STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K023	A. BUILDING 00 B. WING	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELP AT HOME SKILLED CARE	6855 SHORE TERRACE SUITE 240 INDIANAPOLIS, IN 46254

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G 0000 Bldg. 00	This visit was for a Federal Recertification and State Re-Licensure Survey of a Medicaid Home Health provider in conjunction with 4 complaints. Complaint #: IN 00315933 Unsubstantiated. Complaint #: IN 00307150 Substantiated - Deficiencies were cited. Complaint #: IN 00306992 Unsubstantiated. Complaint #: IN 00285475 Unsubstantiated. Survey Date: 06/29/21, 06/30/21, 07/01/21, 07/02/21, 07/06/21, 07/07/21, and 07/08/21 Facility #: 004966 Provider #: 15K1023 Medicaid #: 200465840 These deficiencies reflects Sate Findings cited in accordance with 410 IAC 17. Quality Review Completed 07/20/2021 by Area 3	G 0000		
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review and	G 0528	1. The comprehensive assessment was revised on	08/10/2021

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

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	interview the agency failed to evidence the comprehensive assessments provided were complete and accurately reflected the patient's status, and all the patient's current health, psychosocial and cognitive status in 5 of 13 active records reviewed. (Patient #2, 5, 6, 7, 8) Findings Include: 1. Review of an undated agency policy titled "Initial Assessments/Comprehensive Assessments" Policy #9.5.1 indicated, "Policy Each patient admitted by the Agency will have appropriate initial assessments performed and documented ...Procedure 1. Each patient admitted will receive a comprehensive assessment. The assessment will reflect the patient's current health status and include information to demonstrate the patient's progress toward achievement of desired outcomes ..." 2. Review of an undated agency policy titled "Reassessments/Update of the Comprehensive Assessment" Policy #9.6.1 indicated, "Policy Each patient will have appropriate reassessments performed and documented ...Procedure 1. The comprehensive assessment ...must be updated and revised as frequently as the patient's condition warrants ...Recertification: the last 5 days of every 60 days ...3. Staff will additionally reassess each patient on an ongoing basis to evaluate current problems and needs as well as to adjust the care provided. Such reassessments will be documented ..." 3. During a home visit at patient #2's home on 7/2/21 at 11:15 AM, when Employee I, RN case manager queried about pain the patient stated, "My neck gets really sore. My back pain has improved with meds." Patient #2 then showed soft		7/26/2021 to include individualized client assessment criteria which includes complete health, psychosocial, functional and cognition status. All RN Case Managers will be educated on 8/3/2021 via virtual team meeting regarding comprehensive assessment, health, psychosocial, functional and cognition status, client goals, strengths, and care preferences. Administrator improved audit process of all comprehensive assessments to include review by Territory Clinical Manager and Area Clinical Manager with timely 1:1 feedback provided to the RN Case Manager after review. Administrator/designee to provide 1:1 coaching and teaching to RN Case Manager if continued deficiencies are noted. RN Case Managers to complete comprehensive assessment on all clients identified in SOD by 8/10/2021. Client's physician to be notified of any changes needed to plan of care and an order will be obtained. 2. Administrator/designee will ensure compliance by tracking comprehensive assessment completion with each recertification and admission on Medical Record Review form. Training on comprehensive assessment completion will be incorporated into agency orientation.	

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	collar cushion for neck and demonstrated how she moves she lounge in a better positioned back if pain starts. The caregiver of patient #2 stated, "Her pain would be a 10 if not for those pain pills." Caregiver further indicated patient had chest pain and had to take nitroglycerin twice for chest pain and patient's blood pressure has been high. Patient #2 stated, "The chest pain wasn't like I use to have it and have to take 3 pills before when I had it." When the RN case manager queried about her last bowel movement, the RN case manager stated the doctor has recently added prunes to her diet due to constipation. Review of the recertification comprehensive assessment dated 05/03/21 indicated "No changes since last assessment" under psychosocial, cardiac status, and fall risk assessment. The comprehensive assessment failed to evidence the patient's current health status of cardiac issues evidenced by multiple medication changes as follow: on 04/28/21 discontinue Hydralazine 25mg by mouth daily in AM, discontinue Hydralazine 50mg by mouth at noon & evening, start HCTZ(Hydrochlorothiazide) 25mg by mouth at noon, on 04/08/21 Discontinue HCTZ 25mg tablet by mouth daily, discontinue Hydralazine 50 mg by mouth three times daily, start Hydralazine 25mg by mouth daily in AM, stat Hydralazine 50mg by mouth twice daily at noon & evening, Start HCTZ 12.5 by mouth daily, on 04/06/21 Hydralazine 50mg by mouth three times daily on 04/06/21, on 04/01/21 discontinue Amlodipine 2.5 mg daily at bedtime, on 03/30/21 Discontinued Hydralazine 25mg by mouth in AM Start Hydralazine three times daily. The comprehensive assessment failed to evidence the patient's current health status. 4. During a home visit with patient #6 on 07/01/21 at 3:00 PM patient stated, "I would like to ride my		Administrator/designee will track RN Case Manager comprehensive assessment completion, with threshold of 80% compliance for 4 weeks. Administrator/designee to audit 80% of comprehensive assessments for 4 weeks. Once threshold of 80% is met, will decrease to 50% audits by Administrator/designee. RN Case Managers to continue completing comprehensive assessments with each recertification/admission to ensure compliance. 3. If thresholds are not met, the agency will continue 80% audits of all comprehensive assessments and provide 1:1 coaching to RN Case Managers until threshold is met. 4. The deficiency will be completed by 8/10/2021.	

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	stationary bike. I also want to get my meds straightened out they keep sending me so much. I also have to cut down on my fruit. I gained weight and the doctor said there is a lot of sugar in fruit." Patient #6 indicated she had issues getting her breathing masks for her nighttime machine. When queried about falls patient indicated she had a fall. Review of the recertification comprehensive assessment dated 05/03/21 indicated, "No changes since last assessment" under psychosocial, neuro status, musculoskeletal status. The comprehensive assessment failed to evidence the patient's current health status with musculoskeletal status received a new walker and had a fall. Patient #6 has Cerebral palsy and Epilepsy as diagnoses neuro status not addressed. The comprehensive assessment failed to evidence the patient's current health status. 5. During a home visit on 07/02/21 at 3:30 PM observed poster signs on patient's living room wall that gave patient #7 steps to take when upset, when hears voices, and to wear gloves to protect hands form injury. Employee D, RN (Registered Nurse) case manager was not observed asking any questions regarding psychosocial or depression. When queried by the RN case manager regarding falls the patient indicated that patient #7 had fallen in the bathroom slipped on water and showed the RN the bruising on left leg. The clinical record of patient #7 was reviewed on 07/30/21 and revealed a start of care date of 05/13/20. The record contained a recertification comprehensive assessment dated 05/06/21 indicated "no changes since previous assessment" under clinical findings in psychosocial, neuro status, musculoskeletal			

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	status. The comprehensive assessment failed to evidence the patient's current health status psychosocial diagnosis of Bipolar, Schizophrenia, and Depression. Patient #7 indicated has fallen in the bathroom and uses a walker for ambulation. The comprehensive assessment failed to evidence the patient's current health status. 6. These findings were reviewed with the administrator/clinical manager and alternate administrator/alternate clinical manager on 07/01/21 at 1:45 PM to 2:10 PM in which they had no further information or documentation to provide. 7. Review of clinical record of Patient #5, revealed the patient has Diagnoses of Moderate Intellectual Disabilities, unsteady gait, HTN (Hypertension), Anemia, Hypothyroidism, Anxiety Disorder Major Depressive Disorder, GERD (Gastric esophageal reflux disease), Epilepsy, Rheumatoid Arthritis, and Obesity. Review of comprehensive assessment completed on 04/26/2021 for certification period of 04/29/2021,-06/27/2021; Mental Status was marked N/A (not applicable), Psychosocial was not completed, "Inability to cope with altered health status as evidenced by: ...." "How does the patient's psychosocial condition affect functional ability and/or safety" was not addressed. A review of comprehensive assessment dated 06/23/2021 for the certification period 06/28/2021-08/26/2021, diagnoses Epilepsy, Anxiety Disorder, Major Depressive Disorder, rheumatoid Arthritis, and GERD were not listed on comprehensive assessment. The Mental Status was marked N/A (not applicable) and Psychosocial was not completed. During an interview on 7/1/2021 at 1:50 PM, the			

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	primary diagnosis on the plan of care was discussed but yet the recertification comprehensive assessment is marked "N/A" as well as some psychosocial areas were left blank. When asked if a patient has a mental illness, would the agency expect documentation on the assessment, the administrator responded, "Absolutely." 8. A review of clinical record of Patient #8, revealed the patient has Diagnoses of Chronic Pain Syndrome, Diabetes, COPD (Chronic Obstructive Pulmonary Disease), Generalized Weakness, Degenerative Disc disease Edema, and CHF (Congested Heart Failure). A review of a comprehensive assessment dated 05/26/2021 for certification period 05/30/2021-07/28/2021, under Sensory status, the code for vision was not completed, under Diabetic Foot exam, it was checked N/A, under Musculoskeletal, it was check that there was no problem but documented patient has weakness in lower extremities related to back pain, the question of "How does the patient's condition affect their functional ability and/or safety" was not completed. 410 IAC 17-14-1(a)(1)(A)(B)			
G 0530 Bldg. 00	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;	G 0530	1. The comprehensive	08/10/2021

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	Based on record review and interview, the agency failed to ensure comprehensive assessments contained patient goals, strengths, and care preferences for 12 of 13 active records reviewed. (Patient #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13) Findings include: 1. Review of Agency's Policy titled "Initial Assessments/Comprehensive Assessments" Policy #9.5.1 indicated, "Each patient admitted by the Agency will have appropriate initial assessments performed and documented ... Procedure ...7. The Initial Comprehensive Assessment also includes: ...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 measurable outcomes identified by the Agency ..." 2. Review of Agency's Policy titled, "IX Provision of Care, Treatment, and Services (PC), policy Initial Assessments/Comprehensive Assessments, 9.5.1", indicated "Each patient admitted by the Agency will have appropriate initial assessments performed and documented. Procedure #7, The initial comprehensive Assessment also includes, 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 measurable outcomes identified by the Agency." 3. The clinical record of patient #2 was reviewed on 06/30/21 and indicated a start of care date of 09/18/18. The record contained a plan of care for the recertification period of 05/05/21 to 07/03/21 that indicated diagnoses, Muscle Weakness, Pain		assessment was revised on 7/26/2021 to include individualized client assessment criteria which includes complete health, psychosocial, functional and cognition status, goals, patient strengths, and care preferences. All RN Case Managers will be educated on 8/3/2021 via virtual team meeting regarding comprehensive assessment, health, psychosocial, functional and cognition status, client goals, strengths, and care preferences. Administrator improved audit process of all comprehensive assessments to include review by Territory Clinical Manager and Area Clinical Manager with timely 1:1 feedback provided to the RN Case Manager after review. Administrator/designee to provide 1:1 coaching and teaching to RN Case Manager if continued deficiencies are noted. RN Case Managers to complete comprehensive assessment on all clients identified in SOD by 8/10/2021. Client's physician to be notified of any changes needed to plan of care and an order will be obtained. 2. Administrator/designee will ensure compliance by tracking comprehensive assessment completion with each recertification and admission on Medical Record Review form. Training on comprehensive assessment completion will be	

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	disorder with psychological factors, Scoliosis, Arthritis, Idiopathic Progressive Neuropathy, Restless Leg Syndrome, Essential Hypertension, Heart Failure, Hypothyroidism, and Hyperlipidemia. A review of the recertification comprehensive assessment dated 05/03/21, failed to evidence weaknesses, patient care preferences, and patient centered goals. 4. The clinical record of patient #6 was reviewed on 06/30/21 and indicated a start of care date of 09/17/18. The record contained a plan of care for the recertification period of 05/04/21 to 07/02/21 that indicated diagnoses, Cerebral Palsy, Epilepsy, IBS (Irritable Bowel Syndrome), Spastic Bladder, Acid Reflux, Chronic Constipation, Arthritis, and Migraines. A review of the recertification comprehensive assessment dated 05/03/21, failed to evidence patient care preferences, weaknesses, measurable outcomes, and patient centered goals. During a home visit with patient #6 on 07/01/21 at 3:00 PM patient stated, "I would like to ride my stationary bike. I also want to get my meds [medications] straightened out, they keep sending me so much. I also have to cut down on my fruit. I gained weight and the doctor said there is a lot of sugar in fruit." 5. The clinical record of patient #7 was reviewed on 07/30/21 and indicated a start of care date of 05/13/20. The record contained a plan of care for the recertification period of 05/08/21 to 07/06/21 that indicated diagnoses, Chronic Pain, Bipolar/Schizophrenia, Hypothyroidism, GERD (Gastric Esophageal Reflux Disease), History of		incorporated into agency orientation. Administrator/designee will track RN Case Manager comprehensive assessment completion, with threshold of 80% compliance for 4 weeks. Administrator/designee to audit 80% of comprehensive assessments for 4 weeks. Once threshold of 80% is met, will decrease to 50% audits by Administrator/designee. RN Case Managers to continue completing comprehensive assessments with each recertification/admission to ensure compliance. 3. If thresholds are not met, the agency will continue 80% audits of all comprehensive assessments and provide 1:1 coaching to RN Case Managers until threshold is met. 4. The deficiency will be completed by 8/10/2021.	

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	Seizures, MDD (Major Depressive Disorder), Generalized Weakness, Arthritis, and Depression. A review of the recertification comprehensive assessment dated 05/06/21, failed to evidence patient care preferences, weaknesses, measurable outcomes, and patient centered goals. 6. The clinical record of patient #9 was reviewed on 07/06/21 and indicated a start of care date of 08/03/17. The record contained a plan of care for the recertification period of 05/14/21 to 07/12/21 that indicated diagnoses, Cognitive Impairment, Autistic disorder, Seizure disorder, and GERD (Gastric Esophageal Reflux Disease). A review of the recertification comprehensive assessment dated 05/10/21, failed to evidence patient care preferences, weaknesses, measurable outcomes, and patient centered goals. 7. The clinical record of patient #10 was reviewed on 07/07/21 and indicated a start of care date of 02/05/21. The record contained a plan of care for the recertification period of 04/06/21 to 06/04/21 that indicated diagnoses, Altered mental status unspecified, Autistic disorder, Seizure disorder, and Acne. A review of the recertification comprehensive assessment dated 04/01/21, failed to evidence patient care preferences, weaknesses, measurable outcomes, and patient centered goals. 8. The clinical record of patient #11 was reviewed on 07/07/21 and indicated a start of care date of 10/5/15. The record contained a plan of care for the recertification period of 05/10/21 to 07/08/21 that indicated diagnoses, Generalized Weakness, CHF (Congestive Heart Failure), TIA (Transient			

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	Ischemic Attack), Chronic Pain, Constipation, Cardiac Dysrhythmia, Pacemaker, GERD (Gastric Esophageal Reflux Disease), and Overactive Bladder. A review of the recertification comprehensive assessment dated 05/07/21, failed to evidence patient care preferences, strengths, weaknesses, measurable outcomes. 9. The clinical record of patient #3, SOC (start of care date) 07/05/2013, was reviewed 06/30/202,. The record contained a plan of care for a recertification period of 05/12/2021-07/10/2021. Patient diagnosis included: TIAs' (Transient Ischemic Attacks) and cerebral infarction without residual deficits, History of Falls, HTN, Diabetes Mellitus, Gastro-esophageal reflux disease, Functional Urinary incontinence, Major Depressive Disorder, Chronic Kidney Disease, Stage 3, Anemia, Gout, Unspecified Speech disturbances, and Constipation. A review of the recertification assessment dated 05/04/2021, failed to evidence patient strengths, goals, and care preferences. 10. The clinical record of patient #4, SOC 04/05/2021, was reviewed 06/30/2021. The record contained a plan of care for a recertification period of 06/04/2021-08/02/2021. Patient diagnosis included: Muscle Weakness, Gastro-esophageal reflux disease without esophagitis, Essential hypertension, Type 2 Diabetes Mellitus, Fibromyalgia, Chronic Obstructive Pulmonary Disease, Rheumatoid Arthritis, Other Idiopathic peripheral autonomic Neuropathy, Urinary Incontinence, Full incontinence of feces, and Shortness of breath. A review of recertification assessment dated			

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	06/02/2021, failed to evidence patient strengths, goals, and care preferences. 11. The clinical record of patient #5, SOC 03/08/2006, was reviewed 06/30/2021. The record contained a plan of care for a recertification period of 04/29/2021-06/27/2021. Patient diagnosis included: Moderate Intellectual Disabilities, Unsteady Gait, HTN (Hypertension), Anemia, History of Colon Cancer, Hypothyroidism, GERD (Gastro-esophageal reflux disease), Anxiety Disorder, Major Depressive Disorder. A review of the recertification comprehensive assessment dated 06/23/2021, failed to evidence patient strengths, goals, and care preferences. 12. The clinical record of patient #8, SOC 06/10/2019, was reviewed 06/30/2021. The record contained a plan of care for a recertification period of 05/30/2021-07/28/2021. Patient diagnosis included: Chronic Pain, Type 2 DM (Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), and Muscle Weakness. A review of the recertification comprehensive assessment dated 05/26/2021, failed to evidence patient strengths, goals, and care preferences. 13. The clinical record of patient #12, SOC 07/10/2020, was reviewed 07/06/2021. The record contained a plan of care for a recertification period of 05/06/2021-07/04/2021. Patient diagnosis included: Chronic Back Pain, Chronic Obstructive Pulmonary Disease, End Stage Renal Disease, Dysphasia, and Diabetes. A review of the recertification comprehensive assessment dated 05/04/2021, failed to evidence patient strengths, goals, and care preferences.			

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	14. The clinical record of patient #13, SOC 03/10/2020, was reviewed 07/06/2021. The record contained a plan of care for a recertification period of 05/04/2021-07/02/2021. Patient diagnosis included: CVA (Cardiac Vascular Accident) with Right Side Weakness/Paralysis, Diabetes Mellitus, Depression, and Hypertension. A review of the recertification assessment dated 04/30/2021, failed to evidence patient strengths, goals, and care preferences. 15. These findings were reviewed with the administrator/clinical manager and alternate administrator/alternate clinical manager on 07/06/21 at 4:45 PM to 4:30 PM in which they had no further information or documentation to provide. 16. During an interview on 07/07/21 at 4:15 PM, when queried about goals being patient specific/ individualized, an example of patient #6's plan of care indicating, "Patient will maintain medication compliance throughout the cert period" and the patient expressing their goals was to ride their stationary bike, the administrator/clinical manager stated, "Absolutely".			
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 or allowed practitioner refers a			

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	patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review, and interview the agency failed to ensure patient needs were met by failing to provide home health aide services for 2 (Patient #7, 9) out of 12 active records reviewed of patients receiving home health aide services and failed to ensure all plan of care were individualized for 10 out of 13 active patients (Patient #3, 4, 5, 7, 8, 9, 10, 11, 12, 13). Findings Include: 1. Review of an undated agency policy titled "Plan of Care-CMS #485 and Physician Orders" Policy #9.9.1 indicated, " ... Procedure ...2. Each patient must receive an individualized written plan of care, including revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s)and measurable outcomes that Agency anticipates will occur as a result of implementing and coordinating the plan of care. ... Services must be furnished in accordance with accepted standards of practice ..." 2. During a home visit on 07/02/21 at 3:30 PM, observed poster signs on patient's living room wall that gave patient #7 steps to take when upset, when hears voices, and to wear gloves to protect hands from injury. The RN case manager queried the patient regarding falls, in which the patient responded they had fallen in the	G 0572	1. The comprehensive assessment was revised on 7/26/2021 to include individualized client assessment criteria which includes complete health, psychosocial, functional and cognition status. All RN Case Managers will be educated on 8/3/2021 via virtual team meeting regarding comprehensive assessment, client goals, strengths, and care preferences. Administrator improved audit process of all comprehensive assessments to include review by Administrator/designee with timely 1:1 feedback provided to the RN Case Manager after review. All audit reviews to be completed on Medical Record Review form created on 7/29/2021 and tracked per RN Case Manager. Administrator/designee to provide 1:1 coaching and teaching to RN Case Manager if continued deficiencies are noted. RN Case Managers to complete comprehensive assessment on all clients identified in SOD by 8/10/2021. Client's physician to be notified of any changes needed to plan of care and an order will be obtained. All RN Case Managers will be educated via virtual team meeting on 8/3/2021 regarding	08/10/2021

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	15K023	A. BUILDING 00 B. WING	07/08/2021

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	bathroom, slipped on water, and showed the RN the bruising on left leg. Patient #7 stated, "When am I going to get my showers and aide again, haven't had one since last month?" The RN case manager stated, "We are working on it." The clinical record of patient #7 was reviewed on 07/30/21 and revealed a start of care date of 05/13/20. The record contained a plan of care for the recertification period of 05/08/21 to 07/06/21, with diagnoses of Chronic Pain, Bipolar/ Schizophrenia, Hypothyroidism, GERD (Gastric Esophageal Reflux Disease), History of Seizures, MDD (Major Depressive Disorder), Generalized Weakness, Arthritis, and Depression. Review of home health aide visit notes evidenced the following: Missed visits awaiting staffing 06/04/21, 06/08/21, 06/10/21, 06/15/21, 06/17/21, 06/22/21, 06/29/21, 06/08/21, and 07/01/21. A review of the plan of care for the recertification period of 05/08/21 to 07/06/21 indicated " ...Orders for Discipline and Treatments (specify Amount/ Frequency/ Duration): ... HHA 1 hr/d, 1-3 days/week x 9 weeks to assist with ADL's and IADL's ... Measurable Goals and Outcomes: Patient's ADL's and IADL's will be met this cert period with the assistance of the home health aide. The patient's safety will be enhanced throughout the home care service as evidenced by no injury r/t falls or seizures within the cert period time.... " The agency failed to evidence an individualized patient care needs and goals and failed to ensure they provided home health aide services as ordered per the plan of care. 3. The clinical record of patient #9 was reviewed on 07/06/21 and indicated a start of care date of 08/30/17. The record contained a plan of care for		comprehensive plan of care that is individualized to the client and his/her care needs. This includes individualized goals with interventions, individualized orders consisting of call orders and signs/symptoms of disease processes to observe. Administrator/designee will audit comprehensive plan of care in conjunction with comprehensive assessment. Adminsitrator/designee to provide 1:1 coaching and teaching if continued deficiencies are noted. On 7/27/2021 a meeting template was created to be utilized weekly with all members of the team which discusses scheduled new hires, plans for competency evaluations, open client schedules, nurse schedules, planned admissions and discharges, and grievances needing follow-up. Administrator/designee to review all meeting minutes on a weekly basis and provide feedback as applicable. 2. Administrator/designee will ensure compliance by tracking comprehensive assessment completion with each recertification and admission on Medical Record Review form. Training on comprehensive assessment completion will be incorporated into agency orientation. Administrator/designee will track	

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	the recertification period of 03/15/21 to 05/13/21 that indicated diagnoses, Cognitive Impairment, Autistic disorder, Seizure disorder, and GERD. A review of the plan of care for the recertification period of 03/15/21 to 05/13/21 indicated " ...Orders for Discipline and Treatments (specify Amount/ Frequency/ Duration): HHA 1-3 h/d, 3-5 days/week x 9 weeks to assist with ADL's and IADL's ...Measurable Goals and Outcomes: Patient's ADL's and IADL's will be met this cert period with the assistance of the home health aide. The patient's safety will be enhanced throughout the home care service as evidenced by no injury r/t falls or seizures within a 60 day period of time ...." The plan of care failed to evidence individualized patient care needs and individualized patient centered goals. Review of home health aide visit notes evidenced the following: Missed visits on 04/02/21, 05/04/21, 05/05/21, 05/19/21 thru 05/21/21. Review of an agency document dated 05/25/21 titled "Missed Visit Form" indicated, "All available staff refused shifts." The agency failed to provide home health aide services as ordered per the plan of care and provide a frequency specific to the patient's care needs. 4. The clinical record of patient #10 was reviewed on 07/07/21 and indicated a start of care date of 02/05/21. The record contained a plan of care for the recertification period of 04/06/21 to 06/21/21 that indicated diagnoses, Altered mental status unspecified, Autistic disorder, Seizure disorder, and Acne. Review of a plan of care for the recertification period of 04/06/21 to 06/04/21 indicated " ...Orders for Discipline and Treatments (specify Amount/		RN Case Manager comprehensive assessment completion, with threshold of 80% compliance for 4 weeks. Administrator/designee to audit 80% of comprehensive assessments for 4 weeks. Once threshold of 80% is met, will decrease to 50% audits by Administrator/designee. RN Case Managers to continue completing comprehensive assessments with each recertification/admission to ensure compliance. Administrator/designee to review 80% of meeting minutes per week. 1:1 coaching will be providing to office personnel if meetings are not held per standard. 3. If thresholds are not met, the agency will continue 80% audits of all comprehensive assessments and provide 1:1 coaching to RN Case Managers until threshold is met. If meeting minutes are not completed per standard, Administrator/designee to provide 1:1 coaching to office personnel until standard level is achieved. 4. The deficiency will be completed by 8/10/2021.	

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	Frequency/ Duration): HHA 1-2 hour/visit, 5-7 days/week x 9 weeks to assist with ADL's and IADL's. HHA to apply bilateral AFO's (Ankle foot orthosis) every visit ... Measurable Goals and Outcomes: Patient's ADL's and IADL's will be met this cert period with the assistance of the home health aide. The patient's safety will be enhanced throughout the home care service as evidenced by no injury r/t falls this cert period of time. The patient will remain free of injury r/t seizures this cert period ...." The plan of care failed to evidence individualized patient care needs and individualized patient centered goals. 5. The clinical record of patient #11 was reviewed on 07/07/21 and indicated a start of care date of 10/07/15. The record contained a plan of care for the recertification period of 05/10/21 to 07/08/21 that indicated diagnoses, Generalized Weakness, CHF, TIA, Chronic Pain, Constipation, Cardiac Dysrhythmia, Pacemaker, GERD, and Overactive Bladder. Review of a plan of care for the recertification period of 05/10/21 to 07/08/21 indicated " ...Orders for Discipline and Treatments (specify Amount/ Frequency/ Duration): HHA 2-4 hrs/visit, 1-2vs (visits)/day, 5-7 days/week x 9 weeks to assist with ADL's and IADL's. HHA ... Measurable Goals and Outcomes: Patient's ADL's and IADL's will be met this cert period with the assistance of the home health aide. The patient's safety will be enhanced throughout the home care service as evidenced by no injury r/t falls within cert period ..." The plan of care failed to evidence individualized patient care needs and individualized patient centered goals. 6. The clinical record of patient #3, SOC (start of care) 07/05/2013, was reviewed 06/30/2021. The record contained a plan of care for a recertification			

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	period of 05/12/2021-07/10/2021. Patient diagnoses included: TIAs' (Transient Ischemic Attacks) and cerebral infarction without residual deficits, History of Falls, HTN (Hypertension), DM (Diabetes Mellitus), GERD (Gastro-esophageal reflux disease), Urinary incontinence, Major Depressive Disorder, Chronic Kidney Disease Stage 3, Anemia, Gout, Unspecified Speech disturbances, and Constipation. A review of the Home Health Certification/ Recertification Plan of Care dated 05/04/202, revealed orders for Hha home (health aide services) 1-2 hours/day, 3-5 days per week for 9 weeks to assist with ADL's(activities of daily living) and IADL's (instrumental activities of daily living). The measurable goals and outcomes revealed: "Patients ADL's and IADL's will be met this cert period with the assistance of the home health aide. Patient's safety will be enhanced through the home care service as evidenced by no injuries from falls within certification period of time." The agency failed to ensure an individualized plan of care that identifies patient-specific measurable outcomes and goals. 9. The clinical record of patient #4, SOC 04/05/2021, was reviewed 06/30/2021. The record contained a plan of care for a recertification period of 06/04/2021-08/02/2021. Patient diagnoses included: Muscle Weakness, Gastro-esophageal reflux disease without esophagitis, Essential hypertension, Type 2 Diabetes Mellitus, Fibromyalgia, Chronic Obstructive Pulmonary Disease, Rheumatoid Arthritis, Other Idiopathic peripheral autonomic Neuropathy, Urinary Incontinence, Full incontinence of feces, and Shortness of breath.			

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	A review of the Home Health Certification/ Recertification Plan of Care dated 06/02/2021, revealed orders for home health aide services 1-2 hours/visit, 2-3 times a week for 9 weeks to assist with ADL's and IADL's. The goals revealed were: "No declared goals at this time". The measurable goals and outcomes revealed: "The patient's safety will be enhanced throughout the home care services as evidenced by no injuries from falls within cert period of time. Patient's ADL's and IADL's will be met this certification period with the assistance of the home health aide. The agency failed to ensure an individualized plan of care that identifies patient-specific measurable outcomes and goals. 10. The clinical record of patient #5, SOC 03/08/2006, was reviewed 06/30/2021. The record contained a plan of care for a recertification period of 04/29/2021-06/27/2021. Patient diagnoses included: Moderate Intellectual Disabilities, Unsteady Gait, HTN (Hypertension), Anemia, History of Colon Cancer, Hypothyroidism, GERD (Gastro-esophageal reflux disease), Anxiety Disorder, Major Depressive Disorder. A review of the Home Health Certification/Recertification Plan of Care Order dated 06/23/2021, revealed orders for Hha (home health aide services) 1-3 hours per visit, 1-2 days per week x 9 weeks to assist with ADL's and IADL's. The measurable goals and outcomes: "The patient's safety will be enhanced throughout ....Patient's ADL's and IADL's will be met....". The agency failed to ensure an individualized plan of care that identifies patient-specific measurable outcomes and goals. 11. The clinical record of patient #8, SOC 06/10/2019, was reviewed 06/30/2021. The record			

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	contained a plan of care for a recertification period of 05/30/2021-07/28/2021. Patient diagnosis included: Chronic Pain, Type 2 DM (Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), and Muscle Weakness. A review of the Home Health Certification/Recertification Plan of Care Order dated 05/26/2021, revealed orders for home health aide services 1-2 hour visit, 3-5 days/week x 9 weeks for assistance with ADL's and IADL's. The Measurable Goals and outcomes revealed: "Patient's ADL's and IADL's will be met...The patient's safety will be enhanced throughout ...." The agency failed to ensure an individualized plan of care that identifies patient-specific measurable outcomes and goals. 12. The clinical record of patient #12, SOC 07/10/2020, was reviewed 07/06/2021. The record contained a plan of care for a recertification period of 05/06/2021-07/04/2021. The Patient diagnoses included: Chronic Back Pain, COPD, End Stage Renal Disease, Dysphasia, and DM. A review of the Home Health Plan of Care/Certification dated 05/04/2021, revealed orders for home health aide services 7-8 hours/visit, 4-5 days/week x 9 weeks for assistance with ADL's and IADL's. Measurable Goals and Outcomes revealed: "Patient's ADL's and IADL's will be met..The patient's safety will be..." The agency failed to ensure an individualized plan of care that identifies patient-specific measurable outcomes and goals. 13. The clinical record of patient #13, SOC 03/10/2020, was reviewed 07/06/2021. The record contained a plan of care for a recertification period of 05/04/2021-07/02/2021. Patient diagnosis			

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	included: CVA (Cardiac Vascular Accident) with Right Side Weakness/ Paralysis, Diabetes Mellitus, Depression, and Hypertension. A review of the Home Health Plan of Care/Certification dated 04/30/2021, revealed orders for home health aide services for 9-11 hours/visit, 2-4 days/week x 9 weeks for assistance with ADL's and IADL's. The Patient/ Representative Identified Measurable Goals and Outcomes revealed: Patient will remain at current level of independence through the certification period. The Measurable Goals and Outcomes revealed: "Patient's ADL's and IADL's will be met....The patient's safety will be...". The agency failed to ensure an individualized plan of care that identifies patient-specific measurable outcomes and goals. 14. These findings were reviewed with the administrator/clinical manager and alternate administrator/alternate clinical manager on 07/06/21 at 4:45 PM to 4:30 PM in which they had no further information or documentation to provide. 410 AC 17-13-1 (a)			
G 0574 Bldg. 00	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;			

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	(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 or allowed practitioner may choose to include. Based on observation, record review and interview, the agency failed to ensure the individualized plan of care, failed to ensure the plan of care included nutritional requirements, all accurate medications, treatments, all safety measures, all necessary interventions to address the underlying risk factors and the specific education and training to be provided, measurable outcomes and goals identified by the home health agency and patient, for 11 of 13 active patients. (Patient #2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 13) Findings Include: 1. Review of an undated agency policy titled "Plan of Care-CMS #485 and Physician Orders" Policy #9.9.1 indicated, " ...Procedure ...2. Each patient must receive an individualized written plan of care,	G 0574	1. The comprehensive assessment was revised on 7/26/2021 to include individualized client assessment criteria which includes complete health, psychosocial, functional and cognition status. All RN Case Managers will be educated on 8/3/2021 via virtual team meeting regarding comprehensive assessment, client goals, strengths, and care preferences. Administrator improved audit process of all comprehensive assessments to include review by Territory Clinical Manager and Area Clinical Manager with timely 1:1 feedback provided to the RN Case Manager after review. All	08/10/2021

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	including revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s)and measurable outcomes that Agency anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice ...4. The individualized plan of care must include the following ...The frequency and duration of visits made ...A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address underlying risk factors ...Patient specific interventions and education, measurable outcomes and goals identified by the Agency and the patient ...14. Recertification requirements include: ...A revised plan of care must reflect current information concerning the patient's updated comprehensive assessment, and contain information the patient's progress toward the measurable goals identified by the Agency and patient in the plan of care ..." 2. During a home visit at patient #2's home on 7/2/21 at 11:15 AM, when Employee I, RN case manager queried about pain the patient stated, "My neck gets really sore. My back pain has improved with meds." Patient #2 then showed soft collar cushion for neck and demonstrated how she moves she lounge in a better positioned back if pain starts. Entity M of patient #2 stated, "Her pain would be a 10 if not for those pain pills." Entity M further indicated patient had chest pain and had to take nitroglycerin twice for chest pain and patient's blood pressure has been high.		audit reviews to be completed on Medical Record Review form created on 7/29/2021 and tracked per RN Case Manager. Administrator/designee to provide 1:1 coaching and teaching to RN Case Manager if continued deficiencies are noted. RN Case Managers to complete comprehensive assessment on all clients identified in SOD by 8/10/2021. Client's physician to be notified of any changes needed to plan of care and an order will be obtained. All RN Case Managers will be educated via virtual team meeting on 8/3/2021 regarding comprehensive plan of care that is individualized to the client and his/her care needs. Administrator/designee will audit comprehensive plan of care in conjunction with comprehensive assessment. Administrator/designee to provide 1:1 coaching and teaching if continued deficiencies are noted. This includes individualized goals with interventions, individualized orders consisting of call orders and signs/symptoms of disease processes to observe. On 7/27/2021 a meeting template was created to be utilized weekly with all members of the team which discusses scheduled new hires, plans for competency evaluations, open client schedules, nurse schedules, planned admissions and discharges, and grievances	

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	Patient #2 stated, "The chest pain wasn't like I use to have it and have to take 3 pills before when I had it." When the RN case manager queried about her last bowel movement client stated, "I had one this morning." RN case manager indicated the doctor has recently added prunes to her diet due to constipation. The clinical record of patient #2 was reviewed on 06/30/21 and indicated a start of care date of 09/18/18 and contained an agency document titled "Medication Profile" indicated the following: Hydralazine 50 mg (milligrams)/ tab (tablet) ½ tablet by mouth three times per day. If B/P (blood pressure) is lower than 120/60 in the evening hold that dose, Furosemide 20 mg by mouth daily at noon, HCTZ 25 mg by mouth daily at noon, Isosorbide Mononitrate 90 mg ER 1 tab by mouth daily in the morning, Lisinopril 40 mg by mouth daily at bedtime, Clopidogrel 75 mg; 1 tab by mouth daily, Aspirin 81 mg 1 tab by mouth daily at bedtime, Nitroglycerin 0.4 mg SL (sublingual); 1 tab every 5 minutes as needed for chest pain up to 3 times. If not resolved after 3 tabs notify MD (Medicine Doctor) and call 911, Carvedilol 3.125 mg 1 tab by mouth daily in the morning, Oxycodone-Acetaminophen 5-325 mg; tab by mouth four times daily, Diclofenac Topical 1% gel apply 2 gm (grams) topical four times daily as needed for pain, Gabapentin 100 mg by mouth 1 tab every morning and 2-3 tabs every night, Senna with Docusate 8.5-50 mg 1 tab by mouth daily at bedtime, Sorbitol 70% 10 ml (milliliters) by mouth daily, and Polyethylene Glycol 3350; 17 gm mixed with 8 oz(ounces) of H20 (water) by mouth daily at bedtime as needed for constipation. The daughter is to check B/P. The record contained a plan of care for the recertification period of 05/05/21 to 07/03/21 that		needing follow-up. Administrator/designee to review all meeting minutes on a weekly basis and provide feedback as applicable. 2. Administrator will ensure compliance by tracking comprehensive assessment completion with each recertification and admission on Medical Record Review form. Training on comprehensive assessment completion will be incorporated into agency orientation. Administrator/designee will track RN Case Manager comprehensive assessment completion, with threshold of 80% compliance for 4 weeks. Administrator/designee to audit 80% of comprehensive assessments for 4 weeks. Once threshold of 80% is met, will decrease to 50% audits by Administrator/designee. RN Case Managers to continue completing comprehensive assessments with each recertification/admission to ensure compliance. Administrator/designee to review 80% of meeting minutes per week. 1:1 coaching will be providing to office personnel if meetings are not held per standard. 3. If thresholds are not met, the agency will continue 80% audits of all comprehensive assessments and provide 1:1 coaching to RN Case Managers until threshold is met. If meeting minutes are not	

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HELP AT HOME SKILLED CARE	6855 SHORE TERRACE SUITE 240 INDIANAPOLIS, IN 46254

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	indicated diagnoses, Muscle Weakness, Pain disorder with psychological factors, Scoliosis, Arthritis, Idiopathic Progressive Neuropathy, Restless Leg Syndrome, Essential Hypertension, Heart Failure, Hypothyroidism, and Hyperlipidemia with " Orders for Discipline and Treatments(Specify Amount/ Frequency/ Duration): SN 1hr (hour)/visit, 1 day/week x 9 weeks to assess VS (Vital Signs)& all body systems, set up medications and monitor medication compliance every visit ...HHA (Home Health Aide) 3-5hr/visit, 3-5 days/week x 9 weeks to assist with ADLs (Activities of Daily Living) and IADLS (Instrumental Activities of Daily Living) .. .Measurable Goals and Outcomes: The patient's safety will be enhanced throughout the home care service as evidenced by no injury r/t (related to) falls within the cert period of time. The patient's hygiene and personal care needs will be met this cert period with the assistance of the HHA. The patient will maintain medication compliance throughout the cert period ..." The plan of care failed to evidence that the daughter is to check the patient's B/P, call parameters for blood pressure, pulse, and weight gain, education to be provided, CHF interventions, pain interventions, constipation interventions with measurable outcomes and goals. 3. During a home visit with patient #6 on 07/01/21 at 3:00 PM patient stated, "I would like to ride my stationary bike. I also want to get my meds straightened out they keep sending me so much. I also have to cut down on my fruit I gained weight and the doctor said there is a lot of sugar in fruit." Patient #6 indicated she had issues getting her breathing masks for her night time machine. The clinical record of patient #6 was reviewed on 06/30/21 and indicated a start of care date of		completed per standard, Administrator/designee to provide 1:1 coaching to office personnel until standard level is achieved. 4. The deficiency will be completed by 8/10/2021.	

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	09/17/18. The record contained a plan of care for the recertification period of 05/04/21 to 07/02/21 that indicated diagnoses, Cerebral Palsy, Epilepsy, IBS (Irritable Bowel Syndrome), Spastic Bladder, Acid Reflux, Chronic Constipation, Arthritis, and Migraines. This plan of care indicated, " ...Measurable Goals and Outcomes: To remain at current level of independence throughout the cert period...Orders for Discipline and Treatments (Specify Amount/ Frequency/ Duration): SN (Skilled Nurse) 1 hr (hour)/visit, 1 day every other week x 9 weeks to assess vital signs and all body systems and prefill med planner and assess medication compliance every visit ..." The plan of care failed to evidence interventions and goals for constipation, interventions and goals for IBS, interventions and goals for pain, individualized patient centered goals, failed to address CPAP (Continuous Positive Airway Pressure), a breathing machine used for individuals who stop breathing at night, settings and call parameters for oxygen saturations, the measurement of oxygen. 4. During a home visit on 07/02/21 at 3:30 PM observed poster signs on patient's living room wall that gave patient #7 steps to take when upset, when hears voices, and to wear gloves to protect hands form injury. Employee D, RN (Registered Nurse) case manager was not observed asking any questions regarding psychosocial or depression. When queried by the RN case manager regarding falls patient indicated that patient #7 had fallen in the bathroom slipped on water and showed the RN the bruising on left leg. Patient #7 stated to surveyor, " When am I going to get my showers and aide again haven't had one since last month?" The RN case manager stated, "We are working on it." The clinical record of patient #7 was reviewed on			

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	07/30/21 and indicated a start of care date of 05/13/20. The record contained a plan of care for the recertification period of 05/08/21 to 07/06/21 that indicated diagnoses, Chronic Pain, Bipolar/ Schizophrenia, Hypothyroidism, GERD (Gastric Esophageal Reflux Disease), History of Seizures, MDD (Major Depressive Disorder), Generalized Weakness, Arthritis, and Depression with " ... Orders for Discipline and Treatments (specify Amount/ Frequency/ Duration): SN 1 hr/visit, 1 d (day)/week x 9 weeks to assess VS & all body systems, set up medications and monitor medication compliance every visit ...Measurable Goals and Outcomes: ... Client will remain compliant with medication regimen for this cert period ...Patient/ Representative Measurable Goals and Outcomes: None at this time." The plan of care failed to evidence individualized patient care needs. The plan of care failed to address interventions for depression and Bipolar/ Schizophrenia, pain interventions and goals, constipation interventions and goals, and patient centered goals. 5. The clinical record of patient #9 was reviewed on 07/06/21 and indicated a start of care date of 08/30/17. The record contained a plan of care for the recertification period of 03/15/21 to 05/13/21 that indicated diagnoses, Cognitive Impairment, Autistic disorder, Seizure disorder, and GERD. " ...Orders for Discipline and Treatments (specify Amount/ Frequency/ Duration): HHA 1-3 h/d, 3-5 days/week x 9 weeks to assist with ADL's and IADL's ...Measurable Goals and Outcomes: ... Patient/ Representative Measurable Goals and Outcomes: Caregiver declines to set a goal at this time." The plan of care failed to evidence patient centered goals. During a phone interview with patient #9's			

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	caregiver Entity N on 07/06/21 at 1:45 PM when queried about queried about complaint regarding staffing stated, "I am a Theology teacher. We have a prior authorization for 5 days a week 2 hours in the AM and 3 hours in the afternoon so I can teach my classes Monday thru Friday. I do not have consistent staff. They even have pulled my aide to send to another patient. They have terrible communication. The scheduler one time she isn't there anymore told my Entity O when she called to say they could not staff that day that he better go to plan B. Entity O had to go to work and could not stay and watch patient #9. I have told them consistently to let me know on my phone if there is a staffing issue do not call my home phone. Patient #9 need 24 hour supervision you cannot take your eyes off him. I had to have my Entity P sit in the garage with him one time and it was cold out because they could not staff. They know my work hours patient #9 needs consistency due to his behaviors. The prior authorization is for the hours I work." 6. The clinical record of patient #10 was reviewed on 07/07/21 and indicated a start of care date of 02/05/21. The record contained a plan of care for the recertification period of 04/06/21 to 06/21/21 that indicated diagnoses, Altered mental status unspecified, Autistic disorder, Seizure disorder, and Acne. Review of a plan of care for the recertification period of 04/06/21 to 06/04/21 indicated " ...Orders for Discipline and Treatments (specify Amount/ Frequency/Duration): HHA 1-2 hour/visit, 5-7 days/week x 9 weeks to assist with ADL's and IADL's. HHA to apply bilateral AFO's (Ankle foot orthosis) every visit ... Measurable Goals and Outcomes: Patient's ADL's and IADL's will be met this cert period with the assistance of the home			

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	health aide. The patient's safety will be enhanced throughout the home care service as evidenced by no injury r/t falls this cert period of time. The patient will remain free of injury r/t seizures this cert period ...Patient/ Representative Measurable Goals and Outcomes: CG (Caregiver) doesn't wish to set pt (patient) specific goal ..." The plan of care failed to evidence individualized patient care needs in regards to prevention of skin impairments related to AFO with measurable goals and patient centered goals. 7. The clinical record of patient #11 was reviewed on 07/07/21 and indicated a start of care date of 10/07/15. The record contained a plan of care for the recertification period of 05/10/21 to 07/08/21 that indicated diagnoses, Generalized Weakness, CHF, TIA, Chronic Pain, Constipation, Cardiac Dysrhythmia, Pacemaker, GERD, and Overactive Bladder. Review of a plan of care for the recertification period of 05/10/21 to 07/08/21 indicated " ...Orders for Discipline and Treatments (specify Amount/ Frequency/ Duration): HHA 2-4 hrs/visit, 1-2vs (visits)/day, 5-7 days/week x 9 weeks to assist with ADL's and IADL's. HHA ... Measurable Goals and Outcomes: Patient's ADL's and IADL's will be met this cert period with the assistance of the home health aide. The patient's safety will be enhanced throughout the home care service as evidenced by no injury r/t falls within cert period ..." The plan of care failed to include interventions for the home health aide to weigh patient and report weight gains 2 plus a day to the case manager. The plan of care failed to include interventions for the home health aide to monitor the patient's bowel movements and report to the case manager if the patient does not have a bowel movement in 72 hours. The plan of care failed to			

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	include interventions for the home health aide to report increased pain to case manager and give a pain scale of reporting. The plan of care failed to have goals for the patient's pain, constipation, and heart failure. 8. During an interview on 07/07/21 at 4:15 PM, when queried about goals being patient specific/ individualized, an example of patient #6's plan of care indicating, "Patient will maintain medication compliance throughout the cert period" and the patient expressing their goals was to ride their stationary bike, the administrator/clinical manager stated, "Absolutely". 9. The clinical record of patient #3, SOC (start of care) 07/05/2013, was reviewed 06/30/2021. Patient diagnoses included: TIAs' (Transient Ischemic Attacks) and cerebral infarction without residual deficits, History of Falls, HTN (Hypertension), DM (Diabetes Mellitus), GERD (Gastro-esophageal reflux disease), Urinary incontinence, Major Depressive Disorder, Chronic Kidney Disease Stage 3, Anemia, Gout, Unspecified Speech disturbances, and Constipation. A review of the Home Health Certification/Recertification Plan of Care dated 05/04/2021 and assessment dated 05/04/2021, revealed patient is taking Metoprolol Tartrate 100 mg 2 times a day, Hydralazine 50 mg 4 times a day, and Amlodipine 10 mg 1 x a day for HTN (blood pressure). The Patient/Family is to check patient's blood sugar daily. The Plan of Care failed to evidence diabetic foot care and physician call parameters with blood sugars and vital signs. The Hha (home health aide) provides ADL's (activities of daily living), Monday through Friday, the Plan of Care Hha orders revealed Hha services 1-2 hr/day, 3-5 days/week x 9 weeks. The agency			

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	failed to provide an individualized Plan of Care with patient centered goals. 10. The clinical record of patient #4, SOC 04/05/2021, was reviewed 06/30/2021. Patient diagnoses included: Muscle Weakness, Gastro-esophageal reflux disease without esophagitis, Essential hypertension, Type 2 Diabetes Mellitus, Fibromyalgia, Chronic Obstructive Pulmonary Disease, Rheumatoid Arthritis, Other Idiopathic peripheral autonomic Neuropathy, Urinary Incontinence, Full incontinence of feces, and Shortness of breath. A review of the Home Health Certification/ Recertification Plan of Care dated 06/02/2021 and assessment dated 06/02/2021, revealed there were Pain Goals on the Pain assessment, with patient pain goals 0-4/10., the Plan of Care revealed the patient "Declared no goals". The patient has COPD and HTN and is receiving O2 2L Nasal Cannula Continuous and a CPAP machine, being monitored and supplied by Other K. Patient is taking Metoprolol 25 mg 2 times day for HTN (blood pressure). The Plan of Care failed to evidence diabetic foot care, CPAP settings and physician call parameters with oximeter (oxygen) readings and blood pressure ranges. The agency failed to provide an individualized Plan of Care with patient centered goals. 11. The clinical record of patient #5, SOC 03/08/2006, was reviewed 06/30/2021. Patient diagnoses included: Moderate Intellectual Disabilities, Unsteady Gait, HTN (Hypertension), Anemia, History of Colon Cancer, Hypothyroidism, GERD (Gastro-esophageal reflux disease), Anxiety Disorder, Major Depressive Disorder.			

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	A review of the Home Health Certification/ Recertification Plan of Care dated 06/23/2021 and assessment dated 06/23/2021, revealed the patient is taking Furosemide 20 mg 2 x day, Metoprolol Succinate ER 25 mg (blood pressure), and Losartan-hydrochlorothiazide (blood pressure) 100 mg 1 x day for HTN (blood pressure). The Plan of Care failed to evidence physician call parameters ranges for blood pressure and patient centered goals. The Agency failed to provide an individualized Plan of Care with patient centered goals. 12. The clinical record of patient #8, SOC 06/10/2019, was reviewed 06/30/2021. Patient diagnosis included: Chronic Pain, Type 2 DM (Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), and Muscle Weakness. A review of the Home Health Certification/Recertification Plan of Care dated 05/26/2021 and assessment dated 05/26/2021 revealed diabetic foot exam failed to be completed on assessment. The Plan of Care failed to evidence diabetic foot care. The patient is to perform glucometer readings (blood sugar testing) daily in AM before breakfast, the Plan of Care failed to evidence physician call parameters for glucometer readings. The Agency failed to evidence an individualized plan of care with patient centered goals. 13. The clinical record of patient #12, SOC 07/10/2020, was reviewed 07/06/2021. Patient diagnoses included: Chronic Back Pain, COPD, End Stage Renal Disease, Dysphasia, and DM. A review of the Home Health Certification/Recertification Plan of care dated 05/04/2021 and a recertification comprehensive			

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	assessment dated 05/04/2021, revealed patient is receiving midodrine 5 mg 3 times a week before dialysis for hypotension (low blood pressure) and 5 mg 3 times a week during dialysis. The Plan of Care failed to indicate physician call parameter ranges for blood pressure. The assessment revealed patient has Pain goals of "0-3, progress toward pain goal, met, ongoing, monitoring required". The Plan of Care failed to identify pain goals. The assessment revealed family member(s) checks patient's blood sugar weekly. The Plan of Care failed to evidence glucometer readings and physician call parameters. The Agency failed to evidence an individualized plan of care with patient centered goals. 14. The clinical record of patient #13, SOC 03/10/2020, was reviewed 07/06/2021. Patient diagnosis included: CVA (Cardiac Vascular Accident) with Right Side Weakness/Paralysis, Diabetes Mellitus, Depression, and Hypertension. A review of the Home Health Certification/Recertification Plan of Care dated 04/30/2021 and assessment dated 04/30/2021 revealed the patient is to receive Hha services 9-11 hrs per visit, 2-4 days per week. Per record review, Hha services are being provided 4 days a week, 10 - 11 hours each day. Patient is receiving Metoprolol 100 mg 2 times a day and Amlodipine 5 mg 1 time a day for HTN (blood pressure), the Plan of Care failed to identify physician call parameters for blood pressure readings. The Plan of Care failed to identify diabetic foot care. The agency failed to to provide an individualized Plan of Care with patient centered goals. 15. These findings were reviewed with the administrator/clinical manager and alternate administrator/alternate clinical manager on			

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	07/06/21 at 4:45 PM to 4:30 PM in which they had no further information or documentation to provide. 16. During an interview on 07/07/21 at 4:15 PM, when queried about goals being patient specific/ individualized, an example of patient #6's plan of care indicating, "Patient will maintain medication compliance throughout the cert period" and the patient expressing their goals was to ride their stationary bike, the administrator/clinical manager stated, "Absolutely". 410 AC 17-13-1(d)(iii)(xii)			
G 0682 Bldg. 00	484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observations, record review, and interview the agency failed to use standard precautions to prevent the transmission of infections and communicable diseases for 3 of 7 home visits conducted. (Patients #1, #3, and #5) Findings include: 1. Review of an agency policy titled, V. Infection Prevention and Control (IC), revealed "5.2.1 POLICY The Agency has developed, and implemented infection control practices that conform to OSHA regulations, CDC guidelines, state and local regulations and currently accepted standards of practice...5.6.1 Blood and body fluid precautions will be followed for all patients...5.7.1 Hand hygiene will be done by all employees and	G 0682	1. Administrator completed immediate re-education to the RN Case Managers and home health aides observed on home visits during survey process on proper infection control practices related to hand hygiene and donning/doffing of gloves, as well as bag barrier technique with RN Case Managers only. On 7/27/2021 Administrator began competency assessment process for all RN Case Managers related to hand hygiene and bag barrier technique. On 7/27/2021 a Home Observation Form was created for RN Case Managers to complete during 80% of all home visits	08/10/2021

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	Home Care Infection Control Guidelines for COVID-19". 2. During a home visit observation on 06/30/2021 at 8:45 AM at Patient's #1 home, with Employee D RN (registered nurse), and Employee M Hha (home health aide), Employee M was observed applying gloves, without any hand hygiene, began assisting patient #1 with undressing, ambulation into bathroom, showering, drying off, assisting to bedroom, assisting with dressing, all while using the same pair of gloves. After the patient was fully dressed, with same gloves, Employee M handed the alarm and necklace for patient to put on. Employee M was observed placing their personal bag on the chair without the use of a barrier. During an interview on 06/30/2021 at 11 am, Employee D was queried about the home visit, in which Employee D admitted the aide did not use hand hygiene properly. 3. During a home visit observation on 07/02/2021 at 06:55 AM at Patient's #3 home with Employee K Hha (home health aide). Employee K answered the door without wearing a mask. Employee K stated patient #3 was not awake. Employee K went into the bedroom, with no mask, woke patient #3 up and assisted patient #3 to bathroom. Employee K had not used hand hygiene, no gloves, and no mask. Employee K brushed Patient #3 hair and assisted the patient to the kitchen. Employee K, not wearing mask or gloves, and had not performed hand hygiene, fixed patient a drink to take medications, put drink on table, went to medication box, emptied medications onto their non-gloved hand and without use of hand hygiene, put pills into cup for patient. Employee K then started washing dishes,		which ensures proper infection control techniques by home health aides and skilled nurses is performed. All home health aides and skilled nurses will watch video on donning/doffing PPE by 8/6/2021. All RN Case Managers to watch video on proper bag technique created on 7/30/2021 by 8/6/2021. 2. Administrator/designee to ensure compliance by tracking completion of home observation forms on 80% of home visits and 100% completion of video education by 8/6/2021. 3. If threshold of 80% home observation forms is not met, 1:1 coaching will be provided to employees. If threshold of 100% compliance with video education is not met, employee to be removed from their schedule until complete. 4. The deficiency will be completed by 8/10/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K023	A. BUILDING 00 B. WING	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	no hand hygiene performed and gloves not applied. 4. During a home visit observation on 07/02/2021 at 09:45 AM at Patient's #5, Employee F RN (registered nurse) was observed performing hand hygiene at the sink, placed a paper towel barrier on patient #5's bed, and put clip board and notebook/IPad directly on patient's bed without barrier. 410 IAC 17-12-1 (m)			