STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683	A. BUILDING <u>00</u> C			COMPL	3) DATE SURVEY COMPLETED 03/26/2021	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
N 0000 Bldg. 00	This was a federal and state complaint survey. Facility ID: 013602		N 00	000				
	Current Census: 49 Complaint # IN003 Resident/Patient/Cl	47950 - Allegations: ient Rights, Quality of arsing Services: Substantiated						
N 0484 Bldg. 00	with findings 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 04	484	Client #1 & #4 are In-Active Records, therefore no action we 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 ensure all disciplines assigned the patients maintained effective	/e n to I to	04/23/2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		r í	UILDING	00	COMPL 03/26/	ETED	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
IAU	Objectives To prodesigned according 2. Review of an unce "Admission Policy" accepted for home of the agency can provinceds" 3. Record review for 3/25/2021 and again date (Sunday) 2/7/2 2/7/2021 - 4/7/2021 evidenced a docume "Patient Assessment Informatiated " Interventif [occupational therapaide patient agrees services they can ge and decrease them a record failed to evid with other disciplinateds for services/treview on 3/29/21 for diagnosis: Encounted for surgery concerned the Musculoskeletal care 12/17/2020, evittled "Physical The 12/18/2020, signed Assistant) PTA E. was rated a 6 (on a spain and 10 being the clinician failed to not the pain rating of 6.	by ide personalized care to the client's needs" lated agency policy titled stated " Clients will be tare with the expectation that ide the services the client r patient #1 was completed on a on 3/29/2021, start of care 021, for certification period . This clinical record review tent dated 2/7/2021, titled to OASIS [Outcome and ation Set] D1 (Full)" which tons planned: OT by] referral [home health] ss They would like all the to especially at the beginning the sappropriate" The clinical lence coordination occurred the sereferred to meet the patient's treatment. 4. Clinical record for patient #4, primary the for other orthopedic (branch down with conditions involving the system) aftercare, start of idenced an agency document trapy Progress," dated by (Physical Therapy This document stated the pain to the scale of 0-10 with 0 being no the most severe pain). The totify the appropriate staff of		IAU	interdisciplinary communication 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 Clinin Manager will perform reviews and Progress Notes for all disciplines on 10% of the active patients for the next 30 days to the ensure 100% compliance is must be ensure 100% compliance is must be ensured to support the objectives of patient care. The Administrator will be responsible for oversight and monitoring of compliance with deficient practice to ensure the does not re occur.	n to cal of s e o et	DATE	
	Administrator, indic	eated there was no pain goal. was no contact with the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE COMPL 03/26	LETED		
	PROVIDER OR SUPPLIER		6	STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	status.	r physician regarding the pain						
	Clinical Manager in common judgement	or on 3/9/2021 at 3:52 PM, the edicated the clinicians use (on whether to notify physical an) if there is a change in what it.						
N 0488	410 IAC 17-12-2(i							
Bldg. 00	must develop and requiring a notice the patient, the pa or other individual	A home health agency implement a policy of discharge of service to tient's legal representative, responsible for the patient's n (15) calendar days before						
	subsection (i) of the the following circu (1) The health, sa home health agen immediate and sig) day period described in nis rule does not apply in mstances: Ifety, and/or welfare of the cy's employees would be at prificant risk if the home stinued to provide services						
	(2) The patient re agency's services (3) The patient's services reimbursable base reimbursement rehealth agency infocommunity resour following discharg (4) The patient no regulatory criteria, physician's order, agency informs the	services are no longer ed on applicable quirements and the home brms the patient of ces to assist the patient e; or b longer meets applicable						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157683	B. W	ING		03/26	/2021
			I	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			ORTH MAIN STREET, SUITE 2	2Λ	
	A HOME CARE LLC					.5A	
AUNUVA	A LIOIVIE CARE LLC	,		GRANG	GER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	discharge.						
		view and interview, the agency	N 0	488	On 05/25/2021 Agency update	ed	05/26/2021
		policy which indicated the			Discharge Policy to include the	е	
		ide a notice of discharge of			language from the Indiana		
	service to the patient, the patient's legal				Administrative Code 17-12-2(i)	
	representative, or of	ther individual responsible for			(i) A home health agency mus	t	
	the patient's care at	least fifteen (15) calendar days			develop and implement a police	СУ	
	before the services	were stopped, and failed to			requiring a notice of discharge	of	
	_	days' notice for 1 of 1 patients			service to the patient, the		
	who were discharge	ed for reasons requiring 15			patient's legal representative,	or	
	days' notice. (#2)				other individual responsible fo	r the	
					patient's care at least fifteen (15)	
	The findings includ	e:			calendar days before the servi	ices	
					are stopped.		
	Review of a policy	with revision date 1/2018, titled			(j) The fifteen (15) calendar da	ay	
	"Transfer/Discharge	e/Referral Procedures" stated			period described in subsection	n (i)	
	" Patients are info	ormed prior to discharge of	does not apply in any of the				
	plans for discharge	", but failed to evidence the	following circumstances:				
	patient should be pr	ovided at least 15 days' notice			(1) The health, safety, or welfa	are of	
	of intent to discharg	ge.			the home health agency's		
					employees would be at immed	diate	
		patient #2 was completed on			and significant risk if the home	;	
	3/26/2021 and again	n on 3/29/2021, start of care			health agency continued to pro	ovide	
	date 2/10/2021, for	certification period 2/10/2021 -			services to the patient.		
	4/10/2021, evidence	ed a document dated and			(2) The patient refuses the ho	me	
	signed by the patier	nt on 3/8/2021, titled "AuNova			health agency's services.		
	Home Care Notic	ce of Medicare Non-Coverage",			(3) The patient's services are	no	
	which evidenced the	e patient's home care services			longer reimbursable based on		
	would end 3/11/202	21, (3 days after notice was			applicable reimbursement		
	given), and the reco	ord evidenced the patient was			requirements and the home		
	discharged on 3/11/	2021. Clinical record review			health agency informs the pati	ent	
	failed to evidence the	he home health agency gave			of community resources to ass	sist	
	the patient a 15 day	discharge notice.			the patient following discharge	.	
					(4) The patient no longer mee	ts	
	_	v on 3/29/2021 at 3:17 PM, the			applicable regulatory criteria, s	such	
		ated the agency typically gave			as lack of physician's order, a	nd	
		ischarge, and also indicated			the home health agency inforr	ns	
	she was unaware of	The 15 day notice of discharge			the patient of community		
	requirement.				resources to assist the patient	:	
					following discharge.		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157683	B. W	ING		03/26/	/2021
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ORTH MAIN STREET, SUITE 2	2 A	
\	N HOME CARE LLC				GER, IN 46530	.5A	
AUNOVA	THOME CARE LLC	,		GIVAING	3EK, IN 40330		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					(k) A home health agency mus	st	
					continue, in good faith, to atte	mpt	
					to provide services during the		
					fifteen (15) calendar day perio	d	
					described in subsection (i). If t	he	
					home health agency cannot		
					provide such services during t	hat	
					period, its continuing attempts		
					to provide the services must b	е	
					documented.		
					Please note cited Patient #2 d	id	
					not meet the 15 day discharge)	
					notice requirement based on		
					patient scheduled for discharg	e	
					based on the following criteria		
					The patient's services are no	` ,	
					longer reimbursable based on		
					applicable reimbursement		
					requirements and the home		
					health agency informs the pati	ent	
					of community resources to ass		
					the patient following discharge		
					(4) The patient no longer mee		
					applicable regulatory criteria,		
					as lack of physician's order, a		
					the home health agency inforr		
					the patient of community	110	
					resources to assist the patient		
					following discharge.		
					Notice of Medicare Non-Cover	rane	
					was issued in accordance with	_	
					CMS guidelines.	•	
					Civio galdollilos.		
N 0502	410 IAC 17-12-3(I	b)(2)(C)					
-	Patient Rights	-/(-/(-/					
Bldg. 00	_	patient has the right to					
zg. 00		r rights as a patient of the					
	home health ager	-					
		nas the right to the	1				
		ias are right to the	1		I		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/26/2021		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N E RIATE	(X5) COMPLETION DATE
	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:		N (0502	The Administrator notified a Clinicians to correct the Stat Hotline phone number in the Admission packets in the pahome currently active with a The Administrator corrected pre-made (prepared) Admis packets in the office with the	te e atients gency. all sion	03/30/2021
N 0504	provided to the pati was reviewed on 3/2 packet titled "AuNo Orientation For Hot" You may also co. Hot Line at 1-800-8 PM, the surveyor ca was the Michigan s recorded greeting st state of Michigan cadmission packet fa hotline number for During an interview administrator indica hotline number in a	on 3/24/2021 at 3:18 PM, the sted she would correct the ll admission packets and attents receive the corrected			corrected State Hotline phornumber. The Administrator has upda original document labeled the Admission Packets with the correct State Hotline phone number for all future document 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 reconstructed.	ted the ne ents	
Bldg. 00	Patient Rights Rule 12 (b) The period exercise his or he home health agen	atient has the right to r rights as a patient of the					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157683	B. W	ING		03/26	/2021
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ORTH MAIN STREET, SUITE 2	3Δ	
ΔΙΙΝΟ\/Δ	A HOME CARE LLC				GER, IN 46530	.57	
AUNOVA		,		OIVAIV			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	` '	about the care to be					
		any changes in the care to					
	be furnished as fo						
	(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		NO	504	Client #4 & #7 are In-Active		04/22/2021
	interview, the agency failed to ensure agency		N 0	304	Records, therefore no action v	100	04/23/2021
	_	ned of the care to be furnished			taken to correct the deficient	vas	
	_	ne care to be furnished in 2 of			practice for the client.		
					practice for the cheft.		
	7 clinical records reviewed. (#4, #7)				Administrator has educated th	۵	
	The findings includ	e·			Admitting RN clinician identifie		
	The intended				have found to be in	, u 10	
	1. Review of an age	ency policy dated 01/2018 titled			non-compliance with the Cons	ent	
	_	ghts" stated "Patients Rights			for Treatment to identify RN in		
		formed about, and consent to			evaluation on the CONSENTS		
	_	vance and during treatment			FOR TREATMENT.		
	establishing and rev	vising the plan of care			All Admitting staff were educate	ted	
	disciplines that will	furnish the care any			during an in-service on 04/23/2		
	changes in the care	" Additionally, the agency			on the proper way to complete	:	
	failed to provide a p	policy on how to furnish care			admission consent paperwork	at	
	to patients who wer	re symptomatic for COVID-19.			Start of Care to ensure that pa	itient	
					is informed verbally and in writ	ting	
		dated agency policy titled			of all evaluating disciplines.		
		ated " Patient Rights and					
	Responsibilities	_			Effective 05/25/2021 The		
	_	all be respected by all agency			Administrator will audit a 100%	₀ all	
		rated into all agency health			admission paperwork will be		
	care programs"				audited by the Administrator fo		
	2.0	1. 1 4 101/2010 2:4 1			compliance of proper consent		
	_	ency policy dated 01/2018 titled			paperwork over the next 30 da	ays.	
	-	Home Care of Patients Plan of			The Administrator will be		
		rders" stated " Each patient			The Administrator will be		
		ed plan of care. The plan is			responsible for monitoring for		
	_	uated in partnership with the			100% compliance with all		
	Any revision to the	ive (if any), and caregiver(s)			admission paperwork to ensur		
	Any revision to the	pian of care is			that the Admission consents a	IE	I

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		157683	B. W	'ING		03/26/	2021
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD	2.4	
A L IN 10 \ / A	LIONE OADELLO				ORTH MAIN STREET, SUITE 2	3A	
AUNOVA	N HOME CARE LLC			GRANG	SER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	communicated to: 1	. The patient; 2. The			being completed correctly to		
	representative (if an	ny); 3. The caregiver"			ensure that this deficiency is		
	`				corrected and will not reoccur.		
	4. During a home visit with patient #7 on 3/29/2021						
	_	atient's home folder was					
		to evidence a current plan of					
		therapy assistant] F indicated					
		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 agend	cy staff provided a					
	current/updated cop	by of the patients' plans of					
	care to all patients'	homes to incorporate into the					
	home folders, the ac	dministrator stated "No"					
	and indicated the ag	gency would begin doing that.					
	5. Clinical record re	eview on 3/29/21 for patient #4,					
	primary diagnosis:	Encounter for other orthopedic					
	(branch of surgery of	concerned with conditions					
	involving the Musc	uloskeletal system) aftercare,					
	start of care 12/17/2	2020, evidenced an agency					
	document titled "Ho	ome Health Certification and					
	Plan of Care," for c	ertification period					
	12/17/2020-2/14/20	21, and signed by the primary					
	care physician on 12	2/17/2020. This document had					
	a subsection titled "	21. Orders for Discipline and					
	Treatments (Specify						
		/Duration)." This subsection					
	stated " Skilled n	ursing [evaluation] eval only					
	"						
		idenced an agency document					
		ome Care - Admission					
		17/2020, signed by patient #4					
		rse) RN G. This document had					
		Consent for Treatment." This					
		d the agency was to provide					
		PT evaluation and treatments.					
		d to include the RN initial					
	evaluation complete	ed by the agency.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/26/2021			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	administrator indica did an initial evalua an ortho (orthopedic regular visits from t paperwork should h nursing (SN) evalua						
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.						
	health agency failed advance about chan	riew and interview, the home I to inform the patient in ges in the care to be clinical records reviewed. (#4)	N 0505	Client #4 was an In-Active Re therefore no action was taken correct the deficient practice fithe client.	to		
	of Ethics" stated " Responsibilities Responsibilities sha	ed agency policy titled "Code Patient Rights and		Administrator has educated the Admitting RN clinician identified have found to be in non-compliance with the Constor Treatment to identify RN in evaluation on the CONSENTS FOR TREATMENT. All Admitting staff were educated during an in-service on 04/23/	ed to sent itial S ted		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/26/2021	
	ROVIDER OR SUPPLIER . HOME CARE LLC		6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	23A	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG	Review of an agence "Patient's Bill of Rights and Respons Participate in, be to or refuse care in a treatment, where ap the care to be furnis affect treatment effect the care to be furnis (branch of surgery of involving the Muscostart of care 12/17/2 document titled "How Plan of Care," for contact 12/17/2020-2/14/20 physician for patien document had a sub Discipline and Treat Amount/Frequency, stated " Skilled n" A record review evititled "AuNOVA How Consent," dated 12/2 and (Registered Numand Registered Numand Regi	y policy revised 01/2018, titled ghts," stated " Patient's ibilities (Patient Bill of Rights) informed about, and consent advance of and during propriate, with respect to: hed any factors that could ectiveness any changes in hed" ew on 3/29/21 for patient #4, Encounter for other orthopedic concerned with conditions alloskeletal system) aftercare, 2020, evidenced an agency ome Health Certification and ertification period 21, signed by person L, t #4 on 12/17/2020. This section titled "21. Orders for timents (Specify 'Duration)." This subsection tursing [evaluation] eval only denced an agency document ome Care - Admission 17/2020, signed by patient #4 rse) RN G. This document had Consent for Treatment." This is the agency was to provide PT evaluation and treatments. did to include the RN initial	TAG	on the proper way to complete admission consent paperwork Start of Care to ensure that pais informed verbally and in wri of all evaluating disciplines. Effective 05/25/2021 The Administrator will audit a 100% 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 a being completed correctly to ensure that this deficiency is corrected and will not reoccur.	e at at atient ting % all or ays.	
	an ortho (orthopedio	es) case, which did not require he nurse. The admission				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/26/2021			
NAME OF PROVIDER OR SUPPL AUNOVA HOME CARE L		6910 N	STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
PREFIX (EACH DEFICE	RY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
paperwork shoul nursing (SN) eva 17-12-3 (b)(2)(D							
following: (1) Investigate patient or the parepresentative in following: (A) Treatment furnished. (B) The lack of property by any behalf of the hot (2) Document complaint and the failed to docume the failed in f	health agency shall do the ecomplaints made by a satient's family or legal regarding either of the ecor care that is (or fails to be) of respect for the patient's one furnishing services on me health agency. It both the existence of the he resolution of the complaint. The review and interview, the agency of the existence of a ecolution of the complaint for 2 ewed with complaint(s) made to 4)	N 0514	Client #3 & #4 were In-Active Records, therefore no action w taken to correct the deficient practice for the client. On 04/23/2021 All staff have be instructed and re-educated that complaints are to be immediated directed to the Administrator for documentation and resolution. Staff educated to ensure that a patients are aware of the grieve procedure upon admission and ongoing during episode of serve Effective 05/25/2021 The Clinic Manager to review 10% of new documented communication not for all active patients for the new taken to communication and the communicati	een t all ely or all ance d vice. cal			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157683	B. W	ING		03/26/2021	
				CTREET	ADDRESS STEW STATE ZID SOD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	0.4	
A L IN (O) (A	HOME OADE II O				ORTH MAIN STREET, SUITE 2	3A	
AUNOVA	HOME CARE LLC			GRANG	SER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Whether the com	plaint is resolved"			30 days to ensure both the		
					existence of a complaint and the	he	
	2. Review of the agency's complaint log was		resolution of the complaint is				
	-	2021 at 1:22 PM. The log			documented and logged in a		
	evidenced one com	plaint in 2017, and evidenced			separate Complaint Log.		
		18, 2019, 2020, or 2021.					
	-	eview on 3/29/21 for patient #3,			The Administrator will be		
		Гуре 2 Diabetes Mellitus (high			responsible for ongoing		
		e blood), start of care			compliance to ensure both the	. [
	-	ed an unsigned agency			existence of a complaint and the		
		ommunication Note" dated			resolution of the complaint is	-	
		cument stated " Based on			being performed to ensure this	,	
		ehavior of yelling at [person I,			deficiency does not reoccur.		
	-	Administrator], using foul					
		g Clinicians 'incompetent', 'liar',					
		of 'making stuff up', I asked if					
	_	nces patients would like					
	-	agency to care for them, and					
	spouse agreed"	igency to care for them, and					
	spouse agreed						
	During a phone inte	erview on 3/24/2021 at 2:32 PM,					
		they called the agency when					
	-	ow up a couple days after the					
		out. She stated they (the					
	_	hysical Therapist) PT's word					
		neadache and fever and she					
	_	toms the PT claimed she had.					
		and eventually told the					
		allowed back on 1/15/2021.					
	During a phone inte	erview on 3/24/2021 at 2:35					
		icated the PTA [Physical					
		didn't know how to use the					
		did not have it in her ear					
		cated she was laying on a					
	-	nat side prior to having her					
		and that was why the					
	thermometer read h						
	mermometer read it	1511.					
	During a nhone into	erview on 3/24/2021 at 2:40					
	During a phone line	1 view Oil 3/24/2021 at 2.40					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COME	E SURVEY PLETED 6/2021
	PROVIDER OR SUPPLIER A HOME CARE LLC		6910 N	ADDRESS, CITY, STATE, ZIP IORTH MAIN STREET, GER, IN 46530		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	because she wouldn	cated they discharged her 't go get a COVID test.				
	primary diagnosis: 1 (branch of surgery of involving the Musci start of care 12/17/2 document titled "Ph dated 1/12/2021, signed assistant) PTA E. Subsection titled "Subsection stated " [sic] temperature with which registered 10 subsequently took put thermometer which which registered 98 A record review evititled "Communicat signed by (Licensed document stated " hold until negative to	denced an agency document ion Note," dated 1/13/2021, Practical Nurse) LPN I. This agency will place patient on test or 10-14 days of symptom				
	this time" A record review evititled "AuNOVA Hesigned by person L, document stated " agency due to unsaft care" Was this cidischarge tag? It was tag I wrote for G454. A record review evititled "Communicat signed by person I,	denced an agency document ome Care," dated 1/15/2021, Physician for patient #4. This Patient discharged from the environment to continue ated under a patient rights is not. Should I add it to the 4? I added this to G454 denced an agency document ion Note," dated 1/15/2021, former employee. This patient request a referral to				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00		SURVEY LETED 5/2021
	PROVIDER OR SUPPLIER		6910 N	ADDRESS, CITY, STATE, ZIP IORTH MAIN STREET, GER, IN 46530		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	PT and labs draws p	-				
	titled "Communicat signed by person I, document stated " to follow up on state could make plans to very irate with me s	denced an agency document ion Note," dated 1/15/2021, former employee. This Called patient this morning us of covid testing so we experient Patient got tating wife never had any was yelling and using foul wer the phone"				
	document titled "Co 1/15/2021. This do former employee] was using foul lang for 'lying' about syn with patient, he info called him and told think they needed to symptoms He co 'lying' and used the incorrectly which is and when used her owas normal in 98 had no symptoms and started raising he did tell him giv you like the referral	denced an unsigned agency ommunication Note," dated cument stated " [Person I, vas on phone with patient who uage and yelling at clinician optoms Upon speaking ormed me that his dr [doctor] him and his wife that he didn't to get tested and had no ontinued to say PTA was patient's thermometer why she had a reading of 101 own thermometer the reading. He continued to say spouse patient was not receptive his voice At this point, I en the circumstances, would to be made to another home in of you'. Patient states t trust you at all'"				
	completed on 3/24/2 complaint in 2017, a 2018, 2019, 2020, o document both the complete of the	cy's complaint log was 2021. The log evidenced one and evidenced no complaints in or 2021. The agency failed to existence and resolution of the gragraph to indicate the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		A. BU	A. BUILDING 00 B. WING			COMPLETED 03/26/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
N 0524	patient #4 indicated supposed to come or draw never showed the cough/sore throat never had. He also shim off on the phone administrator that shindicated that on 1/1 indicated they would and he stated he wor anymore. During an interview administrator indicated who was on the pholoud, aggressive, and physician didn't war the therapist was a hincompetent staff. 5. During an interview the administrator indocumented in the alagency had no compagency had not had agency had not had complained, and if containing home visits, tidentified in the patients.	the person who was at on 1/13/21, to do a blood up. He indicated they added to symptoms, which patient #3 indicated they kept cutting and he said to the see was unprofessional. He 5/2021, the administrator of not come out due to COVID add not let them come out on 3/29/2021 at 2:05 PM, the sted she was the final person me with patient #4, he was divided yelling, he indicated his at him to get a COVID-19 test, fair, and he was upset about ew on 3/24/2021 at 10:42 AM, dicated complaints were gency complaint log, the plaints documented, the any patients that called and complaints were made to staff the complaint would be ent's medical record.					
Bldg. 00	Patient Care Rule 13 Sec. 1(a)(plan of care shall: (A) Be developed home health agence	As follows, the medical in consultation with the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		157683	B. W	ING	G 03/26/2021		
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530			
(X4) ID	(4) ID SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCE NEAR OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	skilled service is b (B) Cover all perti (C) Include the fo (i) Mental statu (ii) Types of ser required. (iii) Frequency a (iv) Prognosis. (v) Rehabilitatio (vi) Functional lii (vii) Activities per (viii) Nutritional re (ix) Medications (x) Any safety ra against injury. (xi) Instructions referral. (xii) Therapy mod treatment. (xiii) Any other ap Based on record rev failed to ensure all p all required element care reviewed (#1, 2 The findings includ 1. Review of an age date of 01/2018, tit Care of Patients Pla stated " The plan of pertinent diagnosis including verbal orc cognitive, psychoso services, supplies, a Duration and freque Prognosis and Reha Functional limitatio	peing provided. inent diagnoses. Illowing: s. vices and equipment and duration of visits. In potential. Initiations. Initi	N 0	524	Client #1, #2, #3, #4, #5, #6 al In-Active Records, therefore n action was taken to correct the deficient practice for the client. After a review of 100% of Active charts, on 04/23/21 The Admit Clinicians were educated on proper completion of the patie plans of care included all requelements to include Cover all pertinent diagnoses and Medications and treatmer Effective 05/25/2021 The Clini Manager will perform reviews Comprehensive Assessments those patient's plan of care on 10% of the admitted patients of the next 30 days to ensure 10 compliance is met with Clinicians.	ve tting nts' ired of and of or 0%	04/23/2021

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/26/2021		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	measures to protect patient during a natidescription of the prodepartment visits are all necessary intervolunderlying risk fact education and trainidischarge Patient education Homeloutcomes and goals [agency] and the parany advance directritems the organization include" 2. Record review for 3/25/2021 and again date 2/7/2021, for creative discountered and 2/4 Summary Note" (freevidenced the patients shoulder replaceme limited to) breast caseizure disorder, and LUE [left upper exthospitalist in with properties and the patients in control of the patients of	or drug allergies Safety against injury Plans for the ural or man-made disaster A atients risk for emergency ad hospital readmission, and entions to address the ors Patient and caregiver ing to facilitate timely respecific interventions and bound status Measurable identified by the organization tient Information related to ves; and Any additional on or physician may choose to r patient #1 was completed on in on 3/29/2021, start of care ertification period 2/7/2021 - ical record review evidenced a //2021, titled "Discharge om hospital E). This document int was hospitalized for a left int, had a history of (but not uncer, high cholesterol, and id stated " Sling in place on remity], anesthesiologist and attent discussing the On-Q an pump with tube inserted use was present" ent signed by PT [physical 2021 and physician assistant , titled "Home Health an of Care" evidenced the us included (but were not (a chemotherapy medication), rosuvastatin (a cholesterol vetiracetam (an anti-seizure ugnoses list failed to evidence		completing all required element 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 qual QAPI activities. The Administrator will be responsible for oversight and monitoring of compliance with deficient practice to ensure the does not re occur.	rterly		

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	OF CORRECTION	IDENTIFICATION NUMBER 157683	A. BUILDING B. WING	00 00	COMPLETED 03/26/2021
	PROVIDER OR SUPPLIER A HOME CARE LLC		6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	23A
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	breast cancer, high of disorder, and failed Q-ball pain pump are interventions/patien. 3. Record review fo 3/26/2021 and again date 2/10/2021, for 4/10/2021. This clin document dated 2/9 "Clinical Summary' had active diagnose stenosis (a narrowin spine, which can put travel through the spicoronary artery dise reflux, and hypothy. Review of a hospitatitled "History and I [patient] has severe condition in which the fragile from loss of hormonal changes, witamin D]" Review of a docume by PT H on 2/14/20 OASIS [Outcome at Set] D1 (Full)" evid patient had severe of presence of a cardia surgically implanted abnormal heart rhyto.	cholesterol, and seizure to evidence presence of the and clinician t caregiver teaching. r patient #2 was completed on a on 3/29/2021, start of care certification period 2/10/2021 - nical record review evidenced a /2021, from hospital J, titled which evidenced the patient s of (but not limited to) spinal ag of the spaces within your t pressure on the nerves that bine), chronic back pain, ase (CAD), arthritis, acid roidism. I J document dated 1/8/2021, Physical" stated " She osteoporosis [a medical the bones become brittle and tissue, typically as a result of or deficiency of calcium or ent dated 2/10/2021 and signed 21, titled "Patient Assessment: and Assessment Information enced (but not limited to) the steoporosis, obesity, and c pacemaker/defibrillator (a d device to help control	IAU		DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 03/26/2021		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE COMPLETION		
	2/10/2021, and phy "Home Health Cert evidenced the patie: were not limited to) treat osteoporosis), reduces blood clotti stroke in patients w levothyroxine (a me hypothyroidism), ar used to treat acid re evidence the patient stenosis, chronic ba reflux, hypothyroid cardiac pacemaker/ evidence the patient (sulfamethoxazole- 4. Record review for 3/29/2021, start of occrtification period evidenced a docume on 3/12/2021, titled [Outcome and Asse (Full)" which evide the patient was disc 3/10/2021, after a ri patient had diabetes Review of a docum 3/12/2021, and phy "Home Health Cert evidenced the patient were not limited to) to treat high blood p medication for cons medication used to atropine/CPM/hyos	or patient #5 was completed on care date 3/12/2021, for 3/12/2021 - 5/10/2021, ent dated and signed by PT J Patient Assessment: OASIS essment Information Set] D1 ncced (but was not limited to) charged from hospital J on ight hip replacement, and the					

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	OF CORRECTION	IDENTIFICATION NUMBER 157683	A. BUILDING B. WING	00	COMPLETED 03/26/2021
	PROVIDER OR SUPPLIER		6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	23A
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	syndrome or duoder medication used to a medication used to a medication used to a tropine/CPM/hyose ER, and failed to evor diagnoses related took, such as high bhigh cholesterol, irriduodenal ulcers, GE 5. Record review for 3/26/2021 and again date 3/1/2021, for cut 4/9/2021, evidenced "Patient Profile" which from [hospital A] for [occupational therap Patient will be DC [2/24/2021" Review of a docume 3/1/2021, and physis "Home Health Certification used to be scale (additional documed include the paramet the sliding scale insumed for t	nal ulcers), pantoprazole (a creat GERD), and tamsulosin (a creat an enlarged prostate). It to evidence the dose of cyamine/PE/PPA/Scopalamine idence diagnoses of diabetes, to medications the patient lood pressure, constipation, itable bowel syndrome or ERD, or enlarged prostate. The patient #6 was completed on an on 3/29/2021, start of care ertification period 3/1/2021 - It an undated document titled ich stated " Received referral or SN [skilled nursing] PT OT by HHA [home health aide]. discharged] to home on cian M on 3/16/2021, titled fication and Plan of Care" in the smedications included (but humalog (an injectable creat diabetes), plus a sliding see based on blood sugar ly. The document failed to the error of the administration of coulin. View on 3/29/21 for patient #3, Type 2 Diabetes Mellitus here the body is unable to in to bring glucose into the 1/6/2020, evidenced an			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		A. BUILDING B. WING	00 00	COMPLETED 03/26/2021	
	ROVIDER OR SUPPLIER HOME CARE LLC		6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	3A
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	document had a sub	LSC IDENTIFYING INFORMATION section titled "10. Route/Frequency (N)ew	TAG	DEFICIENCY	DATE
	(C)hanged." This su	bsection stated "Mupirocin reat skin infections] 2%			
	Topical Ointment (2	22 gm [grams]); apply topically ee times daily (N)" The			
		nclude where the affected apply the Mupirocin.			
	primary diagnosis: It (branch of surgery convolving the Muscu start of care 12/17/2 document titled "How Plan of Care," for content 12/17/2020-2/14/20. Physician for patien subsection titled "Government Potential/Discharge Notes," which failed During an interview Administrator indicates.	21, signed by person L, t #4. This document had a oals/Rehabilitation Plans/Referral Plan/Other d to include a goal for pain. on 3/29/2021 at 3:15 PM, the ated that medication scontinued on 1/4/2021. It			
	During an interview	on 3/29/2021 at 3:50 PM, the ted there was no pain goal.			
N 0540	410 IAC 17-14-1(a Scope of Services				
Bldg. 00	Rule 14 Sec. 1(a) services are limited purposes of practice setting, the register following: (A) Make the init	(1)(A) Except where d to therapy only, for ce in the home health ered nurse shall do the cial evaluation visit.	N 0540	On 04/23/2021 All In-take staf	f 04/23/2021
	Based on record rev	iew and interview, the agency		were in-serviced on The regist	ered

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AND PLAN OF CORRECTION DENTIFICATION NUMBER 157683 NAME OF PROVIDER OR SUPPLIER AUNOVA HOME CARE LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION failed to ensure a registered nurse (RN) conducted the initial assessment visit was made either within 48 hours of referral, or 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 severed the patient's responsible for the provider of the patient's responsible for the provider of the patient's responsible for the provider of the patient's responsible for the patient's responsible for the provider of the provider of the patient's responsible for the provider of the patient'	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
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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 to therapy services only. The Administrator is responsible		1. Review of an und	lated agency policy titled					
the agency can provide the services the client needs and that the client's condition can be The Administrator is responsible		"Admission Policy"	stated " Clients will be			visit except where order is limi	ted	
needs and that the client's condition can be The Administrator is responsible		accepted for home of	care with the expectation that			to therapy services only.		
		the agency can prov	ride the services the client					
monopol pofely. Initial Approximant Visits A		needs and that the c	lient's condition can be			The Administrator is responsit	ole	
managed safely Initial Assessment Visit: A for ongoing monitoring and		managed safely I	nitial Assessment Visit: A			for ongoing monitoring and		
home visit is made within 48 hours of referral or compliance to ensure this		home visit is made	within 48 hours of referral or			compliance to ensure this		
according to physician's orders and/or deficiency does not reoccur.		according to physic	ian's orders and/or			deficiency does not reoccur.		
patient/family wishes"		patient/family wish	es"					
2. Review of an undated agency policy titled		2. Review of an und	lated agency policy titled					
"Comprehensive Assessments and OASIS		"Comprehensive As	ssessments and OASIS					
[outcome assessment information data set]"		[outcome assessmen	nt information data set]"					
stated " The SOC [start of care/admission]		stated " The SOC	[start of care/admission]					
Assessment is completed in a timely manner		Assessment is comp	oleted in a timely manner					
(within 48 hours) Referral to other disciplines		(within 48 hours)	Referral to other disciplines				ļ	
for Evaluation will be completed no later than		for Evaluation wi	ill be completed no later than					
2-5 days after the start of care"		2-5 days after the st	art of care"				ļ	
							ļ	
3. Record review for patient #1 was completed on		3. Record review fo	r patient #1 was completed on				ļ	
3/25/2021 and again on 3/29/2021, start of care		3/25/2021 and again	n on 3/29/2021, start of care				ļ	
date (Sunday) 2/7/2021, for certification period		date (Sunday) 2/7/2	021, for certification period				ļ	
2/7/2021 - 4/7/2021. The record failed to evidence		2/7/2021 - 4/7/2021	. The record failed to evidence				ļ	
the initial assessment was completed by a		the initial assessmen	nt was completed by a				ļ	
registered nurse when both nursing and therapy								

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PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 157683	A. BUILDING B. WING	00	COMPLETED 03/26/2021
	PROVIDER OR SUPPLIER A HOME CARE LLC		6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	23A
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)	(X5) COMPLETION DATE
140	was ordered, and fai assessment was mad agency convenience comprehensive asse 2/7/2021, and signed Review of a docume physician D on 2/5/2	iled to ensure the initial de based on patient need, not e or availability. The initial ssment was completed, dated d on 2/11/2021 by PT H. ent dated and signed by 2021, titled "AuNova Home rral/Order Form" stated "	TAU		DATE
	Home Health Skille Skilled Nursing F	ral/Order Form" stated " d Services to eval & treat: Physical Therapy [PT] py [OT] Home Health Aide			
	author) dated 2/5//2/ "Referred for Admis physician D was the stated " Received SN [skilled nursing]	ned document (unknown 021 at 10:19 AM, titled ssion [order]" evidenced e referring physician, and referral from [hospital E] for PT OT HHA. Patient will be home on 2/5/2021. Dr. ow"			
	clinical manager on "Admission Order" physician was physi patient was discharg agency to admit on assessment), and RN	ent dated and signed by the 2/5/2021 at 3:40 PM, titled evidenced the ordering ician assistant (PA) G, the ged to home on 2/5/2021, 2/7/2021 (PT to perform initial N to assess on 2/8/2021 for and constipation education.			
	on 2/5/2021, titled " " AuNova Home of [hospital E] regardin This therapist called reporting fall and ur stated patient should	ent dated and signed by PT H Communication Note" stated care received notification from ng patient fall at home today. I [physician assistant G] nknown status of patient. He d call him to report her current ceide what needs to be done.			

State Form Event ID: BMKH11 Facility ID: 013602 If continuation sheet Page 23 of 39

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 157683		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/26/2021	
	PROVIDER OR SUPPLIE		6910 N	ADDRESS, CITY, STATE, ZIP COD IORTH MAIN STREET, SUITE GER, IN 46530	23A
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE
TAG	He stated she should ER [emergency roneurological injuring requested clarificated stated patient should for 2 weeks after sated patient should for 2 weeks after sated patient should part to address how navigation, ambulated [activities of daily would be appropriated information number to call to rather the stated patient in bathroom. Is sore the stated patient in the patient Assessme Interventions plant therapy] referral agrees They wonget especially at the as appropriate was the initial start assessment, and the registered nurse. During a phone into the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (shoulder replacem (Friday) 2/5/2021, when they were su with the nurse, it was the introduction of the patient indicated (sh	al assessment document dated and on 2/11/2021 by PT H, titled ant: OASIS D1 (Full)" stated " and: OT [occupational [home health] aide patient ald like all the services they can be beginning and decrease them The document evidenced it of care comprehensive e visit was not performed by a service on 3/25/2021 at 3:38 PM, and she had her surgery ment) and came home on the agency staff didn't come prosed to, there was a mix up was just one thing after another, omeone was supposed to come,	TAG	DEPOLIT OF THE PROPERTY OF THE	DATE

State Form Event ID: BMKH11 Facility ID: 013602 If continuation sheet Page 24 of 39

PRINTED: 06/08/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 157683	A. BUILDING B. WING	00 00	COMPLETED 03/26/2021
	ROVIDER OR SUPPLIER		6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	23A
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	AM, the patient's spout of the hospital of expected to see a nubut the agency said there until Sunday (Sunday just to ask quantity of 2/11/2021 no aid schedule a visit, it whe stated " We never after a while, she was didn't need it. I can nurses really didn't of therapy) helped a loanymore" 4. Record review for 3/26/2021 and again date 3/1/2021, for cut 4/9/2021, evidenced "Patient Profile" where from [hospital A] for HHA. Patient will be 2/24/2021" Review of a document clinical manager on physician M on 3/10 Order" stated " Pathospital] to home of physician M's office to follow for home I schedule start of care on 3/01/2021"	ouse indicated the patient got in Friday (2/5/2021), they are either Friday or Saturday, they couldn't get anyone 2/7/2021), and someone came questions and sign papers, as a had contacted patient to as just "too late by then", and wer refused OT or aide, but as getting better and we just seled services because the do anything, and PT (physical tt, but I didn't need them are patient #6 was completed on an on 3/29/2021, start of care certification period 3/1/2021 - I an undated document titled ich stated " Received referral or SN [skilled nursing] PT OT the DC [discharged] to home on the county of the county			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULTIPLE (A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2021		
	PROVIDER OR SUPPLIE		6910 1	FADDRESS, CITY, STATE, ZIP CO NORTH MAIN STREET, SU IGER, IN 46530	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
	3/29/2021, start of certification period evidenced a docum physician C on 3/9 letterhead]" stated 3/10 [2021] Rev to continue to increskilled nursing r/t [management; and be review of a docum on 3/12/2021 at 10 Order" stated " d [physician N's of following for home schedule start of ca on 3/16/2021" the physician was not care date during physician N's office During a home obs 11:45 AM, family delay the start of ca days) when the pat nursing rehab facil 6. During an interview the administrator in staff called patients staff availability, b	thent dated and signed by RN G sil2 AM titled "Admission ischarged to home on 3/10/2021 [ffice] verified MD will be thealth. Upon calling to be patient requested to be seen The document failed to evidence notified of the change in start the phone conversation with e on 3/12/2021. The document failed to evidence notified of the change in start the phone conversation with e on 3/12/2021.			
N 0541 Bldg. 00		, , , ,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		157683	B. WING 03/26/2021			2021	
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	2)	
ALINIO) (A	HOME CARELLO				ORTH MAIN STREET, SUITE 2	13A	
AUNOVA	HOME CARE LLC			GRANC	GER, IN 46530		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	purposes of practi	ce in the home health					
setting, the registered nurse shall do the		ered nurse shall do the					
	following:						
	(B) Regularly ree	valuate the patient's nursing					
	needs.						
			N 0	541	Client #1, #2, #3, #4, #5 were		04/23/2021
	Based on record rev	view and interview, the			In-Active Records, therefore n	10	
	clinician failed to en	nsure the comprehensive			action was taken to correct the	е	
	assessment included	d a complete picture of the			deficient practice for the client	i.	
		alth status for 5 of 7 clinical					
	records reviewed (#	1, 2, 3, 4, 5).			After a review of 100% of Acti	ve	
					charts, on 04/23/21 The Admi	tting	
	The findings includ	e:			Clinicians were educated on		
					proper completion of the		
		lated agency policy titled			Comprehensive assessment t	:О	
		stated " The comprehensive			include a complete picture of t	the	
		g Outcome and Assessment			patient's current health status.		
		ASIS) includes, at a minimum,			Effective 05/25/2021 The Clin		
	-	on of the client, his functional			Manager will perform reviews		
		nd desires, the abilities and			Comprehensive Assessments		
		amily care givers, and the			10% of the admitted patients f		
	adequacy of the env	vironment"			the next 30 days to ensure 10		
					compliance is met with Clinicia		
		reference site on 03/25/2021 at			completing a picture addressi	ng	
	-	xcli.net/wp-content/uploads/20			the patient's current health		
		ochure_catheterremoval-mk-00			status.		
		itled "On-Q* Catheter			Clinical Manager has included		
		The catheter is a small tube			review of the Comprehensive		
	•	ite that is connected to your			Assessment to ensure on-goir	-	
	infusion pump"				compliance as part of the qua	rterly	
	2 D1				QAPI activities.		
		r patient #1 was completed on			The Administrator will be		
	-	on 3/29/2021, start of care			The Administrator will be		
		ertification period 2/7/2021 -			responsible for oversight and	thic	
		record review evidenced a /2021 titled "Patient			monitoring of compliance with		
					deficient practice to ensure the	aı II	
		S [Outcome and Assessment			does not re occur.		
	_	(Full)". The document failed					
		ssessed the patient's vital					
	signs (blood pressul	re, heart rate, respirations, and					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683 A. BUILDING 00 B. WING		COMPLETED 03/26/2021			
	PROVIDER OR SUPPLIER		6910 NO	.DDRESS, CITY, STATE, ZIP COD DRTH MAIN STREET, SUITE 2 ER, IN 46530	3A	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		and lung sounds, or the (a non-narcotic pain pump) nt's left upper arm.				
	"Discharge Summa evidenced the patient replacement, and sta [left upper extremit	ent dated 2/4/2021 titled ry Note" (from hospital E) nt had a left shoulder ated " Sling in place on LUE y], anesthesiologist and patient discussing the On-Q esent"				
	patient's spouse stat Ball myself, becaus	7 3/26/2021 at 9:43 AM, the ted " I had to remove the Q e she said she couldn't do She wasn't a nurse I also g myself"				
	clinical manager ind was uncomfortable and PT H "walked I time, the administra [PT H] didn't add the her start of care assomanager and admin failed to evidence v sounds, or the patie patient's left upper a indicated it could pu	on 3/29/2021 at 2:05 PM, the dicated the patient's husband with the removal of the Q-ball, him through it". During this ator stated " I'm surprised that hat [presence of the Q-ball] to essment" The clinical istrator agreed the assessment ital signs, heart and lung nt's On-Q ball present on the farm, and the administrator at the agency at risk if seed due to not being assessed ensive assessment.				
	3/26/2021 and again date 2/10/2021, for 4/10/2021, evidence and signed by PT H Assessment: OASIS	or patient #2 was completed on n on 3/29/2021, start of care certification period 2/10/2021 - ed a document dated 2/10/2021 on 2/14/2021 titled "Patient S [Outcome and Assessment I (Full)". The document				

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	of correction identification number 157683	A. BUILDING B. WING	00	COMPLETED 03/26/2021
	PROVIDER OR SUPPLIER A HOME CARE LLC	6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 BER, IN 46530	3A
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	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	TAG	DEFICIENCY)	
	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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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683 A. BUILDING 00 B. WING		COMPLETED 03/26/2021			
	PROVIDER OR SUPPLIER		6910 NO	.DDRESS, CITY, STATE, ZIP COD DRTH MAIN STREET, SUITE 2 EER, IN 46530	3A	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	3/29/2021, start of of certification period evidenced a docume on 3/12/2021 titled [Outcome and Asse (Full)" evidenced thospital J on 3/10/2 replacement, and the incision was assed. Clinical record reprimary diagnosis: levels of sugar in the 11/5/2020, evidence "Patient Assessment Information 1/7/2021, signed by subsections titled "Neurological," "Nut "Equipment and Suinclude the patient's neurological status; patient; and include walker, transfer chathospital bed) the pacomprehensive asset During an interview Administrator indiction box for musculoske patient #3). It did nor abnormal. During an interview Clinical Manager in was considered obehave been addressed.	eview on 3/29/21 for patient #3, Type 2 Diabetes Mellitus (high e blood), start of care ed an agency document titled to the CASIS [Outcome and attion Set] D1 (Full)," dated RN G. This document had Musculoskeletal, tritional Status," and pplies." The clinician failed to a musculoskeletal and the overweight status of the the equipment (wheelchair, ir, grab bars, shower chair, and tient is using, in the essment. If on 3/29/2021 at 2:59 PM, the ated RN G did not check the letal/neurological status (for not say whether it was normal of the original of the patient (patient #3) se. She indicated that should				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/26/2021		
	PROVIDER OR SUPPLIE		6910 N	ADDRESS, CITY, STATE, ZIP COD NORTH MAIN STREET, SUITE 2 GER, IN 46530	23A
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PR	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	equipment was not #3). 7. Clinical record r primary diagnosis: (branch of surgery involving the musc start of care 12/17/document titled "P (Full)," dated 12/1 document had a su Throat." The clinic of the neck and thr assessment. During an interview Administrator indicates.	addressed here (for patient #4, Encounter for other orthopedic concerned with conditions uloskeletal system) aftercare, 2020, evidenced an agency atient Assessment: OASIS D1 7/2020, signed by RN G. This osection titled "Neck and cian failed to include the status out in the comprehensive w on 3/29/2021 at 3:38 PM, the cated if the neck and throat 44) was blank, then I'm going to assessed.	TAG	DEFICIENCY	DATE
N 0546 Bldg. 00	services are limite purposes of pract setting, the regist following: (G) Inform the phappropriate medite the patient's condition the patient and farelated needs, paprograms, and sunursing personners. Based on record rehealth agency faile education and documents.	(1)(G) Except where ed to therapy only, for ice in the home health ered nurse shall do the aysician and other cal personnel of changes in lition and needs, counsel mily in meeting nursing and rticipate in inservice pervise and teach other l. view and interview, the home d to ensure it provided patient umentation of the patient's rehension of the education for	N 0546	Client #1 & #2 were In-Active Records, therefore no action taken to correct the deficient practice for the client. After a review of 100% of Acti	was

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		ľ í	JILDING	onstruction 00	(X3) DATE COMPL 03/26 /	ETED	
	PROVIDER OR SUPPLIER A HOME CARE LLC			6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	3A	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The findings includ	e:			charts, on 04/23/21 The Admit Clinicians were educated on proper completion of the	ting	
	http://1797f0cd94.r. 19/09/ap_patient-br 456-rev1_90d.pdf t Removal" stated " near your incision s infusion pump. The clear or golden. RE your doctor has insticatheter, then follow mind these key step thoroughly with soathoroughly Rem catheter site Rem Grasp the catheter or pull on the catheter and not painful. Docatheter during rem remove or stretches Continued pulling on to cut or pull hard WARNING: After the catheter tip for the catheter was you don't see the bl dressing over the cayour doctor" 2. Record review for 3/25/2021 and again date 2/7/2021, for ce 4/7/2021. This clind document dated 2/4 Summary Note" (frindicated the patients)	2021 of a web reference site axcli.net/wp-content/uploads/20 rochure_catheterremoval-mk-00 itled "On-Q* Catheter". The catheter is a small tube ite that is connected to your color of the catheter may be MOVAL OF CATHETER If tructed you to remove the value in instructions keeping in sec Wash your hands ap and warm water. Dry ove the dressing covering the love any skin adhesive strips close to the skin, and gently and trug or quickly pull on the lovel. If it becomes hard to the strip in the coval. If it becomes hard to the strip in the coval of the catheter Do to remove the catheter side as instructed by the patient #1 was completed on an on 3/29/2021, start of care ertification period 2/7/2021 - ical record review evidenced a wideling in place on LUE and the catheter and a left shoulder and " Sling in place on LUE			proper completion of the Comprehensive assessment to include patient education and documentation of the patient's response and comprehension the education. Effective 05/25/2021 The Clini Manager will perform reviews Comprehensive Assessments 10% of the admitted patients of the next 30 days to ensure 10 compliance is met with Clinicians ensure it provided patient education and documentation of the patient's response and comprehension the education Clinical Manager has included review of the Comprehensive Assessment to ensure on-goir compliance as part of the qual QAPI activities. The Administrator will be responsible for oversight and monitoring of compliance with deficient practice to ensure the does not re occur.	of cal of on or 0% of	
		ated " Sling in place on LUE y], anesthesiologist and					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683	(X2) MULTIPLE C A. BUILDING B. WING	00	COM	e survey pleted 6/2021
	ROVIDER OR SUPPLIER		6910 l	ADDRESS, CITY, STATE, ZII NORTH MAIN STREET IGER, IN 46530		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	-	patient discussing the On-Q pain pump]. Spouse was				
	"Patient Assessment Information evidence PT [physic patient and/or careg patient's On-Q ball, infection control, prinspection of cathet	ent dated 2/7/2021, titled t: OASIS [Outcome and ation Set] D1 (Full)" failed to cal therapist] H provided the giver education related to the such as (but not limited to) recedure for removal, er tip, post catheter removal ymptoms to report to the				
	patient's spouse stat Ball myself, becaus	or on 3/26/2021 at 9:43 AM, the red " I had to remove the Q e she said she couldn't do She wasn't a nurse I also g myself"				
	clinical manager inc was uncomfortable and PT H "walked I time, the administra [PT H] didn't add the her start of care asso manager and admin	on 3/29/2021 at 2:05 PM, the dicated the patient's husband with the removal of the Q-ball, nim through it". During this ator stated " I'm surprised that hat [presence of the Q-ball] to essment" The clinical istrator agreed the assessment he patient's On-Q ball present upper arm.				
	3/26/2021 and again date 2/10/2021, for 4/10/2021. This cli document dated 2/1 by PT H titled "Pati (Full)" This document	or patient #2 was completed on a on 3/29/2021, start of care certification period 2/10/2021 - nical record review evidenced a 0/2021, and signed 2/14/2021 ent Assessment: OASIS D1 ent indicated (but was not nt had a history of UTIs				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/26/2021				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
N 0557	(urinary tract infects antibiotics, and did she was tested in the evidence the patient signs/symptoms of agency and/or physical A10 IAC 17-14-1(a Scope of Services	ions), took preventative not know she had a UTI until he hospital. The record failed to was educated on UTI and when to contact ician. a)(2)(E)				
Bldg. 00	practice in the hor licensed practical following:	ient in learning appropriate				
	health agency failed professionals provide	riew and interview, the home I to ensure the skilled ded patient and caregiver clinical records reviewed. (#3)	N 0557	Client #3 was an In-Active Ro therefore no action was taked correct the deficient practice the client.	n to	
	"Medication Monitoring/Orders/ stated " The agen family/caregiver wi	e: ed agency policy titled Teaching/Documentation" cy will provide the patient and the information needed to optimum use of medications		After a review of 100% of Accharts, on 04/23/21 The Adm Clinicians were educated on proper completion of the Comprehensive assessment include patient education and documentation of the patient response and comprehension the education.	to d 's	
	Documentation in the provided includes the Patient/caregiver into teaching"	ne patient record of services		Effective 05/25/2021 The Clin Manager will perform reviews Comprehensive Assessment 10% of the admitted patients the next 30 days to ensure 1 compliance is met with	s of ss on for	
	(Disease process wheeffectively use insulated cells), start of care	nere the body is unable to lin to bring glucose into the 11/5/2020, evidenced an tled "Patient Assessment:		Clinicians ensure it provided patient education and documentation of the patient' response and comprehension		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157683	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/26/2021
	ROVIDER OR SUPPLIER		6910 N	ADDRESS, CITY, STATE, ZIP COD ORTH MAIN STREET, SUITE 2 GER, IN 46530	23A
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
N 0610 Bldg. 00	Set] D1 (Full)," data (registered nurse) R subsection titled "So subsection stated " see medication labe document indicated that the patient does Record review failed the clinician educate the proper administrator indicated that the proper administrator indicated the proper administrator indicated husband that lived was one one must help who is a nurse, but indocumentation that with her medication 410 IAC 17-15-1(at Clinical Records Rule 15 Sec. 1. (at legible, clear, compauthenticated and must include signate computer entry. Based on record revisited to ensure all complete, appropriating timed for 6 of 7 records and the findings included 1. Record review for 3/25/2021 and again date 2/7/2021, for conference of the subset of the s	Partially impaired: cannot ls or newsprint" This under the same subsection not use any visual aids. d to evidence documentation at the patient's caregivers on rations of medications. on 3/29/21 at 2:55 PM, the lated the patient had a son and with them. She indicated ther and she has a daughter at did not say in the lated the family was helping her lated. Authentication latures or a secured liew and interview, the agency clinical document entries were tely authenticated, dated, and lords reviewed (#1, 2, 3, 4, 5, 6).	N 0610	Clinical Manager has included review of the Comprehensive Assessment to ensure on-goir compliance as part of the qual QAPI activities. The Administrator will be responsible for oversight and monitoring of compliance with deficient practice to ensure the does not re occur. After a review of 100% of Activities not re occur.	this at it ve 04/23/2021 must id and red

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157683		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/26/2021		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	intake/payroll office a date of the signatu	ced an electronic signature by e person, but failed to evidence ure; a document dated forward for Admission!" failed to		electronically sign documents assigned to them.	ical	
	evidence any agency signature; a docume Profile" evidenced an RN (registered ny practical nurse), but nurse's signature or dated 2/20/2021, tit OASIS [Outcome a Set] D1 (Full)" evidence	ferred for Admission" failed to y staff signature or date of ent titled "Patient Medication a section for the signature of urse) or LPN (licensed failed to evidence a skilled date of signature; a document led "Patient Assessment: and Assessment Information enced PT [physical therapist] and the document, but failed to		Effective 05/25/2021 The Clini Manager will perform reviews Communication Notes and Medication Profiles on 10% of active patients for the next 30 days to ensure 100% compliation is met. The Administrator will be responsible for oversight and monitoring of compliance with	of the nce	
	3/26/2021 and again date 2/10/2021, for 4/10/2021. Clinical document titled "Pa document evidenced	r patient #2 was completed on n on 3/29/2021, start of care certification period 2/10/2021 - record review evidenced a tient Medication Profile" This d a section for the signature of		deficient practice to ensure the does not re occur.	at it	
	nurse's signature or dated and signed by "Home Health Certi which evidenced ad incorporated to the but the document fa reviewed and appro dated 1/26/2021,title failed to evidence a date of signature; ar titled "Communicat	failed to evidence a skilled date of signature; a document PT H on 2/10/2021, titled fication and Plan of Care", ditional information was document, effective 2/18/2021, illed to evidence the clinician ved the changes; a document ed "Referred for Admission" my agency staff signature or and a document dated 2/8/2021, iion Note" which failed to				
	3/29/2021, start of certification period	or patient #5 was completed on eare date 3/12/2021, for 3/12/2021 - 5/10/2021. This ew evidenced a document titled				

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 157683		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/26/2021			
NAME OF PROVIDER OR SUPPLIER AUNOVA HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION (X5) OULD BE PPROPRIATE COMPLETION DATE			
TAG	"Patient Medication section for the signar failed to evidence a date of signature; ar 3/25/2021, titled "C evidenced the admin but failed to evidence the admin but failed to evidence 4. Record review for 3/26/2021 and again date 3/1/2021, for consider 4/9/2021. This clim document dated and titled "Home Health Care" which evidence incorporated to the document, but the evidence the clinicist changes. Review of a document on 3/3/2021, titled "Evaluation/Plan of Cevaluation was complan of Care, and we document; a document; a document; a document; a document; a document of 2/1/2021, titled evidenced the office signature or dated 3/1/2021, titled evidenced the office signature; and a document on Nadministrative assis failed to evidence the clinical record reprimary diagnosis: In the signature of the	Profile" which evidenced a sture of an RN or LPN, but skilled nurse's signature or and a document dated communication Note" which instrator's electronic signature, be the date of signature. The patient #6 was completed on an on 3/29/2021, start of care certification period 3/1/2021 - dical record review evidenced and signed 3/1/2021, by RN G and Certification and Plan of ceed additional information was adocument after the RN signed the document failed to an reviewed and approved the sent dated and signed by PT J. Physical Therapy Treatment" evidenced the pleted after the RN signed the as later incorporated to the ent titled "Patient Medication and section for the signature of failed to evidence a skilled date of signature; a document and "Communication Note" examager's electronic to evidence the date of sument dated 3/10/2021, titled one" evidenced the tant's electronic signature, but the date of signature. The profile which which was a signature of the date of signature, but the date of signature. The profile which was completed and approved the stant's electronic signature, but the date of signature. The profile which was completed and approved the stant's electronic signature, but the date of signature. The profile which was completed and approved the stant's electronic signature, but the date of signature. The profile which was completed and approved to the stant's electronic signature, but the date of signature.	TAG	DEFICIENCY				
		re 12/17/2020, evidenced an ed document titled "Patient						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
157683		B. W	ING		03/26	/2021	
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					ORTH MAIN STREET, SUITE 2	3A	
AUNOVA	A HOME CARE LLC	;		GRANG	GER, IN 46530		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTROL OF THE APPROPRIA		IE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY		DATE
		Medication Profile." The agency failed to authenticate the medication profile with a					
	signature, title, and	-					
	signature, titre, and	aut.					
	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						
	with a signature and	te the communication record					
	with a signature and	u uuc.					
	A record review ev	idenced an unsigned agency					
	document titled "Co	ommunication Note," dated					
	1/12/2021. This document indicated						
		s made for possible COVID 19					
	symptoms. The agency failed to authenticate the						
	communication record with a signature, title, and date of signature.						
	date of signature.						
	A record review evidenced an unsigned agency						
	document titled "Co	document titled "Communication Note," dated					
		cument indicated the					
	Administrator communicated with the patient. The						
	agency failed to authenticate the communication						
	record with a signature, title, and date of signature.						
	signature.						
	6. Clinical record re	eview on 3/29/21 for patient #3,					
	, , ,	Type 2 Diabetes Mellitus					
		here the body is unable to					
	I	llin to bring glucose into the					
	l '	11/5/2020, evidenced an					
		ted document titled "Patient" The agency failed to					
		dication profile with a					
	signature, title, and						
	7. During an intervi	iew on 3/29/21 at 3:55 PM, the					
	Administrator indicated these documents						
		etes) should be signed. She					
	I		1				I

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STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
157683		B. WING			03/26/2021		
NAME OF PROVIDER OR SUPPLIER AUNOVA HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 6910 NORTH MAIN STREET, SUITE 23A GRANGER, IN 46530				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION				DATE	
	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 pe	cople are supposed to sign					
	these documents.						

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