STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157683	A. BUILDING 00 B. WING	03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUNOVA HOME CARE LLC	6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530

(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
N 0000 Bldg. 00	This was a federal and state complaint survey. Facility ID: 013602 Provider # 157683 Dates of Survey: 03/24/2021 - 03/29/2021 Current Census: 49 Complaint # IN00347950 - Allegations: Resident/Patient/Client Rights, Quality of Care/Treatment, Nursing Services: Substantiated with findings	N 0000		
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview, the agency failed to ensure all disciplines assigned to the patients maintained effective interdisciplinary communication to meet the patient's needs and treatment effectiveness for 2 of 7 records reviewed (#1, 4). The findings include: 1. Review of an agency policy dated (revised) 1/2014 titled "Agency Information" stated "...	N 0484	Client #1 & #4 are In-Active Records, therefore no action was taken to correct the deficient practice for the client. After a review of 100% of Active charts, on 04/23/2021 all staff were educated on effective interdisciplinary communication to ensure all disciplines assigned to the patients maintained effective	04/23/2021

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

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	Objectives ... To provide personalized care designed according to the client's needs ...." 2. Review of an undated agency policy titled "Admission Policy" stated "... Clients will be accepted for home care with the expectation that the agency can provide the services the client needs ...." 3. Record review for patient #1 was completed on 3/25/2021 and again on 3/29/2021, start of care date (Sunday) 2/7/2021, for certification period 2/7/2021 - 4/7/2021. This clinical record review evidenced a document dated 2/7/2021, titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)" which stated "... Interventions planned: ... OT [occupational therapy] referral ... [home health] aide ... patient agrees ... They would like all the services they can get especially at the beginning and decrease them as appropriate ...." The clinical record failed to evidence coordination occurred with other disciplines referred to meet the patient's needs for services/treatment. 4. Clinical record review on 3/29/21 for patient #4, primary diagnosis: Encounter for other orthopedic (branch of surgery concerned with conditions involving the Musculoskeletal system) aftercare, start of care 12/17/2020, evidenced an agency document titled "Physical Therapy Progress," dated 12/18/2020, signed by (Physical Therapy Assistant) PTA E. This document stated the pain was rated a 6 (on a scale of 0-10 with 0 being no pain and 10 being the most severe pain). The clinician failed to notify the appropriate staff of the pain rating of 6. During an interview on 3/9/2021 at 3:50 PM, the Administrator, indicated there was no pain goal. She indicated their was no contact with the		interdisciplinary communication to meet the patient's needs and treatment effectiveness. Staff were educated to ensure interdisciplinary communication was being performed and documented to support the objectives of patient care. Effective 05/25/2021 The Clinical Manager will perform reviews of Initial Case Conferences notes and Progress Notes for all disciplines on 10% of the active patients for the next 30 days to ensure 100% compliance is met with effective interdisciplinary communication to support the objectives of patient care. The Administrator will be responsible for oversight and monitoring of compliance with this deficient practice to ensure that it does not re occur.	

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	physical therapist or physician regarding the pain status. During an interview on 3/9/2021 at 3:52 PM, the Clinical Manager indicated the clinicians use common judgement (on whether to notify physical therapist or physician) if there is a change in what they are normally at.			
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following			

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	discharge. Based on record review and interview, the agency failed to evidence a policy which indicated the agency would provide a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services were stopped, and failed to provide at least 15 days' notice for 1 of 1 patients who were discharged for reasons requiring 15 days' notice. (#2) The findings include: Review of a policy with revision date 1/2018, titled "Transfer/Discharge/Referral Procedures" stated "... Patients are informed prior to discharge of plans for discharge ....", but failed to evidence the patient should be provided at least 15 days' notice of intent to discharge. Record review for patient #2 was completed on 3/26/2021 and again on 3/29/2021, start of care date 2/10/2021, for certification period 2/10/2021 - 4/10/2021, evidenced a document dated and signed by the patient on 3/8/2021, titled "AuNova Home Care ... Notice of Medicare Non-Coverage", which evidenced the patient's home care services would end 3/11/2021, (3 days after notice was given), and the record evidenced the patient was discharged on 3/11/2021. Clinical record review failed to evidence the home health agency gave the patient a 15 day discharge notice. During an interview on 3/29/2021 at 3:17 PM, the administrator indicated the agency typically gave 14 days' notice of discharge, and also indicated she was unaware of the 15 day notice of discharge requirement.	N 0488	On 05/25/2021 Agency updated Discharge Policy to include the language from the Indiana Administrative Code 17-12-2(i) (i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) calendar day period described in subsection (i) does not apply in any of the following circumstances: (1) The health, safety, or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge. (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.	05/26/2021

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			(k) A home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) calendar day period described in subsection (i). If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Please note cited Patient #2 did not meet the 15 day discharge notice requirement based on patient scheduled for discharge based on the following criteria: (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge. (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Notice of Medicare Non-Coverage was issued in accordance with CMS guidelines.	
N 0502 Bldg. 00	410 IAC 17-12-3(b)(2)(C) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the			

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	following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on record review and interview, the home health agency failed to ensure all agency patients were advised of the Indiana Department of Health toll free home health telephone hot line, its contact information, or its hours of operation. The findings include: The agency's admission packet/home folder provided to the patient during the admission visit was reviewed on 3/24/2021. The folder included a packet titled "AuNova Home Care Patient Orientation For Home Health Care" which stated "... You may also contact the State's Home Health Hot Line at 1-800-882-6006 (toll free) ...." At 2:20 PM, the surveyor called the number, verified it was the Michigan state hotline number, and the recorded greeting stated "You have reached the state of Michigan complaint hotline ...." The admission packet failed to evidence a home health hotline number for the state of Indiana. During an interview on 3/24/2021 at 3:18 PM, the administrator indicated she would correct the hotline number in all admission packets and ensure all current patients receive the corrected information.	N 0502	The Administrator notified all Clinicians to correct the State Hotline phone number in the Admission packets in the patients home currently active with agency. The Administrator corrected all pre-made (prepared) Admission packets in the office with the corrected State Hotline phone number. The Administrator has updated the original document labeled the Admission Packets with the correct State Hotline phone number for all future documents that will be printed. The Administrator will be responsible for monitoring to ensure corrected Admission Packets are being printed to ensure the error will not recur.	03/30/2021
N 0504 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following:			

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	(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on observation, record review and interview, the agency failed to ensure agency patients were informed of the care to be furnished or any changes in the care to be furnished in 2 of 7 clinical records reviewed. (#4, #7) The findings include: 1. Review of an agency policy dated 01/2018 titled "Patient's Bill of Rights" stated "Patients Rights ... Participate in, be informed about, and consent to or refuse care in advance and during treatment ... establishing and revising the plan of care ... disciplines that will furnish the care ... any changes in the care ...." Additionally, the agency failed to provide a policy on how to furnish care to patients who were symptomatic for COVID-19. 2. Review of an undated agency policy titled "Code of Ethics" stated "... Patient Rights and Responsibilities ... Patient Rights and Responsibilities shall be respected by all agency personnel and integrated into all agency health care programs...." 3. Review of an agency policy dated 01/2018 titled "Physician Role in Home Care of Patients Plan of Care and Interim Orders" stated "... Each patient has an individualized plan of care. The plan is developed and evaluated in partnership with the patient, representative (if any), and caregiver(s) ... Any revision to the plan of care ... is	N 0504	Client #4 & #7 are In-Active Records, therefore no action was taken to correct the deficient practice for the client. Administrator has educated the Admitting RN clinician identified to have found to be in non-compliance with the Consent for Treatment to identify RN initial evaluation on the CONSENTS FOR TREATMENT. All Admitting staff were educated during an in-service on 04/23/2021 on the proper way to complete admission consent paperwork at Start of Care to ensure that patient is informed verbally and in writing of all evaluating disciplines. Effective 05/25/2021 The Administrator will audit a 100% all admission paperwork will be audited by the Administrator for compliance of proper consent paperwork over the next 30 days. The Administrator will be responsible for monitoring for 100% compliance with all admission paperwork to ensure that the Admission consents are	04/23/2021

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	communicated to: 1. The patient; 2. The representative (if any); 3. The caregiver...." 4. During a home visit with patient #7 on 3/29/2021 at 11:45 AM, the patient's home folder was observed and failed to evidence a current plan of care. PTA [physical therapy assistant] F indicated she did not drop off a copy of the plan of care for the home folder. During an interview on 3/29/2021 at 2:05 PM, when asked if agency staff provided a current/updated copy of the patients' plans of care to all patients' homes to incorporate into the home folders, the administrator stated "No ...." and indicated the agency would begin doing that. 5. Clinical record review on 3/29/21 for patient #4, primary diagnosis: Encounter for other orthopedic (branch of surgery concerned with conditions involving the Musculoskeletal system) aftercare, start of care 12/17/2020, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 12/17/2020-2/14/2021, and signed by the primary care physician on 12/17/2020. This document had a subsection titled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)." This subsection stated "... Skilled nursing [evaluation] eval only ...." A record review evidenced an agency document titled "AuNOVA Home Care - Admission Consent," dated 12/17/2020, signed by patient #4 and (Registered Nurse) RN G. This document had a subsection titled "Consent for Treatment." This subsection indicated the agency was to provide (Physical Therapy) PT evaluation and treatments. The document failed to include the RN initial evaluation completed by the agency.		being completed correctly to ensure that this deficiency is corrected and will not reoccur.	

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	During an interview on 3/29/2021 at 3:44 p.m., the administrator indicated she believes nursing only did an initial evaluation because the patient was an ortho (orthopedics) case, which did not require regular visits from the nurse. The admission paperwork should have indicated the skilled nursing (SN) evaluation.			
N 0505 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on record review and interview, the home health agency failed to inform the patient in advance about changes in the care to be furnished in 1 of 7 clinical records reviewed. (#4) The findings include: Review of an undated agency policy titled "Code of Ethics" stated "... Patient Rights and Responsibilities ... Patient Rights and Responsibilities shall be respected by all agency personnel and integrated into all agency health care programs...."	N 0505	Client #4 was an In-Active Record, therefore no action was taken to correct the deficient practice for the client. Administrator has educated the Admitting RN clinician identified to have found to be in non-compliance with the Consent for Treatment to identify RN initial evaluation on the CONSENTS FOR TREATMENT. All Admitting staff were educated during an in-service on 04/23/2021	04/23/2021

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	Review of an agency policy revised 01/2018, titled "Patient's Bill of Rights," stated "... Patient's Rights and Responsibilities (Patient Bill of Rights) ... Participate in, be informed about, and consent to or refuse care in advance of and during treatment, where appropriate, with respect to: ... the care to be furnished ... any factors that could affect treatment effectiveness ... any changes in the care to be furnished ...." Clinical record review on 3/29/21 for patient #4, primary diagnosis: Encounter for other orthopedic (branch of surgery concerned with conditions involving the Musculoskeletal system) aftercare, start of care 12/17/2020, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 12/17/2020-2/14/2021, signed by person L, physician for patient #4 on 12/17/2020. This document had a subsection titled "21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)." This subsection stated "... Skilled nursing [evaluation] eval only ...." A record review evidenced an agency document titled "AuNOVA Home Care - Admission Consent," dated 12/17/2020, signed by patient #4 and (Registered Nurse) RN G. This document had a subsection titled "Consent for Treatment." This subsection indicated the agency was to provide (Physical Therapy) PT evaluation and treatments. The document failed to include the RN initial evaluation completed by the agency. During an interview on 3/29/2021 at 3:44 PM, the administrator indicated she believes nursing only did an initial evaluation because the patient was an ortho (orthopedics) case, which did not require regular visits from the nurse. The admission		on the proper way to complete admission consent paperwork at Start of Care to ensure that patient is informed verbally and in writing of all evaluating disciplines. Effective 05/25/2021 The Administrator will audit a 100% all admission paperwork will be audited by the Administrator for compliance of proper consent paperwork over the next 30 days. The Administrator will be responsible for monitoring for 100% compliance with all admission paperwork to ensure that the Admission consents are being completed correctly to ensure that this deficiency is corrected and will not reoccur.	

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	paperwork should have indicated the skilled nursing (SN) evaluation. 17-12-3 (b)(2)(D)(i)(AA)			
N 0514 Bldg. 00	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the agency failed to document both the existence of a complaint and the resolution of the complaint for 2 of 2 records reviewed with complaint(s) made to the agency. (#3, 4) The findings include: 1. Review of an agency policy dated (revised) 01/2018, titled "Patient Complaints" stated "... A complaint is any expression of dissatisfaction by the client or family ... The organization [agency] investigates complaints made by a patient, the patient's representative ... The organization documents both the existence of the complaint and the resolution of the complaint ... A log is kept of all complaints received ... Source of complaints ... Nature of complaints ... Action taken	N 0514	Client #3 & #4 were In-Active Records, therefore no action was taken to correct the deficient practice for the client. On 04/23/2021 All staff have been instructed and re-educated that all complaints are to be immediately directed to the Administrator for documentation and resolution. Staff educated to ensure that all patients are aware of the grievance procedure upon admission and ongoing during episode of service. Effective 05/25/2021 The Clinical Manager to review 10% of newly documented communication notes for all active patients for the next	04/23/2021

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	... Whether the complaint is resolved ...." 2. Review of the agency's complaint log was completed on 3/24/2021 at 1:22 PM. The log evidenced one complaint in 2017, and evidenced no complaints in 2018, 2019, 2020, or 2021. 3. Clinical record review on 3/29/21 for patient #3, primary diagnosis: Type 2 Diabetes Mellitus (high levels of sugar in the blood), start of care 11/5/2020, evidenced an unsigned agency document titled "Communication Note" dated 1/15/2021. This document stated "... Based on Patient's spouse's behavior of yelling at [person I, former employee], [Administrator], using foul language and calling Clinicians 'incompetent', 'liar', and accusing staff of 'making stuff up', I asked if given the circumstances patients would like another home care agency to care for them, and spouse agreed...." During a phone interview on 3/24/2021 at 2:32 PM, patient #3 indicated they called the agency when the agency didn't show up a couple days after the last time they came out. She stated they (the agency) took the (Physical Therapist) PT's word about her having a headache and fever and she never had the symptoms the PT claimed she had. She stated her husband eventually told the agency they are not allowed back on 1/15/2021. During a phone interview on 3/24/2021 at 2:35 p.m., patient #3 indicated the PTA [Physical Therapy Assistant] didn't know how to use the thermometer as she did not have it in her ear correctly. She indicated she was laying on a heated blanket on that side prior to having her temperature taken, and that was why the thermometer read high. During a phone interview on 3/24/2021 at 2:40		30 days to ensure both the existence of a complaint and the resolution of the complaint is documented and logged in a separate Complaint Log. The Administrator will be responsible for ongoing compliance to ensure both the existence of a complaint and the resolution of the complaint is being performed to ensure this deficiency does not reoccur.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUNOVA HOME CARE LLC	6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530

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	p.m., patient #3 indicated they discharged her because she wouldn't go get a COVID test. 4. Clinical record review on 3/29/21 for patient #4, primary diagnosis: Encounter for other orthopedic (branch of surgery concerned with conditions involving the Musculoskeletal system) aftercare, start of care 12/17/2020, evidenced an agency document titled "Physical Therapy Process," dated 1/12/2021, signed by (Physical Therapy Assistant) PTA E. This document had a subsection titled "Subjective reports:." This subsection stated "... Took [patient #3] patience [sic] temperature with patient's ear thermometer which registered 101.0 degrees Fahrenheit. subsequently took patients temperature with my thermometer which was a temporal thermometer which registered 98.5 degrees...." A record review evidenced an agency document titled "Communication Note," dated 1/13/2021, signed by (Licensed Practical Nurse) LPN I. This document stated "... agency will place patient on hold until negative test or 10-14 days of symptom onset ... No lab draws will be performed during this time ...." A record review evidenced an agency document titled "AuNOVA Home Care," dated 1/15/2021, signed by person L, Physician for patient #4. This document stated "... Patient discharged from agency due to unsafe environment to continue care...." Was this cited under a patient rights discharge tag? It was not. Should I add it to the tag I wrote for G454? I added this to G454 A record review evidenced an agency document titled "Communication Note," dated 1/15/2021, signed by person I, former employee. This document stated "... patient request a referral to			

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	another home care to continue (Physical Therapy) PT and labs draws per oncologist...." A record review evidenced an agency document titled "Communication Note," dated 1/15/2021, signed by person I, former employee. This document stated "... Called patient this morning to follow up on status of covid testing so we could make plans to see patient ... Patient got very irate with me stating wife never had any symptoms, patient was yelling and using foul language with me over the phone ...." A record review evidenced an unsigned agency document titled "Communication Note," dated 1/15/2021. This document stated "... [Person I, former employee] was on phone with patient who was using foul language and yelling at clinician for 'lying' about symptoms ... Upon speaking with patient, he informed me that his dr [doctor] called him and told him and his wife that he didn't think they needed to get tested and had no symptoms ... He continued to say PTA was 'lying' and used the patient's thermometer incorrectly which is why she had a reading of 101 and when used her own thermometer the reading was normal in 98 ... He continued to say spouse had no symptoms ... patient was not receptive and started raising his voice ... At this point, I did tell him ... given the circumstances, would you like the referral to be made to another home care agency for both of you'. Patient states 'absolutely, we don't trust you at all'...." Review of the agency's complaint log was completed on 3/24/2021. The log evidenced one complaint in 2017, and evidenced no complaints in 2018, 2019, 2020, or 2021. The agency failed to document both the existence and resolution of the complaint. (new paragraph to indicate the			

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	complaint was not documented) During a phone interview on 3/24/2021 at 2:49 PM, patient #4 indicated the person who was supposed to come out on 1/13/21, to do a blood draw never showed up. He indicated they added the cough/sore throat symptoms, which patient #3 never had. He also indicated they kept cutting him off on the phone and he said to the administrator that she was unprofessional. He indicated that on 1/15/2021, the administrator indicated they would not come out due to COVID and he stated he would not let them come out anymore. During an interview on 3/29/2021 at 2:05 PM, the administrator indicated she was the final person who was on the phone with patient #4, he was loud, aggressive, and yelling, he indicated his physician didn't want him to get a COVID-19 test, the therapist was a liar, and he was upset about incompetent staff. 5. During an interview on 3/24/2021 at 10:42 AM, the administrator indicated complaints were documented in the agency complaint log, the agency had no complaints documented, the agency had not had any "official" complaints, the agency had not had any patients that called and complained, and if complaints were made to staff during home visits, the complaint would be identified in the patient's medical record.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a			

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	skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure all patients' plans of care included all required elements for 6 of 7 patient's plans of care reviewed (#1, 2, 3, 4, 5, 6). The findings include: 1. Review of an agency policy, with a revision date of 01/2018, titled "Physician Role in Home Care of Patients Plan of Care and Interim Orders" stated "... The plan of care includes: ... All pertinent diagnosis [sic] ... All patient care orders, including verbal orders ... Client's mental, cognitive, psychosocial status ... types of services, supplies, and equipment required ... Duration and frequency of visits to be made ... Prognosis and Rehabilitation potential ... Functional limitations ... Nutritional requirements ... Activities permitted ... All medications and	N 0524	Client #1, #2, #3, #4, #5, #6 are In-Active Records, therefore no action was taken to correct the deficient practice for the client. After a review of 100% of Active charts, on 04/23/21 The Admitting Clinicians were educated on proper completion of the patients' plans of care included all required elements to include Cover all pertinent diagnoses and Medications and treatments. Effective 05/25/2021 The Clinical Manager will perform reviews of Comprehensive Assessments and those patient's plan of care on 10% of the admitted patients for the next 30 days to ensure 100% compliance is met with Clinicians	04/23/2021

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	treatments ... Food or drug allergies ... Safety measures to protect against injury ... Plans for the patient during a natural or man-made disaster ... A description of the patients risk for emergency department visits and hospital readmission, 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 ... Homebound status ... Measurable outcomes and goals identified by the organization [agency] and the patient ... Information related to any advance directives; and ... Any additional items the organization or physician may choose to include ...." 2. Record review for patient #1 was completed on 3/25/2021 and again on 3/29/2021, start of care date 2/7/2021, for certification period 2/7/2021 - 4/7/2021. This clinical record review evidenced a document dated 2/4/2021, titled "Discharge Summary Note" (from hospital E). This document evidenced the patient was hospitalized for a left shoulder replacement, had a history of (but not limited to) breast cancer, high cholesterol, and seizure disorder, and stated "... Sling in place on LUE [left upper extremity], anesthesiologist and hospitalist in with patient discussing the On-Q ball [non-narcotic pan pump with tube inserted near incision]. Spouse was present ...." Review of a document signed by PT [physical therapist] H on 2/7/2021 and physician assistant (PA) G on 3/1/2021, titled "Home Health Certification and Plan of Care" evidenced the patient's medications included (but were not limited to) kadcyla (a chemotherapy medication used to treat cancer), rosuvastatin (a cholesterol medication), and levetiracetam (an anti-seizure medication), the diagnoses list failed to evidence		completing all required elements in a plan of care are met. Clinical Manager has included review of the Comprehensive Assessment and their Plan of cares to ensure on-going compliance as part of the quarterly QAPI activities. The Administrator will be responsible for oversight and monitoring of compliance with this deficient practice to ensure that it does not re occur.	

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	breast cancer, high cholesterol, and seizure disorder, and failed to evidence presence of the Q-ball pain pump and clinician interventions/patient caregiver teaching. 3. Record review for patient #2 was completed on 3/26/2021 and again on 3/29/2021, start of care date 2/10/2021, for certification period 2/10/2021 - 4/10/2021. This clinical record review evidenced a document dated 2/9/2021, from hospital J, titled "Clinical Summary" which evidenced the patient had active diagnoses of (but not limited to) spinal stenosis (a narrowing of the spaces within your spine, which can put pressure on the nerves that travel through the spine), chronic back pain, coronary artery disease (CAD), arthritis, acid reflux, and hypothyroidism. Review of a hospital J document dated 1/8/2021, titled "History and Physical" stated "... She [patient] has severe osteoporosis [a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, or deficiency of calcium or vitamin D] ...." Review of a document dated 2/10/2021 and signed by PT H on 2/14/2021, titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)" evidenced (but not limited to) the patient had severe osteoporosis, obesity, and presence of a cardiac pacemaker/defibrillator (a surgically implanted device to help control abnormal heart rhythms). Review of a document signed by PT H on 2/10/2021, evidenced the patient began taking sulfamethoxazole- TMP (an antibiotic medication) on 2/9/2021, for diagnosis of UTI (urinary tract infection).			

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	Review of a document signed by PT H on 2/10/2021, and physician F on 2/26/2021, titled "Home Health Certification and Plan of Care" evidenced the patient's medications included (but were not limited to) alendronate (a medication to treat osteoporosis), apixaban (a blood thinner that reduces blood clotting and reduces the risk of stroke in patients with abnormal heart rhythms), levothyroxine (a medication used to treat hypothyroidism), and pantoprazole (a medication used to treat acid reflux). The document failed to evidence the patient's diagnosis of spinal stenosis, chronic back pain, CAD, arthritis, acid reflux, hypothyroidism, obesity, and presence of a cardiac pacemaker/defibrillator, and failed to evidence the patient's antibiotic medication (sulfamethoxazole- TMP). 4. Record review for patient #5 was completed on 3/29/2021, start of care date 3/12/2021, for certification period 3/12/2021 - 5/10/2021, evidenced a document dated and signed by PT J on 3/12/2021, titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)" which evidenced (but was not limited to) the patient was discharged from hospital J on 3/10/2021, after a right hip replacement, and the patient had diabetes. Review of a document signed by PT J on 3/12/2021, and physician F on 3/24/2021, titled "Home Health Certification and Plan of Care" evidenced the patient's medications included (but were not limited to) metoprolol (a medication used to treat high blood pressure), docusate sodium (a medication for constipation), atorvastatin (a medication used to treat high cholesterol), atropine/CPM/hyoscyamine/PE/PPA/Scopalamine ER (a medication used to treat irritable bowel			

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	syndrome or duodenal ulcers), pantoprazole (a medication used to treat GERD), and tamsulosin (a medication used to treat an enlarged prostate). The document failed to evidence the dose of atropine/CPM/hyoscyamine/PE/PPA/Scopalamine ER, and failed to evidence diagnoses of diabetes, or diagnoses related to medications the patient took, such as high blood pressure, constipation, high cholesterol, irritable bowel syndrome or duodenal ulcers, GERD, or enlarged prostate. 5. Record review for patient #6 was completed on 3/26/2021 and again on 3/29/2021, start of care date 3/1/2021, for certification period 3/1/2021 - 4/9/2021, evidenced an undated document titled "Patient Profile" which stated "... Received referral from [hospital A] for SN [skilled nursing] PT OT [occupational therapy] HHA [home health aide]. Patient will be DC [discharged] to home on 2/24/2021 ...." Review of a document signed by RN G on 3/1/2021, and physician M on 3/16/2021, titled "Home Health Certification and Plan of Care" evidenced the patient's medications included (but were not limited to) humalog (an injectable medication used to treat diabetes), plus a sliding scale (additional dose based on blood sugar reading) 3 times daily. The document failed to include the parameters for the administration of the sliding scale insulin. 6. Clinical record review on 3/29/21 for patient #3, primary diagnosis: Type 2 Diabetes Mellitus (Disease process where the body is unable to effectively use insulin to bring glucose into the cells), start of care 11/6/2020, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 1/5/2021-3/5/2021, signed by person K, Physician for patient #3, on 1/28/2021. This			

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	document had a subsection titled "10. Medications: Dose/Route/Frequency (N)ew (C)hanged." This subsection stated "Mupirocin [antibiotic used to treat skin infections] 2% Topical Ointment (22 gm [grams]) ; apply topically to affected areas three times daily (N) ...." The document failed to include where the affected areas are located to apply the Mupirocin. 7. Clinical record review on 3/29/21 for patient #4, primary diagnosis: Encounter for other orthopedic (branch of surgery concerned with conditions involving the Musculoskeletal system) aftercare, start of care 12/17/2020, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 12/17/2020-2/14/2021, signed by person L, Physician for patient #4. This document had a subsection titled "Goals/Rehabilitation Potential/Discharge Plans/Referral Plan/Other Notes," which failed to include a goal for pain. During an interview on 3/29/2021 at 3:15 PM, the Administrator indicated that medication [Mupirocin] was discontinued on 1/4/2021. It should have specified the affected area. During an interview on 3/29/2021 at 3:50 PM, the Administrato indicated there was no pain goal.			
N 0540 Bldg. 00	410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Based on record review and interview, the agency	N 0540	On 04/23/2021 All In-take staff were in-serviced on The registered	04/23/2021

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	failed to ensure a registered nurse (RN) conducted the initial assessment visit for 1 of 1 records reviewed for patients who received both nursing and therapy services (#1); failed to ensure the initial assessment visit was made either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date for 2 of 7 records reviewed (#6, 7); and failed to ensure the initial assessment was made based on patient need, not agency convenience or availability for 3 of 7 records reviewed (#1, 6, 7). The findings include: 1. Review of an undated agency policy titled "Admission Policy" stated "... Clients will be accepted for home care with the expectation that the agency can provide the services the client needs and that the client's condition can be managed safely ... Initial Assessment Visit: A home visit is made ... within 48 hours of referral or according to physician's orders and/or patient/family wishes...." 2. Review of an undated agency policy titled "Comprehensive Assessments and OASIS [outcome assessment information data set]" stated "... The SOC [start of care/admission] Assessment is completed in a timely manner (within 48 hours) ... Referral to other disciplines for Evaluation ... will be completed no later than 2-5 days after the start of care ...." 3. Record review for patient #1 was completed on 3/25/2021 and again on 3/29/2021, start of care date (Sunday) 2/7/2021, for certification period 2/7/2021 - 4/7/2021. The record failed to evidence the initial assessment was completed by a registered nurse when both nursing and therapy		nurse shall perform nursing duties in accordance with the Indiana nurse practice act (IC 25-23). Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit. Effective 05/25/2021 the Clinical Manager is reviewing a 100% of referrals received by agency to ensure when an order for home health is received, a registered nurse shall do the initial evaluation visit except where order is limited to therapy services only. The Administrator is responsible for ongoing monitoring and compliance to ensure this deficiency does not reoccur.	

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	was ordered, and failed to ensure the initial assessment was made based on patient need, not agency convenience or availability. The initial comprehensive assessment was completed, dated 2/7/2021, and signed on 2/11/2021 by PT H. Review of a document dated and signed by physician D on 2/5/2021, titled "AuNova Home Care Provider Referral/Order Form" stated "... Home Health Skilled Services to eval & treat: ... Skilled Nursing ... Physical Therapy [PT] ... Occupational Therapy [OT] ... Home Health Aide [HHA] ...." Review of an unsigned document (unknown author) dated 2/5//2021 at 10:19 AM, titled "Referred for Admission [order]" evidenced physician D was the referring physician, and stated "... Received referral from [hospital E] for SN [skilled nursing] PT OT HHA. Patient will be DC [discharged] to home on 2/5/2021. Dr. [physician F] to follow ...." Review of a document dated and signed by the clinical manager on 2/5/2021 at 3:40 PM, titled "Admission Order" evidenced the ordering physician was physician assistant (PA) G, the patient was discharged to home on 2/5/2021, agency to admit on 2/7/2021 (PT to perform initial assessment), and RN to assess on 2/8/2021 for incision monitoring and constipation education. Review of a document dated and signed by PT H on 2/5/2021, titled "Communication Note" stated "... AuNova Home care received notification from [hospital E] regarding patient fall at home today. This therapist called [physician assistant G] reporting fall and unknown status of patient. He stated patient should call him to report her current status and he will decide what needs to be done.			

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	He stated she should go directly to urgent care or ER [emergency room] if any musculoskeletal or neurological injuries noted. This therapist requested clarification on home care orders. PA stated patient should have no shoulder movement for 2 weeks after surgery. Ok for ELBOW PROM [passive range of motion] only during that time. PT to address home accessibility/safety with navigation, ambulation. He stated OT for ADLs [activities of daily living], SN and bath aid all would be appropriate as needed for patient. This therapist spoke with patient's husband ... and provided information from PA including his direct number to call to report physical status since fall. (He stated patient fell in home while walking to bathroom. Is sore but doesn't think she hurt herself/shoulder). He took name and number of PA and stated he would call. Scheduled PT SOC for 2/7/21 at 11:00, with husband ...." Review of the initial assessment document dated 2/7/2021 and signed on 2/11/2021 by PT H, titled "Patient Assessment: OASIS D1 (Full)" stated "... Interventions planned: ... OT [occupational therapy] referral ... [home health] aide ... patient agrees ... They would like all the services they can get especially at the beginning and decrease them as appropriate ...." The document evidenced it was the initial start of care comprehensive assessment, and the visit was not performed by a registered nurse. During a phone interview on 3/25/2021 at 3:38 PM, the patient indicated she had her surgery (shoulder replacement) and came home on (Friday) 2/5/2021, the agency staff didn't come when they were supposed to, there was a mix up with the nurse, it was just one thing after another, and the first day someone was supposed to come, it was car trouble (and no one came).			

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	During a phone interview on 3/26/2021 at 9:43 AM, the patient's spouse indicated the patient got out of the hospital on Friday (2/5/2021), they expected to see a nurse either Friday or Saturday, but the agency said they couldn't get anyone there until Sunday (2/7/2021), and someone came Sunday just to ask questions and sign papers, as of 2/11/2021 no aide had contacted patient to schedule a visit, it was just "too late by then", and he stated "... We never refused OT or aide, but after a while, she was getting better and we just didn't need it. I canceled services because the nurses really didn't do anything, and PT (physical therapy) helped a lot, but I didn't need them anymore ...." 4. Record review for patient #6 was completed on 3/26/2021 and again on 3/29/2021, start of care date 3/1/2021, for certification period 3/1/2021 - 4/9/2021, evidenced an undated document titled "Patient Profile" which stated "... Received referral from [hospital A] for SN [skilled nursing] PT OT HHA. Patient will be DC [discharged] to home on 2/24/2021 ...." Review of a document dated and signed by the clinical manager on 2/25/2021, and signed by physician M on 3/10/2021 titled "Admission Order" stated "... Patient discharged [from hospital] to home on 2/25/2021 ... [nurse at physician M's office] verified MD [medical doctor] to follow for home health. Upon calling to schedule start of care patient requested to be seen on 3/01/2021 ...." The document failed to evidence the physician was notified of the change in start of care date during the phone conversation with nurse at physician M's office on 2/25/2021.			

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	5. Record review for patient #7 was completed on 3/29/2021, start of care date 3/16/2021, for certification period 3/16/2021 - 5/14/2021, evidenced a document dated and signed by physician C on 3/9/2021 titled "[physician clinic B letterhead]" stated "... planning to discharge home 3/10 [2021] ... Review of discharge plans: ... PT/OT to continue to increase strength and endurance ... skilled nursing r/t [related to] medication management; and bath aide...." Review of a document dated and signed by RN G on 3/12/2021 at 10:12 AM titled "Admission Order" stated "... discharged to home on 3/10/2021 ... [physician N's office] verified MD will be following for home health. Upon calling to schedule start of care patient requested to be seen on 3/16/2021 ...." The document failed to evidence the physician was notified of the change in start of care date during the phone conversation with physician N's office on 3/12/2021. During a home observation visit on 3/29/2021 at 11:45 AM, family indicated they did not request to delay the start of care for home health services (6 days) when the patient came home from skilled nursing rehab facility H. 6. During an interview on 3/29/2021 at 2:05 PM, the administrator indicated agency scheduling staff called patients to schedule visits based on staff availability, but then documented it was the patients' request, and that she would address the concern.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for			

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	purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the clinician failed to ensure the comprehensive assessment included a complete picture of the patient's current health status for 5 of 7 clinical records reviewed (#1, 2, 3, 4, 5). The findings include: 1. Review of an undated agency policy titled "Admission Policy" stated "... The comprehensive assessment including Outcome and Assessment Information Set (OASIS) ... includes, at a minimum, a thorough evaluation of the client, his functional limitations, needs and desires, the abilities and willingness of any family care givers, and the adequacy of the environment...." 2. Review of a web reference site on 03/25/2021 at http://1797f0cd94.nxcli.net/wp-content/uploads/2019/09/ap_patient-brochure_catheterremoval-mk-00456-rev1_90d.pdf titled "On-Q* Catheter Removal" stated "... The catheter is a small tube near your incision site that is connected to your infusion pump ...." 3. Record review for patient #1 was completed on 3/25/2021 and again on 3/29/2021, start of care date 2/7/2021, for certification period 2/7/2021 - 4/7/2021. Clinical record review evidenced a document dated 2/7/2021 titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)". The document failed to evidence PT H assessed the patient's vital signs (blood pressure, heart rate, respirations, and	N 0541	Client #1, #2, #3, #4, #5 were In-Active Records, therefore no action was taken to correct the deficient practice for the client. After a review of 100% of Active charts, on 04/23/21 The Admitting Clinicians were educated on proper completion of the Comprehensive assessment to include a complete picture of the patient's current health status. Effective 05/25/2021 The Clinical Manager will perform reviews of Comprehensive Assessments on 10% of the admitted patients for the next 30 days to ensure 100% compliance is met with Clinicians completing a picture addressing the patient's current health status. Clinical Manager has included review of the Comprehensive Assessment to ensure on-going compliance as part of the quarterly QAPI activities. The Administrator will be responsible for oversight and monitoring of compliance with this deficient practice to ensure that it does not re occur.	04/23/2021

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	temperature), heart and lung sounds, or the patient's On-Q ball (a non-narcotic pain pump) present on the patient's left upper arm. Review of a document dated 2/4/2021 titled "Discharge Summary Note" (from hospital E) evidenced the patient had a left shoulder replacement, and stated "... Sling in place on LUE [left upper extremity], anesthesiologist and hospitalist in with patient discussing the On-Q ball. Spouse was present ...." During an interview 3/26/2021 at 9:43 AM, the patient's spouse stated "... I had to remove the Q Ball myself, because she said she couldn't do anything with it ... She wasn't a nurse ... I also took off the dressing myself ...." During an interview on 3/29/2021 at 2:05 PM, the clinical manager indicated the patient's husband was uncomfortable with the removal of the Q-ball, and PT H "walked him through it". During this time, the administrator stated "... I'm surprised that [PT H] didn't add that [presence of the Q-ball] to her start of care assessment ...." The clinical manager and administrator agreed the assessment failed to evidence vital signs, heart and lung sounds, or the patient's On-Q ball present on the patient's left upper arm, and the administrator indicated it could put the agency at risk if problems were missed due to not being assessed during the comprehensive assessment. 4. Record review for patient #2 was completed on 3/26/2021 and again on 3/29/2021, start of care date 2/10/2021, for certification period 2/10/2021 - 4/10/2021, evidenced a document dated 2/10/2021 and signed by PT H on 2/14/2021 titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)". The document			

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	evidenced the patient was discharged from the hospital on 2/8/2021, and failed to evidence PT H performed a head to toe assessment of the patient's integumentary (skin) system. Review of a document dated and signed by PTA E on 2/15/2021 titled "Physical Therapy Progress" stated "... Communicated with [clinical manager] ... also communicated with initial evaluation [PT H] regarding patients [sic] pressure sore to left heel ...." Review of a document dated and signed 2/15/2021 by PT H titled "Communication Note" stated "... pressure sore on ... L [left] heel that patient states occurred while in hospital ...." Review of a document dated and signed by RN G on 2/18/2021 titled "Skilled Nurse Visit Note" indicated the wound on the patient's left heel was a stage 2 (limited to layers of the skin, not underlying tissues) pressure sore. The document also included a picture, which evidenced presence of eschar/necrotic (dead skin tissue) tissue, which would indicate a more severe wound. During an interview on 3/26/2021 at 3:45 PM, the patient indicated she developed the sore on her left heel while she was in the hospital, and a nurse came out to treat it (at her home). During an interview on 3/29/2021 at 2:05 PM, the patient's record was reviewed with the clinical manager and administrator. During this time, the clinical manager observed a picture of the patient's left heel pressure sore and indicated it looked like it had presence of eschar/necrosis , and it was possibly a stage 3 or 4 wound (full thickness, beyond depth of all skin layers).			

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	5. Record review for patient #5 was completed on 3/29/2021, start of care date 3/12/2021, for certification period 3/12/2021 - 5/10/2021, evidenced a document dated and signed by PT J on 3/12/2021 titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)" evidenced the patient was discharged from hospital J on 3/10/2021, the patient had a right hip replacement, and the document failed to evidence the incision was assessed. 6. Clinical record review on 3/29/21 for patient #3, primary diagnosis: Type 2 Diabetes Mellitus (high levels of sugar in the blood), start of care 11/5/2020, evidenced an agency document titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)," dated 1/7/2021, signed by RN G. This document had subsections titled "Musculoskeletal, Neurological," "Nutritional Status," and "Equipment and Supplies." The clinician failed to include the patient's musculoskeletal and neurological status; the overweight status of the patient; and include the equipment (wheelchair, walker, transfer chair, grab bars, shower chair, and hospital bed) the patient is using, in the comprehensive assessment. During an interview on 3/29/2021 at 2:59 PM, the Administrator indicated RN G did not check the box for musculoskeletal/neurological status (for patient #3). It did not say whether it was normal or abnormal. During an interview on 3/29/2021 at 3:03 PM the Clinical Manager indicated the patient (patient #3) was considered obese. She indicated that should have been addressed . During an interview on 3/29/2021 at 3:07 PM, the Administrator indicated the durable medical			

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	equipment was not addressed here (for patient #3). 7. Clinical record review on 3/29/21 for patient #4, primary diagnosis: Encounter for other orthopedic (branch of surgery concerned with conditions involving the musculoskeletal system) aftercare, start of care 12/17/2020, evidenced an agency document titled "Patient Assessment: OASIS D1 (Full)," dated 12/17/2020, signed by RN G. This document had a subsection titled "Neck and Throat." The clinician failed to include the status of the neck and throat in the comprehensive assessment. During an interview on 3/29/2021 at 3:38 PM, the Administrator indicated if the neck and throat status (for patient #4) was blank, then I'm going to say that it was not assessed.			
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview, the home health agency failed to ensure it provided patient education and documentation of the patient's response and comprehension of the education for 2 of 7 records reviewed (#1, 2).	N 0546	Client #1 & #2 were In-Active Records, therefore no action was taken to correct the deficient practice for the client. After a review of 100% of Active	04/23/2021

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	The findings include: 1. Review on 3/25/2021 of a web reference site http://1797f0cd94.nxcli.net/wp-content/uploads/2019/09/ap_patient-brochure_catheterremoval-mk-00456-rev1_90d.pdf titled "On-Q* Catheter Removal" stated "... The catheter is a small tube near your incision site that is connected to your infusion pump. The color of the catheter may be clear or golden. REMOVAL OF CATHETER ... If your doctor has instructed you to remove the catheter, then follow their instructions keeping in mind these key steps: ... Wash your hands thoroughly with soap and warm water. Dry thoroughly ... Remove the dressing covering the catheter site ... Remove any skin adhesive strips ... Grasp the catheter close to the skin, and gently pull on the catheter. It should be easy to remove and not painful. Do not tug or quickly pull on the catheter during removal. If it becomes hard to remove or stretches, then STOP. Call your doctor. Continued pulling could break the catheter ... Do not cut or pull hard to remove the catheter. WARNING: After you remove the catheter, check the catheter tip for the black marking to ensure the entire catheter was removed. Call your doctor if you don't see the black marking ... Place a dressing over the catheter site as instructed by your doctor ...." 2. Record review for patient #1 was completed on 3/25/2021 and again on 3/29/2021, start of care date 2/7/2021, for certification period 2/7/2021 - 4/7/2021. This clinical record review evidenced a document dated 2/4/2021, titled "Discharge Summary Note" (from hospital E). The document indicated the patient had a left shoulder replacement, and stated "... Sling in place on LUE [left upper extremity], anesthesiologist and		charts, on 04/23/21 The Admitting Clinicians were educated on proper completion of the Comprehensive assessment to include patient education and documentation of the patient's response and comprehension of the education. Effective 05/25/2021 The Clinical Manager will perform reviews of Comprehensive Assessments on 10% of the admitted patients for the next 30 days to ensure 100% compliance is met with Clinicians ensure it provided patient education and documentation of the patient's response and comprehension of the education Clinical Manager has included review of the Comprehensive Assessment to ensure on-going compliance as part of the quarterly QAPI activities. The Administrator will be responsible for oversight and monitoring of compliance with this deficient practice to ensure that it does not re occur.	

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	hospitalist in with patient discussing the On-Q ball [a non-narcotic pain pump]. Spouse was present ...." Review of a document dated 2/7/2021, titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)" failed to evidence PT [physical therapist] H provided the patient and/or caregiver education related to the patient's On-Q ball, such as (but not limited to) infection control, procedure for removal, inspection of catheter tip, post catheter removal care, or signs and symptoms to report to the physician. During an interview on 3/26/2021 at 9:43 AM, the patient's spouse stated "... I had to remove the Q Ball myself, because she said she couldn't do anything with it ... She wasn't a nurse ... I also took off the dressing myself ...." During an interview on 3/29/2021 at 2:05 PM, the clinical manager indicated the patient's husband was uncomfortable with the removal of the Q-ball, and PT H "walked him through it". During this time, the administrator stated "... I'm surprised that [PT H] didn't add that [presence of the Q-ball] to her start of care assessment ...." The clinical manager and administrator agreed the assessment failed to evidence the patient's On-Q ball present on the patient's left upper arm. 3. Record review for patient #2 was completed on 3/26/2021 and again on 3/29/2021, start of care date 2/10/2021, for certification period 2/10/2021 - 4/10/2021. This clinical record review evidenced a document dated 2/10/2021, and signed 2/14/2021 by PT H titled "Patient Assessment: OASIS D1 (Full)" This document indicated (but was not limited to) the patient had a history of UTIs			

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	(urinary tract infections), took preventative antibiotics, and did not know she had a UTI until she was tested in the hospital. The record failed to evidence the patient was educated on signs/symptoms of UTI and when to contact agency and/or physician.			
N 0557 Bldg. 00	410 IAC 17-14-1(a)(2)(E) Scope of Services Rule 14 Sec. 1(a) (2)(E) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (E) Assist the patient in learning appropriate self-care techniques. Based on record review and interview, the home health agency failed to ensure the skilled professionals provided patient and caregiver education in 1 of 7 clinical records reviewed. (#3) The findings include: Review of an undated agency policy titled "Medication Monitoring/Orders/Teaching/Documentation" stated "... The agency will provide the patient and family/caregiver with the information needed to reach and maintain optimum use of medications ... Documentation in the patient record of services provided includes the following: ... Patient/caregiver instruction ... Patient response to teaching...." Clinical record review on 3/29/21 for patient #3, primary diagnosis: Type 2 Diabetes Mellitus (Disease process where the body is unable to effectively use insulin to bring glucose into the cells), start of care 11/5/2020, evidenced an agency document titled "Patient Assessment:	N 0557	Client #3 was an In-Active Record, therefore no action was taken to correct the deficient practice for the client. After a review of 100% of Active charts, on 04/23/21 The Admitting Clinicians were educated on proper completion of the Comprehensive assessment to include patient education and documentation of the patient's response and comprehension of the education. Effective 05/25/2021 The Clinical Manager will perform reviews of Comprehensive Assessments on 10% of the admitted patients for the next 30 days to ensure 100% compliance is met with Clinicians ensure it provided patient education and documentation of the patient's response and comprehension of	04/23/2021

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	OASIS [Outcome and Assessment Information Set] D1 (Full)," dated 1/7/2021, signed by (registered nurse) RN G. This document had a subsection titled "Sensory Status." This subsection stated "... Partially impaired: cannot see medication labels or newsprint ...." This document indicated under the same subsection that the patient does not use any visual aids. Record review failed to evidence documentation the clinician educated the patient's caregivers on the proper administrations of medications. During an interview on 3/29/21 at 2:55 PM, the Administrator indicated the patient had a son and husband that lived with them. She indicated someone must help her and she has a daughter who is a nurse, but it did not say in the documentation that the family was helping her with her medication.		the education Clinical Manager has included review of the Comprehensive Assessment to ensure on-going compliance as part of the quarterly QAPI activities. The Administrator will be responsible for oversight and monitoring of compliance with this deficient practice to ensure that it does not re occur.	
N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the agency failed to ensure all clinical document entries were complete, appropriately authenticated, dated, and timed for 6 of 7 records reviewed (#1, 2, 3, 4, 5, 6). The findings include: 1. Record review for patient #1 was completed on 3/25/2021 and again on 3/29/2021, start of care date 2/7/2021, for certification period 2/7/2021 - 4/7/2021. Clinical record review evidenced a document dated 2/5/2021 titled "Communication	N 0610	After a review of 100% of Active charts, on 04/23/2021 All staff were educated on All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must includes signatures or a secured computer entry specific to Communication Notes and Medication Profiles. Agency contacted software company to ensure administrative staff (non-clinical) were able to	04/23/2021

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	Note" which evidenced an electronic signature by intake/payroll office person, but failed to evidence a date of the signature; a document dated 2/5/2021, titled "Referred for Admission" failed to evidence any agency staff signature or date of signature; a document titled "Patient Medication Profile" evidenced a section for the signature of an RN (registered nurse) or LPN (licensed practical nurse), but failed to evidence a skilled nurse's signature or date of signature; a document dated 2/20/2021, titled "Patient Assessment: OASIS [Outcome and Assessment Information Set] D1 (Full)" evidenced PT [physical therapist] H electronically signed the document, but failed to evidence a time. 2. Record review for patient #2 was completed on 3/26/2021 and again on 3/29/2021, start of care date 2/10/2021, for certification period 2/10/2021 - 4/10/2021. Clinical record review evidenced a document titled "Patient Medication Profile" This document evidenced a section for the signature of an RN or LPN, but failed to evidence a skilled nurse's signature or date of signature; a document dated and signed by PT H on 2/10/2021, titled "Home Health Certification and Plan of Care", which evidenced additional information was incorporated to the document, effective 2/18/2021, but the document failed to evidence the clinician reviewed and approved the changes; a document dated 1/26/2021,titled "Referred for Admission" failed to evidence any agency staff signature or date of signature; and a document dated 2/8/2021, titled "Communication Note" which failed to evidence a signature or date. 3. Record review for patient #5 was completed on 3/29/2021, start of care date 3/12/2021, for certification period 3/12/2021 - 5/10/2021. This clinical record review evidenced a document titled		electronically sign documents assigned to them. Effective 05/25/2021 The Clinical Manager will perform reviews of Communication Notes and Medication Profiles on 10% of the active patients for the next 30 days to ensure 100% compliance is met. The Administrator will be responsible for oversight and monitoring of compliance with this deficient practice to ensure that it does not re occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157683	A. BUILDING 00 B. WING	03/26/2021

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	"Patient Medication Profile" which evidenced a section for the signature of an RN or LPN, but failed to evidence a skilled nurse's signature or date of signature; and a document dated 3/25/2021, titled "Communication Note" which evidenced the administrator's electronic signature, but failed to evidence the date of signature. 4. Record review for patient #6 was completed on 3/26/2021 and again on 3/29/2021, start of care date 3/1/2021, for certification period 3/1/2021 - 4/9/2021. This clinical record review evidenced a document dated and signed 3/1/2021, by RN G titled "Home Health Certification and Plan of Care" which evidenced additional information was incorporated to the document after the RN signed the document, but the document failed to evidence the clinician reviewed and approved the changes. Review of a document dated and signed by PT J on 3/3/2021, titled "Physical Therapy Evaluation/Plan of Treatment" evidenced the evaluation was completed after the RN signed the Plan of Care, and was later incorporated to the document; a document titled "Patient Medication Profile" evidenced a section for the signature of an RN or LPN, but failed to evidence a skilled nurse's signature or date of signature; a document dated 3/1/2021, titled "Communication Note" evidenced the office manager's electronic signature, but failed to evidence the date of signature; and a document dated 3/10/2021, titled "Communication Note" evidenced the administrative assistant's electronic signature, but failed to evidence the date of signature. 5. Clinical record review on 3/29/21 for patient #4, primary diagnosis: Encounter for other orthopedic aftercare, start of care 12/17/2020, evidenced an undated and unsigned document titled "Patient			

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	Medication Profile." The agency failed to authenticate the medication profile with a signature, title, and date. A record review evidenced an unsigned agency document titled "Communication Note," dated 1/13/2021. This document indicated the Administrator spoke with the patient. The agency failed to authenticate the communication record with a signature and title. A record review evidenced an unsigned agency document titled "Communication Note," dated 1/12/2021. This document indicated communication was made for possible COVID 19 symptoms. The agency failed to authenticate the communication record with a signature, title, and date of signature. A record review evidenced an unsigned agency document titled "Communication Note," dated 1/15/2021. This document indicated the Administrator communicated with the patient. The agency failed to authenticate the communication record with a signature, title, and date of signature. 6. Clinical record review on 3/29/21 for patient #3, primary diagnosis: Type 2 Diabetes Mellitus (Disease process where the body is unable to effectively use insulin to bring glucose into the cells), start of care 11/5/2020, evidenced an unsigned and undated document titled "Patient Medication Profile." The agency failed to authenticate the medication profile with a signature, title, and date. 7. During an interview on 3/29/21 at 3:55 PM, the Administrator indicated these documents (communication notes) should be signed. She			

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	indicated she spoke with the software company about the agency's capabilities to sign these electronic documents, but if they are not a clinician then they cannot sign everything. She indicated clinical people are supposed to sign these documents.			