen 200 mg 2 po Q6h prn." The medication list failed to evidence an indication for the use of the as needed medications. 7. During an interview on 3/11/21 at 3:31 PM when queried about the medications not having routes or prn indications and not being in layman's terms for patient and caregiver understanding, the Administrator and Clinical Manager stated, " That makes sense it should." 8. Review of the medication list for patient #2, certification period 4/10/21 - 6/8/21, revealed a document "Medication Flow Sheet", with visit dates of 3/30, 4/13, 4/27, which revealed the following medications that did not match the medications ordered on patient #2's plan of care and/or listed on the "Medication Profile": sertraline 100 mg po q am; Omeprazole 40 mg Q D PRN; Vit [vitamin] D3 2000 u PO Q D; multivitamin PO Q D; oxybutinin [sic] 5 mg PO BID; melatonin PO; ibuprofn [sic] 200 mg po PRN. The medication listed failed to indicate indications for use, indications for prn use, document the date started. Review of a document for patient #2, titled "Addendum to Comprehensive Assessment Medication Profile" revealed sertraline 100 mg po Q AM depression; Prilosec 40 mg po QD prn GERD (gastro-esophageal reflux); Vit D3 (Vitamin) 2000 iu ii (2) po QD supplement; ibuprofen 200 mg po prn pain; oxybuntin [sic] 5 mg po BID (twice per day) bladder; melatonin 5 mg po [illegible] qhs sleep; colace 100 mg po q hs bowel. The medication profile addendum failed to match the		understanding, compliance, and patient medication education needs. In addition, the Director of Clinical Service/designee will also evaluate the nurse's ability and compliance with documentation of potential risks for drug interactions, the patient education provided, and the documentation of MD notification of any concerns. The QAPI Committee will receive monthly reports of compliance and areas of concerns. The Administrator is responsible for reporting compliance and any areas of concern to the Governing Body. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services/designee is responsible for ensuring ongoing compliance with G536. **6. Date of Compliance: 6/25/21**	

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	medication profile on the medical plan of care, failed to include correct dosages, indications for prn use, and failed to document the date started. 9. Review of the medication profile for patient #3, titled "Addendum to Comprehensive Assessment) Medication Profile" revealed methylphenidate 10 mg g-tube BID, TBI (Traumatic Brain Injury); simethicone gtts g-tube prn flatulence; amontadine [sic] 50 ml/5 ml 20 ml BID, TBI; Baclofen 10 mg g-tube prn, spasms; levetiractem 10 ml g-tube prn pain; dulcolax 10 mg supp prn, constipation; MVI 15 ml QD supplement; The profile failed to match the medication profile on the plan of care, failed to include correct dose, frequency, route, date started, and accepted abbreviations per agency policy; and failed to include all medications ordered. Review of a second "(Addendum to Comprehensive Assessment) Medication Profile" for patient #2 revealed an identical copy of the 1st Medication Profile above, with the addition of Vimpat 10 mg 10 ml gtube TID (Three times per day), seizures, start date 4/19/21; and Rubinol 1 mg gtube BID, secretions, start date blank. The date the profile was last updated was unchanged from 4/9/21. The profile failed to evidence how the Rubinol was prepared, whether it was mixed or diluted for g-tube, and who gave the medications. Review of orders failed to evidence documentation that showed the addition or confirmation of the two medications, when they were added to the medication profile, or why they were not discussed in the comprehensive assessment. Review of the plan of care medication profile for patient #3, certification period 4/10/21 - 6/8/21			

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	revealed methylphenidate 10 mg per g-tube (gastrostomy tube) BID; simethicone gtts (drops) per g-tube prn; amantadine 50 mg/5 ml (milliliters) give 20 ml BID; Baclofen 10 mg per g-tube prn; levetiracetam 10 ml per g-tube prn; dulcolax 10 mg supp (suppository) per rectum prn; multivitamin 15 ml per g-tube QD. The agency failed to obtain discharge information so that medication could be reconciled; failed to include correct reason for medications ordered, failed to identify the reason for prn medications, pailed to include the date the medication was started; failed to correctly update the ordered medications; failed to include all medications ordered, including gastrostomy feedings, post-hospitalization antibiotics, failed to include the Baclofen pump; and failed to ensure all medications included the correct dose, route, and frequency. Review of a "Medication Reconciliation Report" for patient #3 for 4/9/2, signed by the physician on 5/3/21 was marked as no changes. A second "Medication Reconciliation Report" dated 4/19/21, was signed by the physician on 5/6/21 and was marked as no changes. Neither document evidenced the addition of Vimpat or Robinul. 10. Review of the "(Addendum to Comprehensive Assessment) Medication Profile", last updated 4/29/21 by employee I, revealed the following medications with a start date of 3/4/21: Albuterol Iprat [sic] INH 3 ml per neb QID PRN, Res (respiratory); ASA (Aspirin) 81 mg po QD, heart; budesonide 2 ml inh BID, Resp); clonazepam 1 mg QHS PRN, anxiety; clonazepam 0.5 mg po BID, anxiety; Famotidine 20 mg po GIS, GI (Gastrointestinal); Furosemide 20 mg po BID diuretic; glucosamine 1500 mg po QD BID arthritis; levothyroxine 75 mcg po Q AM, thyroid; metoprolol 25 mg QED, BP (Blood Pressure); Fish			

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	Oil 1200 mg po BID, heart; Predestine 10 mg po BID seizures; KCL (Potassium) 10mEq (millequvalents) po BID supp; simvastatin 10 mg po q HS, cholesterol; theophylline 100 mg po q 12 h, resp (respiratory); Remeron 15 mg po Q HS, depression; and cymbalta 60 mg PO Q D, depression. The profile also evidenced Oxybutnin [sic] 10 mg po BID, bladder was discontinued on 3/5/21 and Ramipril 25 mg po QD, cardiac was discontinued 5/5/25. The profile evidenced Oxybutrin {Oxybutynin) 5 mg po BID, bladder was added 5/5/21. The profile failed to evidence the reason for prn medications; failed to ensure all medications had the correct dose, route, frequency; and failed to document the effectiveness, side effects of the medication. 11. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provide that time.			
G 0538 Bldg. 00	484.55(c)(6)(i,ii) Primary caregiver(s), if any The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule in in 2 of 3 home visits (Patient #1, 3) and 3 of 4 active record reviews. (Patients #1, 3, 5) Findings included:	G 0538	**G538** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Patient's latest assessment documentation has been updated to include their primary caregiver (if applicable), their willingness to provide care, and their availability.	06/25/2021

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	1. During a home visit observation on 5/12/21 at 1:00 PM patient #1 introduced her caregiver who lives there to the surveyor and stated, "This is my night nurse, who lives here and takes care of me at night." The clinical record of patient #1 was reviewed on 5/11/21 and indicated a recertification comprehensive assessment dated 4/20/21 for recertification period 4/25/21 to 6/23/21 indicated diagnoses of CHF, DM II, and Spinal Stenosis. The recertification assessment indicated under a section titled "Living Arrangements/ Supportive Assistance: Primary Caregiver NA (not applicable)" documented by the RN, Alternate Clinical Manager. The recertification assessment had multiple sections that were incomplete: the section titled "Cardiopulmonary subsection Disorders,and Disease Management Problems" both were left blank. The patient name and patient identifier were missing on multiple pages. The section titled " Strengths/ Limitations participates in all care, obesity, spinal stenosis, weakness and SOB (shortness of breath)" the RN, Alternate Clinical Manager documented. The recertification assessment failed to list the patient caregiver representative information. During an interview on 5/12/21 at 12:55 PM when queried about Entity L, Alternate Clinical Manager indicated that the caregiver lives there and cares for patient #1 at night. 2. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provided that time. 3. On 5/12/21 during a home visit at 9 AM with patient #3, person F and person G were		**Patient #3:** Patient's latest assessment documentation has been updated to include their primary caregiver (if applicable), their willingness to provide care, and their availability. **Patient #5:** Patient's latest assessment documentation has been updated to include their primary caregiver (if applicable), their willingness to provide care, and their availability. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Service/designee audited 100% of all comprehensive assessments of all active patients to ensure the assessment identified the patient's primary caregivers, (if applicable), their willingness and ability to provide care, and their availability and schedule. Any identified gaps or errors in documentation will be returned to the RN Case Managers for re-assessment, completion of appropriate documentation, and appropriate notification of the MD as warranted. **3. Agency steps or systemic**	

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	interviewed concerning who provides care for the patient in the absence of the agency. Both individuals stated they are always present and are both primary caregivers. Person G also state, "We are always here, one of us is. But if we aren't," and did not complete the sentence and did not continue. A review of the clinical record for patient #3 revealed a comprehensive assessment dated 4/19/21 for certification period 4/10/21 - 6/8/21, failed to evidence the patient's mother was also a primary caregiver, and failed to document her willingness to provide care. 4. A review of the clinical record for patient #5 revealed a comprehensive assessment dated 4/29/21, for certification 5/3/21 - 7/1/21, which evidenced the primary caregiver was "NA". The agency failed to include the patient's husband as her primary caregiver, and failed to include his willingness and availability to provide care. On 5/18/21 at 2:30 PM, during a phone interview, patient #5 was queried concerning the services she received from the agency. Patient #5 stated the aide does dishes, dusts, and mops but denied the aide assists with personal care. Patient #5 stated her husband provided all personal care including toileting and bathing. When queried who would meet her needs if the aide wasn't available tomorrow, the patient stated, "Well, the house is clean so there is really nothing to do."		**changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee has retrained the RN Case Managers r/t the requirement to include the identification of the patient's primary caregiver, if applicable, to assess and document their willingness and ability to provide care, and their availability and schedule. This information is to be documented on the comprehensive assessment form. In addition, all concerns r/t the caregiver's ability or availability is to be reported to the Director of Clinical Services/designee and the physician. This communication of concern is to be documented in the clinical notes of the patient clinical record. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit 100% of all comprehensive assessments utilizing the Home Health Comprehensive Assessment Audit Tool. This will be an ongoing process that is to be completed at all certification timepoints. The Director of Clinical Services/designee will perform random unannounced supervisory visits of the RN Case Managers as	

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			they perform comprehensive assessments of patients in the home setting to assess their clinical skills regarding all aspects of the assessment process including assessment of the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule. The QAPI Committee will receive monthly reports of compliance and areas of concern. The Administrator is responsible for reporting compliance and any areas of concern to the Governing Body. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services/designee is responsible for ensuring ongoing compliance with G538. **6. Date of Compliance:** **----------6/25/21**	
G 0570 Bldg. 00	484.60 Care planning, coordination, quality of care 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			

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	individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the agency failed to ensure that each patient received an individualized plan of care; provide services as ordered on the plan of care; failed to ensure the plan of care contained all the required elements; failed to ensure verbal orders were complete; failed to ensure physicians were notified; failed to ensure there was documentation of coordination of care. These deficient practices affected 5 of 6 records reviewed. (Patients 1, 2, 3, 5, 6) The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care. Findings include: The agency failed to ensure that each patient received an individualized plan of care that included patient specific, measurable outcomes and goals and failed to ensure services were provided per the plan of care. (See G572)	G 0570	**ALLEGATION OF COMPLIANCE WITH CFR 484.60:** The Governing Body for Visiting Angels Home Health Agency approved the following: additional training, oversite, and QAPI activities to ensure agency operations are in compliance with CFR 484.60: Care Planning, Coordination of Services, and Quality of Care. Clinicians have been retrained on the accurate completion and documentation of all aspects of the Medical Plan of Care. The RN Case Manager notifies the physician/physician representative following the completion of the comprehensive assessment to report the assessment findings and collaborate with the physician on the development of a patient-specific POC to include the following: · Documentation that the patient and/or caregiver	06/25/2021

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	The agency failed to ensure the individualized plan of care included all pertinent diagnoses and their onset date, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures, infection control precautions, risk for emergency department visits and hospital readmission, services being provided by outside agencies/ facilities, all necessary interventions, specific education and training to be provided, measurable outcomes and goals identified by the home health agency and patient, and orders may be received/ accepted by outside physicians. (See G574) The agency failed to ensure verbal orders were complete and contained duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were received. (See G584) The agency failed to ensure prompt notification of a change in condition to the patient's physician. (See G590) The agency failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care to meet the patient's needs. (See G608)		participated in the development of the Plan of Care. · A list of diagnoses, and these diagnoses match the diagnoses as listed on the Assessment & are sequenced based on patient identified need, · All pertinent diagnoses, · The patient's mental, psychosocial, cognitive status, & safety measures to protect against injury, · Services to be provided along with frequency & duration of scheduled visits, · Patient's prognosis, · A list of medications including the name, dosage, strength, route and frequency of administration, as well as all treatments, · Documentation of the patient's nutritional status & rehabilitation potential, · Documentation of the patient's functional limitations and activities permitted, · The patient's risk of ED visits/rehospitalizations along with measures & interventions to address the risk factors, · Patient/caregiver education to facilitate timely discharge, · Patient-specific interventions/education, measurable outcomes/goals & prognosis, · Patient specific Advanced Directive guidance, · Orders from all relevant	

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			physicians involved in the patient's care and who provide MD orders directly r/t home health services, · All orders are recorded on the POC including verbal orders The Director of Clinical Services has re-educated all RN Case Managers on the above requirements and has provided a "POC Content Tool" to ensure all items are addressed with the physician and are included on the Medical Plan of Care. The Director of Clinical Services has re-educated all RN Case Managers on the documentation required on verbal orders including the RN Signature, Date, & Time of receipt. The Director of Clinical Services has re-educated all nurses to ensure physicians are notified of any change in patient status, concerns, non-compliance, missed visits, etc. The Director of Clinical Services has re-educated all nurses on the requirement to coordinate services with all other providers of service the patient is receiving. This coordination of care is to be documented in the clinical record. The Agency has developed an audit tool to assess compliance of communication and coordination of care with other service	

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			providers. The Director of Clinical Services has re-educated all staff members to ensure they follow the care plans as directed by the physician and to provide patient care as directed on the Medical Plan of Care. The Director of Clinical Services has re-educated all nurses of their responsibilities regarding communication and coordination of care with all relevant physicians, other service providers, and team members. The Agency has developed an audit tool to track compliance with collaboration of care with other providers and 100% of all clinical records will be audited every 60 days for the presence of documentation of communication, collaboration, and coordination of services with other service providers. The QAPI Committee and Governing Body have approved the QAPI Indicator that measures compliance with this aspect of care: “Medical Plan of Care for Patients”. This indicator specifically addresses the content of the POC, and the audit tool provides the Director of Clinical Services a specific compliance measurement tool to evaluate staff	

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			compliance with the development of the Medical Plan of Care. The QAPI Project requires a 100% audit of all Medical Plans of Care at all certification time points. The above listed practices and interventions will result in the agency demonstrating compliance with CFR: 484.60. **G570** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Patient's latest assessment has been corrected in all facets to meet the requirements for their plan of care. Caregivers have been re-educated to provide patient care as directed by the physician. **Patient #2:** Patient's latest assessment has been corrected in all facets to meet the requirements for their plan of care. Caregivers have been re-educated to provide patient care as directed by the physician. **Patient #3:** Patient's latest assessment has been corrected in all facets to meet the requirements for their plan of care. Caregivers have been re-educated to provide patient care as directed	

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			by the physician. **Patient #5:** Patient's latest assessment has been corrected in all facets to meet the requirements for their plan of care. Caregivers have been re-educated to provide patient care as directed by the physician. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services/designee audited 100% of all active clinical records to assess compliance of the Medical Plan of Care as outlined in G574. All identified gaps and errors will be returned to the RN Case Managers to correct and resubmit within 48 hours. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Clinical Director of Service/designee has re-educated all RN Case Managers concerning their responsibilities to ensure all content required on the medical plan of care is completed and accurate. The RN Case Managers have a checklist to remind them of what items must be addressed on every plan of care. The Clinical Director of Service will	

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			audit 100% of all Medical Plans of Care for compliance with G574. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Agency Governing Body and QAPI committee has approved a QAPI indicator titled “Medical Plan of Care for Patients” which includes an audit tool to assess compliance on an ongoing basis at certification timepoints. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator and Director of Clinical Service is responsible for ensuring ongoing compliance with G570. **6. Date of Compliance:** **6/25/21**	
G 0572 Bldg. 00	484.60(a)(1) Plan of care 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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure that each patient received an	G 0572	**G572** **1. Actions the Agency took to correct the deficient practice**	06/25/2021

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	individualized plan of care that included patient specific and measurable outcomes and goals in 3 (Patient's 2, 3, 5) of 4 active records reviewed and failed to ensure services were provided per the plan of care for 4 (Patient #1, 2, 3, 5) of 4 active records reviewed. Findings include: 1. Review of a policy titled "C-660 Care Plans" revealed " ... Each client will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs ... 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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan." 2. A review of a plan of care for patient #2, for the certification period 4/10/21 - 6/8/21, revealed a primary diagnosis of intellectual disability and a secondary diagnosis of cerebral palsy. Locator 21 evidenced "The patient will evidence safe mobility practices AEB (as evidenced by) no falls within this certification period, but failed to evidence what safe mobility practices include or how the agency will insure the patient has no falls within the certification period. The plan of care failed to include patient specific and measurable outcomes and goals related to the reason for home health care. The plan of care revealed orders for home health aide services 8 hrs/day x 5 days/week x 7		**for each client cited in the deficiency:** **Patient #1:** Patient's care plan has been modified to include measurable outcomes and goals, and these goals will be assessed for progress at each recertification visit. **Patient #2:** Patient's care plan has been modified to include measurable outcomes and goals, and these goals will be assessed for progress at each recertification visit. **Patient #3:** Patient's care plan has been modified to include measurable outcomes and goals, and these goals will be assessed for progress at each recertification visit. **Patient #5:** Patient's care plan has been modified to include measurable outcomes and goals, and these goals will be assessed for progress at each recertification visit. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services/designee audited 100% of all active clinical records to assess compliance of the Medical Plan of Care to include an	

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	weeks and 8 hours/day x 2 days per week x 1 week. Review of the home health aide visit notes revealed patient #2 received no home health aide visits on week 1; 8 hours/day x 4 days/week x week 2-3; 8 hours/day x 4 days/week x week 4; 6 hours/day x 1 day/week x week 4; 2 hours/day x 1 day/week x week 4; and 8 hours/day x 5 day/week x week 5. The agency failed to provide home health aide services as ordered on the plan of care. 3. A review of a plan of care for patient #3 for the certification period 4/10/21 - 6/8/21, revealed a primary diagnosis of traumatic brain injury and no secondary diagnoses. Locator 21 evidenced a goal of "Pt (patient) will have no injuries related to seizure activity this certification period", but failed to evidence what injuries the patient was to avoid and how the agency would ensure none occurred. The plan of care failed to include patient specific and measurable outcomes and goals related to the reason for home health. The plan of care revealed orders for home health aide services 8 hours/day x 5 days/week for weeks 1-7 and 8 hours/day x 2 days/week during week 8, but failed to include orders for weeks 9 and 10. A review of the home health aide visit notes revealed no aide visits week 1; 1 aide visit week 2; and 5 aide visits weeks 3-5. The agency failed to provide skilled nurse and home health aide services as ordered on the plan of care. 4. A review of a plan of care for patient #5 for the certification period 5/2/21 - 7/1/21, revealed a primary diagnosis of COPD (Chronic Obstructive Pulmonary Disease) and a secondary diagnosis of fibromyalgia. Locator 21 evidenced "The patient		individualized plan of care with measurable outcomes and goals. The charts were also audited to evaluate if clinician visit notes evidenced that care was provided as ordered on the Medical Plan of Care. RN Case Managers whose clinical records evidenced missing documentation to validate a patient-specific plan of care or missing measurable outcomes and goals were reinstructed on the requirements. These RN Case Managers were also instructed to address any missing information r/t the plan of care and the listing of patient-specific measurable outcomes and goals. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee has reinstructed all RN Case Managers on the necessity to ensure the Medical Plan of Care addresses patient-specific needs and includes patient-specific measurable outcomes and goals. The RN Case Managers and Home Health Aides were instructed to provide care and services as ordered on the Medical Plan of Care. The RN Case Managers were instructed to review the home health aide care plans with the	

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	will be compliant with medication regimen within this cert (certification) period", but failed to evidence what compliance was needed (i.e.: misses evening medications, forgets certain morning medications) and how the agency would ensure the compliance. The plan of care failed to include patient specific and measurable outcomes and goals related to the reason for home health care. The plan of care revealed orders for home health aide services 8 hours/day x 5 days per week x weeks 1-7; 8 hours/day x 4 days/week x week 8. Home health aide visit notes from 5/3/21 - 5/11/21 revealed the patient received home health aide services 7.75 hours/day x 1 day per week x week 1; 6 hours/day x 1 day/week x week 2; and 8 hours/day x 1 day/week x week 2. The agency failed to provide home health aide services as ordered on the plan of care. On 5/17/21 at 4:08 PM, patient #5 was queried concerning what services the home health aides provided during the visits. Patient #5 stated the home health aide "swept, mopped, and dusted." The surveyor asked if the aide provided assistance with bathing, toileting, or dressing. Patient #5 stated, "She [home health aide] cleans and talks with me. I shower in the evening when my husband helps me. Sometimes I have a little trouble getting up off the toilet so I like to have someone here in case I need help, but I'm usually ok since my husband helps with that too." Patient #5 stated she did not know who was coming tomorrow and stated, "But I should be fine. The house is already clean so there is nothing I need." On 5/18/21 at 2:30 PM, the administrator and clinical manager were queried concerning services provided to patient #5. Both individuals agreed that patient #5's plan of care stated she was to receive home health aide services for hands on		patient/caregiver and review the visit schedule and length of time the home health aide is to be in the patient's home. The RN Case Managers were instructed to inform their patients that the primary purpose of home health aide services is to assist with the provision of personal care. Light meal preparation and light housekeeping tasks may be performed if time is available. The RN Case Managers were instructed to politely stress with patients and family members that any refusal of service must be reported to the MD. Home Health Aides were instructed to provide the care and services as listed on their home health aide assignment sheet and stay with the patient the physician-ordered length of time/visit. The Home Health Aides were instructed that the primary purpose of home health aide services is to assist with the provision of personal care. Meal preparation and light housekeeping tasks may be performed as time permits. Home Health Aides were instructed that they are not allowed to sleep while in a patient's home. Home Health Aides were instructed that if the patient instructed them to leave and/or refused services to document this	

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	personal care that included bathing and dressing, and they were unaware that the patient was not receiving any personal care services as outlined on the plan of care. 5. On 5/12/21 at 3:30 PM, the administrator and clinical manager were interviewed concerning the contents of the plan of cares. Both stated they had worked very hard to educate and make changes since the previous survey but recognized much of the work went into the audits, and they needed continued education and support to put corrections in place. 6. The clinical record of patient #1 contained a of plan of care for initial certification period of 2/24/21 to 4/24/21, the order for discipline and treatment indicated," HHA (home health aide) x 2 hours/day x 3 days/week x 1 week, HHA x 2 hours/day x 5 days/week x 8 weeks...HHA to assist with ADLs (Activities of Daily Living), Bathing MWF (Monday, Wednesday, Friday) and prn (as needed), bathroom clean up, bed care, change linens, conversation, dressing, encourage fluids, fall risk, grooming, hygiene assistance, medication reminders, and skin care..." Review of a visit note dated 2/25/21 (Thursday), a partial visit was made clock in 9:55 AM to 11:34 AM. Review of visit noted dated 3/4/21(Thursday), a partial visit was made clock in 9:55 AM to 11:32 AM. On week two of eight, home health aide visits were completed on 3/9/21, 3/10/21, 3/11/21, and 3/12/21, the home health aide failed to make a 5th visit for the week. Review of visit note dated 3/19/21 (Friday), a		information and immediately notify the Director of Clinical Services upon leaving the home. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit 100% of all medical plans of care on an ongoing basis to ensure the Medical Plan of Care is specific to each patient and includes patient-specific measurable outcomes and goals. The Administrator will audit 100% of all home health aide visit notes to ensure ongoing compliance with the home health aide care plan. All identified discrepancies will be addressed individually with each staff member. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services and Administrator is responsible for ensuring ongoing compliance with G572. **6. Date of Compliance:** **6/25/21**	

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	partial visit was made clock in 9:56 AM to 11:00 AM. On week five of eight, home health aide visits were completed on 3/29/21, 3/31/21, 4/1/21, and 4/2/21, the home health aide failed to make a 5th visit for the week. Further review partial visits were made visit note dated 3/29/21 (Monday) clock in 10:04 to 11:02 AM and visit note dated 4/1/21 (Thursday) clock in 9:56 AM to 11:38 AM. On week six of eight, home health aide visits were completed on 4/5/21, 4/6/21, 4/8/21, 4/9/21, the home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/5/21 (Monday) clock in 9:55 AM to 11:28 AM. On week seven of eight, home health aide visits were completed on 4/12/21, 4/13/21, 4/15/21, 4/16/21, the home health aide failed to make a 5th visit for the week. On week eight of eight home health aide visits were completed on 4/19/21, 4/20/21, 4/22/21, 4/23/21, the home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/20/21 (Tuesday) clock in 10:44 AM to 12:12 PM. The home health aide failed to provide 2 hour visits, 5 days a week as ordered on the plan of care. During an interview on 5/11/21 at 3:31 PM, when queried about missing home health aide visits, the administrator and clinical manager indicated they do not have a set rule for missed visits. The Administrator stated, "We do not notify the physician unless we see trends of missed visits."			

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	410 IAC 17-13-1(a) 484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and 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 may choose to include.			
G 0574 Bldg. 00	Based on observation, record review and interview, the agency failed to ensure the individualized plan of care included all pertinent diagnoses and their onset date, all supplies and	G 0574	**G574** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:**	06/25/2021

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	equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures, infection control precautions, risk for emergency department visits and hospital readmission, services being provided by outside agencies/ facilities, all necessary interventions, specific education and training to be provided, measurable outcomes and goals identified by the home health agency and patient, and orders may be received/ accepted by outside physicians for 4 of 4 active records reviewed. Findings Include: 1. Review of an undated policy titled "PLAN OF CARE" C-580 stated, "POLICY Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members...PURPOSE To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... SPECIAL INSTRUCTIONS ... 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis (es)...; b. Mental status; c. Type, frequency, and duration of all visits/services...; g. Prognosis; h. Rehabilitation potential ...; i. Functional limitations and precautions; j. Activities permitted or restrictions; k. Special dietary or nutritional requirements or restrictions; l. Medications, treatments, and procedures; m. Medical supplies and equipment required; n. Any safety measures to protect against injury; o. Instructions to client/ caregiver, as applicable; p. Treatment goals; q. Instructions for timely discharge or referral; r. Discharge plans ...; s. Name and address of client's physician; t. Other		**Patient #1:** Patient's care plan has been updated to meet individualization requirements. Specific details of patient's condition have been included to ensure completeness. **Patient #2:** Patient's care plan has been updated to meet individualization requirements. Specific details of patient's condition have been included to ensure completeness. **Patient #3:** Patient's care plan has been updated to meet individualization requirements. Specific details of patient's condition have been included to ensure completeness. **Patient #5:** Patient's care plan has been updated to meet individualization requirements. Specific details of patient's condition have been included to ensure completeness. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services/designee audited 100% of all active clinical records to assess compliance of the Medical Plan of Care to include an individualized plan of care that addresses all the following requirements:	

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	appropriate items; u. All of the above items must always be addressed on the Plan of Care." 2. Review of an undated agency policy titled "C-660 Care Plans" revealed "Each client will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs." and "The Care Plan shall include ... a. Nursing diagnosis(es) problems and needs identified; b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations; c. A list of specific interventions with plans for implementation; d. Indicators for measuring goal achievement and identified time frames. 3. The clinical record of patient #1 start of care 2/24/21 was reviewed and contained an initial comprehensive assessment dated 2/24/21 which revealed a diagnosis Congestive heart failure (CHF), Diabetes Mellitus II (DM II), and Spinal Stenosis. The patient had a recent hospital stay and discharged on 2/20/21 with a bacterial infection of the bloodstream. Patient #1 has a reported history of difficulty complying with any medical instructions, currently taking 5 or more medications, currently reports exhaustion with shortness of breath with minimal exertion RN indicated patient becomes short of breath talking, obese, uses a walker, motorized wheelchair, back pain daily but not consistent causing decrease mobility and weakness, and wears glasses. Patient is a fall risk and requires a home health aide to assist with ADL's, transfers, bathing, meal prep and safety. The care preferences/ patient's personal goals were blank. Section Rehabilitation Potential for anticipated discharge planning indicated, "No dc plan as case is ongoing." Current DME and medical supplies indicated, DME Company "NA" (Not applicable) supplies		· All pertinent diagnoses and their onset date, · The patient's mental, psychosocial, and cognitive status, · The types of services, supplies, and equipment required, · The frequency and duration visits to be made, · Prognosis, · Rehabilitation potential, · Functional limitations, · Activities permitted, · Nutritional requirements, · All medications and treatments, · Safety measures to protect against injury, · A description of the patient's risk for emergency department visits, hospital re-admission, and all necessary interventions to address the underlying risk factors, · Patient and caregiver education and training to facilitate timely discharge, · Patient-specific interventions and education, · Measurable outcomes and goals identified by the HHA and the patient, · Information related to any advanced directives, · PCP orders to accept orders from all relevant physicians seeing the patient, · Any additional items the HHA or physician may choose to include.	

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	marked chemstrips, gloves non-sterile, hospital bed, bath bench, walker, wheelchair. Section Living arrangements/Supportive Assistance Safety Measures indicated "Bleeding precautions, Fall precautions, Clear pathways, Infection control measures, walker/cane. "Care Coordination was blank. RN documented verbal order for HHA x 2 hours/day x 5 days/week and SN x 1 hr/week. Client receives Entity D for attendant care services comprehensive assessment failed to evidence coordination of care. The record contained a plan of care for the initial certification period of 2/24/21 to 4/24/21 that indicated, "Diagnosis CHF, DM II and Spinal Stenosis" The plan of care failed to evidence DME and Supplies glucometer, glucometer strips, and insulin pen needle, Safety Measures indicated, "fall, hypo/ hyperglycemia" failed to evidence bleeding precautions, clear pathways, infection control measures, and walker/cane. Further review of the plan of care failed to contain updated orders for Discipline Skilled Nursing for medication set up weekly for 9 weeks and Home Health Aide Supervisory visits every 14 days, failed to have measurable goals and interventions for CHF and pain. 4. The findings were reviewed with the Administrator, Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provide at that time. 5. Review of the clinical record for patient #2 revealed a physician verbal order for recertification of care, dated 4/5/21, and evidenced home health aide orders for 8 hours/day x 5 days per week to assist with ADLs (Activities of daily living), showers 2x weekly, medication reminders, meal preparation, incontinence care, and light		Patient Plans of Care missing any of required elements of the POC will be returned to the RN Case Managers for correction and re-submission once the corrections were made and/or obtained from the PCP. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The QAPI Committee has met and determined this area of concern requires an ongoing QAPI Project. The committee created the QAPI Project titled “Medical Plan of Care for Patients” and was approved by the agency Governing Body. The project addresses the retraining of all RN Case Managers to ensure all patients have Medical Plans of Care based on their patient-specific comprehensive assessment, physician orders, and patient needs. The Medical Plan of Care is to include all the required elements as listed at G574. The Agency Director of Clinical Services/designee will retrain all RN Case Managers on the required elements of the Medical Plan of Care. RN Case Managers will be provided a written educational tool to assist them in completing the Medical Plan of Care accurately and thoroughly.	

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	housekeeping. Skilled nursing was ordered every 60 days for recertification, supervisory and as needed visits for change in condition, with biweekly medication planner fill. The order evidenced a goal of "Patient to comply with medication regimen within this cert (certification) period." Review of the recertification assessment, dated 4/5/21, revealed patient #2 had a primary diagnosis of intellectual disability and a secondary diagnosis of cerebral palsy. The patient lived alone, had decreased mobility, required assistance with bathing, incontinent care, medication reminders, meals, and light housekeeping. The patient was alert and oriented, non-compliant with hygiene and evening medications, used a walker for short distances, but depended primarily on a wheelchair. Review of the plan of care for certification period 4/10/21 - 6/8/21 revealed the plan of care failed to include dates of onset for the pertinent diagnoses; accurate mental status; correct type, frequency, and duration of all visits/services; physical therapy orders; rehabilitation potential; all functional limitations and precautions; all activities or restrictions; accurate medications and treatments; all medical supplies and equipment required; all safety measures; instructions to client/caregiver; treatment goals; detailed discharge plans; patient selected goals; patient specific interventions and measurable goals, accurate verbal start of care date for continuing services; and other agencies involved in care. 6. Review of the clinical record for patient #3, start of care 8/13/20, revealed a resumption of care assessment dated 4/19/21, which evidenced a primary diagnosis of traumatic brain injury. The		**4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The QAPI project includes an audit tool to be utilized at time of admission and recertification to evaluate ongoing compliance with G574. Administrator will audit 100% of all Medical Plans of Care at SOC and Recertification timepoints for compliance with G547. The Administrator will report the audit findings monthly to the QAPI committee for their review. The Administrator will report the audit findings to the Governing Body on a quarterly basis. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services and Administrator is responsible for ensuring ongoing compliance with G574. **6. Date of Compliance:** **6/25/21**	

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	assessment evidenced the patient was hospitalized from 3/30/21 - 4/18/21 for pneumonia and seizures. The patient was unable to make his needs known and unable to provide any self care, was incontinent, required oral suctioning, and was fed via gastrostomy tube. A review of the clinical record for patient #3 contained a plan of care for certification period 4/10/21 - 6/8/21, which revealed orders for home health aide services 8 hours/day x 5 days/week for weeks 1-7 and 8 hours/day x 2 days/week during week 8, but failed to include orders for weeks 9 and 10. This plan of care also failed to include accurate mental status; correct type, frequency, and duration of all visits/ services; physical therapy orders; rehabilitation potential; all functional limitations and precautions; all activities or restrictions; accurate medications and treatments; all medical supplies and equipment required; all safety measures; instructions to client/caregiver; treatment goals; detailed discharge plans; a patient specific seizure plan; patient selected goals; patient specific interventions and measurable goals, accurate verbal start of care date for continuing services; and other agencies involved in care. 7. Review of the clinical record for patient #5, start of care 3/4/21, revealed a Primary Diagnoses of Chronic Obstructive Pulmonary Disease(COPD) and Fibromyalgia, with orders for home health aide services 8 hours x 5 days. Review of an identical document dated 11/1/18 at page top but with no "Actual start of care date", revealed diagnoses of Rheumatoid Arthritis, fibromyalgia, osteoarthritis, seizures, mild dementia. Other services involved included a medical monitoring company and Homemaker			

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	Attendant Care, agency unknown. The reason for referral evidenced therapy services, bathing, dressing, walking, and home health aide. Review of a face to face document for patient #5, encounter date 3/10/21, evidenced reason for home care as COPD, weakness, seizures, hypertension, osteoarthritis, difficulty ambulating, and dyspnea with exertion. Disciplines ordered included nursing, home health aide, and physical therapy. Review of a recertification assessment dated 4/29/21 revealed a primary diagnosis of COPD and a secondary diagnosis of fibromyalgia. Patient #5 had a history of falls, most recently around March 2021, had pain that did not interfere with activity or movement but reached 6/10 at times, had diminished breath sounds bilaterally, used nebulizer treatments daily, and was short of breath with minimal exertion. The assessment indicated the patient ate a regular diet with food prepared by the home health aide. The patient used pads for incontinence, required prompting when stressed, was occasionally confused and forgetful, had bilateral lower extremity weakness and decreased mobility, and functional limitations of endurance and ambulation. The patient required assist with grooming, dressing, bathing, toileting, transfer. The clinician documented the patient did not want a personal goal. The assessment indicated the equipment used in the home were gloves, bath bench, raised toilet seat, walker, wheelchair. The assessment also revealed the patient took more than 10 medications per day. Review of the plan of care for patient #5, for the certification period of 5/3/21 - 7/1/21, failed to include all pertinent diagnoses with dates of onset; accurate mental status; correct type,			

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	frequency, and duration of all visits/services; physical therapy orders; rehabilitation potential; all functional limitations and precautions; all activities or restrictions; accurate medications and treatments; all medical supplies and equipment required; all safety measures; instructions to client/caregiver; treatment goals; detailed discharge plans; a patient specific seizure plan; patient selected goals; patient specific interventions and measurable goals, accurate verbal start of care date for continuing services; and other agencies involved in care. 8. During an interview on 5/11/21 at 3:31 PM, with Administrator and Clinical Manager, regarding the plan of cares content including; diagnosis, orders, frequency, duration, comprehensive assessment and plan of care not matching, care preferences, psychosocial, mental, durable medical equipment, functional limitations, discharge plans, rehab potential, safety, and seizure plans they stated, they needed to be more detailed. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(i,ii,iii,v,vi,vii,ix,x,xi,xii,xiii)			
G 0584 Bldg. 00	484.60(b)(3)(4) Verbal orders (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state			

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	law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review and interview, the agency failed to ensure verbal orders were complete and contained duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were received for 5 of 6 records reviewed. (Patients 1, 2, 3, 5, 6) Findings include: 1. Review of an undated agency policy "C-635 Physician Orders" revealed "All orders for medications must contain the name of the drug, dosage, route of administration, and directions for use. Orders must be written completely and not contain any of the dangerous abbreviations, acronyms, or signals that may contribute to medication or treatment errors." 2. Review of the clinical record for patient #2, certification period 4/10/21 - 6/8/21, revealed a physician verbal order, signed by employee I on 4/5/21 and awaiting physician signature. The order failed to evidence correct frequency and duration for skilled nursing and failed to be specific as to what changes in condition would warrant a skilled visit, and failed to include specific education to be provided by the nurse. The order also failed to correctly state the frequency and duration of home health aide visits, and failed to match the aide plan of care.	G 0584	**G584** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Verbal orders have been updated to display services to be provided, discipline, date and time order was obtained, frequency and duration, and education as required. **Patient #2:** Verbal orders have been updated to display services to be provided, discipline, date and time order was obtained, frequency and duration, and education as required. **Patient #3:** Verbal orders have been updated to display services to be provided, discipline, date and time order was obtained, frequency and duration, and education as required. **Patient #5:** Verbal orders have been updated to display services to be provided, discipline, date and time order was obtained, frequency and duration, and education as required. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the**	06/25/2021

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	15K165	A. BUILDING 00 B. WING	05/18/2021

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	3. Review of the clinical record for patient #3, certification 4/10/21 - 6/8/21, revealed a physician verbal order signed by the clinician on 12/7/20, which evidenced "Requesting seizure precaution orders: If seizure lasts longer than 5 minutes send to ER (emergency room)." The order failed to include specific instructions to cover the onset through duration of a seizure including, but not limited to who managers the seizure, medications given, positioning, airway, frequency of assessment, and who to notify. Review of a physician verbal order for resumption of care dated 4/19/21 evidenced "Resume Services with no changes to the current plan of care" followed by a new medication listed as Vimpat. The orders failed to include accurate frequency and duration for the skilled nurse and home health aide services, failed to correctly ordered medication. 4. Review of a physician verbal order for patient #5, certification period 5/3/21 - 7/1/21, revealed discipline and frequency for skilled nursing as "q (every) 30 days, and home health aide services 40 hours per week, also written as HHA (home health aide) 8 hours/day x 5 days/week x 60 days to assist with ADLs, bathing, ambulating, meal preparation, companionship, and light housekeeping. The orders failed to include accurate frequency and duration for all services. 5. Review of clinical record #1 was reviewed 5/11/21 and indicated a start of care date 2/24/21. The record contained an agency document titled "Physician Order For Start of Care"dated 2/24/24, indicated " ... Verbal Order: Agency to have Registered Nurse perform assessment and evaluation of the client for admission to home health services. Services requested by referral		**actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Clinical Director of Services/designee will review all active patient verbal orders for the current certification period for the presence of the following elements: · The verbal order must specify the task(s) or service to be performed, what discipline is to perform the task, and the frequency and duration of the task, · The verbal order must specify the type of education to be provided and to whom, · The verbal order nurse signature must also include documentation of the date and time the MD verbal order was obtained. · Verbal orders for medications must include the name of the medication, dosage, route of administration, and the frequency of administration, · Verbal orders for treatments must include the name and type of treatment, frequency of administration and duration. · Verbal orders are to be authenticated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies. **3. Agency steps or systemic changes the agency has made to ensure that the deficient**	

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	source include the following: SN 1 x wk, HHA x 2 hours/ day x 5 days/ week .... " Additional orders include for the SN to assess for environmental, sanitation, and personal safety hazards, Instruct on safety measures identified, instruct on fall prevention, and instruct on Hi-Risk Medications. The order also states "In addition the Registered Nurse will contact the physician following the assessment and evaluation with a summary of findings and receive detailed physician orders to provide care..." The order failed to include specifically the services the home health aide was to provide. Review of an agency document titled "Recertification of Care Physician Verbal Order" dated 4/20/21, indicated "...The physician, patient/caregiver, and nurse have collaborated in the development of the plan of care for the Recertification Period of 4/25/21 to 6/23/21...Nursing Frequency, Duration, & Primary Skilled tasks to include the following: Q60 days recert, Q30days supervisory and prn coc (change in condition) Home Health Aide Frequency, Duration, & Primary tasks to include the following: 2 hrs/day x 5 days/wk to assist with ADLs, transfers, bathing, BR (bathroom) clean up, bed linen changes, fall risk, hygiene..." The order failed to five a duration of home health aide visits and skilled nursing visits, failed to give orders for SN weekly medication set up, and HHA supervisory visits every 14 days. 6. Review of a closed clinical record of patient #6 was reviewed 5/12/21 and indicated a start of care date 3/8/21. The reocrd contained an agency document titled "Physician Order" dated 3/4/21, indicated "Verbal Oders: Requesting order to complete admission assessment 3/8/2021. Please sign and return with med list and H&P(history		**practice does not recur:** The Director of Clinical Services has re-educated the RN Case Managers on the required content of all verbal orders. Going forward, the Director of Clinical Services/designee will review all physician verbal orders to ensure they are complete. Identified gaps or errors will be addressed prior to placing verbal orders into patient's record. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The ongoing review of all verbal orders will provide the Director of Clinical Service/designee with the necessary information to determine the presence of any non-compliance with physician verbal orders and address gaps in documentation or knowledge individually with each clinician. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services is responsible for ensuring ongoing compliance with G584. **6. Date of Compliance:** **6/25/21**	

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	and physical)... The order fails to evidence who is to assess and for what services. 7. During an interview on 5/17/21 at 3:52 PM, when queried about verbal orders missing details or duration and specific services, the Administrator indicated, that they need to work on documenting details. 8. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provideat that time. 401 IAC 17-14-1(a)(H) 401 IAC 17-14-1(a)(F)			
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to ensure prompt notification of a change in condition to the patient's physician in 2 of 4 active records reviewed. (Patient's 2 and 3) Findings include: 1. During a home visit on 5/11/21 at 1 PM, employee I was observed completing a physical assessment that included vital signs, and auscultation of the patient's breath, bowel sounds, and heart. Employee I asked the patient if she had pain, to which she replied she had a	G 0590	**G590** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #2:** Clinicans have been re-educated on importance of reporting changes in condition for their patient along with notification of physician of these changes as warranted. **Patient #3:** Clinicans have been re-educated on importance of reporting changes in condition for	06/25/2021

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	headache of 8/10. Employee I asked if she wanted to take her prn (as needed) ibuprofen ordered on the medication profile and patient #2 declined. Employee I failed to recheck the patient's temperature to verify accuracy and failed to expand the assessment to include a screen for Covid 19. When queried concerning the elevated temperature, employee I stated, "I think my thermometer reads high. I meant to get a new one." When queried as to whether employee I had reported the elevated temperatures to the clinical manager or the patient's physician, employee I stated she had not because she thought her thermometer was reading high. Review of the clinical record for patient #2, revealed patient #2 had a temporal temperature of 100.0 Fahrenheit on 3/30/21; 100.0 on 4/5/21; 99.7 on 4/13/21; 99.2 on 4/27/21; and 99.5 on 5/11/21. The clinician failed to report all elevated temperature findings to the physician or clinical manager. 2. During a home visit on 5/12/21 at 9 AM, the employee DD, a home health aide, was queried concerning what/when he should report to a supervising nurse. Employee DD stated, "You mean like abuse and things?" The surveyor restated the question and asked, "What kinds of things should you tell a nurse about your patient? Do you report their seizures to the nurse?" Employee DD stated he did not report seizures because one of the patient's parents was always present. When queried concerning hospitalization, employee DD stated he would notify the nurse after the patient was admitted to the hospital, but he wasn't sure what to report prior to that. When queried concerning patient #3's change in condition that lead up to hospitalization on 3/30/21, employee DD stated		their patient along with notification of physician of these changes as warranted. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee re-educated all clinicians on the importance of reporting change in condition. All clinicians and caregivers were informed to immediately notify their RN Case Manager whenever they see a change in their patient's condition. Examples of a change in condition could be anything from increased pain, elevated temperature or elevated BP, an increase or decrease in weight, loss of appetite, falls, dizziness, seizure activity, change in behavior, etc. The Director of Clinical Services educated the clinicians and caregivers that the agency is responsible for the care and services they provide and that includes health oversight. Therefore, the Agency RN Case Managers/Agency Management	

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	the patient "became more lethargic each day, and his parents finally "had to take him to the hospital because he was so lethargic." Employee DD stated he did not notify the agency of the patient's increasing lethargy. Review of the clinical record for patient #3, certification period 4/10/21 - 6/8/21, revealed the patient was admitted to the hospital on 3/30/21 for pneumonia and seizures after several days of increased and significant lethargy. The record failed to evidence the patient's daily home health aide reported the patient's change in condition to a registered nurse supervisor. 3. During an interview on 5/13/21 at 3:30 PM, the administrator and the clinical manager were queried concerning patient #2's elevated temperature. The clinical manager stated she was not aware the patient had an elevated temperature and she had not been notified by employee I. The administrator verbalized the same. When queried concerning patient #3's hospitalization, the administrator and clinical manager both stated they were not notified concerning the hospitalization of patient #3, and are not usually notified by family until after patients are admitted. When queried concerning the agency process for change in condition, the clinical manager stated that aide was expected to notify the case manager or clinical at the first sign of a condition change, which was defined as anything different about the patient. 410 IAC 17-13-1(a)(2)		must be notified of any change in patient condition that may need to be reported to the MD as it could indicate a deteriorating health condition that could be averted with prompt treatment. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The RN Case Managers provide a Daily Update Report to the Director of Clinical Services Monday through Friday. Each RN Case Manager is to report the following information concerning their current patient case load: · Patients experiencing a hypo/hyper glycemic reaction in the most recent 24-hour time period, · Patient non-compliance concerns, · Patients who experience a change in condition, · Patients placed on antibiotics in the most recent 24-hour time period, · Patients who have fallen in the last 24 hours, · Patients verbalizing health or safety concerns in the most recent 24-hour time period, · Patients verbalizing complaints, · Patients who have been hospitalized in the most recent 24-hour time period, · Patients who have been seen in the ED in the most recent	

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			24-hour time period, · Patients whose pain has been poorly controlled in the most recent 24-hour time period The above daily report provides the Director of Clinical Services with the necessary tools to follow-up with the patient/doctor r/t any health concerns. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Service is responsible for ensuring ongoing compliance with G590. **6. Date of Compliance:** **6/25/21**	
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care to meet the patient's needs for 4 of 4 active records reviewed. (Patient #1, 2, 3, 5) Findings include: 1. Review of an undated agency policy titled "COORDINATION OF CLIENT SERVICES" C-360 stated, " ... The agency will integrate services ... to assure the identification of client needs and factors that could affect client safety and the	G 0608	**G608** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Information about any other providers involved with the patient's care has been obtained. Coordination with other providers will be evidenced in coordination of care documentation. **Patient #2:** Information about any other providers involved with the patient's care has been obtained. Coordination with other providers will be evidenced in coordination of	06/25/2021

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	effectiveness of treatment ... Coordination of care will include dealing with multiple programs for the complex clients..." 2. During the entrance conference on 5/10/21 at 8:35 AM, when queried about shared patients and contracts the Administrator and Clinical Director indicated they did not have any contracts or shared patients on service. 3. Review of the patient #1's clinical record revealed an agency document titled "Visiting Angels Home Health Agency Collaboration/ Coordination of Care Agreement Between Service Providers" with Entity D, waiver provider, in regards to patient #1 services, revealed the patient was receiving services from an outside provider. Review of the initial comprehensive assessment dated 2/24/21, failed to evidence that the patient was receiving waiver services from another agency. Review of the plan of care for the certification period of 2/24/22 to 4/24/21, failed to evidence that the patient #1 was receiving waiver services from another agency. Review of a Coordination of Care with other providers note dated 2/25/21, failed to evidence the details of collaboration of care patient #1 was receiving from Entity D for waiver services. Review of the a recertification comprehensive assessment dated 4/20/21, failed to evidence that the patient was receiving waiver services from another agency. Review of a coordination of care with other providers note dated 4/20/21, failed to evidence		care documentation. **Patient #3:** Information about any other providers involved with the patient's care has been obtained. Coordination with other providers will be evidenced in coordination of care documentation. **Patient #5:** Information about any other providers involved with the patient's care has been obtained. Coordination with other providers will be evidenced in coordination of care documentation. **2. Actions the Agency to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** RN Case Managers have addressed during their latest patient visit or contacted all active patients to inquire about any additional services the patient may be receiving. Patients or family members were asked what type of services they are receiving and the frequency and duration of this service. All additional patients receiving services from multiple providers were identified. The agency will document Coordination of Care with all patients receiving services from multiple providers; documenting the type of services received along with the frequency and visit schedule.	

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	details of collaboration of care patient #1 was receiving from Entity D for waiver services. Review of the plan of care for the certification period of 4/25/22 to 6/23/21, failed to evidence that the patient #1 was receiving waiver services from another agency. 4. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provided at that time. 5. During a home visit on 5/11/21 at 12:30 PM, patient #2 stated she received waiver services, but did not know the name of the provider. Review of the comprehensive assessment and plan of care for patient #2, certification period 4/10/21 - 6/8/21, failed to evidence the patient also received waiver services provided by another agency. 6. During a home visit on 5/12 21 at 9 AM, employee DD stated he provided waReiver services for patient #3 for 1 hour/week. Review of the comprehensive assessment and plan of care for patient #3, certification period 4/10/21 - 6/8/21, failed to evidence the patient also received waiver services provided by another agency. 7. Review of the comprehensive assessment and plan of care for patient #5, certification period 5/3/21 - 7/1/21, failed to evidenced the patient also received waiver services provided by another agency. During a phone interview on 5/17/21 at 4:15 PM,		The Agency will contact the additional identified service providers to ensure ongoing communication r/t visit schedules, treatment each entity provides, progress to goals, etc. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Clinical Director of Services/designee will retrain all RN Case Managers to ensure the following is completed: · Inquiry of the patient/family at every skilled home visit (assessment, Hha supervisory visit, SN visit) if the patient is receiving additional services from other providers and who the provider is. · Routinely contact the additional service provider to discuss visit schedules, services provided, goals, and progress to goals. · These coordination of care activities are to be documented on the form titled “Coordination of Care with Other Providers”. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** Every 60 days the clinical record is audited to ensure there is documentation coordination of	

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	patient #5 stated she received waiver services from another agency, but was unsure of the agency name. 410 IAC 17-12-2(h)		care activities with other providers by the Director of Clinical Services/designee. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services/designee is responsible for ensuring ongoing compliance with G608. **6. Date of Compliance: 6/25/21**	
G 0652 Bldg. 00	484.65(c)(1)(iii) Activities lead to an immediate correction (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the agency failed to ensure that all improvement actions were evaluated for effectiveness and and that any findings or problems identified were immediately corrected. Findings include: A review of an undated agency policy "B-260 Quality Assessment and Performance Improvement (QAPI) revealed "The programs [sic] activities will lead to an immediate correction of identified problems that directly or potentially threaten health and safety of clients." Review of the agency QAPI program revealed Governing Body Meeting minutes dated 4/22/21 which evidenced in March, 2021 there were 6 comprehensive assessment audits completed with 16% overall accuracy due to verbal orders not detailed; Quarterly review of 22% accuracy total; 1 complaint reported that was 100% resolved, and 6	G 0652	**G652** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **2. Actions the Agency to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Administrator has provided guidance to the Management Team concerning the responsibilities of the QAPI	06/25/2021

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	plan of care audits completed with 100% accuracy. Review of the Governing Body Meeting minutes dated 3/18/21 revealed 2 comprehensive assessment audits with 50% overall accuracy, 2 complaints, 100% resolved, and 41 plan of care audits with 78% compliance. Review of a Performance Improvement Plan titled "Documentation of the Comprehensive Assessment for 1st quarter 2021 (January - April) evidenced 2 of 9 assessments audited scored at 100% compliance. The summary of the audits evidenced "Very few comprehensive assessments were performed in January and February. ...minor issues with times, patient identifers, and specifically listing discharge plannin even when a patient is not preparing for discharge." The verbal orders needed to contain detail including diagnoses, needs, etc. Improvement was expected immediately. The Performance Improvement Plan (PIP) failed to include details, rather than generalizations such as "very Few" and "minor" and "improvement expected in the coming weeks." The PIP also failed to stated how the improvement will occur. The findings were reviewed with the administrator and clinical manager on 5/18/21 at 11:30 AM. They both agreed that a large focus had been placed on gathering data through audits but they had not focused on using the statistical information to implement corrective programs and improve outcomes. The administrator stated that QAPI had been new to them at the previous survey, and they continue to learn what it entails. The administrator stated they would speak with the consultant concerning ongoing education for QAPI performance.		committee to include the following: · Audits and Review of Agency Processes that evidences errors or gaps in review activities must be addressed. This involves the contacting and re-education of staff members responsible for the review and oversite of the designated tasks and educating them on their responsibilities to follow-up with the indicated staff members whose visit practices or documentation was either inadequate, incomplete, incorrect, or missing. The goal is to ensure the provision of quality care and to ensure the clinical record has accurate documentation of all patient activities, orders, progress to goals, etc. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator will ask for monthly written progress reports r/t the various audit findings and their corrections at the QAPI meetings. The Management Team will be responsible for identifying staff members who demonstrate an unwillingness to learn and/or improve their practices. This information will be communicated to the Administrator for appropriate follow-up with the designated employees. **5. Agency staff responsible for ensuring ongoing compliance:**	

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	410 IAC 17-12-2(a)		The Administrator is responsible for ensuring ongoing compliance with G652. **6. Date of Compliance: 6/25/21**	
G 0684 Bldg. 00	484.70(b)(1)(2) Infection control Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the agency failed to ensure all staff continued to follow the CDC (Centers for Disease Control) guidelines for health care providers during the covid 19 pandemic, and failed to ensure the agency developed and maintained an agency wide infection control program in regards to the COVID-19. Findings include: A review of the agency's policy and procedure binders, evidenced an undated addendum to policy "B-403 Infection Prevention and Control" which evidenced "Agency will observe the	G 0684	**G684** **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** Agency Administrator met with the Governing Body who made the determination that CDC guidelines for COVID-19 protocol must be followed inside the agency office and in patient homes at all times. Anyone entering the agency office must fill out a symptoms screening, be temperature screened, and will be required to wear a mask upon entering to	06/25/2021

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	recommended precautions for COVID-19 as identified by the CDC.(Centers for Disease Control) The CDC website will be monitored closely to determine when changes and/or updates are made." The policy and addendum failed to include what the specific CDC precautions were, how staff were to be educated, and how the guidelines would be implemented and compliance tracked. Review of an agency policy titled "B-403 Infection Prevention" revealed "Agency will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC) ... The agency will have an infection prevention and control component to the Infection program. This program will evaluate those client populations to be at risk and implement processes as needed ...; 2. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganisms between other clients or the environment; Target surveillance activities will be identified and implemented based on the results of the total surveillance program. Data related to identified infections will be reviewed and analyzed. On 5/10/21 the Indiana Department of Health surveyors entered the agency for a post condition revisit and observed that agency employees were not wearing face masks. The surveyors were not screened for Covid using the standard CDC questions and did not have a temperature measured. The agency failed to ensure it followed the CDC guidelines and the agency policy for infection control. Review of the agency QAPI (Quality Assessment		prevent the potential spread of COVID-19. Agency COVID-19 policy has been reviewed and updated. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator is responsible for ensuring ongoing compliance with G684. **6. Date of Compliance: 6/25/21**	

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	and Performance Improvement) Plan failed to evidence a an agency wide infection control program outlining surveillance, identification, prevention, control, and investigation of all infectious and communicable disease, and failed to ensure agency staff were instructed to follow CDC guidelines in regards to screening patients for signs and symptoms of covid 19. According to the Centers for Disease and Control website at https://www.cdc.gov/coronavirus/2019, indoor environments with poor ventilation increase the risk of transmission. To prevent infection and to slow transmission of COVID-19, do the following: ... Cover you mouth and nose with a mask when in public settings or around others... " During an interview with the administrator on 5/12/21 at 2:30 PM, the administrator stated the agency was no longer wearing masks because the mask mandate had been lifted for the agency's county. The surveyor reviewed the CDC guidelines with the administrator, who agreed that the CDC recommended masks for medical and health care facilities. 410 IAC 17-12-1(m)			
G 0750 Bldg. 00	484.80 Home health aide services Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the registered nurse failed to ensure the aide care plan	G 0750	**G750** **1. Actions the Agency took to correct the deficient practice**	06/25/2021

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	was individualized to the patient; the home health aides failed to provide services as ordered on the plan of care; the home heath aide failed to ensure hands on personal care was provided; and the case manager failed to ensure they accurately documented supervisory visits. This impacted 4 of 4 active records reviewed during this post condition survey. (Patients 1, 2, 3, 5) The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate Aide care and services which could result in the agency note providing quality health care. Findings inclulde: The Registered Nurse failed to ensure the aide care plan was individualized and patient specific. See (G798) The home health aide failed to ensure they provide all services as outlined on the patient's plan of care. (See G800) The home health aide failed to ensure they provided personal hands on care as ordered on the plan of care. (See G802) The case manager failed to ensure they accurately documented supervisory visits in regards to inaccurately indicating an aide was following the plan of care. (See G818)		**for each client cited in the deficiency:** **Patient #1:** Audits of home health aide visit notes will ensure the plan of care is being adhered to. Any missed visits will entail physician notification on a weekly basis. RN Case Manager supervisory visits will be thorough to keep the care being provided consistent with the physician approved plan of care. **Patient #2:** Audits of home health aide visit notes will ensure the plan of care is being adhered to. Any missed visits will entail physician notification on a weekly basis. RN Case Manager supervisory visits will be thorough to keep the care being provided consistent with the physician approved plan of care. **Patient #3:** Audits of home health aide visit notes will ensure the plan of care is being adhered to. Any missed visits will entail physician notification on a weekly basis. RN Case Manager supervisory visits will be thorough to keep the care being provided consistent with the physician approved plan of care. **Patient #5:** Audits of home health aide visit notes will ensure the plan of care is being adhered to. Any missed visits will entail physician notification on a weekly basis. RN Case Manager supervisory visits will be thorough to keep the care being provided	

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			consistent with the physician approved plan of care. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the** The Director of Clinical Services/designee audited 100% of all active client clinical records to evaluate the patients' need for home health aide services, what the home health aide services are to include to meet the patient's individual needs, and if the home health aide is providing the service as directed. Clients with identified gaps in service will be referred back to the RN Case Manager for immediate follow-up to validate what services are needed, the frequency, and duration and ensure there are physician orders to support and validate the services. The Home Health Aide Scheduler was informed to notify the Administrator and Director of Clinical Services whenever there is a projected or actual staffing shortage. The Administrator is responsible for ensuring there is adequate staff to meet patient needs. **3. Agency steps or systemic changes the agency has made**	

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			to ensure that the deficient practice does not recur: The Director of Clinical Services has retrained the RN Case Managers of their responsibilities at all Hha Supervisory visits to include the following: · That all Hha services are to be patient-specific based on each patient's identified needs, · The Hha Care Plan is to be individualized to meet the needs of the individual client, · That the RN is to evaluate and ensure the Hha is providing hands on personal care as written on the Medical POC. · The RN Case Manager is to review the Hha Care Plan with the client at every supervisory visit to ensure all tasks are being completed, if there are tasks the patient no longer needs, or if there are additional personal care tasks the patient requires to be performed. The RN Case Manager is to obtain approval for all changes to the Hha Care Plan from the Physician. · That all Hha supervisory visits must be accurately documented and must include the following documentation: o The Hha followed patient's Hha care plan for completion of tasks assigned to the Hha, o The Hha maintained an open communication process with the patient, representative, caregivers, and family,	

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			o The Hha demonstrated competency with assigned tasks, o The Hha complied with agency infection prevention and control policies, o The Hha reported any changes in the patient's condition, o The Hha honored the rights of the patient. · That the RN Case Manager is to observe at least one aspect of the Hha's provision of personal care at each supervisory visit; examples: o observe a shower or provision of a bed bath on one visit, o observe the Hha assisting with dressing at another supervisory visit, o observe the Hha assisting with ambulation, o observe the Hha performing or assisting with grooming tasks, etc. · That all RN Case Managers are to notify the patient's physician weekly of any missed visits, requested change of care plan, etc. The Administrator &/or the Director of Clinical Service will meet daily with the Hha Scheduler to review the schedule and address any shortage of staff. The Administrator is responsible for recruitment and hiring of enough home health aides to ensure patient needs are met. The Agency RN Case Managers have been instructed to notify	

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			patients' physicians of any missed visits on a weekly basis. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Administrator &/or the Director of Clinical Services will meet daily with Hha scheduler to review and address all scheduling concerns and shortages. The Administrator is to address any current or ongoing staffing shortages with the Governing Body. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator is responsible for ensuring ongoing compliance with G750. **6. Date of Compliance: 6/25/21**	
G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the Case Manager failed to ensure the aide care plan was individualized and patient specific for 3 of 4 active	G 0798	**G798** **1. Actions the Agency took to correct the deficient practice for each client cited in the**	06/25/2021

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	records reviewed of patients receiving home health aide services. (Patient #1, 2, 3) Findings include: 1. Review of an undated agency policy titled "HOME HEALTH AIDE CARE PLAN" C-751 stated " ... A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... To provide a means of assigning duties to the Home Health Aide that are clear to the Nurse, Home Health Aide, and to the client/caregiver being served ... To provide documentation that the client's care is individualized to his/ her specific needs .... " 2. The clinical record of patient #1 was reviewed on 5/11/21 and indicated a start of care date 2/24/21. The record contained a plan of care for the initial certification period 2/24/21 to 4/24/21, the order for discipline and treatment indicated, home health aide services (HHA) services 2 hours/day, 3 days/week x 1 week, 2 hours/day x 5 days/week x 8 weeks to assist with activities of daily living (ADLs), bathing on Monday, Wednesday, Friday, and prn (as needed), bathroom clean up, bed care, change linens, conversation, dressing, encourage fluids, fall risk, grooming, hygiene assistance, medication reminders, and skin care. 3. Review of a a agency document titled, "Activities of Daily Living" received from the administrator when queried for the home health aide care plan was received 5/11/21 failed to evidence review dates. The Activities of Daily Living indicated the following: Apply Lotion as needed on Sunday and Saturday and always every Monday thru Friday, Bathing as needed		**deficiency:** **Patient #1:** Patient care plan has been audited with re-education provided to RN Case Manager. Aide care plan will be consistent with medical plan of care approved by physician. No PRN activities will be scheduled on aide care plan. **Patient #2:** Patient care plan has been audited with re-education provided to RN Case Manager. Aide care plan will be consistent with medical plan of care approved by physician. No PRN activities will be scheduled on aide care plan. **Patient #3:** Patient care plan has been audited with re-education provided to RN Case Manager. Aide care plan will be consistent with medical plan of care approved by physician. No PRN activities will be scheduled on aide care plan. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services will audit all current active patients for the presence and accuracy of the Home Health Aide Care Plan. All Home Health Aide Care Plans that fail to evidence	

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	Sunday, Tuesday, Thursday, Saturday and always on Monday Wednesday and Friday, Bathing/Tub, shower or partial as needed Sunday thru Saturday, Bathroom Cleanup as needed Sunday and Saturday and always Monday thru Friday, Bed Care as needed on Sunday and Saturday and always Monday thru Friday, Change Bed Linens as needed Sunday thru Saturday, Conversation as needed Sunday and Saturday and always Monday thru Friday, Dressing as needed Sunday, Tuesday, Thursday and Saturday and always on Monday Wednesday and Friday, Encourage Fluids as needed on Sunday and Saturday and always Monday thru Friday, Fall Risk Risk as needed on Sunday and Saturday and always Monday thru Friday, Grooming as needed on Sunday and Saturday and always Monday thru Friday, Hygiene Assistance as needed on Sunday and Saturday and always Monday thru Friday, Medication Reminders as needed on Sunday and Saturday and always Monday thru Friday, Skin Care as needed on Sunday and Saturday and always Monday thru Friday. The agency home health aide care plan failed to be patient specific, showing use of DME, diagnosis, safety measures, assistive devices, specific dates, specific tasks, and allergies of the patient. Review of all home health aide visit notes, failed to evidence services were being provided on Saturday and Sundays and reason for the prn. 4. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provide. 5. Review of the clinical record for patient #2, contained a plan of care for certification period		patient-specific tasks will be returned to the RN Case Manager to contact the client and individualize the plan with the client's input and resubmit it for review. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The audit of home health aide care plans will be ongoing and a critical component of the audit is that the aide care plan be specific to the patient. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The aide care plan will be monitored through the ongoing audit process. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Service is responsible for the ongoing compliance of G798. **6. Date of Compliance:** **6/25/21**	

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	4/10/21 - 6/8/21, with orders for HHA services 8 hours/day x 5 days/week for weeks 1-7, 8 hours/day x 2 days/week for 1 week to assist with ADLs, ambulation, bathing 2x/week and prn, bathroom cleanup, bed linen changes, conversation, dressing, encourage fluids, grooming, hygiene assistance, incontinence care, medication reminders. Review of an undated document identified by the clinical manager as the aide plan of care, revealed the following activities were marked to always be completed Monday - Friday: Assist with walking, bathroom cleanup, conversation, dressing, encourage fluids, grooming, hygiene assistance, incontinence care, medication reminders. The following items were marked to be completed on Monday, Tuesday, and Thursday: Bathing. The following item was marked to be completed on Tuesday and Thursday: Change Bed Linen. The aide plan of care failed to be supported by the plan of care which failed to be consistent with the medical plan of care. Review of the aide visit note for 5/5/21 revealed services provided were assist with walking, bathroom cleanup, change bed linens, conversation, dressing, encourage fluids, grooming, hygiene assistance, incontinence care, medication reminders. The visit notes failed to evidence all the activities ordered on the medical plan of care. Review of the visit note for 5/6/21 revealed the following services were provided: assist with walking, bathing, bathroom cleanup, change bed linens, conversation, dressing, encourage fluids, grooming, hygiene assistance, incontinence care, medication reminders. The visit notes failed to			

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	evidence all the activities ordered on the medical plan of care. 6. During a home visit on 5/12/21 at 9 AM with patient #3, employee DD was queried concerning how he knew what cares to provide at each visit. Employee DD stated, "I have been here so long I just know what to do." When queried if he had an aide plan of care or aide assignment sheet, employee DD stated, "I'm sure there is one, but I don't need it." Review of the clinical record for patient #3, contained a plan of care for certification period 4/10/21 - 6/8/21, with orders for HHA services 8 hours/day x 5 days/week for weeks 1-7, 8 hours/day x 2 days/week for week 8 to assist with ADLs, showers Monday, Wednesday, Friday, bed bath Tuesday and Thursday, transfers, positioning, incontinence care, Passive Range of Motion and companionship. Review of an undated document , identified by the clinical manager as the aide plan of care, evidenced the following items were marked to always be completed Monday - Friday: assist shaving, bathing, bathroom cleanup, bed care, change bed linens, dressing, grooming, incontinence care, nail care, oral care, peri care, positioning, range of motion exercises, and skin care. The aide plan of care failed to be supported by the plan of care which failed to be consistent with the medical plan of care. The visit notes failed to evidence only the activities ordered on the medical plan of care. Review of the aide visit notes for dates 4/10/21 - 5/11/21, revealed the notes listed all activities			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	above. All activities were marked as performed for each day. The visit notes failed to evidence only the activities ordered on the medical plan of care. During an interview on 5/11/21 at 3:31 PM, when queried about the home health aide care plans not being patient specific, the administrator and clinical manager stated the aides must mark every task daily in order for the aides to clock in/out and close the note with the new EVV (Electronic Visit Verification) system. The administrator stated the EVV system will not let the them adjust it to where the aide can select certain or selected items on particular days. 410 IAC 17-13-2(a)			
G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the home health aides failed to ensure they provide all services as outlined on the patient's plan of care in 4 of 4 active records reviewed of patients receiving home health aide services. (Patients #1, 2, 3, 5) Findings include: 1. A review of undated agency policy "C-660 Care Plans" revealed "Each client will have a care plan	G 0800	**G800** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Home health aide notes are audited on an ongoing basis to ensure all services are being provided as outline in plan of care. Inconsistencies will be addressed during supervisory visits by RN Case Managers.	06/25/2021

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	15K165	A. BUILDING 00 B. WING	05/18/2021

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	on file that addresses their identified needs and the agency's plan to respond to those needs." The policy also stated the purpose of the care plan included providing an "updated, coordinated document that reflects the current home care services. 2. A review of the clinical record for patient #2, included a plan of care for the certification period 4/10/21 - 6/8/21, with orders for home health aide 8 hrs/day x 5 days/week x 7 weeks and 8 hours/day x 2 days per week x 1 week. Review of the home health aide visit notes revealed patient #2 received no home health aide visits on week 1; 8 hours/day x 4 days/week x week 2-3; 8 hours/day x 4 days/week x week 4; 6 hours/day x 1 day/week x week 4; 2 hours/day x 1 day/week x week 4; and 8 hours/day x 5 day/week x week 5. The agency failed to provide home health aide services as ordered on the plan of care. 3. A review of the clinical record for patient #3, included a plan of care for certification period 4/10/21 - 6/8/21, with orders for home health aide services 8 hours/day x 5 days/week for weeks 1-7 and 8 hours/day x 2 days/week during week 8, but failed to include orders for weeks 9 and 10. A review of the home health aide visit notes revealed no aide visits week 1; 1 aide visit week 2; and 5 aide visits weeks 3-5. The agency failed to provide home health aide services as ordered on the plan of care. 4. On 5/17/21 at 4:08 PM, patient #5 was queried concerning what services the home health aides provided during the visits. Patient #5 stated the home health aide "swept, mopped, and dusted."		**Patient #2:** Home health aide notes are audited on an ongoing basis to ensure all services are being provided as outline in plan of care. Inconsistencies will be addressed during supervisory visits by RN Case Managers. **Patient #3:** Home health aide notes are audited on an ongoing basis to ensure all services are being provided as outline in plan of care. Inconsistencies will be addressed during supervisory visits by RN Case Managers. **Patient #5:** Home health aide notes are audited on an ongoing basis to ensure all services are being provided as outline in plan of care. Inconsistencies will be addressed during supervisory visits by RN Case Managers. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services has audited 100% of all current active patients, Medical Plans of Care, and the Home Health Aide Care Plans for congruence. All discrepancies identified are to be corrected by the RN Case Managers and returned to the Director of Clinical Service for review. The RN Case Managers have been instructed to contact	

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	The surveyor asked if the aide provided assistance with bathing, toileting, or dressing. Patient #5 stated, "She [home health aide] cleans and talks with me. I shower in the evening when my husband helps me. Sometimes I have a little trouble getting up off the toilet so I like to have someone here in case I need help, but I'm usually ok since my husband helps with that too." Patient #5 stated she did not know who was coming tomorrow and stated, "But I should be fine. The house is already clean so there is nothing I need." Review of the clinical record for patient #5 contained a plan of care for certification period 5/3/21 - 7/1/21, with orders for home health aide services 8 hours/day x 5 days per week for weeks 1-7; 8 hours/day x 4 days/week for week 8. Review of the home health aide visit notes from 5/3/21 - 5/11/21 revealed the patient received home health aide services 7.75 hours/day x 1 day per week x week 1; 6 hours/day x 1 day/week x week 2; and 8 hours/day x 1 day/week x week 2. The agency failed to provide home health aide services as ordered on the plan of care. On 5/18/21 at 2:30 PM the administrator and clinical manager were queried concerning services provided to patient #5. Both individuals agreed that patient #5's plan of care stated she was to receive home health aide services for hands on personal care that included bathing and dressing, and they were unaware that the patient was not receiving any personal care services as outlined on the plan of care. 5. On 5/18/21 at 2:15 PM the administrator and clinical manager were interviewed and the findings were reviewed. They stated they do not report missed visits to the physician. No further		the patients if changes need to be made to the Hha Care Plan to make sure it addresses the exact services and frequency of services the patient is needing. If changes are made to the Hha care plan, the RN Case Manager will contact the physician to receive updated physician orders for the modifications. The Medical Plan of Care will then be updated with verbal orders received from the physician/designee. The RN Case Manager is to get a copy of the updated Hha Care Plan into the patient's home folder. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Governing Body has approved a QAPI project to address the lack of congruence between the Medical Plan of Care, the Hha Care Plan, and the Hha visit documentation. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Scheduler will review 100% of all paraprofessional documentation for compliance with the care plan. This is to be completed daily and submitted to the Director of Clinical Services for review on a weekly basis. Failure of the Scheduler to perform	

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	information was available at that time. 6. The clinical record of patient #1 contained a of plan of care for initial certification period of 2/24/21 to 4/24/21, the order for discipline and treatment indicated, HHA 2 hours/day x 3 days/week for 1 week, 2 hours/day x 5 days/week for 8 weeks to assist with ADLs, Bathing MWF (Monday, Wednesday, Friday) and prn (as needed), bathroom clean up, bed care, change linens, conversation, dressing, encourage fluids, fall risk, grooming, hygiene assistance, medication reminders, and skin care..." Review of a visit note dated 2/25/21 (Thursday), a partial visit was made clock in 9:55 AM to 11:34 AM. Review of visit noted dated 3/4/21(Thursday), a partial visit was made clock in 9:55 AM to 11:32 AM. On week two of eight, home health aide visits were completed on 3/9/21, 3/10/21, 3/11/21, and 3/12/21, the home health aide failed to make a 5th visit for the week. Review of visit note dated 3/19/21 (Friday), a partial visit was made clock in 9:56 AM to 11:00 AM. On week five of eight, home health aide visits were completed on 3/29/21, 3/31/21, 4/1/21, and 4/2/21, the home health aide failed to make a 5th visit for the week. Further review partial visits were made visit note dated 3/29/21 (Monday) clock in 10:04 to 11:02 AM and visit note dated 4/1/21 (Thursday) clock in 9:56 AM to 11:38 AM. On week six of eight, home health aide visits were completed on 4/5/21, 4/6/21, 4/8/21, 4/9/21, the		the audits of the paraprofessional visit documentation will result in disciplinary action up to and including termination. The Director of Clinical Service/designee will review all paraprofessional chart documentation at all certification timepoints to ensure ongoing compliance. The Audit results will be reported on a weekly basis to the Director of Clinical Services & to the Administrator. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator and the Director of Clinical Service is responsible for ensuring ongoing compliance with G800. **6. Date of Compliance:** **6/25/21**	

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	home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/5/21 (Monday) clock in 9:55 AM to 11:28 AM. On week seven of eight, home health aide visits were completed on 4/12/21, 4/13/21, 4/15/21, 4/16/21, the home health aide failed to make a 5th visit for the week. On week eight of eight home health aide visits were completed on 4/19/21, 4/20/21, 4/22/21, 4/23/21, the home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/20/21 (Tuesday) clock in 10:44 AM to 12:12 PM. The home health aide failed to provide 2 hour visits, 5 days a week as ordered on the plan of care. During an interview on 5/11/21 at 3:31 PM, when queried about missing home health aide visits, the administrator and clinical manager indicated they do not have a set rule for missed visits. The Administrator stated, "We do not notify the physician unless we see trends of missed visits." 410 IAC 17-13-1(a)			
G 0802 Bldg. 00	484.80(g)(3) Duties of a HH aide 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.			

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	Based on record review and interview, the home health aide failed to ensure they provided personal hands on care as ordered on the plan of care in 1 out of 4 active records reviewed. (Patient #5) Finding includes: On 5/17/21 at 4:08 PM, patient #5 was queried concerning what services the home health aides provided during the visits. Patient #5 stated the home health aide "swept, mopped, and dusted." When queried if the aide provided assistance with bathing, toileting, or dressing. Patient #5 stated, "She [home health aide] cleans and talks with me. I shower in the evening when my husband helps me. Sometimes I have a little trouble getting up off the toilet so I like to have someone here in case I need help, but I'm usually ok since my husband helps with that too." Patient #5 stated she did not know who was coming tomorrow and stated, "But I should be fine. The house is already clean so there is nothing I need." Review of the clinical record for patient #5 contained a plan of care for certification period 5/3/21 - 7/1/21, with orders for home health aide services 8 hours/day x 5 days per week for weeks 1-7; 8 hours/day x 4 days/week for week 8. A review of the home health aide visit notes from 5/3/21 - 5/11/21, revealed the patient received home health aide services 7.75 hours/day x 1 day per week x week 1; 6 hours/day x 1 day/week x week 2; and 8 hours/day x 1 day/week x week 2 and indicated the patient received all services as ordered on the plan of care. On 5/18/21 at 2:30 PM, the administrator and	G 0802	**G802** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #5:** All home health aide visit documentation is being audited on an ongoing basis. RN Case Manager is to evaluate the need for hands-on care and make changes to the aide plan of care as needed. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** 100% of all current patients receiving Hha services will receive an audit of their visit notes to ensure the patients are receiving personal hands-on care as ordered on the Medical Plan of Care. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Service /designee will educate all home health aides on their job responsibilities: · The Hha is to arrive on the scheduled day of service at the assigned time and stay the required length of time/MD orders. · The Hha is to review the	06/25/2021

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	clinical manager were queried concerning services provided to patient #5. Both individuals agreed that patient #5's plan of care stated she was to receive home health aide services for hands on personal care that included bathing and dressing, and they were unaware that the patient was not receiving any personal care services as outlined on the plan of care. 410 IAC 17-14-1(h)(3)		Hha care plan and provide all direct hands-on care as assigned. · The Hha is to practice appropriate handwashing and infection control measures. · The Hha is to change gloves at all required timepoints in the provision of personal care. · The Hha treats the client and caregiver with respect and honors patient rights. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** Hha compliance with the provision of hands-on personal care will be evaluated and tracked by the following methods: · Audit of their visit documentation · Hha supervisory visits performed by the RN Case Managers · The QAPI Project addressing Compliance of Paraprofessionals with documentation of care as ordered on the Hha Care Plan. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Service is responsible for ensuring ongoing compliance with G802. **6. Date of Compliance:** **6/25/21**	
G 0818	484.80(h)(4)(i-vi) HH aide supervision elements			

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Bldg. 00	Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review, the Case Manager failed to ensure they accurately documented supervisory visits in regards to inaccurately indicating an aide was following the plan of care for 1 out of 4 active records reviewed. (Patients #1). Findings Include: Review of an undated agency policy titled "HOME HEALTH AIDE SUPERVISION" C-340 indicated, "SPECIAL INSTRUCTIONS 1. The Nursing Supervisor or designated Registered Nurse/Therapist will give the Home Health Aide direction for client care by way of the Care Plan... A copy of this written plan is to be left in the client's home and revised periodically, as necessary..." The clinical record of patient #1 was reviewed and contained a plan of care for certification period	G 0818	**G818** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** RN Case Managers have been re-educated on documentation of aide supervisory visits. Missed visits, partial visits, and activities on the aide care plan that are not being performed routinely will be addressed by RN Case Managers at each supervisory visit. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as**	06/25/2021

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	2/24/21 to 4/24/21, with orders for home health aide services 2 hours/day x 3 days/week x 1 week, 2 hours/day x 5 days/week x 8 weeks, to assist with Activities of Daily Living, bathing Monday, Wednesday, Friday, and prn, bathroom clean up, bed care, change linens, conversation, dressing, encourage fluids, fall risk, grooming, hygiene assistance, medication reminders, and skin care. A review of agency documents titled "Home Health Aide Supervisory Visit" dated 3/13/21, 3/17/21, 3/24/21, 3/31/21, 4/13/21, 4/17/21, and 4/2021, revealed in the section titled,"The Home Health Aide performs the following:...2. Implements & follows the Home Health Aide Care Plan?...4. Arrives on time, stays the required length of time and is reliable?...5. Demonstrates competency & performs assigned tasks per standard care protocol..." The supervisory visits failed to answer the home health aide supervision accurately as evidence by the following: Review of a visit note dated 2/25/21 a partial visit was made clock in 9:55 AM to 11:34 AM. Review of visit noted dated 3/4/21 a partial visit was made clock in 9:55 AM to 11:32 AM. On week two of eight, home health aide visits were completed on 3/9/21, 3/10/21, 3/11/21, and 3/12/21, the home health aide failed to make a 5th visit for the week. Review of visit note dated 3/19/21 a partial visit was made clock in 9:56 AM to 11:00 AM. On week five of eight, home health aide visits were completed on 3/29/21, 3/31/21, 4/1/21, and 4/2/21, the home health aide failed to make a 5th visit for the week. Further review partial visits		**being affected:** The Director of Clinical Services audited 100% of currently active patients to assess compliance with the home health supervisory visit requirements. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services has retrained the RN Case Managers r/t Hha Supervision responsibilities to ensure the following: · The Hha must follow the patient's plan of care/home health aide care plan for completion of tasks assigned by the registered nurse. · The Hha must maintain an open communication process with the patient, representative (if any), caregivers, and family, · The Hha must demonstrate competency with assigned tasks, · The Hha must comply with infection prevention and control policies and procedures, · The Hha must report changes in the patient's condition, · The Hha must honor patient rights. The Director of Clinical Services has re-educated the home health aides on the above listed responsibilities and requirements of their job. **4. How the corrective action will be monitored to ensure the**	

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	were made visit note dated 3/29/21 clock in 10:04 to 11:02 AM and visit note dated 4/1/21 clock in 9:56 AM to 11:38 AM. On week six of eight, home health aide visits were completed on 4/5/21, 4/6/21, 4/8/21, 4/9/21, the home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/5/21 clock in 9:55 AM to 11:28 AM. On week seven of eight, home health aide visits were completed on 4/12/21, 4/13/21, 4/15/21, 4/16/21, the home health aide failed to make a 5th visit for the week. On week eight of eight home health aide visits were completed on 4/19/21, 4/20/21, 4/22/21, 4/23/21, the home health aide failed to make a 5th visit for the week. Further review a partial visit was made on 4/20/21 clock in 10:44 AM to 12:12 PM. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provided at that time.		**deficient practice will not recur:** Prior to the supervisory visit, the RN Case Manager is to review Hha home visit audit logs r/t the assigned staff member comparing the number of visits per week and tasks completed with the orders as written on the Medical Plan of Care. · At the supervisory visit, the RN Case Manager is to review the Hha Care Plan tasks and visit frequency with the patient/caregiver. · If the MD ordered number of visits per week is 5 and the Hha is only making 4 visits, the RN Case Manager discusses this with the patient and Hha to determine the reason and cause of this discrepancy. If the patient states he or she really only wanted 4 visits instead of 5 visits each week; the RN Case Manager is to contact the physician to see if he/she will approve the visit reduction. If the patient states they want 5 visits per week but the aide is only coming 4 x a week; the MD must be notified of the missed visit and the agency will work to ensure there is a caregiver available for the specified number of visits. · The Scheduler will review 100% of all paraprofessional documentation for compliance with the Hha Care Plan. This is to be completed daily and submitted to	

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			the Director of Clinical Services for review on a weekly basis. o Failure of the Scheduler to perform the audits of the paraprofessional visit documentation will result in disciplinary action up to and including termination. · The Director of Clinical Service/designee will review all paraprofessional chart documentation at all certification timepoints to ensure ongoing compliance with the Hha care plan. · The Audit results will be reported on a weekly basis to the Director of Clinical Services & the Administrator. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator and the Director of Clinical Services is responsible for ensuring ongoing compliance with G818. **6. Date of Compliance: 6/25/21**	
G 0942 Bldg. 00	484.105(a) Governing body Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	ased on record review and interview, the Governing Body failed ensure that it contained an acceptable outline of the agency's organizational and failed to ensure policy and procedures to manage patient and staff during the Coronavirus pandemic. Findings Include: Review of an undated agency policy titled "GOVERNING BODY" B-100 stated " ... The Governing Body (or designated persons so functioning) shall assume full legal authority and responsibility for the overall management and operation of Agency...New governing body members are oriented to the agency as appropriate to responsibilities. PURPOSE To provide direction and supervision of the agency's operation and services. To ensure lines of authority are established . To ensure clients are provided with appropriate, quality of services ..." Review of the Organizational chart that was provided by the Administrator on 5/17/21, revealed having the CNAs (Certified Nursing Assistants) report to Employee X, a CNA/Scheduler. During an interview on 5/17/21 at 3:52 PM when queried about who the CNAs report to the Administrator stated, "CNAs should report to the case managers and the Clinical Manager." The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provide that time.	G 0942	**G942** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** The agency Governing Body and Administrator have met and approved and updated Organizational Chart. The Home Health Aides report to the RN Case Managers and Director of Clinical Services. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Governing Body Meeting has established agenda items. One of the items includes the Agency Organization Chart. This is to ensure the Governing Body addresses staff changes and position changes in their routine meetings to ensure there is not any breakdown or gap in agency organizational processes. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** This process will be monitored on a quarterly basis during the routinely scheduled Governing Body Meetings. **5. Agency staff responsible for ensuring ongoing compliance:** The Agency Administrator and Governing Body is responsible for ensuring ongoing compliance with G942.	06/25/2021

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	15K165	A. BUILDING 00 B. WING	05/18/2021

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	410 IAC 17-12-1(b)		**6. Date of Compliance: 6/25/21**	
G 0948 Bldg. 00	484.105(b)(1)(ii) Responsible for all day-to-day operations (ii) Be responsible for all day-to-day operations of the HHA; Based on record review, the Administrator failed to ensure they were responsible for the day to day operation of the home health agency in regards to incomplete documentation on comprehensive assessments and medication profiles, lack of individualization of care plans, coordination of care, and services being provided to meet the patient's needs, incomplete documentation, an effective Quality Assessment Performance Improvement Program (QAPI), an effective Infection Control Program, and clinical records are complete and contain accurate information, legible signatures, and dates and times. Findings Include: 1. In regards to incomplete comprehensive assessment and medication reconciliation by Registered Nurses The administrator failed to ensure the comprehensive assessments were completely filled out, accurately reflected the patient's current health status and past medical history, failed to ensure assessments included patient's strengths, goals, and care preferences, failed to ensure assessments included the patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with the patient, health care representative, outside agencies and ordering physicians to ensure drug interactions	G 0948	**G948** **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Administrator has reviewed the regulations and been made aware of and accepts his responsibilities. The Administrator has access to a consultant for guidance and advice. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Agency has implemented multiple audit activities and QAPI projects to assist the Administrator in measuring compliance with the CoPs. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** Progress and compliance will be measured by the outcomes of the QAPI Projects and audits that will be reported to the QAPI committee and Governing Body	06/25/2021

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	and duplication is identified, failed to ensure assessments identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, and failed to ensure the assessment included information concerning a patient selected representative. 2. In regards to lack of individualized care planning, coordination of services, and quality of care The administrator failed to ensure that each patient received an individualized plan of care; provide services as ordered on the plan of care; failed to ensure the plan of care contained all the required elements; failed to ensure verbal orders were complete; failed to ensure physicians were notified; failed to ensure there was documentation of coordination of care. 3. In regards to an effective QAPI Program The Administrator failed to ensure performance improvement projects were analyzed and their causes and implemented appropriate actions and tracked the performance to ensure improvements are achieved. 4. In regards to an effective Infection Control Program The Administrator failed to ensure all staff wear masks while in patients home and failed to ensure the agency developed and maintained an agency wide infection control program and failed to ensure agency staff were instructed to follow CDC guidelines in regards to having signs posted, visitor and staff screening, masks and social distancing.		and which include the following: · Home Health Comprehensive Assessment Audits, · Audit of Collaboration of Care with Other Providers, · Compliance with Paraprofessionals with documentation QAPI Indicator, · Home Health Aide Daily Scheduling results, · Daily Update Reports by the RN Case Managers, · Coordination/Collaboration of care within the Agency and with other Providers, · QAPI Indicator: Medical Plan of Care. **5. Agency staff responsible for ensuring ongoing compliance:** Agency Administrator and the Governing Body President is responsible for ensuring ongoing compliance with G948. **6. Date of Compliance: 6/25/21**	

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	During an interview on 5/11/21at 4:20 PM, when queried regarding COVID-19 precautions the Administrator stated, "Our owner made the choice since we are in Putnam county and they lifted the mask mandate that we do not have to wear mask in the office only feild staff do when caring for patients." 5. In regards to Home Health Aide Services The Administrator failed to ensure the aide care plan was individualized to the patients, services are provided as ordered on the plan of care; ensure hands on personal care was provided; and ensure case managers accurately documented supervisory visits. 6. In regards to Clinical Records The administrator failed to ensure a discharge summary was written and sent to the primary care physician who is responsible for the patient's care after discharge within 5 business days of the patient's discharge and within 2 days of a patient's transferred to another facility and failed to ensure all entries were clear, complete, authenticated, dated and timed.			
G 0962 Bldg. 00	484.105(c)(2) Coordinate patient care Coordinating patient care, Based on record review and interview, the Clinical Manager failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care to meet the patient's needs for 4 of 4 active records reviewed. (Patient #1, 2, 3, 5)	G 0962	**G962** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** RN Case Manager has inquired with patient about any further services are being	06/25/2021

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	Findings include: 1. Review of an undated agency policy titled "COORDINATION OF CLIENT SERVICES" C-360 stated, " ... The agency will integrate services ... to assure the identification of client needs and factors that could affect client safety and the effectiveness of treatment ... Coordination of care will include dealing with multiple programs for the complex clients..." 2. During the entrance conference on 5/10/21 at 8:35 AM, when queried about shared patients and contracts the Administrator and Clinical Director indicated they did not have any contracts or shared patients on service. 3. Review of the patient #1's clinical record revealed an agency document titled "Visiting Angels Home Health Agency Collaboration/ Coordination of Care Agreement Between Service Providers" with Entity D, waiver provider, in regards to patient #1 services, revealed the patient was receiving services from an outside provider. Review of the initial comprehensive assessment dated 2/24/21, failed to evidence that the patient was receiving waiver services from another agency. Review of the plan of care for the certification period of 2/24/22 to 4/24/21, failed to evidence that the patient #1 was receiving waiver services from another agency. Review of a Coordination of Care with other providers note dated 2/25/21, failed to evidence the details of collaboration of care patient #1 was receiving from Entity D for waiver services.		provided by other agencies. Any findings of agencies providing care that has not yet been noted or documented is followed up by coordination of care with that entity that is then placed in coordination of care tab in patient's chart. **Patient #2:** RN Case Manager has inquired with patient about any further services are being provided by other agencies. Any findings of agencies providing care that has not yet been noted or documented is followed up by coordination of care with that entity that is then placed in coordination of care tab in patient's chart. **Patient #3:** RN Case Manager has inquired with patient about any further services are being provided by other agencies. Any findings of agencies providing care that has not yet been noted or documented is followed up by coordination of care with that entity that is then placed in coordination of care tab in patient's chart. **Patient #5:** RN Case Manager has inquired with patient about any further services are being provided by other agencies. Any findings of agencies providing care that has not yet been noted or documented is followed up by coordination of care with that entity that is then placed in coordination of care tab in	

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	Review of the a recertification comprehensive assessment dated 4/20/21, failed to evidence that the patient was receiving waiver services from another agency. Review of a coordination of care with other providers note dated 4/20/21, failed to evidence details of collaboration of care patient #1 was receiving from Entity D for waiver services. Review of the plan of care for the certification period of 4/25/22 to 6/23/21, failed to evidence that the patient #1 was receiving waiver services from another agency. 4. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provided at that time. 5. During a home visit on 5/11/21 at 12:30 PM, patient #2 stated she received waiver services, but did not know the name of the provider. Review of the comprehensive assessment and plan of care for patient #2, certification period 4/10/21 - 6/8/21, failed to evidence the patient also received waiver services provided by another agency. 6. During a home visit on 5/12 21 at 9 AM, employee DD stated he provided waReiver services for patient #3 for 1 hour/week. Review of the comprehensive assessment and plan of care for patient #3, certification period 4/10/21 - 6/8/21, failed to evidence the patient also received waiver services provided by another agency.		patient's chart. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services immediately audited all clinical records to determine if there were additional agency patients who are receiving services from multiple providers. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** Agency RN Case Managers have been retrained on coordination of care with other providers including the following: · RN Case Managers are instructed to ask patients at all home visits if they are receiving services from another provider, · RN Case Managers were retrained on the form "Coordination of Care with other Providers". The clinician is instructed to contact all providers who are involved in each patient's overall care, · The goal is to collaborate with the other providers to learn and share patient information so there is no overlap of service times, · At a minimum, the RN	

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	7. Review of the comprehensive assessment and plan of care for patient #5, certification period 5/3/21 - 7/1/21, failed to evidenced the patient also received waiver services provided by another agency. During a phone interview on 5/17/21 at 4:15 PM, patient #5 stated she received waiver services from another agency, but was unsure of the agency name.		Case Manager is to try to obtain the following information: o The name and phone number of the provider, o Contact person, o The services the entity provides, o The frequency, duration, and timing of visits, o Diagnoses the provider is treating and what the treatment consists of, o Goals of the service and the patient's progress toward goal achievement, o Any medications the other service provider is administering, o Who is providing the medical oversight for the service being provided, · The frequency of contact with the other provider depends upon the acuity of the patient, the severity of their condition, and the services the entity is providing the client. At a minimum there should be documentation of collaboration with the other provider at least once every 60 days if the patient's condition is stable. If the patient's condition becomes more acute, there is to be more frequent contact and communication. The Director of Clinical Services has instructed the home health aides to notify their RN Case Managers whenever they are made aware of another provider's involvement in the case.	

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			4. How the corrective action will be monitored to ensure the deficient practice will not recur: The Agency will implement an audit tool entitled Collaboration of Care with Other Providers. The clinical records will be audited once every 60 days to ensure there is documentation of communication and collaboration with any other provider involved in the patient's care. Additional documentation may be present based on the acuity of the patient's condition. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services is responsible for ensuring ongoing compliance with G962. **6. Date of Compliance:** **6/25/21**	
G 0966 Bldg. 00	484.105(c)(4) Assure patient needs are continually assessed Assuring that patient needs are continually assessed, and Based on record review and interview, the Clinical Manager failed to ensure patient needs are continuously assessed for 4 of 4 active records (Patient #1, 2, 3, 5). Findings include: Review of an agency undated policy titled "CLINICAL MANAGER" B-105 states, "POLICY	G 0966	**G966** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Patient's latest assessment has been audited for completeness and accuracy. Any findings of incomplete or	06/25/2021

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	Agency will appoint one or more qualified individuals for the position of clinical manager. This position provided clinical oversight over all client care services and staff...SPECIAL INSTRUCTIONS...4. The oversight provided by the clinical manager(s) includes:...b.Coordinating client care. c.Coordinating referrals. d. Assuring the client needs are continually assessed. e. Assuring the development, implementation, and updates to the individualized plans of care..." The Director of Clinical Services failed to ensure the comprehensive assessment of Patients #1, 2, 3, and 5 were completely filled out, accurately reflected each patient's current health status and past medical history, failed to ensure each assessment included each patient's strengths, goals, and care preferences, failed to ensure each assessment included each patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with each patient/ health care representative, outside agencies and ordering physicians to ensure drug interactions and duplication is identified, failed to ensure each assessment identified each patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, and failed to ensure each assessment included information concerning each patient's selected representative. During an interview on 5/12/21 at 3:58 PM, when queried about review of each patient's comprehensive assessments and plan of care information, the Clinical Manager and Administrator stated they needed to be more detailed with dates and times and documentation on audit tools when reviewing comprehensive assessments.		inaccurate elements of the assessment will be returned to RN Case Manager for revision and correction. **Patient #2:** Patient's latest assessment has been audited for completeness and accuracy. Any findings of incomplete or inaccurate elements of the assessment will be returned to RN Case Manager for revision and correction. **Patient #3:** Patient's latest assessment has been audited for completeness and accuracy. Any findings of incomplete or inaccurate elements of the assessment will be returned to RN Case Manager for revision and correction. **Patient #5:** Patient's latest assessment has been audited for completeness and accuracy. Any findings of incomplete or inaccurate elements of the assessment will be returned to RN Case Manager for revision and correction. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services/designee has audited all active clinical records to assess the following:	

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	The findings were reviewed with the Administrator, Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provided at that time.		· The assessment form was filled out in its entirety, · The assessment reflected the following: o each patient's current health status and past medical history, o each assessment includes the patient's strengths, goals, and care preferences, o each assessment includes the patient's medical, nursing, rehabilitative, social, and discharge planning needs, o each assessment includes medications that are correctly reconciled with each patient/health care representative, outside agencies, & ordering physicians to ensure any potential drug interaction & duplication are identified, o each assessment is to identify the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, o each assessment is to include information concerning each patient's selected representative. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services/designee will continue to audit all comprehensive assessments to ensure ongoing compliance utilizing the Home Health Comprehensive	

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			Assessment Audit Tool. All identified gaps or errors in documentation of the comprehensive assessment will be returned to the RN Case Manager for correction. The Director of Clinical Services will re-audit the identified problem areas once they are resubmitted. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Service/designee will maintain a log of all completed or in-process audits. The Director of Clinical Services will provide progress reports to the Administrator and the QAPI committee on a monthly basis. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services and the Administrator are responsible for ensuring ongoing compliance with G966. **6. Date of Compliance:** **6/25/21**	
G 0968 Bldg. 00	484.105(c)(5) Assure implementation of plan of care Assuring the development, implementation, and updates of the individualized plan of care. Based on record review and interview, the Clinical Manager failed to ensure the Registered Nurses accurately developed and updated an individualized plan of care and failed to ensure services were provided as ordered on the plan of	G 0968	**G968** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** Re-education provided	06/25/2021

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	care for 4 of 4 active records reviewed (Patients #1, 2, 3, 5). Findings include: 1. Review of an agency undated policy titled "CLINICAL MANAGER" B-105 states, "POLICY Agency will appoint one or more qualified individuals for the position of clinical manager. This position provided clinical oversight over all client care services and staff...SPECIAL INSTRUCTIONS...4. The oversight provided by the clinical manager(s) includes:...b.Coordinating client care. c.Coordinating referrals. d. Assuring the client needs are continually assessed. e. Assuring the development, implementation, and updates to the individualized plans of care..." 2. Review of an agency undated document titled "RECERTIFICATION CHECKLIST" was provided by the Administrator and Clinical Director as the audit tool checklist for the Registered Nurses to complete on recertification assessments of the clients for compliance. The document indicates a checklist for the "RN Case Manager to place a check mark N/A in the column beside all items completed at time or recertification. RN auditor to place check in the column beside all items completed correctly &/or Indicate corrections required." 3. The Clinical Manager failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized care plan that identified patient specific and measurable outcomes and goals that was periodically reviewed and signed by a physician. (See G572) During an interview on 5/11/21 at 3:31 PM, when		to RN Case Manager regarding individualization of care plan. All elements of the patient's plan of care have been audited with any missing or inaccurate element sent back to RN Case Manager for revision. **Patient #2:** Re-education provided to RN Case Manager regarding individualization of care plan. All elements of the patient's plan of care have been audited with any missing or inaccurate element sent back to RN Case Manager for revision. **Patient #3:** Re-education provided to RN Case Manager regarding individualization of care plan. All elements of the patient's plan of care have been audited with any missing or inaccurate element sent back to RN Case Manager for revision. **Patient #5:** Re-education provided to RN Case Manager regarding individualization of care plan. All elements of the patient's plan of care have been audited with any missing or inaccurate element sent back to RN Case Manager for revision. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services	

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	queried about missing home health aide visits, the administrator and clinical manager indicated they do not have a set rule for missed visits. The Administrator stated, "We do not notify the physician unless we see trends of missed visits." On 5/12/21 at 3:30 PM, the administrator and clinical manager were interviewed concerning the contents of the plan of care. Both stated they had worked very hard to educate and make changes since the previous survey but recognized much of the work went into the audits, and they needed continued education and support to put corrections in place. 4. The Clinical Manager failed to ensure the individualized plan of care included all pertinent diagnoses, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures to protect against injury, patient specific interventions, measurable outcomes and goals identified by the home health agency and patient. (See G574) During an interview on 5/11/21 at 3:31 PM, with Administrator and Clinical Manager, regarding the plan of cares content including; diagnosis, orders, frequency, duration, comprehensive assessment and plan of care not matching, care preferences, psychosocial, mental, durable medical equipment, functional limitations, discharge plans, rehab potential, safety, and seizure plans they stated, they needed to be more detailed. 5. The Clinical Manager failed to ensure verbal orders were complete and contained included duties/ services that the home health aides were to provide and the specific frequency, duration and services provided by the nurses. (See G584)		has audited all active patient Medical Plans of Care to ensure its accuracy and that it is updated as needed based on the patient's condition. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services has re-instructed all RN Case Managers on the requirements of the Medical Plan of Care to include the following: · All pertinent diagnoses and their onset date, · The patient's mental, psychosocial, and cognitive status, · The types of services, supplies, and equipment required, · The frequency and duration visits to be made, · Prognosis, · Rehabilitation potential, · Functional limitations, · Activities permitted, · Nutritional requirements, · All medications and treatments, · Safety measures to protect against injury, · 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, · Patient and caregiver education and training to facilitate	

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	15K165	A. BUILDING 00 B. WING	05/18/2021

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	During an interview on 5/17/21 at 3:52 PM, when queried about verbal orders missing details or duration and specific services, the Administrator indicated, that they need to work on documenting details. 6. The Clinical Manager failed to ensure prompt notification of a change in condition to the patient's physician (See G590). During an interview on 5/13/21 at 3:30 PM, the administrator and the clinical manager were queried concerning patient #2's elevated temperature. The clinical manager stated she was not aware the patient had an elevated temperature and she had not been notified by employee I. The administrator verbalized the same. When queried concerning patient #3's hospitalization, the administrator and clinical manager both stated they were not notified concerning the hospitalization of patient #3, and are not usually notified by family until after patients are admitted. When queried concerning the agency process for change in condition, the clinical manager stated that aide was expected to notify the case manager or clinical at the first sign of a condition change, which was defined as anything different about the patient. 7. The Clinical Manager failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs. (See G608) During the entrance conference on 5/10/21 at 8:35 AM, when queried about shared patients and contracts, the Administrator and Clinical Director indicated they did not have any contracts or		timely discharge, · Patient-specific interventions and education, · Measurable outcomes and goals identified by the HHA and the patient, · Information related to any advanced directives, · PCP orders to accept orders from all relevant physicians seeing the patient, · Physician approved vital sign parameters, · Any additional items the HHA or physician may choose to include. The QAPI Committee has met and determined this area of concern requires an ongoing QAPI Project. The committee created the QAPI Project titled “Medical Plan of Care for Patients” and was approved by the agency Governing Body. · The project addresses the retraining of all RN Case Managers to ensure all patients have Medical Plans of Care based on their patient-specific comprehensive assessment, physician orders, and patient needs. The Medical Plan of Care is to include all the required elements as listed at G574. · The Agency Director of Clinical Services/designee will retrain all RN Case Managers on the required elements of the Medical Plan of Care.	

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	shared patients on service. 8. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provideat that time.		· RN Case Managers will be provided a written educational tool to assist them in completion of a patient specific Medical Plan of Care accurately and thoroughly. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** · The QAPI project includes an Audit tool to evaluate ongoing compliance with G574. The Director of Clinical Services/designee will audit 100% of all Medical Plans of Care at SOC and Recertification timepoints for compliance with G574 and G968. · The Director of Clinical Services will report the audit findings monthly to the QAPI committee for their review. The Administrator will report the audit findings to the Governing Body. **5. Agency staff responsible for ensuring ongoing compliance:** · The Director of Clinical Services is responsible for ensuring ongoing compliance with G968. **6. Date of Compliance: 6/25/21**	
G 1022 Bldg. 00	484.110(a)(6)(i-iii) Discharge and transfer summaries (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be			

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	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. Based on record review and interview, the agency failed to ensure a discharge summary was written and sent to the primary care physician who is responsible for the patient's care after discharge within 5 business days of the patient's discharge and within 2 days of a patient's transferred to another facility for 2 of 2 discharged records reviewed. (Patients #4 and #6) Findings Include: 1. Review of an undated agency policy titled "Discharge Summary" C-820, indicated, "POLICY A Discharge Summary will be completed for client's discharged from Agency. PURPOSE To record a summary of care received by the client from the start of care through discharge. To document client status at the time of discharge, identified unmet needs, and referrals initiated. To document instructions given to the client/family regarding medications, treatment, referrals, and necessary follow up. SPECIAL INSTRUCTIONS 1. When a client is discharged from the agency, the supervising professional shall complete a	G 1022	**G1022** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #4:** Re-education provided to RN Case Manager that physician must be notified within 5 days of discharge of services along with completion of discharge summary, goals, medication list at time of discharge, post discharge instructions, and notification of discharge to other agencies providing services for patient. **Patient #6:** Re-education provided to RN Case Manager that physician must be notified within 5 days of discharge of services along with completion of discharge summary, goals, medication list at time of discharge, post discharge instructions, and notification of discharge to other agencies providing services for patient.	06/25/2021

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	Discharge Summary form and sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the client after agency discharge. 2. The Discharge Summary will incorporate findings from the discharge OASIS assessment and shall include, but not be limited, to: a. Admission and discharge dates b. reason for admission to home health c. Type of services provided and frequency of services ...e. Medications the client is one at the time of discharge f. Client discharge condition ...j. Transfer information, as applicable ...4. If the client is being transferred to another agency or facility, a Transfer Summary form shall also be completed and sent within 2 business days of transfer ..." 2. Review of an undated agency policy titled "CLIENT DISCHARGE PROCESS" C-500, indicated, "POLICY Discharge Planning is initiated for every home care client at the time of the client's admission for home care..PURPOSE To facilitate the client's discharge or transfer to another entity when circumstances exist that this is the best solution for the client. To ensure continuity of care, treatment and services when needed ...SPECIAL INSTRUCTIONS Discharge Procedure: 1. Planning for discharge is provided as part of the ongoing assessment of needs in accordance with expected care outcomes. The client/family and/or client representative will participate in this process beginning with the initial assessment visit ...e. A completed discharge summary will be sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the client after discharge within 5 business days of the client's discharge; or f. A transfer summary is sent within two business days of a planned transfer, if the client's care will be		**2. Actions the Agency to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Services/designee audited all patients' clinical records that were discharged in the last quarter. A Transfer or Discharge Summary was completed and sent to the appropriate person/entity for any patients identified as being transferred or discharged in the last quarter that failed to evidence either a Transfer Summary or Discharge Summary. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Director of Clinical Services re-educated all RN Case Managers on the requirement to complete and send to the patient/caregiver or appropriate provider a Discharge and/or Transfer Summary based on whether the patient was discharged or transferred. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will remind RN Case Managers of their	

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	continued in a health care facility; or g. A completed transfer summary is sent within two business days of becoming aware of an unplanned transfer ..." 3. The clinical record for patient #4 was reviewed on 5/11/21 and contained a discharge OASIS assessment dated 4/6/21 and a signed physician order to discharge services patient has picked up waiver services dated 4/6/21. The clinical record further contained a case note dated 3/29/21 indicating patient given 15 day notice due to Entity D coming in for wound care and patient had picked up more waiver ours with Entity E. The clinical record failed to evidence a discharge summary that summarized the patient's care while on service with the agency, goals achieved or not achieved, current medication list patient is on at time of discharge, and patient and family post discharge instructions to the physician, Entity D and Entity E for continuity of patient care. 4. The clinical record for patient #6 was reviewed on 5/11/21 and contained a discharge OASIS (Outcome and Assessment Information Set) assessment dated 4/19/2021 and an unsigned physician order to discharge services as of 4/19/21. The clinical record failed to evidence a discharge summary that summarized the patient's care while on service with the agency, goals achieved or not achieved, and if the patient was discharged to the community or if the patient was going to receive services with another agency, current medication list patient was on at time of discharge, and patient and family post discharge instructions. 5. During an interview on 3/12/21 at 3:53 PM, when quarried about the location of summaries being sent to where a patient was being		responsibility to complete, submit for review, and send the appropriate Transfer or Discharge Summary. **5. Agency staff responsible for ensuring ongoing compliance:** The Director of Clinical Services is responsible for ensuring ongoing compliance with G1022. **6. Date of Compliance: 6/25/21**	

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	transferred or discharged the Clinical Manager identified order and summary sent to physician only. 6. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25 PM, they had no further information or documentation to provide at that time. 410 IAC 17-15-1(a)(6)			
G 1024 Bldg. 00	484.110(b) Authentication Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure all entries were clear, complete, authenticated, dated and timed for 1 of 4 (Patients #1) active records reviewed and 1 of 2 (Patient #4) closed records reviewed. Findings Include: 1. The clinical record of patient #1 was reviewed and contained a home health aide supervisory visit dated 2/24/21 and 4/20/21 failed to evidence a time in and out. Review the Coordination of Care with other Providers document failed to evidence times of	G 1024	**G1024** **1. Actions the Agency took to correct the deficient practice for each client cited in the deficiency:** **Patient #1:** RN Case Manager has been educated that there must be complete documentation that is authenticated, dated, and timed as appropriate. Blanks are not to be left in regards to supervisory visit times in and out, coordination of care communication times, verbal order receipt times, physician notification times, and home	06/25/2021

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	communication on dates 2/25/21 and 4/20/21. 2. The clinical record of patient of patient #4 was reviewed and contained a Recertification physician order dated 12/4/20, failed to evidence the time the verbal order was received. Review of a physician order signed 3/15/21, failed to evidence time the order was received. Review of an agency documents titled, "Case Notes" dated: 3/29/21 by the administrator, 3/29/21, 3/22/21, by Employee I, the RN case manager, failed to evidence a time when communication occurred. Review of an agency documents titled "Clinical Addendum Note", coordination of care, signed and dated by Employee I, RN case manger dated 3/15/21 and 3/25/21 failed to evidence a time physician was notified. Review of (HHA) Home health aide visit logs dated 12/2/20, 12/3/20, 12/420, 12/15/20, 12/16/20, and 12/17/20 failed to evidence time in and time out. Review of Home Health Aide Supervisory visits dated 12/4/20, 1/4/21, and 2/4/21 failed to evidence time in and time out. 3. During an interview on 5/13/21 at 3:30 PM when quarried about times and dates of conferences, and care coordination, notes in the chart without times and details, the Administrator stated, " We need more details, I get it." 4. The findings were reviewed with the Administrator,Clinical Manager, and the Alternate Clinical Manager on 5/18/21 from 2:10 PM to 3:25		health aide visit times. **Patient #4:** RN Case Manager has been educated that there must be complete documentation that is authenticated, dated, and timed as appropriate. Blanks are not to be left in regards to supervisory visit times in and out, coordination of care communication times, verbal order receipt times, physician notification times, and home health aide visit times. **2. Actions the Agency took to review all clients in the agency that could be affected by the same deficient practice and the actions the agency took to correct the deficiency for any client the agency identified as being affected:** The Director of Clinical Service/designee re-educated the RN Case Managers to ensure that documents and orders are properly authenticated. Emphasis has been placed on clear, complete, and legible documentation that is signed, dated, and timed; specifically in regards to physician verbal orders, patients consents, and assessment documentation. **3. Agency steps or systemic changes the agency has made to ensure that the deficient practice does not recur:** The Administrator has instructed all agency staff that it is a requirement to signature, time,	

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	PM, they had no further information or documentation to provideat that time. 410 IAC 17-15-1(a)(7)		and date all clinical record documentation. **4. How the corrective action will be monitored to ensure the deficient practice will not recur:** The Director of Clinical Services/designee will audit for documentation of signatures, time, and date on all clinical record documentation. **5. Agency staff responsible for ensuring ongoing compliance:** The Administrator and the Director of Clinical Services is responsible for ensuring ongoing compliance with G1024. **6. Date of Compliance:** **6/25/21**	
N 0000 Bldg. 00	This visit was for a follow-up to a State Relicensure survey of a Medicaid Home Health Agency that was conducted on 11/7/2020. Survey Dates: 5/10/2021 thru 5/18/2021 Facility #: 014225 CCN: 15K165 Medicaid#: 300012386 During this survey, the 4 state required deficiencies were corrected.	N 0000		

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N 9999 Bldg. 00	Quality Review Completed on 06/15/2021 by Area 3 N/A: Deficiency was corrected.	N 9999	N/A	06/25/2021