STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K151	A. BUILDING 00 B. WING	09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOUCH OF LOVE HOME HEALTH CARE INC	6919 E 10TH STREET, SUITE B-2 INDIANAPOLIS, IN 46219

(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
G 0000 Bldg. 00		G 0000		
	This was a federal recertification and state re-licensure survey with one complaint, and focused COVID-19 infection control survey of a home health agency. The survey was partially extended on 9/25/20 at 5:07 PM. Complaint #IN00328386; Substantiated with findings Survey Dates: September 23, 24, 25, 28, 29, 30; 2020 Facility Number: 014003 Provider Number: 15K151 Unduplicated admissions past 12 months: 48 Skilled patients: 4 Home Health Aide Only Patients: 13 Personal Service Only Patients: 0 Total Active Patients: 15 Sample selection: Records with home visits: 3 Records without home visits: 2 Discharge records: 2 Total records reviewed: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.			
G 0454	484.50(d)(1) HHA can no longer meet the patient's needs			

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

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Bldg. 00	The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities; Based on observation, record review, and interview, the agency failed to ensure they did not require the patients to have a written primary caregiver prior to admission to homecare as the responsibility of the home health agency was to ensure the agency could meet the patient's needs for 1 of 3 home visit observations (#2). Findings include: An undated agency policy titled "Admission Policy," policy number C-120, stated " ... Patients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency ...." An undated agency policy titled "Client Admission Process," policy number C-140, stated " ... Special Instructions 1. Admission criteria are standards by which a client can be deemed appropriate for admission. These standards include: ... b. The client/caregivers' ability and willingness to provide interim care, when necessary ...." An agency document titled "Emergency Preparedness Alternative Plan for Care," revised 2/1/19, stated "Touch of Love Home Health Care, Inc. (T.O.L) may only provide care to individuals	G 0454	G0454 The Administrator conducted a in service with the Clinical Supervisor and administrative staff on G Tag G0454, Policy C-120 Admission Policy, Policy C-140 Admission Process and reviewed Agency Admission Documentation Alternative Plan for Care. The Agency revised the Alternative Plan for Care to be used solely to document patients alternative plan for care and removed patients signature and or requirement to have a caregiver as a admission requirement. /pThe Clinical Supervisor or designee will ensure all patients receive a updated Alternative Plan for Care per the patients needs by 12.31.2020	12/31/2020

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	with home care needs if the individual can be safely maintained in the home setting when a caregiver is not present. This includes both when T.O.L is not scheduled to be present and if T.O.L cannot provide the requested care. T.O.L will strive to provide all care ordered by the physician and requested by the individual and/or primary caregiver but cannot guarantee services. All patients/clients must have an alternative plan to meet the patient's needs and keep them safe when T.O.L is unable to be in the home for any reason ... If, at any time, the circumstances change, and this plan no longer meets the patient's needs or there is no primary caregiver who is able and willing to provide care I will immediately notify T.O.L so that alternative placement may be arranged ...." The document included a line where a "Primary Caregiver" could be written in, and a line for signature of the patient and/or patient representative. A home visit observation was conducted with Patient #2 (Start of Care 4/22/20) on 9/24/20 at 10:17 AM. During the visit, an "Emergency Preparedness Alternative Plan for Care" was observed within the patient's home care binder. The form was completed and signed by the patient on 4/22/20. An interview was conducted with the administrator on 9/30/20 at 6:05 PM. During the interview, the administrator indicated the agency required patients to name an alternative caregiver and sign the "Emergency Preparedness Alternative Plan for Care" on admission.			
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status;			

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	Based on observation, record review and interview, the home health agency failed to ensure the comprehensive assessment included a complete and thorough health and psychosocial status for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 7 records. Findings include: 1. An undated agency policy titled "Comprehensive Patient Assessment," policy number C-145, stated " ... Policy ... A thorough, well-organized, comprehensive, and accurate assessment ... will be fully completed for all patients ... Special Instructions ... 3. In addition to general health status/system assessment, the agency comprehensive assessment ... will include: ... g. Formal Pain Assessment, pain intervention and management h. Elimination status ... j. Integumentary [skin] status ... m. Neuro/emotional/behavioral status ...." 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a comprehensive recertification assessment, completed on 8/13/20 by Former Employee A, Registered Nurse (RN), for the certification period of 8/18/20 - 10/16/20. The comprehensive assessment failed to evidence an assessment of the patient's cardiac system (heart tones, presence or absence of edema also known as swelling, capillary refill (measurement of how long it takes for color to return to a nail bed after pressure is applied, typically measured as less than or greater than 3 seconds), failed to include an up-to-date "last bowel movement" date (last bowel movement was noted to be 6/15/20),	G 0528	G0528 The Administrator conducted a mandatory in services to all Management Nursing Staff on Comprehensive Assessments and Plan of Cares content. Policy #C-145 Comprehensive Patient Assessment, Policy #C-155 Patient Re-Assessment, Update to Comprehensive Assessment Policy #C-580 Plan of Care, Policy #C-873 Documentation of Changes to the Medical Record was reviewed during in service and a copy was provided to attending staff. “Date of completion 11.27.2020”. The Clinical Supervisor or designee will initiate an audit of 100% of all current agency census comprehensive assessments to examine the assessment incorporates a complete, accurate and thorough health and psychosocial status that focuses on the patients current and history of co-morbidities. Addendums will be made to the comprehensive assessment content that is found to be out of compliance per agency policy and state deficiencies by way of follow up Oasis Comprehensive Assessment, Oasis Recertification Comprehensive Assessment until 100% compliance is achieved. Ongoing all new census comprehensive assessments will be QR prior to submission for 100% compliance	12/15/2020

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	and failed to include the range of blood sugars the patient had reported over the last certification period (patient had a diagnosis of Type 2 Diabetes, and had an order for once a day blood sugar check). The comprehensive assessment also indicated the patient had urinary retention, which required intermittent catheterization (tube inserted through the urethra to drain the bladder, then removed) "1-2 times a day" by the agency nurse and a "condom catheter during the nights and most of the days," however the "Durable Medical Equipment" section of the comprehensive assessment failed to evidence the patient required intermittent catheterization supplies and condom catheters. The clinical record of Patient #1 included a "Physician Order," dated 7/16/20, written and signed by Former Employee B, Registered Nurse. The new order indicated the patient was to have wound care treatment to a newly identified wound to the left plantar (bottom part) of the foot daily. The patient's comprehensive assessment, completed on 8/13/20, failed to evidence a description of the patient's wound to the left foot (type of wound, location, size, color, presence, or absence of drainage) or wound care orders. A document titled "Medication Profile," written and signed by Former Employee A, RN, on 8/13/20, indicated current patient medications of "Neosporin [antibiotic ointment] ...clean the affected area ...(penis blister area) ... Gabapentin [taken for seizure prevention or nerve pain] ... Carbamazepine [taken for seizure prevention or nerve pain] ... Baclofen [taken for muscle spasms] ...." The comprehensive assessment dated 8/13/20 failed to evidence a description of the patient's wound to the penis (type of wound, location, size, color, presence or absence of drainage) or wound		for the next 90days. Ongoing 10% (minimum of 5) of census charts will be audited monthly for the next 90days and quarterly thereafter to ensure compliance with plan of correction. The Clinical Supervisor will be responsible for ongoing compliance. Audits will start with active Records 1-5 in statement of deficiencies to address findings and will be completed in total by 12.15.2020	

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	care order. The comprehensive assessment also failed to evidence diagnoses related to the patient's medications of Gabapentin, Carbamazepine, and Baclofen. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. A home visit observation was conducted on 9/24/20 at 10:17 AM with Patient #2 (start of care 4/22/20) and Employee D, Home Health Aide (HHA). During the visit, Employee D was observed performing a full bed bath on Patient #2. During the bathing procedure, a wound was observed to the patient's sacrum (the bone at the base of the spine, immediately above the tailbone). The wound was covered with a foam dressing and was dated as changed on 9/24/20 by Employee F, RN. Patient #2 reported Employee F had changed the dressing to this wound prior to the surveyor's arrival. The clinical record included a comprehensive recertification assessment, completed on 8/17/20 by Former Employee A, RN, for the certification period of 8/20/20 - 10/18/20. The comprehensive assessment indicated patient diagnoses including, but not limited to, "Hoarding disorder ... Attention-deficit hyperactivity disorder [ADHD] ... Essential (primary) hypertension [high blood pressure without a known cause]" The assessment failed to evidence an assessment of the patient's hoarding disorder or ADHD, and failed to evidence a complete cardiac assessment, including presence of edema (swelling) or capillary refill. The comprehensive assessment also included an "Integumentary Assessment" which stated " ...Patient currently has 2 pressure areas, left buttock and proximal s/p cath site			

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	[suprapubic catheter- a drainage tube placed into the bladder through a surgically-created stoma in the lower abdomen]. Patient's wounds are almost healed ...." The comprehensive assessment failed to include a complete assessment of the patient's wounds, including size, color, presence or absence of drainage, and wound care orders. 4. The clinical record of Patient #3 was reviewed on 9/25/20 and 9/28/20, and indicated a start of care of 4/9/19, with the primary diagnosis of Type 2 Diabetes. The clinical record included a comprehensive recertification assessment completed on 7/28/20 by Former Employee B, RN, for the certification period of 8/1/20 - 9/29/20. The comprehensive assessment indicated Patient #3's diagnoses included, but were not limited to, anxiety disorder and multiple drug abuse (cannabis, opioid, alcohol, cocaine). The comprehensive assessment failed to evidence an assessment of the patient's anxiety or status of the patient's drug abuse. 5. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. A home visit observation with Patient #4 was conducted on 9/28/20 at 8:27 AM. During the visit, Patient #4 indicated she was on a daily fluid restriction as ordered by her doctor, and she kept a record of her fluid intake each day. The clinical record included a comprehensive recertification assessment completed on 8/6/20 by Former Employee B, RN, for the certification period of 8/9/20 - 10/7/20. The comprehensive			

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	assessment indicated patient diagnoses included, but were not limited to, "Essential (primary) hypertension ... Chronic diastolic [congestive] heart failure ... Obstructive sleep apnea [OSA, intermittent periods during sleep where a patient stops breathing] ...." The comprehensive assessment failed to indicate a cardiac assessment was completed, including heart tones, presence, or absence of heart failure symptoms (weight gain, fatigue, shortness of breath, etc), and capillary refill. The assessment did indicate the presence of "slight edema" to the patient's bilateral lower extremities, but failed to indicate a grading of the amount of edema (1+ to 4+) or if pitting was noted (skin remains indented after being pressed). The assessment failed to evidence the patient's fluid restriction orders, or the patient's adherence to the order. Lastly, the assessment failed to include an assessment of the patient's OSA, including if the patient required the use of a CPAP (continuous positive airway pressure) or BIPAP (bilevel positive airway pressure) while sleeping. 6. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." A comprehensive recertification assessment was completed on 7/23/20 by Former Employee B, RN, for the certification period of 7/28/20 - 9/25/20. The comprehensive assessment indicated the patient's diagnoses included, but were not limited to "Type 2 diabetes ... Low back pain ... Essential (primary) hypertension ...." The comprehensive assessment indicated patient's "Pain Relief Measures" included "medication," but failed to indicate which medications the patient was taking for pain, how often the patient required the medication, and the medication's efficacy. The			

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	comprehensive assessment also failed to include an assessment of the patient's anxiety or cardiac system (heart tones, presence or absence of edema, and capillary refill). The clinical record contained a "Medication Profile," completed by Employee F, RN, on 9/21/20. The medication list indicated the patient's current medication orders included, but were not limited to, "Promethazine [taken for cough] ... Benzonatate [taken for cough] ... Hyscyamine [taken for stomach cramping] ... Miralax [taken for constipation] ... Pantoprazole [taken for acid reflux] ...." The comprehensive assessment completed on 7/23/20 failed to evidence diagnoses related to the above medications. 7. An interview with the administrator was conducted on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the comprehensive assessment should "most definitely" include the patient's current health and psychosocial status. 17-14-1(a)(1)(B)			
G 0530 Bldg. 00	484.55(c)(2) Strengths, goals, and care preferences The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the home health agency failed to ensure the comprehensive assessment included the patient's strengths, progress towards goals, and care preferences for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a	G 0530	G0530 The Administrator conducted a mandatory in services to all Clinical Staff completing Oasis data on Comprehensive assessments and Plan of Cares content. Policy	12/15/2020

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	total sample of 7 records. Findings include: 1. An undated agency policy titled "Patient Reassessment/Update of Comprehensive Assessment," policy number C-155, stated " ... Purpose ... To identify progress towards goals and effectiveness of interventions ... Special Instructions ... 7. Special attention will be paid to patient-centered goal setting, clarifying the patient's personal goals and his/her expectations of the home care services. This will include evaluating processes used and effectiveness of plan established previously ... 8. The assessment will identify the ... needs, and strengths of the patient ... The initial and ongoing assessments include consideration of the following: ... b. Description of any applicable strength the patient has including physical, psychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... f. Progress toward goals since previous assessment and clarify the problems that require continuing home care services ...." 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a comprehensive recertification assessment, completed on 8/13/20 by Former Employee A, Registered Nurse (RN), for the certification period of 8/18/20 - 10/16/20. The comprehensive assessment failed to evidence the patient's strengths, progress towards goals, and care preferences. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20,		#C-145 Comprehensive Patient Assessment, Policy #C-155 Patient Re-Assessment, Update to Comprehensive Assessment Policy #C-580 Plan of Care, Policy #C-873 Documentation of Changes to the Medical Record was reviewed during in service and a copy was provided to attending staff. “Date of completion 11.27.2020”. The Clinical Supervisor or designee will initiate an audit of 100% of all current agency census comprehensive assessments to examine the assessment content identifies the patients needs, the patient strengths to include but not limited to physical, psychosocial, spiritual or community resources, and care preferences, that increase the patients ability to learn and respond effectively to treatment plans. Audit will review patients progress toward treatment goals from the previous assessment interventions and goals and clarify the problems that require ongoing home care services. Addendums will be made to the comprehensive assessment content that is found to be out of compliance per agency policy and statement of deficiencies content by way of follow up Oasis Comprehensive Assessment, Oasis Recertification Comprehensive Assessment and or addendum to POC until 100% compliance is	

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	with the primary diagnosis of quadriplegia. The clinical record included a comprehensive recertification assessment, completed on 8/17/20 by Former Employee A, RN, for the certification period of 8/20/20 - 10/18/20. The comprehensive assessment failed to evidence the patient's strengths, progress towards goals, and care preferences. 4. The clinical record of Patient #3 was reviewed on 9/25/20 and 9/28/20, and indicated a start of care of 4/9/19, with the primary diagnosis of Type 2 Diabetes. The clinical record included a comprehensive recertification assessment completed on 7/28/20 by Former Employee B, RN, for the certification period of 8/1/20 - 9/29/20. The comprehensive assessment failed to evidence the patient's strengths, progress towards goals, and care preferences. 5. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a comprehensive recertification assessment completed on 8/6/20 by Former Employee B, RN, for the certification period of 8/9/20 - 10/7/20. The comprehensive assessment evidence to indicate the patient's strengths, progress towards goals, and care preferences. 6. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." A comprehensive recertification assessment was completed on 7/23/20 by Former Employee B, RN, for the certification period of 7/28/20 - 9/25/20. The comprehensive assessment failed to indicate the patient's strengths, progress towards goals, and		achieved. Ongoing 10% (minimum of 5) of charts will be audited monthly for the next 90days and quarterly thereafter to ensure compliance with plan of correction. Clinical Case Conference with interdisciplinary team will be conducted biweekly on Thursday to coordinate patient progress towards the treatment plan, changes, and updates in the patient plan of care to ensure compliance with plan of correction. Audits will start with active Records 1-5 in plan of correction to address findings and will be completed in total by 12.15.2020 The Clinical Supervisor will be responsible for ongoing compliance.	

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	care preferences. 7. An interview was conducted with the administrator on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the comprehensive assessment should include patient's strengths, progress towards goals, and care preferences.			
G 0534 Bldg. 00	484.55(c)(4) Patient's needs The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the home health agency failed to ensure the comprehensive assessment included individualized patient discharge planning needs for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 7 records. Findings include: 1. An undated agency policy titled "Comprehensive Patient Assessment," policy number C-145, stated " ... A thorough, well-organized, comprehensive and accurate assessment ... will be fully completed for all patients ... Purpose ... To identify patients medical ... and discharge planning needs ... Special Instructions ... 7. Discharge planning is initiated ...." 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a comprehensive recertification assessment, completed on 8/13/20 by Former Employee A, Registered Nurse (RN), for the certification period of 8/18/20 - 10/16/20.	G 0534	G0534 The Administrator conducted a mandatory in services to all Clinical Staff completing Oasis data on Comprehensive assessments and Plan of Cares content. Policy #C-145 Comprehensive Patient Assessment, Policy #C-155 Patient Re-Assessment, Update to Comprehensive Assessment Policy #C-580 Plan of Care, Policy #C-873 Documentation of Changes to the Medical Record was reviewed during in service and a copy was provided to attending staff. “Date of completion 11.27.2020”. The Clinical Supervisor or designee will initiate an audit of 100% of all current agency census comprehensive assessments to examine the assessment content identifies patient specific discharge planning that is individualized to include rationale if and when a patient can be discharged per patient medical	12/15/2020

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	15K151	A. BUILDING 00 B. WING	09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOUCH OF LOVE HOME HEALTH CARE INC	6919 E 10TH STREET, SUITE B-2 INDIANAPOLIS, IN 46219

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	The comprehensive assessment included a section titled "Plan of Care: Rehabilitation Potential and Discharge Plans," which stated " ... Discharge to care of: Physician ... Discharge Patient When: Other: When patient needs a higher level of care, upon patient request or patient moves out to a geographical location out of agency service area. Agency may discharge from services for no payer source or no MD orders. The patient or payer will no longer pay for the care; The physician and HHA [Home Health Agency] agree that the patient has achieved the measures outcomes/goals stated in the plan of care; the patient refuses services; HHA determines, pursuant to a written policy, that the patient must be discharged for-cause; 'Discharge For Cause': the patient dies; or the HHA closes. The patient or patient CG [caregiver] has become disruptive/abusive thus rendering services are unsafe. All discipline visits may be cancelled by patient/caregiver for MD appts [appointments], inclement weather or per patient/caregiver request. Upon discharge from agency MD may ask formal [sic] copy of discharge summary." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a comprehensive recertification assessment, completed on 8/17/20 by Former Employee A, RN, for the certification period of 8/20/20 - 10/18/20. The comprehensive assessment included a section titled "Plan of Care: Rehabilitation Potential and Discharge Plans," which stated " ... Discharge to care of: Physician ... Discharge Patient When: Other: When patient		and discharge planning needs. Addendums will be made to the comprehensive assessment that is found to be out of compliance per agency policy and statement of deficiencies report content by way of follow up Oasis Comprehensive Assessment, Oasis Recertification Comprehensive Assessment and or addendum to POC until 100% compliance is achieved. Ongoing 10% of charts (minimum of 5) will be audited monthly for the next 90days and quarterly thereafter to ensure compliance with plan of correction. Clinical Case Conference with interdisciplinary team will be conducted biweekly on Thursday to coordinate patient progress towards the treatment plan, changes, and updates in the patient plan of care to ensure compliance with plan of correction. Audits will start with active Records 1-5 in statement of deficiencies to address findings and will be completed in total by 12.15.2020 The Clinical Supervisor will be responsible for ongoing compliance.	

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	needs a higher level of care, upon patient request or patient moves out to a geographical location out of agency service area. Agency may discharge from services for no payer source or no MD orders. The patient or payer will no longer pay for the care; The physician and HHA agree that the patient has achieved the measures outcomes/goals stated in the plan of care; the patient refuses services; HHA determines, pursuant to a written policy, that the patient must be discharged for-cause; 'Discharge For Cause': the patient dies; or the HHA closes. The patient or patient CG has become disruptive/abusive thus rendering services are unsafe. All discipline visits may be cancelled by patient/caregiver for MD appts, inclement weather or per patient/caregiver request. Upon discharge from agency MD may ask for discharge summary. No current plans for discharge." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 4. The clinical record of Patient #3 was reviewed on 9/25/20 and 9/28/20, and indicated a start of care of 4/9/19, with the primary diagnosis of Type 2 Diabetes. The clinical record included a comprehensive recertification assessment completed on 7/28/20 by Former Employee B, RN, for the certification period of 8/1/20 - 9/29/20. The comprehensive assessment included a section titled "Plan of Care: Rehabilitation Potential and Discharge Plans," which stated " ... Discharge to care of: Caregiver ... Discharge Patient When: Other: When patient needs a higher level of care, upon patient request or patient moves out to a geographical location out of agency service area. Agency may discharge from services for no payer source or no MD orders. The patient or payer will no longer pay for the care; The physician and			

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	HHA agree that the patient has achieved the measures outcomes/goals stated in the plan of care; the patient refuses services; HHA determines, pursuant to a written policy, that the patient must be discharged for-cause; 'Discharge For Cause': the patient dies; or the HHA closes. The patient or patient CG has become disruptive/abusive thus rendering services are unsafe. All discipline visits may be cancelled by patient/caregiver for MD appts, inclement weather or per patient/caregiver request. Upon discharge from agency MD may ask formal [sic] copy of discharge summary." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 5. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a comprehensive recertification assessment completed on 8/6/20 by Former Employee B, RN, for the certification period of 8/9/20 - 10/7/20. The comprehensive assessment included a section titled "Plan of Care: Rehabilitation Potential and Discharge Plans," which stated " ... Discharge to care of: [sic] ... Discharge Patient When: Other: When patient needs a higher level of care, upon patient request or patient moves out to a geographical location out of agency service area. Agency may discharge from services for no payer source or no MD orders. The patient or payer will no longer pay for the care; The physician and HHA agree that the patient has achieved the measures outcomes/goals stated in the plan of care; the patient refuses services; HHA determines, pursuant to a written policy, that the patient must			

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	be discharged for-cause; 'Discharge For Cause': the patient dies; or the HHA closes. The patient or patient CG has become disruptive/abusive thus rendering services are unsafe. All discipline visits may be cancelled by patient/caregiver for MD appts, inclement weather or per patient/caregiver request. Upon discharge from agency MD may ask formal [sic] copy of discharge summary." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 6. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." A comprehensive recertification assessment was completed on 7/23/20 by Former Employee B, RN, for the certification period of 7/28/20 - 9/25/20. The comprehensive assessment included a section titled "Plan of Care: Rehabilitation Potential and Discharge Plans," which stated " ... Discharge to care of: Self ... Discharge Patient When: Other: When patient needs a higher level of care, upon patient request or patient moves out to a geographical location out of agency service area. Agency may discharge from services for no payer source or no MD orders. The patient or payer will no longer pay for the care; The physician and HHA agree that the patient has achieved the measures outcomes/goals stated in the plan of care; the patient refuses services; HHA determines, pursuant to a written policy, that the patient must be discharged for-cause; 'Discharge For Cause': the patient dies; or the HHA closes. The patient or patient CG has become disruptive/abusive thus rendering services are unsafe. All discipline visits may be cancelled by patient/caregiver for MD appts, inclement weather			

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	or per patient/caregiver request. Upon discharge from agency MD may ask formal [sic] copy of discharge summary." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 7. An interview was conducted with the administrator on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the comprehensive assessment should include a patient's discharge planning needs. 17-14-1(a)(1)(B)			
G 0536 Bldg. 00	484.55(c)(5) A review of all current medications A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained a complete review of medications and the medication list was maintained for 3 of 5 active records reviewed (#1, 2, 3), in a total sample of 7 records. Findings include: 1. An undated agency policy titled "Comprehensive Patient Assessment," policy number C-145, stated " ... Special Instructions ... 2. The Comprehensive Assessment will include a review of all medications the patient is using	G 0536	G0536 The Administrator conducted 1 on 1 training with the Clinical Supervisor and agency Clinical staff on Policy #C709 Medication Reconciliation, Policy# C700 Medication Profile, Policy # C705 Medication Management & Medication Interaction Policy “Fax Cover” Guidelines. G tagged reviewed and explained. Policy # C700 Medication Profile Policy updated to clarify medications to be written in layman terms to include specific dx associated with meds and specific	12/31/2020

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	(prescription and nonprescription). This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with therapy ...." The undated agency policy titled "Medication Reconciliation," policy number C-709, stated " ... Policy ... Agency will reconcile all medications taken by the patient ... at 60-day reassessment visits ... Special Instructions ... 4. If the patient continues to receive home care after the first 60 days, the clinician doing the reassessment will again review all medications patient is taking, update the records and the patient plan of care ...." 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a comprehensive recertification assessment, completed on 8/13/20 by Former Employee A, RN, for the certification period of 8/18/20 - 10/16/20. The clinical record also included a "Medication Profile," reviewed and signed by Former Employee A on 8/13/20. The medication list included orders for "Betadine [antiseptic cleanser] ... change the dressing daily PRN [as needed] ... Neosporin [antibiotic ointment] ... apply Neosporin or equivalent daily as needed ... Baclofen [taken for muscle spasms] ... as needed ... Betamethasone Diproprionate 0.05% [topical steroid] ... Apply sufficient amount twice daily externally to the affected area ...." The medication list failed to evidence indications to administer the PRN medications Betadine, Neosporin, and Baclofen, and failed to indicate the location Betamethasone Diproprionate cream		parameters associated if applicable, location of applied medications, parameters and indications for PRN medications administration and current med list in the patients home to be checked against medication orders at supervisory and recertification home visits . Internal RNCM will audit and addendum medication profiles for all current census to include profiles are in layman terms, include diagnosis and description of what the medication is taken for, list parameters and indication for PRN “as needed” medications and when to administer. Finally complete drug interactions and coordinate findings with attending MD to reflect plan of correction requirements by 12.31.20. RNCM will notify and in service all agency clinical field staff on updates to medications communication by 12.31.20 Clinical supervisor will initiate an audit on 100% of completed medication profiles & interaction and MD notification until 100% compliance is achieved. 10% of charts will be audited monthly to ensure compliance with plan of correction for the next 90days and quarterly thereafter. The Clinical Supervisor will be responsible for ongoing compliance.	

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	was to be applied. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a comprehensive recertification assessment, completed on 8/17/20 by Former Employee A, RN, for the certification period of 8/20/20 - 10/18/20. The clinical record also included a "Medication Profile," reviewed and signed by Former Employee A on 7/27/20 and 8/27/20. The medication list included an order for "Clonidine [taken for high blood pressure] 0.3 mg [milligrams] ... 1 tablet two times a day as needed for blood pressure By mouth ...." The medication list failed to evidence an indication of blood pressure parameters for when to administer Clonidine. The clinical record also failed to indicate a review of the patient's medications for potential adverse effects and drug reactions at the time of the comprehensive assessment. 4. The clinical record of Patient #3 was reviewed on 9/25/20 and 9/28/20, and indicated a start of care of 4/9/19, with the primary diagnosis of Type 2 Diabetes. A home visit observation with Patient #3 was conducted on 9/28/20 at 11:22 AM, with Employee F, RN. During the visit, Employee F was observed performing a comprehensive recertification assessment of Patient #3. Employee F failed to review the current medication orders with the patient or compare the patient's medications in the home against the medication orders. 5. An interview was conducted on 9/28/20 at 4:15 PM with the administrator. During the interview, the administrator indicated the RN should review the patient's medication orders with the patient			

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	and/or compare the medication orders to the medications in the patient's home when completing the comprehensive assessment. 6. An interview was conducted on 9/30/20 at 2:00 PM with the administrator. During the interview, the administrator indicated all PRN medications should include an indication for administration. 17-14-1(a)(1)(B)			
G 0544 Bldg. 00	484.55(d) Update of the comprehensive assessment Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the Registered Nurse (RN) failed to update and revise the comprehensive assessment to reflect a major change in the patient's condition for 1 of 5 active clinical records (#1) and 1 of 2 discharge records (#7), in a total of 7 records reviewed. Findings include: 1. An undated agency policy titled "Patient Reassessment/Update of Comprehensive Assessment", policy number C-155, stated " ... Policy. The Comprehensive Assessment will be updated and revised as often as the patient's condition warrants due to major decline or improvement in health status ... Purpose. To identify decline or improvement in health status, modify the plan of care and document changes that may affect care and reimbursement ... Special	G 0544	G0544 The Administrator conducted a mandatory in services to all agency clinical staff completing Oasis data on Comprehensive assessments. Policy #C-145 Comprehensive Patient Assessment, Policy #C-155 Patient Re-Assessment, Update to Comprehensive Assessment Policy #C-580 Plan of Care, Policy #C-873 Documentation of Changes to the Medical Record was reviewed during in service and a copy was provided to attending staff. “11.27.2020”. Agency clinical staff voice competency of understanding G0544 and the following changes	12/31/2020

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	Instructions ... 2. Patients are reassessed when significant changes occur in their condition ...." 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record indicated a certification period of 6/19/20 - 8/17/20, which included a "Physician Order," documented and signed by Former Employee B, RN on 7/16/20. The new order indicated the patient was to have wound care treatment to a newly identified wound to the left plantar (bottom part) of the foot daily. Patient #1's clinical record failed to evidence an updated comprehensive assessment was completed to reflect the patient's new wound and wound care orders until the next recertification date (8/13/20). 3. The clinical record of Patient #7 was reviewed on 9/25/20 and indicated a discharge date of 8/13/20. The clinical record indicated a certification period of 7/23/20 - 9/20/20, which included a plan of care with orders for skilled nurse and home health aide services. The plan of care indicated the patient's "Mental/Cognitive Status" was "Oriented x 3 [aware of who she is, where she is, and the date and time], Forgetful, Depressed, Agitated." The clinical record also contained a "Communication Note" dated 8/10/20, documented by Former Employee A, RN. The communication note indicated "Coordination of Care completed with [hospice agency]. Patient admitted to Hospice care 8/10/20. Home health aide services to continue ... Hospice SN to take over Skilled Nursing for right heel ... Patient has had a decline. Patient alert and oriented to name only. Patient with increase in lethargy and sleeping on and off throughout the day ...." Patient #7's clinical record failed to evidence an		that warrant a update to the Oasis Comprehensive Assessment to include improvement or decline. Improvement examples: reduction in services, discontinuation of skilled services, goals met; Decline examples: addition of skilled care to plan, transfer of skilled services i.e wound clinic, hospice, death, increase in services needed. During the Clinical audit of a 100% compliance with all Agency census Oasis Comprehensive assessments the audits will QR patients current status and addendums will be made for all charts found out of compliance by way of Follow Up “Update” Oasis Comprehensive Assessment. Daily Case Conference with interdisciplinary team are held daily to discuss census and will be conducted biweekly on Thursday with all clinical staff to coordinate patient progress towards the treatment plan, changes, and updates in the patient plan of care. In addition the Clinical Supervisor or designee will QR all daily visit notes to monitor or indicate changes in patients conditions that warrant a update to the comprehensive assessment. The Clinical Supervisor will be responsible for ongoing compliance.	

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	updated comprehensive assessment was completed to reflect the patient's decline in health and discontinuation of skilled nurse visits. A discharge comprehensive assessment was completed on 8/13/20 by Former Employee A, which indicated the reason for discharge was "Death at home." 4. An interview was conducted with the administrator on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the comprehensive assessment should be updated for a serious improvement or decline in a patient's condition. 17-14-1(a)(1)(B)			
G 0550 Bldg. 00	484.55(d)(3) At discharge At discharge. Based on record review and interview, the Registered Nurse (RN) failed to update and revise the comprehensive assessment at discharge to reflect the patient's progress towards their goals for 2 of 2 discharge clinical records (#6, 7), in a total of 7 records reviewed. Findings include: 1. An undated agency policy titled "Patient Reassessment/Update of Comprehensive Assessment," policy number C-155, stated " ... Policy. The Comprehensive Assessment will be updated and revised as often as the patient's condition warrants due to major decline or improvement in health status ... Reassessments must be done at least: ... 3. Within forty-eight (48) hours of (or knowledge of) discharge or transfer ... Purpose ... To identify progress toward goals and effectiveness of interventions ..."	G 0550	G0550 The Administrator reviewed G Tag G-0550 and focused on Policy #C-155 Patient Re-Assessment, Update to Comprehensive Assessment and Policy # C-500 Client Discharge Process 11.21.2020 - 11.27.2020 during mandatory in serviced with all agency clinical staff completing Oasis data. Education focused on ensuring Oasis Transfer/Discharge/Death and additionally recertifications comprehensive assessment included the patients progress toward treatment goals, measured from assessment points, if the goals were met/unmet, and ensuring proper referrals are made to assist with ongoing care as	11/27/2020

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	An undated agency policy titled "Client Discharge Process," policy number C-500, stated " ... Special Instructions ... 7. The Registered Nurse/Therapist shall ensure that the treatment goals and client outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing client needs ...." 2. The clinical record of Patient #6 was reviewed on 9/25/20 and indicated a discharge date of 7/14/20 for the reason of "Patient request." A discharge comprehensive assessment was completed by Former Employee B, RN, on 7/14/20, and indicated the patient's discharge disposition was "Patient remained in the community (with formal assistive services)." The discharge assessment failed to evidence the patient's progress towards her goals prior to discharge, and failed to evidence the nurse had assessed for any appropriate referrals to be made to other agencies to meet the patient's continuing needs, per agency policy. 3. The clinical record of Patient #7 was reviewed on 9/25/20 and indicated a discharge date of 8/13/20 for the reason of "Death at home." A discharge comprehensive assessment was completed by Former Employee A, RN, on 8/13/20, but failed to indicate the patient's progress towards her goals prior to discharge. 4. An interview was conducted with the administrator on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the discharge comprehensive assessment should evidence the patient's progress towards their goals.		appropriate and safe and timely transfers . Agency will implement Case Conferences summaries at each point of visits within the certification period (supervisory visits, recerts, transfers, discharges) to capture pt progress towards treatment plan goals. Also if patient is receiving SN services case conference summaries will be completed biweekly to assess and measure progress towards goals. The Clinical Supervisor will initiate audit of a 100% compliance for the next 90days then 10% (minimum of 5) chart audits quarterly thereafter. The Clinical Supervisor will be responsible for ongoing compliance.	

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G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Based on observation, record review and interview, the home health agency failed to ensure the plan of care (POC) included all pertinent diagnoses, the patient's psychosocial status, all equipment and supplies required, frequency and duration of visits to be made, the patient's rehabilitation potential and nutritional requirements, a complete and accurate list of the	G 0574	G0574 The Administrator conducted a mandatory in services to all Nursing Staff on Comprehensive assessments and Plan of Cares content. Policy #C-145 Comprehensive Patient Assessment, Policy #C-155 Patient Re-Assessment, Update	12/15/2020

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	patient's medications, all necessary interventions to address the patient's risk factors for emergency department visits and hospital re-admission, patient and caregiver education and training to facilitate timely discharge, patient-specific and measurable goals, and advanced directive information for 5 of 5 active records reviewed (# 1, 2, 3, 4, 5), in a total sample of 7 records. Findings include: 1. An agency policy titled "Plan of Care," policy number C-580, stated "... Policy ... The Plan of Care is based on a comprehensive assessment ... Purpose ... To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... Special Instructions ... 2. The Plan of Care shall be completed in full to include a. All pertinent diagnosis(es) ... b. Mental status. c. Type, frequency, and duration of all visits/services ... h. Rehabilitation potential ... k. Specific dietary or nutritional requirements or restrictions. l. Medications ... m. Medical supplies and equipment required ... p. Treatment goals. q. Instructions of timely discharge ... r. Discharge plans ... t. Other appropriate items ...." 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a plan of care (POC) for the certification period of 8/18/20 - 10/16/20. The clinical record contained a comprehensive recertification assessment, completed on 8/13/20 by Former Employee A, Registered Nurse (RN). The comprehensive assessment indicated Patient #1 had urinary retention, which required intermittent catheterization (tube inserted through the urethra to drain the bladder, then removed)		to Comprehensive Assessment Policy #C-580 Plan of Care, Policy #C-873 Documentation of Changes to the Medical Record was reviewed during in service and a copy was provided to attending staff. “11.27.2020” The Administrator educated Agency Clinicians on EMR system comprehensive assessment content that auto generates POC and POC format requirements to ensure frequency and duration of visits are clear and non-conflicting. The Clinical Supervisor or designee has initiated and will complete an audit of 100% of all current agency census comprehensive assessments and Plan of Care content to examine the assessment and plan of treatment incorporates a complete, accurate and thorough health and psychosocial assessment as outlined in statement of deficiencies and Policy C580 that includes clear and non-conflicting frequencies and duration of visits for the episode period. Addendums will be made to the comprehensive assessment and Plan of Cares content that is found to be out of compliance per agency policy and statement of deficiencies by way of Follow up “Update” Oasis Comprehensive Assessment, Oasis Recertification Comprehensive Assessment and	

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	"1-2 times a day" by the agency nurse, and a "condom catheter during the nights and most of the days." The POC indicated the patient had a diagnosis of Type 2 Diabetes. The POC also contained a section titled "DME [Durable Medical Equipment] and Supplies," which stated "DME: Wheelchair, Other (mechanical lift, incontinence supplies, chux [disposable under pads], emergency guardian, gloves, pill boxes, hand brace) ... catheter supplies ... electric w/c [wheelchair] ...." The POC failed to evidence condom catheter and blood sugar monitoring supplies (glucometer testing strips, lancets or needles) included within the supplies required. The POC included a medication list with the orders for "Betadine [antiseptic cleanser] ... change the dressing daily PRN [as needed] ... Neosporin [antibiotic ointment] ... apply Neosporin or equivalent daily as needed ... Baclofen [taken for muscle spasms] ... as needed ... Betamethasone Diproprionate 0.05% [topical steroid] ... Apply sufficient amount twice daily externally to the affected area ...." The medication list failed to evidence indications to administer the PRN medications Betadine, Neosporin, and Baclofen, and failed to indicate the location Betamethasone Diproprionate cream was to be applied. The POC contained a section titled "Orders for Discipline and Treatment," which included orders for "Frequency: SN [Skilled Nurse] Frequency: 5dwk1, 7d7wks, 6dwk9 [5 visits per week for Week 1, 7 visits per week for Weeks 2 - 8, 6 visits per week for Week 9]. SN AM 1hr 1x day x 7d/wk [1 hour per visit, 1 visit per day for 7 days per week] ongoing. SN PM 1 x day x 3 days /wk ... Medicaid State Frequency and Duration: ... SN :1-2hr/dx3-7 days/wk/2 months [1-2 hours per visit, 3-7 visits		or addendum to Plan of Care until 100% compliance is achieved. Ongoing all census Plan of Care will be QR by Clinical Supervisor prior to submission for 100% compliance for the next 90days. Ongoing 10% of census charts (minimum of 5) will be audited monthly for the following 90days and 10% (minimum of 5 charts) quarterly thereafter to ensure compliance with plan of correction. The Clinical Supervisor will be responsible for ongoing compliance. Audits has started with active Records 1-5 in the statement of deficiencies to address findings and will be completed in total by 12.15.2020 **Record # 5 completed 11/25/2020** Record # 2 completed 11/27/2020	

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	per week for 2 months] ... Medicaid PA [Prior Authorization] ... SN Frequency and Duration: ... SN am 1 hr 1xday x 5-7 dys/wk and SN pm 1 hr 1xday x 1-3 days week up to 14 hrs week [sic throughout]." The POC also included orders for "HHA [Home Health Aide] Frequency: 5dwk1, 7d7wks, 6dwk9. 7-8 hrs/d x 7 d/wk ongoing ... Medicaid State Frequency and Duration: HhA frequency beginning 08/18/2020-08/22/20201to [sic] 2 visits/dx5-10 hrs /dx1-2 d/wk for week 1, then weeks 8/23/2020 - 10/10/2020 1-2visits/dx5-10hrs/dx5-7 d/week for 7 weeks, then 10/11/2020 - 10/16/2020 1-2visits/dx5-6 d/wk for week 9 [sic throughout] ... Medicaid PA HhA ... Frequency and Duration: HhA 5-10 hours per day x 5-7 days per week 53 hrs week." The POC failed to evidence clear concise orders for home health aide and skilled nurse services that were not conflicting. The POC failed to evidence patient discharge planning and education to facilitate a timely discharge. The POC contained a section titled "Goals," which stated "Patient's personal healthcare goal(s): Wound and skin management for no skin breakdown, or if skin breakdown begins to heal fast. To remain safe in home. Nursing [goals] ... Patient will be free to verbalize signs of COVID 19, wound and/or urinary tract infections to report and demonstrate proper infection precautions by end of certification period. Patient will demonstrate appropriate skin care precautions by end of certification period. Patient will achieve optimal wound healing without further s/s [signs and symptoms] of infection or complications by end of certification period. Patient will have optimal bowel evacuation throughout this episode of care." The POC failed to evidence			

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	individualized, patient-specific, and measurable goals with attainable dates. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/20/20 - 10/18/20. The POC indicated patient diagnoses including, but not limited to, "Attention-deficit hyperactivity disorder [ADHD] ... Hoarding disorder." The POC included a section titled "Psychosocial Status," which stated "Home Environment Altered (Cluttered/soiled living conditions) ... Comments (Patient has a diagnosis of hoarding.)," but failed to evidence the patient diagnosis of ADHD. A comprehensive assessment was completed on 8/17/20 by Former Employee A, RN. The comprehensive assessment included an "Integumentary Assessment" which stated " ...Patient currently has 2 pressure areas, left buttock and proximal s/p cath site [suprapubic catheter, a drainage tube placed into the bladder through a surgically-created stoma in the lower abdomen]. Patient's wounds are almost healed ...." The POC contained a section titled "DME And Supplies," which stated "DME: Wheelchair, Other (r: slide board, electric wheelchair, and mechanical lift if needed. [sic] The POC failed to evidence the equipment and supplies needed for the patient's wounds and suprapubic catheter. The POC contained a medication list, which included an order for "Clonidine [taken for high blood pressure] 0.3 mg [milligrams] ... 1 tablet two times a day as needed for blood pressure By mouth ...." The medication list failed to evidence an indication of blood pressure parameters for when to administer Clonidine.			

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	The POC contained a section titled "Orders for Discipline and Treatment," which indicated the patient had orders for "HHA Frequency and Duration: 3dwk1, 7d8wks, 1 dwk10 ... 3rs [sic]/day x 7 days/wk ... Medicaid State Frequency and Duration: HhA: Beginning 8/20/2020 - 8/22/2020 1 - 6 hrs/day x 1-3 days/wk, then weeks 8/23/2020 - 10/17/2020 1-2 v/d x 1-6 hrs/d x 5-7 days/wk, then 10/18/2020 1-2 v/d x 1-6 hrs/d x 1 day ... Medicaid PA Frequency and Duration: HhA: 1-6 hours/day x 5-7 days/wk 21 hrs week." The POC also indicated orders for "SN Frequency and Duration: 1vwk, 4v4wks, 3v4wks, 1v2wks ... 1hr 2 -4's x wk [sic] ... Medicaid State Frequency and Duration ... SN: Beginning 8/20/2020 - 8/22/2020 1hr 1-3 x's/week, then weeks 08/23/2020 - 10/17/2020 1 hr 2-4x's/wk, then 10/18/2020 - 1 hr x 1 day ... Medicaid PA Frequency and Duration: ... SN 1 hr x 2-4 x's a week." The POC failed to evidence clear concise orders for home health aide and skilled nurse services that were not conflicting. The POC failed to evidence patient discharge planning and education to facilitate a timely discharge. The POC contained a section titled "Goals," which stated "Patient's personal healthcare goal(s): Patient's goal is to remain safe in home environment with home health services. Nursing [goals] Patient will have promotion of healing and restoration of skin integrity without complications within certification. Patient will receive safe and effective personal care during this episode of care ...." The POC failed to evidence individualized, patient-specific, and measurable goals with attainable dates. 4. The clinical record of Patient #3 was reviewed			

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	on 9/25/20 and 9/28/20, and indicated a start of care of 4/9/19, with the primary diagnosis of Type 2 Diabetes. The clinical record included a plan of care for the certification period of 8/1/20 - 9/29/20. The POC indicated patient diagnoses included, but were not limited to, "Anxiety disorder," opioid dependence, and alcohol, cannabis, and cocaine abuse. The POC also contained a section titled "Psychosocial Status," which stated "Home Environment Altered (Lack of caregiver/family support). Barriers to Health Status (Multiple co-morbidities) ...," but failed to indicate the patient mental disorder and history of drug and alcohol abuse. Patient #3's clinical record included a comprehensive recertification assessment completed on 7/28/20 by Former Employee B, RN, for the certification period of 8/1/20 - 9/29/20. The comprehensive assessment included a section titled "Endocrine," which stated " ... Patient reports doing better with ... checking his blood sugar at least 3 times a day. But patient stated that he is only willing to check BS [blood sugar] twice a day regardless SN 's [Skilled Nurse] education, SN notified MD [medical doctor] office and change the BS check twice a day and PRN , Patient is agree to check BS twice a day and PRN [sic throughout]." The POC included orders for "accu check aviva [brand of glucometer used to check blood sugar] ... check blood glucose levels three times a day and at bedtime ... " The POC failed to reflect the updated frequency of use for the patient's glucometer. The POC included a section titled "Orders for Discipline and Treatment," which indicated the patient had orders for "HHA Frequency and Duration: 0dwk1, 5d8wks, 2dwk10; 2hrs /day x 5days /wk ... Medicaid State Frequency and			

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	Duration: HHA Frequency: Beginning 08/01/2020 to 08/01/2020 0 visit a day then 00/02/2020 [sic] -09/26/2020 1-2 visits a day x 2-4 hrs/d x 4-6 days/per week, then 09/27/2020-09/29/2020 1-2 visits a day x 2-4 hrs/d x 1-2 days/week ...." The POC failed to evidence clear concise orders for home health aide services that were not conflicting. The POC indicated the patient was "assessed to be at high risk for emergency department visits and/or hospital readmission. All necessary interventions to address the underlying risk factors are as follows: SN to minimize/eliminate risk for hospitalization due to high risk principal diagnosis, multiple comorbidities and physical limitations ... Risk for Hospitalization: comorbidities, needs ADL assistance, polypharmacy." The POC failed to evidence patient - specific interventions to decrease the patient's risk for emergency department visits or hospital admissions. The POC failed to evidence patient discharge planning and education to facilitate a timely discharge. The POC contained a section titled "Goals," which stated "Patient's personal healthcare goal(s): Stays safe at home. Nursing [goals] ... Patient will demonstrate steps to protect oneself and others from COVID-19 infection within time period ... Patient will receive safe and effective personal care during this episode of care ... Patient demonstrate [sic] ability to effectively manage medication regimen within time- period [sic] ... Patient will demonstrate proper use of assistive devices within time- period ... Patient's home will be equipped with adequate lighting within time-period ...." The POC failed to evidence			

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	individualized, patient-specific, and measurable goals with attainable dates. 5. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20. A comprehensive recertification assessment for this certification period was completed on 8/6/20 by Former Employee B, RN. The comprehensive assessment indicated the patient was diabetic and incontinent of urine, however the POC failed to indicate diagnoses related to these conditions. The comprehensive assessment also included a "Medication Profile," reviewed and signed by Former Employee B, RN, on 8/6/20. The medication list included an active medication order for "Glycolax (Obsolete) [taken for constipation] ...." The POC failed to indicate a diagnosis associated with this medication. The POC indicated patient diagnoses including, but not limited to "Schizoaffective disorder, bipolar type ... Schizoaffective disorder, depressive type ... Anxiety disorder ...." The POC's "Psychosocial Status" stated "Community Resources Providing Assistance ..." but failed to evidence the presence of the patient's mental disorders. The POC included a section titled "Orders for Discipline and Treatment," which stated "HHA Frequency: 7 hrs/d X 7 days/8 weeks ,7 hours/dx4ds/wk for week 9 ... 7 hours /d x 7d/wk, 49 hrs/wk ... Medicaid State Frequency and Duration: 1-2 visits/d x 5-9 hrs/day X 5-7 days per week - Not to exceed 49 hrs a week. Beginning 08/09/2020 -10/03/2020 1-2 visits/d X 5-9 hrs/day x			

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	5-7 ds/wk for 8 wks , then 10/04/2020-10/07/2020 1-2 visits, 3-4 days X 5-9 hrs/day for wk9 ...." The POC failed to evidence orders for home health aide services that were not conflicting. The POC failed to indicate the patient's rehabilitation potential and failed to evidence patient discharge planning and education to facilitate a timely discharge. A home visit observation with Patient #4 was conducted on 9/28/20 at 8:27 AM. During the visit, Patient #4 indicated she was on a daily fluid restriction as ordered by her doctor, and she kept a record of her fluid intake each day. The POC included a section titled "Nutritional Requirements," which stated "No Added Salt, No Concentrated Sweets." The POC failed to evidence the patient's orders for fluid restriction. The POC indicated the patient's "Risk for Hospitalization: High as patient has ; reported or observed history of complying with physician orders and instructions, taking over 5 medications, fall risk with a recent fall, nutrition alteration, and co-morbidities. The POC failed to evidence patient - specific interventions to decrease the patient's risk for emergency department visits or hospital admissions. The POC included a section titled "Goals," which stated "Patient's personal healthcare goal(s): remains safe at home. Nursing [goals] ... Patient will receive safe and effective personal care during this episode of care ... Patient will demonstrate steps to protect oneself and others from COVID-19 infection within time period ... Patient will demonstrate ability to effectively manage medication regimen within time- period." The POC failed to evidence individualized, patient-specific,			

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	and measurable goals with attainable dates. The POC included a section titled "Advanced Directives," which stated "Advanced Care Plan (Power of Attorney for Health (Name of Person: [Employee E] ..." An interview with the administrator was conducted on 9/30/20 at 3:20 PM. During the interview, the administrator indicated Employee E was not Patient #4's Healthcare Power of Attorney. 6. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." The clinical record contained a plan of care for the certification period of 7/28/20 - 9/25/20. A comprehensive recertification assessment for this certification period was completed on 7/23/20 by Former Employee B, RN. The comprehensive assessment indicated the patient was incontinent of urine and had "heartburn/reflux," however the POC failed to indicate diagnoses related to these symptoms. The comprehensive assessment also included a "Medication Profile," reviewed and signed by Employee F, RN, on 9/21/20. The medication list included active medication orders for "Promethazine DM [for cough] ... Benzonatate [for cough] ... Hyoscyamine [for stomach cramping] ... Miralax [for constipation] ...." Patient #5's POC failed to include diagnoses associated with the above medications. The POC indicated the patient's primary diagnosis was "Generalized anxiety disorder," and the patient's "Psychosocial Status" was "Home Environment Altered ... Barriers to Health Status (Multiple co-morbidities, Other (lives alone), Discouraged ...." The POC failed to evidence the patient's anxiety within the psychosocial status.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOUCH OF LOVE HOME HEALTH CARE INC	6919 E 10TH STREET, SUITE B-2 INDIANAPOLIS, IN 46219

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	The POC included "Orders for Discipline and Treatment" which stated "Hha frequency and duration: 5d/wkwk1 [5 visits per week for Week 1] ,7d/wk7wks [7 visits per week for Weeks 2 - 8] 6d/wkwk9 [6 visits per week for Week 9]. 3-7hrs/dayx5-7d/wk [3-7 hours per visit, 5-7 visits per week] 35 hrs/wk ... Medicaid State Frequency and Duration: Hha Frequency: Beginning 07/28/2020-08/01/2020 1-2visits/ 3-7hrs /dx4-5ds/wk , then 08-02-2020-09/19/2020 1-2visits/dx 3-7hrs/dx5-7 ds/wk for7wks, then 09/20/2020-09/25/2020 4-6ds/wk for wk 9 ... Medicaid PA Frequency and Duration: 3-7 h/d x 5-7 d/wk ...." The POC failed to evidence clear concise orders for home health aide services that were not conflicting. The POC indicated Patient #5 was "assessed to be at high risk for emergency department visits and/or hospital readmission. All necessary interventions to address the underlying risk factors are as follows: SN to minimize/eliminate risk for hospitalizations due to problems associated with physical limitations ... Risk for Hospitalization: comorbidities, needs ADL assistance, polypharmacy." The POC failed to evidence patient-specific interventions to decrease the patient's risk for emergency department visits or hospital admissions. The POC failed to evidence patient discharge planning and education to facilitate a timely discharge. The POC included a section titled "Goals," which stated "Patients personal healthcare goal(s): Keep safe at home. Nursing ... Patient will demonstrate steps to protect oneself and others from COVID-19 infection within time period. Patient will			

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	demonstrate ability to effectively manage medication regimen within time- period ... Patient's home will be equipped with adequate lighting within time- period ... Patient will receive safe and effective personal care during this episode of care." The POC failed to evidence individualized, patient-specific, and measurable goals with attainable dates. 7. An interview with the administrator was conducted on 9/29/20 at 4:45 PM. During the interview, the administrator indicated orders for services, such as nursing or home health aide, should be clear and not contradictory. The administrator also indicated the POC contained multiple service orders because the first order was an "outline," the second order was more descriptive "for the doctors," and the POC also contained the patient's 6 month service hour total "for PA [prior authorization -payor source] purposes." 8. An interview with the administrator was conducted on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the plan of care should include all pertinent diagnoses, the patient's current psychosocial status, all durable medical equipment required, and patient education to facilitate a timely discharge. The administrator also indicated all patient goals should be patient-specific and measurable. 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(i) 17-13-1(a)(1)(D)(ii) 17-13-1(a)(1)(D)(iii) 17-13-1(a)(1)(D)(v) 17-13-1(a)(1)(D)(viii) 17-13-1(a)(1)(D)(ix)			

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G 0576 Bldg. 00	484.60(a)(3) All orders recorded in plan of care All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the agency failed to ensure all physician orders were recorded in the plan of care (POC) for 1 of 5 active records reviewed (#1), in a sample of 7 total records. Findings include: An undated agency policy titled "Plan of Care," policy number C-580, stated " ... Policy. Home care services are furnished under the supervision and direction of the patient's physician ... Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be ... updated as necessary .... Special Instructions ... 2. The Plan of Care shall be completed in full to include: ... Medications, treatments, and procedures ...." The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/20/20 - 10/18/20. The clinical record also included a "Physician Order" dated 8/14/20, signed by Former Employee A, Registered Nurse (RN), which contained treatment orders for wounds to the patient's "left buttock ulcer ... right posterior hand ulcer ... proximal to super pubic catheter - midline lower abdomen Ulcer." The POC failed to evidence the current wound care orders so that all staff were working from an updated and current plan of care. An interview was conducted with the administrator on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the plan of	G 0576	G0576 The Administrator review G-Tag G0576 and educated all Clinical Staff on the importance of ensuring all orders “current, changed, or discontinued” from the previous episode period to be captured within the next certification Plan of Care to ensure staff are aware and providing up to date services as ordered. All updated orders will be sent via EMR to all clinical staff on the case and discussed during biweekly clinical case conferences and as needed to ensure all clinicians are working from an updated and current plan of care. The Clinical Supervisor or designee will initiate an audit of 100% of all Plan of Cares. Addendums will be made to the Plan of Care content that is found to be out of compliance per agency policy and statement of deficiencies by way of a addendum order to POC. Ongoing all census Plan of Care will be QR by Clinical Supervisor prior to submission for 100% compliance for the next 90days. Ongoing 10% of census charts (minimum of 5) will be audited monthly for the following 90days and 10% (minimum of 5 charts) quarterly thereafter to ensure compliance with plan of correction.	12/31/2020

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	care should contain wound care orders, and all physician orders should be reflected on the next plan of care.		The Clinical Supervisor will be responsible for ongoing compliance.	
G 0592 Bldg. 00	484.60(c)(2) Revised plan of care A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the home health agency failed to ensure the revised plan of care (POC) contained the patient's progress towards their goals for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 7 records. Findings include: 1. An undated agency policy titled "Plan of Care," policy number C-580, stated " ... Policy ... The Plan of Care ... will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary ... Purpose ... To reflect patient's ability to make choices and actively participate in establishing and following the plan designated to attain personal health goals ... Special Instructions ... 2. The Plan of Care shall be completed in full to include: ... p. Treatment goals ... 9. At the time of certification and recertification, a written summary of the patient's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: ... patient response to care/services and outcome of care and services ...."	G 0592	G0592 The Administrator reviewed G Tag C-0592 Education focused on ensuring Oasis comprehensive assessment and plan of care included the patients progress toward treatment goals, measured from assessment points, if the goals were met/unmet, and ensuring proper referrals are made to assist with ongoing care and treatment plans. Agency will implement Case Conferences summaries at each point of visits within the certification period (supervisory visits, recerts, transfers, discharges) to review current plan of care and capture patients progress towards treatment plan goals. Also if patient is receiving SN services case conference summaries will be completed biweekly to assess and measure progress towards goals. The Clinical Supervisor or designee will initiate an audit of 100% of all Plan of Cares.	12/31/2020

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	2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a plan of care for the certification period of 8/18/20 - 10/16/20. The POC failed to evidence Patient #1's progress towards their goals and outcomes. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/20/20 - 10/18/20. The POC failed to evidence Patient #2's progress towards their goals and outcomes. 4. The clinical record of Patient #3 was reviewed on 9/25/20 and 9/28/20, and indicated a start of care of 4/9/19, with the primary diagnosis of Type 2 Diabetes. The clinical record included a plan of care for the certification period of 8/1/20 - 9/29/20. The POC failed to evidence Patient #3's progress towards their goals and outcomes. 5. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20. The POC failed to evidence Patient #4's progress towards their goals and outcomes. 6. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." The clinical record contained a plan of care for the certification period of 7/28/20 - 9/25/20. The POC failed to evidence		Addendums will be made to the Plan of Care content that is found to be out of compliance per agency policy and statement of deficiencies by way of a addendum order to POC. Ongoing all census Plan of Care will be QR by Clinical Supervisor prior to submission for 100% compliance for the next 90days. Ongoing 10% of census charts (minimum of 5) will be audited monthly for the following 90days and 10% (minimum of 5 charts) quarterly thereafter to ensure compliance with plan of correction. The Clinical Supervisor or designee will be responsible for ongoing compliance.	

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	Patient #5's progress towards their goals and outcomes. 7. An interview was conducted with the administrator on 9/30/20 at 2:00 PM. During the interview, the administrator indicated the plan of care should include the patient's progress towards the goals.			
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the home health agency failed to evidence coordination of care with other entities who provided care for 3 of 3 patients who received care from other entities (#1, 4, 5), in a total sample of 7 records reviewed. Findings include: 1. An undated agency job description titled "Position: RN [Registered Nurse] Case Manager" stated " ... Essential Functions/Areas of Accountability ... 2. Performs initial and ongoing client assessments ... c. Collaborates with physicians, other health care professionals (therapists, social services, pastoral care, supportive services), clients, and families in developing a comprehensive, coordinated plan for care ...." An undated agency job description titled "Position: Clinical Supervisor," policy number C-125, stated " ... Essential Functions/Areas of Accountability ... 5. Attends case conferences and other clinical meetings to facilitate coordination of care	G 0608	G0608 The Administrator reviewed Agency Policy and COP's on Care Coordination requirements. Agency has documented said coordination within all patients Comprehensive Assessments and Plan of Care at minimum but has revised its policy content and will add monthly communication notes titled Care Coordination for chart summary to be used for by the assigned Agency case manager to chart appropriately at assessment and recertification points. Agency has implemented scheduled Care Coordination visit notes within EMR system to be completed monthly to document contact made with other providers within the home to include but not limited to: Authorized family and or patient selected representative, MD, PT/OT/Speech, Wound Clinic, Medicare HHA,	12/31/2020

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	2. An agency document titled "Patient Orientation," revised 9/21/20, stated " ...Plan for Care, Treatments And Services ... We involve you, your caregiver or designee, key professionals and other staff members in developing your individualized plan for care, treatment and services ...." 3. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/18/20 - 10/16/20, which indicated the patient received attendant care services from Entity D, an attendant-care services agency. The clinical record failed to evidence coordination of care was completed between the home health agency and Entity D. 4. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20, which indicated the patient received attendant care services from Entity D. The clinical record failed to evidence coordination of care was completed between the home health agency and Entity D. 5. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." The clinical record contained a plan of care for the certification period of 7/28/20 - 9/25/20, which indicated the patient received attendant care services from Entity D. The clinical record failed to evidence coordination		PSA/Waiver Provider, MSW/Casemanagement, Dialysis, Coumadin Clinic and other Clinics etc. Documentation will include communication notes, frequencies, duration & service of provider visits, contact person name and title and any agency services coordinated. The Clinical Supervisor or designee will initiate an audit of 100% of all patient charts. Complete CC with all other service providers by 12.31.2020. Ongoing 100% charts will be audited for the next 90days until 100% compliance and 10% (minimum of 5) quarterly thereafter to ensure compliance with plan of correction. The Clinical Supervisor or designee will be responsible for ongoing compliance.	

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	of care was completed between the home health agency and Entity D. 6. An interview was conducted with the administrator on 9/28/20 at 4:15 PM. During the interview, the administrator indicated the agency did not have shared patient agreements or perform care coordination for patients shared with other home care agencies. 17-12-2(d)			
G 0682 Bldg. 00	484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure all employees followed agency infection control policies and procedures and standard precautions for 3 of 3 home visit observations (#2, 3, 4). Findings include: 1. An undated agency policy titled "Handwashing/Hand Hygiene," policy number D-330, stated " ... Policy ... thorough hand washing/hand antisepsis is required of all employees ... Special Instructions ... 3. Indications for hand washing and hand antisepsis: ... c. When there is prolonged or intense contact with the client (bathing the client). d. Between tasks on the same client ... f. After removing gloves ... k. After assisting client to use the bathroom ... n. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Alternatively, wash	G 0682	**G0682 The Administrator reviewed G Tag 0682 with all Administrative Staff and Agency policy and procedures D-330 Hand Washing/Hygiene, D-245 Standard Precautions during mandatory State Deficiency in-service and a copy of each was given to all attendees. The Agency has implemented effective 10.13.2020 Handwashing, PPE Donning/Doffing skills competency and in service with all Agency staff upon arrival to Agency and will complete in service on above mentioned and additional Standard Precautions/Infection Control, Bag Technique to all**	12/31/2020

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	hands with antimicrobial soap and water in all clinical situations ... f. Decontaminate hands after removing gloves ... Hand Hygiene Technique ... 2. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by manufacturer to hands and rub hands together vigorously for at least twenty (20) seconds, covering all surfaces of hand and fingers. A. Rinse hands with water and dry thoroughly with a disposable towel ...." An undated agency policy titled "Standard Precautions for All Health Care Workers," policy number D-245, stated " ... Gloves should be changed after each client contact. When gloves are removed, thorough hand washing is required. Gloves do not take the place of hand washing ...." An undated agency policy titled "Nursing Bag," policy number N-120, stated "... Purpose ... To prevent contamination of the nursing bag ... Guidelines. The inside of the bag and its contents are considered clean. Therefore: Hand washing must occur before entering the bag for any reason. All items removed from the bag should be cleaned before returning to the bag ...." 2. A home visit observation was conducted on 9/24/20 at 10:17 AM with Patient #2 (start of care 4/22/20) and Employee D, Home Health Aide (HHA). During the visit, Employee D was observed performing a full bed bath on Patient #2. During the bathing procedure, the HHA was observed failing to perform hand hygiene after removing her gloves a total of 7 times. The HHA reported the patient preferred to do his own suprapubic catheter care. The HHA assisted the patient in performing catheter care by applying soap around the catheter, then handed the patient a washcloth that had been used to clean the patient's face, extremities, chest, and back. The		**agency staff by 12.31.2020 via point of care visits and mandatory in-services.** **Upon hire all orientees are in-serviced and skills checked on Handwashing, PPE Donning/Doffing, Standard Precautions/Infection Control and Bag Technique. To ensure ongoing compliance the Clinical Supervisory Staff will complete ongoing Infection Control audits during all supervisory and points of care visits in order to educate/skill check all staff and patients on proper infection control procedures and annually thereafter. Any staff found out of compliance or not practicing appropriate universal precautions will be re educated, trained and competency on Agency policies and procedures.** All staff who have not completed these mandatory in-service opportunities by 12-31-2020 will be removed from the schedule. Employee D has been in-serviced and competency on Handwashing, Standard Precautions/Infection Control, Bag Technique, Covid 19 Protocol on 11.23.2020. Employee E has been in-serviced and competency on Handwashing,	

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	patient used the dirty washcloth to perform his suprapubic catheter and perineal care. After the bath, the HHA was observed performing hand hygiene by washing her hands with soap and water. The HHA turned on the water, applied soap to her hands, scrubbed her hands for 4 seconds outside of the water, 15 seconds underneath running water (for a total of 19 seconds), turned off the faucet with her elbow, and dried her hands with a paper towel. The HHA failed to perform hand hygiene after removing her gloves, failed to scrub her hands with soap for 20 seconds outside of running water when washing her hands with soap and water, and failed to provide the patient with a clean washcloth for him to perform suprapubic catheter care. 3. A home visit observation was conducted on 9/24/20 at 8:27 AM with Patient #4 (start of care 6/21/18) and Employee E, HHA. During the visit, the HHA was observed washing her hands with soap and water prior to assisting the patient with a shower. The HHA scrubbed her hands with soap for 7 seconds, turned off the faucet with her hands, and applied gloves with her hands still wet. The HHA then assisted the patient to undress and get into the shower. After the patient was seated on a shower chair, the HHA removed a set of keys from her pocket, unlocked a closet door, retrieved the patient's bathing supplies, locked the closet, and started to assist the patient with her shower. The HHA washed the patient's hair, then realized she had forgotten the patient's body wash. She went back to the closet, pulled out the keys from her pocket, unlocked the door, retrieved the patient's body wash, locked the door, and returned to assist the patient with the remainder of the shower. After the shower, the HHA assisted the patient into her bedroom, helped the patient dry off, and began to		Standard Precautions/Infection Control, Bag Technique, Covid 19 Protocol on 11.27.2020. **Employee F no longer employed. Administrator educated Employee F following survey exit conference on appropriate Clinical Bag & Glove uses. Employee F demonstrated compliance.**	

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	assist the patient with dressing. The patient reported she had to void, so the HHA assisted the patient back to the bathroom. After the patient was done voiding, the HHA washed the patient's rectum with a washcloth and assisted the patient back into the bedroom, where the HHA assisted the patient with dressing. The HHA then assisted the patient into the kitchen, where the HHA brushed the patient's hair and put it into a ponytail. The HHA then removed her gloves, went to the kitchen sink, washed her hands for 12 seconds, turned off the faucet with her wrist, went to her nursing bag, removed gloves, and applied new gloves to wet hands. The HHA failed to remove her gloves and perform hand hygiene between tasks and after wiping the patient's rectum and failed to scrub her hands with soap for 20 seconds when washing her hands with soap and water. 4. A home visit observation was performed with Patient #3 (start of care 4/9/19) and Employee F, Registered Nurse (RN). During the visit, the RN was observed performing hand hygiene using alcohol-based hand sanitizer (ABHS), removed vital sign equipment and gloves from her nursing bag, and applied 2 gloves to each hand. The nurse obtained the patient's vitals using a thermometer, SpO2 monitor, and automatic blood pressure wrist cuff, placed the used equipment on a drape, then performed a physical assessment of the patient. After she completed the physical assessment, the RN removed 1 glove from each hand (still had 1 glove on each hands), placed the used vital sign equipment into a plastic bag, and placed the bag full of dirty vital sign equipment back into the nursing bag. The RN reported the agency's office staff was responsible for cleaning the equipment (she did not know the name of the staff member responsible) and she would not use			

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	this equipment again "until it was cleaned." The RN reached into her nursing bag with her gloves on, retrieved a trash bag, opened the bag and laid it on the floor, and removed the second set of gloves. The nurse then reached into her nursing bag, stopped before she removed anything, took her hands out of the bag and performed hand hygiene using ABHS, started to reach back into the nursing bag, stopped again and rubbed her hands together, then put on 1 pair of gloves. The RN failed to clean the vital sign equipment prior to returning it to the nursing bag, failed to perform hand hygiene immediately after removing gloves (both the first and second set of gloves), and failed to perform hand hygiene prior to entering the nursing bag. 5. An interview was conducted with the administrator on 9/28/20 at 4:15 PM. During the interview, the administrator indicated when performing hand hygiene with soap and water, staff's hands should scrubbed with soap for "15 - 20 seconds," hands should scrubbed outside of running water, and hands should be dried after washing and before applying gloves. The administrator indicated hand hygiene should be performed after removing gloves, and staff should remove gloves and perform hand hygiene between tasks and after cleaning a patient's perineal area. The administrator also indicated catheter care should be performed using a clean washcloth, staff should perform hand hygiene before entering the nursing bag, and staff should not enter the nursing bag with dirty gloves. The administrator was unable to indicate if the practice of "double gloving" (wearing two sets of gloves, and only performing hand hygiene after the second set of gloves was removed) was allowed by agency policy.			

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	An interview was conducted with the administrator on 9/30/20 at 9:59 AM. During the interview, the administrator indicated all used equipment should be cleaned and allowed to dry prior to placing back into a nursing bag. The administrator also indicated cleaning the used equipment was the responsibility of the field staff, and there were no other agency staff in charge of cleaning the nursing bags or equipment used in the field. 17-12-1(m)			
G 0684 Bldg. 00	484.70(b)(1)(2) Infection control Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the home health agency failed to ensure an agency-wide infection control program was maintained for the surveillance, identification, prevention, control, and investigation of patient and staff infections, for 2 active patients (#8, 11) and 2 discharged patients (#10, 12) with COVID-19 symptoms and/or positive test results noted on agency tracking and log records, which had the potential	G 0684	G0684 The Administrator and interdisciplinary team reviewed Policy B-402, Infection Control Surveillance, and Agency Coronavirus Protocol and Reporting Guidelines to re-educate the Agency on Infection Control and Prevention Policies and Procedures. The Agency has	10/28/2020

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	to effect all agency patients. Findings include: 1. An undated agency policy titled "Infection Control Surveillance," policy number B-402, stated " ... Policy. Touch of Love will establish a continuous data monitoring and collecting system to detect infections or identify changes in infection trends ... Touch of Love will implement a process of identifying all infections in the client and/or employee population ... Special Instructions: Touch of Love will perform targeted infection control surveillance as follows: Client infections that will be reported at the time of admission include ... COVID-19 ... Employee infections are to be reported if an employee develops or has a known exposure to: ... COVID-19 ... 1. Touch of Love Home Health Care staff will attempt to identify the source of infection to determine if it was acquired while the client was receiving home care ..., from the community ..., or during a recent inpatient facility stay ... 4. A home-acquired infection (agency acquired) results from contact between a client and a staff member during the time Touch of Love Home Health Care is proving home care services. This may include transmission from either the staff member to the client or client to the staff member ... b. When a pattern or trend in infections is identified, Touch of Love Home Health Care will investigate where clients and/or staff may have acquired the infections and what the source of contamination was... 6. An infection control log will be maintained. Touch of Love Home Health Care will identify follow up actions taken as a result of identified infections ...." An agency policy titled "TOL [Touch of Love] Coronavirus Protocol," updated 3/23/2020, stated		implemented an Employee/Patient Infection Surveillance Log 10.28.2020 to log, track, and analyze all staff and patients suspected or confirmed to have infections to include Covid-19. Surveillance includes patients and staff members who potentially may have been exposed to infectious disease. Additional surveillance to include logging, tracking and analyzing patients and staff that could be/are infected in order to assist the agency in better identifying trends and responding accordingly. The Clinical Supervisor or designee will review patient and/or employee infection reports during the Agencys daily meetings and ensure all confirmed or suspected infections are logged/reported weekly. This action will be audited for 100% compliance on a monthly basis ongoing. The Clinical Supervisor is responsible for ongoing compliance.	

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	"... Agency Update. For the past 2 weeks, we have been tracking: Patients who have visited the ER, are coughing/sick, have concerns about sick relatives who have visited them, etc, and need follow up phone calls to ensure they are not COVID-19 positive ... Clinicians who call in sick due to their own illness or that of a family member ...." 2. An agency document titled "Infection Surveillance Report," dated "1/1/2020 to 9/30/2020," was reviewed on 9/24/20. The report indicated Patient #10 (discharge date 5/5/20) developed symptoms of COVID-19 ("abnormal breath sounds, dyspnea [difficulty breathing]") on 2/18/20, however it failed to indicate if Patient #10 was tested or treated for COVID-19, and failed to indicate which employees provided care to the patient prior to the patient's development of symptoms. The Infection Surveillance Report indicated Patient #8 (start of care 12/20/18) reported symptoms of COVID-19 ("Dyspnea, New or increased cough ... nausea, headache, no appetite , and a lot of pain") on 3/16/2020. The report also indicate Patient #8 tested positive COVID-19, with positive test results received on 3/26/20. The report failed to indicate which employees provided care to the patient prior to the patient's development of symptoms, or which patients were seen after potential exposure. The Infection Surveillance Report indicated Patient #11 (start of care #4/19/19) reported a positive COVID-19 test result to the agency on 9/13/20. The report failed to indicate if the patient was symptomatic but did indicate the patient was exposed to a family member who was positive for COVID-19. The report also failed to indicate			

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	which employees provided care to the patient prior to the patient's positive test results. 3. The agency's Infection Control Log from 1/1/2020 to 9/24/20 was reviewed on 9/30/20. The log indicated Patient #12 (discharge date 5/5/20) reported symptoms of COVID-19 (decreased blood pressure, lethargy) on 4/13/20, tested positive for COVID-19 (date of result unknown), and was admitted to the hospital for their infection. The Infection Control log also noted Patient #8's COVID-19 infection (see Finding #3 for further information). The log contained an undated "Infection Control Report," signed by Former Employee B, Registered Nurse (RN). The Infection Control Report indicated an investigation of Patient #8's diagnosis of COVID-19 was performed, which listed Former Employee B, Registered Nurse (RN); Employee J, Home Health Aide (HHA); Employee K, HHA; and Employee L, HHA as "Involved Staff." The Infection Control Report failed to indicate how the staff were involved (did they provide direct care to the patient, and if so, when was the last date of patient care prior to the patient's start of symptoms?). The Infection Control Log failed to evidence an Infection Control Report was completed for Patient #12, failed to evidence the infections of Patient #9, #10, and #11 were noted or analyzed (see Finding #3 for further information); failed to evidence the agency logged, tracked and analyzed suspected or confirmed cases of COVID -19 of employees; and failed to evidence the agency logged and tracked employees who provided care for patients with suspected or confirmed COVID-19.			

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	4. An interview with the administrator was conducted on 9/30/20 at 6:05 PM. During the interview, the administrator indicated the agency's Infection Control Log was the complete tracking of all patient infections, and the agency did not perform any tracking of employee infections. The administrator also indicated employees who provided care to patients with presumptive or confirmed COVID-19 should be tracked for development of symptoms.			
G 0686 Bldg. 00	484.70(c) Infection control education Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview, the home health agency failed to ensure all staff received infection control education in relation to daily self-monitoring for COVID-19, and failed to ensure all staff received and implemented infection control education related to performing a pre-visit screening of the patient for COVID-19 symptoms for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), which had the potential to impact all employees and patients of the agency. Findings include: 1. The Entrance Conference was conducted with the administrator and Employee C, Client Services Director, on 9/23/20 at 10:41 AM. During the Entrance Conference, the administrator indicated agency staff were educated and updated on the agency's COVID-19 policies by text messages sent through the agency electronic medical record (EMR), or by a "forum" the agency had on a social media page. The administrator also indicated all field staff were to check their	G 0686	G0686 The Administrator and Interdisciplinary team reviewed Policy B-402, Infection Control Surveillance, and Agency Coronavirus Protocol and Reporting Guidelines. The Administrator educated all staff regarding pre-visit screening of all patients. This included review reporting of any symptoms. The Administrator re-educated 1:1 with the Clinical Supervisory Staff on the Agency Policy for COVID Protocol. These policies were e-mailed and mailed to all agency staff. 100% of re-education of employees has been initiated on 10/13/2020 regarding Infection control and T.O.L. COVID Protocol to include pre-visit staff and patient screening via email. Agency updated COVID Protocol	12/31/2020

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	temperature each morning and "input" their temperature into the EMR, and all field staff were advised to screen patients for COVID-19 prior to each visit. The COVID-19 screening involved asking patients if they or anyone in the household had traveled outside of the country, had symptoms of COVID-19, and if they were exposure to someone with COVID-19. The administrator denied any agency expectation of staff to document the pre-visit screening within the patient's visit record. 2. An agency policy titled "TOL [Touch of Love] Coronavirus Protocol," updated 3/23/2020, stated " ... Pre-Visit Screening. Effective immediately, all clinicians and field staff must conduct a screening call immediately before each visit. Please ask your patients the following 3 screening questions: 1 - Travel: In the past 14 days have you or anyone in your home/facility returned from travel outside the United States? {yes/no}. 2 - In the past 14 days, have you or anyone in your home/facility had close contact with anyone diagnosed with or suspected to have COVID-19? {yes/no}. 3 - Symptoms: Do you or anyone in your home/facility have raspy/itchy throat, cough, fever, or shortness of breath? {yes/no} ... Once these questions have been answered, include the response in your visit note to document that you conducted the pre-visit screening ... temperatures ... Check your temperature every morning before leaving the house to do visits. Email via [EMR] your temperature reading to the office. " An undated agency policy titled "OSHA Infection Control/ Exposure Control Plan," policy number B-405, stated " ... Exposure Determination for Tuberculosis/COVID19 ... For pandemic outbreaks. Daily symptom checks will be completed for all scheduled care visits with		and resent it out via email on 11/23/2020. Upon hire all orientees are in-serviced and competency checked on the agencies Covid-Protocol. Clinical Supervisory Staff will complete ongoing Infection Control/ Covid Protocol education and audits during new hire orientation/skills checks, all supervisory and points of care visits in order to educate all staff and patients on proper procedures. Any staff found out of compliance or not following protocol will be re educated, trained and competency on Agency policies and procedures. The Clinical Supervisor and designees will ensure ongoing compliance with this plan of correction. Completion Date: Ongoing	

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	employees and clients prior to arrival to the residence ...." 3. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a plan of care for the certification period of 8/18/20 - 10/16/20, which indicated orders for skilled nurse and home health aide (HHA) services. All HHA visit notes from 8/18/20 - 9/23/20 failed to evidence the aide completed a COVID-19 screening prior to or during the visit. 4. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/20/20 - 10/18/20, which indicated orders for skilled nurse, home health aide, and respite home health aide services. All HHA and respite home health aide visit notes from 8/20/20 - 9/23/20 failed to evidence the aide completed a COVID-19 screening prior to or during the home visit. An interview was conducted with Patient #2 (start of care 4/22/20) on 9/24/20 at 12:29 PM. During the interview, the patient indicated agency staff "called every couple of weeks to make sure" he had no symptoms of COVID-19 when the pandemic first started, but no longer performed these calls. The patient also indicated agency staff did not perform a screening for COVID-19 via telephone or in person prior to his home visits. 5. The clinical record of Patient #3 was reviewed on 9/25/20 and 9/28/20, and indicated a start of care of 4/9/19, with the primary diagnosis of Type			

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	2 Diabetes. The clinical record included a plan of care for the certification period of 8/1/20 - 9/29/20, which indicated orders for home health aide services. All HHA visit notes from 8/1/20 - 9/23/20 failed to evidence the aide completed a COVID-19 screening prior to or during the home visit. 6. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20, which indicated orders for home health aide services. All HHA visit notes from 8/9/20 - 9/23/20 failed to evidence the aide completed a COVID-19 screening prior to or during the home visit. 7. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." The clinical record contained a plan of care for the certification period of 7/28/20 - 9/25/20, which indicated orders for home health aide services. All HHA visit notes from 7/28/20 - 9/23/20 failed to evidence the aide completed a COVID-19 screening prior to or during the home visit. 8. An interview was conducted with Employee D, Home Health Aide (HHA), on 9/24/20 at 12:34 PM. During the interview, the employee indicated the agency had provided COVID-19 education and updates through "email, phone calls or text [message]." The employee also indicated staff were to check their temperature daily and contact the office if their temperature was greater than "98.6 [degrees Fahrenheit]."			

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	An interview was conducted with Employee E, HHA, on 9/28/20 at 9:05 AM. During the interview, the HHA indicated the agency had provided COVID-19 education and updates through "weekly pop quizzes ... webinar ... updates every day." The HHA also indicated agency nurses called all staff every day to perform a COVID-19 screening, and HHAs were instructed they could check their temperature, but it was "not a priority." An interview was conducted with Employee F, Registered Nurse (RN) on 9/28/20 at 11:57 AM. During the interview, the RN indicated all agency staff were to perform a daily "personal COVID screening" including obtaining the employee's temperature. The employee also indicated staff were to report any temperature greater than "100 [degrees Fahrenheit]."			
G 0706 Bldg. 00	484.75(b)(1) Interdisciplinary assessment of the patient Ongoing interdisciplinary assessment of the patient; Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct a complete physical assessment per professional standard for 1 of 1 skilled nurse visit observations (#3), in a total of 3 home visit observations. Findings include: An undated agency job description titled "Position: RN Case Manager," policy number C-215, stated " ... Essential Functions/Areas of Accountability ... 2. Performs initial and ongoing client assessments based on Agency policy and standard of practice ...."	G 0706	G0706 The Administrator and Clinical Supervisor reviewed tag G0706 regarding comprehensive head to toe assessment 11.21.2020. The Clinical Supervisor has implemented a training to include all clinical skilled nursing staff on proper procedure to complete head to toe physical assessment per professional standards to include demonstrating correct techniques for inspection, palpitation, percussion, and auscultation. Clinical Supervisor will complete a 1:1 training, education and	12/31/2020

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	Constantine, Salmon, & Maryniak (January 16, 2012). "Overview of Nursing Health Assessment." Retrieved 10/19/20 from RN.com. " ... Cardiovascular Assessment ... Auscultate [listen with a stethoscope] heart sounds. Auscultate in a Z-pattern listening over the aortic, pulmonic, mitral, and tricuspid valves and over Erb's point (location of the center of the heart, located in between the 3rd and 4th left ribs) ... Listen for any extra heart sounds ... Listen for murmurs ... Pulmonary Assessment ... Auscultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth. Auscultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds ..." A home visit observation with Patient #3 was conducted on 9/28/20 at 11:22 AM, with Employee F, RN. During the visit, Employee F was observed performing a nursing health assessment of Patient #3. The RN auscultated the patient's lung sounds posteriorly (on the back) in 4 areas instead of 5. The RN failed to auscultate the patient's lung sounds anteriorly (front of chest) and failed to auscultate the patient's heart sounds. An interview was conducted with the administrator on 9/28/20 at 4:15 PM. During the interview, the administrator indicated when performing a nurse assessment, the nurse should auscultate lung sounds in 5 areas both anteriorly and posteriorly and should auscultate heart sounds.		competency on-site for all agency clinical skilled nursing staff by 12.31.2020. To ensure compliance with state deficiency and plan of correction on hire all clinical skilled nursing staff will be competency checked off prior to giving direct patient care on physical assessments, and will be documented. QA Supervisory visits for all clinical staff will be made quarterly until 100% compliance is achieved. The Clinical Supervisor and designees will ensure ongoing compliance with this plan of correction.	
G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on observation, record review and interview, the Registered Nurse (RN) failed to develop an aide care plan that was specific, not generalized, for each home health aide (HHA) shift for 3 of 5 active records reviewed (#1, 2, 4), in a total sample of 7 records. Findings include: 1. An undated agency policy titled "Home Health Aide Supervision," policy number C-340, stated " ... Policy. Agency shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse ... Special Instructions. 1. The Nursing Supervisor or designated Registered Nurse ... will give the Home Health Aide direction for client care by way of the Care Plan ...." An undated agency job description, titled "Position: RN Case Manager," policy number C-215, stated " ... Essential Functions/Areas of Accountability ... 4. Manages/supervises a team of ... Home Health Aides ... to provide effective and quality home care services ...." 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a plan of care for the certification period of 8/18/20 - 10/16/20, which	G 0798	G0798 The Administrator reviewed G Tag 0798, Policy C-340 Hha Supervision. Clinical Supervisory staff educated on completing Hha Care Plans that are individualized and specific to include directions for specific task the Hha are to complete at each shift for all census with multiple visit frequencies in a calendar day i.e Am/Pm services and directions specifically for those times of day. The Clinical Supervisor or designee will initiate an audit of 100% of all Hha Care Plans. Addendums will be made to the Hha Care Plan and additionally to the Plan of Care on all content that is found to be out of compliance per agency policy and statement of deficiencies. Ongoing all census Hha Care Plan will be QR by the Clinical Supervisor prior to submission for 100% compliance for the next 90days. Then 10% of census charts (minimum of 5) will be audited monthly for the following 90days and 10% (minimum of 5 charts) quarterly thereafter to ensure compliance with plan of correction. All staff will be in-serviced on Hha	12/31/2020

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	15K151	A. BUILDING 00 B. WING	09/30/2020

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	contained an order for HHA services of "HhA frequency beginning 08/18/2020-08/22/20201to [sic] 2 visits/ [per] d [day] x [for] 5-10 hrs /dx1-2 d/wk [week] for week 1, then weeks 8/23/2020 - 10/10/2020 1-2visits/dx5-10hrs/dx5-7 d/week for 7 weeks, then 10/11/2020 - 10/16/2020 1-2visits/dx5-6 d/wk for week 9 [sic throughout]." A "HHAide [sic] Care Plan" for Patient #1 was completed and signed by Former Employee A, RN, on 8/14/20. The aide care plan indicated tasks were to be completed as marked, either "Every visit" or "Weekly" The clinical record failed to evidence an aide care plan for each shift which directed the specific tasks for the HHA to complete at each shift. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/20/20 - 10/18/20. The plan of care contained orders for both HHA services, written as "Beginning 8/20/2020 - 8/22/2020 1hr [hour] 1-3 x's [times] / week, then weeks 08/23/2020 - 10/17/2020 1 hr 2-4x's/wk, then 10/18/2020 - 1 hr x 1 day," and Respite HHA services, written as "39 hours/month." A "HHAide Care Plan" for Patient #2 was completed and signed by Former Employee A, RN, on 8/18/20. The aide care plan indicated tasks were to be completed as marked, either "Every visit" or "Weekly." The clinical record failed to evidence an aide care plan for Respite HHA shift which directed the specific tasks for the HHA to complete at each shift. 4. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of		Careplans, content, and documentation. by 12.31.2020 The following pertain to Records # 1,2,4 Record #2 Respite Hha Careplan created on 10.15.2020 and POC updated. Record #4 Will be completed on or before 12.6.2020 Record #1 Will be completed on or before 12.15.2020. The Clinical Supervisor or designees will ensure ongoing compliance with this plan of correction.	

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	care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20, which contained an order for HHA services, written as "Beginning 08/09/2020 -10/03/2020 1-2 visits/d X 5-9 hrs/day x 5-7 ds/wk for 8 wks , then 10/04/2020-10/07/2020 1-2 visits, 3-4 days X 5-9 hrs/day for wk9 ...." An "HHAide Care Plan" for Patient #4 was completed and signed on 8/6/20 by Former Employee B, RN. The aide care plan indicated tasks were to be completed as marked, either "Every visit" or "Weekly." The clinical record failed to evidence an aide care plan for each shift which directed the specific tasks for the HHA to complete at each shift. 5. An interview was conducted with the administrator on 9/30/20 at 9:59 AM. During the interview, the administrator indicated the agency did not have separate aide care plans for patients with both HHA and Respite HHA service orders. 17-13-2(a)			
G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the home health aide (HHA) failed to follow the plan of care for 3 of 5 active records reviewed, in a total sample of 7 records (#1, 2, 4).	G 0800	G0800 The Administrator reviewed G Tag 0800, Policy Hha Supervision with all Clinical Staff and requirements for weekly visit	12/31/2020

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	Findings include: 1. An undated agency policy titled "Home Health Aide Supervision," policy number C-340, stated " ... Policy. Agency shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse/Therapist when personal services are indicated and ordered by the physician ... Special Instructions ... 1. The Nursing Supervisor or designated Registered Nurse/Therapist will give the Home Health Aide direction for client care by way of the Care Plan ... " 2. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia (paralysis of all 4 extremities). The clinical record included a plan of care for the certification period of 8/18/20 - 10/16/20, which contained an order for HHA services of "HhA frequency beginning 08/18/2020-08/22/20201to [sic] 2 visits/ [per] d [day] x [for] 5-10 hrs /dx1-2 d/wk [week] for week 1, then weeks 8/23/2020 - 10/10/2020 1-2visits/dx5-10hrs/dx5-7 d/week for 7 weeks, then 10/11/2020 - 10/16/2020 1-2visits/dx5-6 d/wk for week 9 [sic throughout]." A "HHAide [sic] Care Plan" for Patient #1 was completed and signed by Former Employee A, Registered Nurse (RN), on 8/14/20. The care plan indicated tasks to be completed "Every visit" which included "Bed bath ... Assist with dressing ... Lotion ... Comb hair ... Oral care ... Incontinence care ... Catheter care ... Empty drainage bag ... Meal set-up ... Meal preparation ... Assist with eating ... Encourage fluids ... Assist with transfer ... Hoyer lift ... Turn and position ... Passive ROM [Range of Motion] per		audits to ensure Hha staff are following the Hha Careplan and reporting requirements. All Hha Staff will be in serviced by 12.31.2020 on Hha Careplans, Precautions definitions category, reporting and documentation. Any staff not in-serviced or fails to attend in service on or before due date will be removed from schedule until in service is complete. The Agency submitted a EMR ticket 9.30.2020 day of exit conference due to error with equipment care not populating on Hha visit note due to error Hha staff was not given the option to select the equipment care task. EMR error corrected on 11.4.2020 all task selected by RNCM now populates on the Hha visit note accordingly. To ensure compliance the Clinical Supervisory team will audit and review Hha Visit Notes weekly, complete on-site supervisory visits to ensure Hha staff are following the individualized Hha Careplan. If at anytime a staff is found out of compliance the Clinical Manager over the patients treatment plan will re-educate staff on Agency guidelines, policy and procedures per the Hha Careplan services and documentation requirements. The Clinical Supervisor or designees will be responsible for ongoing compliance with this plan of correction.	

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	PT/OT [Physical Therapy / Occupational Therapy] ... Equipment Care ... Make bed ... Tidy bathroom ... Tidy bedroom ... Tidy kitchen ... Tidy patient's area ... Take out trash ... Back rub ...." The care plan also indicated "Infection Precautions ... Standard Precautions" (infection control practices used to prevent the transmission of diseases with all patients, regardless of their diagnoses; includes hand washing and wearing gloves whenever there is a potential for exposure to bodily fluids) were to be followed at each visit. The HHA visit notes, completed by Employee P, HHA, documented on 8/18/20, 8/21/20, 8/22/20, 8/24/20, 8/25/20, 8/28/20, 8/29/20, 8/30/20, 8/31/20, 9/1/20, 9/2/20, 9/3/20, 9/4/20, 9/7/20, 9/8/20, 9/11/20, 9/12/20, 9/20/20, failed to indicate the task of "Equipment Care" was completed. The visit notes also indicated "Droplet precautions" (type of transmission-based infection control precautions, based on presence or risk of specific infections and diseases, and requires the healthcare worker to wear a mask, gown and gloves, in addition to Standard Precautions) were followed. The HHA visit notes, completed by Employee U, HHA, documented on 8/19/20, failed to indicate the task of "Equipment Care" was completed. The visit notes also failed to indicate Standard Precautions were followed. The HHA visit notes, completed by Employee T, HHA, documented on 8/21/20, failed to indicate the task of "Equipment Care" was completed. The visit notes also indicated Contact Precautions (type of transmission-based infection control precautions, based on presence or risk of specific infections and diseases, and requires the healthcare worker to wear a gown and gloves in			

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	addition to Standard Precautions), Droplet Precautions, and Respiratory Precautions were followed, which were not indicated on the HHA care plan. The HHA visit notes, completed by Employee J, HHA, documented on 8/22/20, 8/27/20, 9/7/20, 9/9/20, 9/19/20, 9/20/20, failed to indicate the task of "Equipment Care" was completed. The visit notes also failed to indicate Standard Precautions were followed. The HHA visit notes, completed by Employee R, HHA, documented on 8/25/20, 8/27/20, 8/31/20, 9/1/20, 9/3/20, 9/5/20, 9/6/20, 9/8/20, 9/10/20, failed to indicate the task of "Equipment Care" was completed. The visit notes also failed to indicate Standard Precautions were followed. The HHA notes, completed by Employee N, HHA, documented on 8/29/20, 8/30/20, 9/10/20, 9/11/20, failed to indicate the task of "Equipment care" was completed. The visit notes also failed to indicate Standard Precautions were followed. A HHA visit note completed by Employee S, HHA, documented on 9/2/20, failed to indicate the task of "Equipment Care" was completed. The visit note also failed to indicate Standard Precautions were followed. A HHA visit note, completed by Employee C, Licensed Practical Nurse (LPN), documented on 9/6/20, failed to indicate the task of "Equipment Care" was completed. The visit note also failed to indicate Standard Precautions were followed. A HHA visit note, completed by Employee Q, HHA, documented on 9/12/20, failed to indicate the task of "Equipment Care" was completed. The			

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	visit note also failed to indicate Standard Precautions were followed. 3. The clinical record of Patient #2 was reviewed on 9/25/20, and indicated a start of care of 4/22/20, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/20/20 - 10/18/20. The plan of care contained orders for both HHA services, written as "Beginning 8/20/2020 - 8/22/2020 1hr [hour] 1-3 x's [times] / week, then weeks 08/23/2020 - 10/17/2020 1 hr 2-4x's/wk, then 10/18/2020 - 1 hr x 1 day," and Respite HHA services, written as "39 hours/month." A "HHAide Care Plan" for Patient #2 was completed and signed by Former Employee A, RN, on 8/18/20. The care plan indicated tasks to be completed "Every visit" included "Bed bath ... Assist with dressing ... Lotion ... Comb hair ... Shampoo hair ... Oral care ... Clean/File nails ... Incontinence care ... Catheter care ... Empty drainage bag ... Meal set-up ... Meal preparation ... Assist with transfer ... Passive ROM per PT/OT ... Make bed ... Tidy bathroom ... Tidy bedroom ... Tidy kitchen ... Tidy patient's area ... Take out trash ... Back rub ...." The care plan also indicated "Infection Precautions ... Standard Precautions" were to be followed at each visit. The HHA visit notes, completed by Employee N, HHA, and documented on 8/21/20, 8/22/20, and 9/3/20, failed to indicate the task of "Equipment Care" was completed, and failed to indicate "Standard precautions" were followed. A HHA visit note, completed by Employee O, HHA, and documented on 8/25/20, failed to indicate the task of "Equipment Care" was completed, and failed to indicate "Standard			

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	precautions" were followed. The HHA visit notes, completed by Employee M, HHA, documented on 8/28/20, 8/31/20, 9/1/20, 9/4/20, 9/8/20, 9/9/20, 9/10/20, 9/15/20, 9/16/20, 9/17/20, 9/18/20 failed to indicate the task of "Equipment care" was completed. The visit notes also indicated "Contact precautions" were followed, which were not indicated on the HHA Care Plan. The HHA visit notes, completed by Former Employee A and documented on 8/27/20, 9/12/20, and 9/14/20, failed to indicate the task of "Equipment care" was completed. The visit notes also indicated "Contact Precautions" and "Droplet Precautions" were followed, which were not indicated on the HHA Care Plan. A HHA visit notes, completed by Employee J, HHA, and documented on 8/30/20, failed to indicate the task of "Equipment Care" was completed, and failed to indicate "Standard precautions" were followed. 4. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20, which contained an order for HHA services, written as "Beginning 08/09/2020 -10/03/2020 1-2 visits/d X 5-9 hrs/day x 5-7 ds/wk for 8 wks , then 10/04/2020-10/07/2020 1-2 visits, 3-4 days X 5-9 hrs/day for wk9 ...." The clinical record contained a "HHAide Care Plan," completed and signed by Former Employee B, RN, on 8/6/20. The care plan indicated tasks to be completed "Every visit" included "Shower with			

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	chair ... Assist with dressing ... Lotion ... Comb hair ... Shampoo hair ... Oral care ... Incontinent care ... Meal set-up ... Meal preparation ... Assist with transfer ... Equipment care ... Make bed ... Tidy bathroom ... Tidy bedroom ... Tidy kitchen ... Tidy patient's area ... Vacuum ... Take out trash ...." Tasks to be completed "Weekly" included "Shave (electric) ... Change linen ... Back rub ...." The HHA visit notes, completed by Employee E, HHA, documented on 8/9/20, 8/10/20, 8/11/20, 8/12/20, 8/14/20, 8/15/20, 8/16/20, 8/17/20, 8/18/20, 8/19/20, 8/20/20, 8/21/20, 8/22/20, 8/23/20, 8/24/20, 8/25/20, 08/26/20, 8/27/20, 8/28/20, 8/29/20, 8/30/20, 8/31/20, 9/1/20, 9/2/20, 9/3/20, 9/4/20, 9/5/20, 9/6/20, 9/7/20, 9/8/20, 9/9/20, 9/10/20, 9/11/20, 9/12/20, 9/13/20, 9/14/20, 9/15/20, 9/16/20, 9/18/20, 9/19/20, 9/20/20, 9/21/20, 9/22/20, 9/23/20, 9/24/20, and 9/25/20, failed to evidence the task of "Equipment care" was completed. 5. An interview was conducted with the administrator on 9/30/20 at 2:00 PM. During the interview, the agency indicated all tasks on the aide care plan should be completed, "unless the client refuses, or the RN tells them [HHA staff] not to do it."			
G 0954 Bldg. 00	484.105(b)(2) Ensures qualified pre-designated person When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Based on record review and interview, the home health agency's administrator failed to ensure a	G 0954	G0954 The Administrator has appointed a Alternate	09/30/2020

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	qualified, pre-designated person, who was approved by the governing body, was available to assume the same responsibilities and obligations as the administrator in their absence; which had the potential to effect all agency patients. Findings include: An Entrance Conference was conducted on 9/23/20 at 10:41 AM with the administrator (via phone) and Employee C. During the Entrance Conference, the administrator reported she was currently in Georgia, and was "trying to find a flight back." The administrator indicated she had attempted to replace Former Employee A, Registered Nurse (RN), as Alternate Administrator with Employee C, Licensed Practical Nurse (LPN), however she received a letter on 9/10/20 from the state survey agency which indicated Employee C did not meet the qualification requirements for Alternate Administrator. The administrator also indicated Former Employee A "walked out" of the agency on 9/17/20, and Employee B, RN, was the agency's interim Alternate Administrator. An undated job description titled "Position: Administrator/Alt [Alternate] Administrator" stated " ... Reports to: Governing body/Board of Directors ... Essential Functions ... 3. Directs and coordinates the overall development and administration of the Agency ... 14. Participates in the hiring, orientation, and development of management staff ...." The employee file of Employee B, RN, was reviewed on 9/29/20 at 12:01 PM. The employee file indicated a job description titled "Administrator/Alt Administrator" was received and signed by Employee B, however the job description failed to evidence a date it was		Administrator approved by the governing body 9/26/2020. The Administrator will ensure said Alternate is notified in advance when the Administrator will need Alternate to assume agency responsibilities due to absence. The Administrator will be responsible for ongoing compliance with this plan of correction.	

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	received by the employee. The employee file also failed to evidence the agency's Governing Body approved the employee to the role as Alternate Administrator. An interview was conducted with Employee F, RN, on 9/28/20 at 11:57 AM. During the interview, the RN identified Employee A as the administrator, however she stated she would contact Employee C before the administrator for any issues not related to "skilled care" (nursing care). The agency's Governing Body minutes were reviewed on 9/30/20 at 5:04 PM. The Governing Body minutes failed to evidence the Governing Body had approved Employee B as Alternate Administrator. A follow up interview with the administrator was conducted on 9/25/20 at 4:55 PM. During the interview, the administrator indicated when she left for Georgia, the agency's request to place Employee C in the role of Alternate Administrator was pending. The agency received the letter notifying them that Employee C was not qualified to be Alternate Administrator on 9/18/20, while the administrator was in Georgia. She did not return to Indiana until 9/23/20. 17-12-1(d)(8)			
G 0978 Bldg. 00	484.105(e)(2)(i-iv) Must have a written agreement An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided			

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	15K151	A. BUILDING 00 B. WING	09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOUCH OF LOVE HOME HEALTH CARE INC	6919 E 10TH STREET, SUITE B-2 INDIANAPOLIS, IN 46219

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	under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. Based on record review and interview, the agency failed to ensure that written agreements were in place (and signed by both parties) that delineated the services each agency was to provide for all patients with shared agencies 3 of 3 patients who received care from another agency (#1, 4, 5), in a total sample of 7 records. Findings include: 1. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia. The clinical record included a plan of care for the certification period of 8/18/20 - 10/16/20, which indicated the patient received attendant care services from Entity D, an attendant-care services agency. The clinical record failed to evidence a shared patient agreement with Entity D. 2. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20, which indicated the patient received attendant care services from Entity D.	G 0978	G0978 Agency has implemented a MOA that outlines a agreement is in place with other service providers whom the agency has a shared patient with this agreement is to be used outline services each agency provides to ensure no conflict in services, service hours occur, to set the requirement for each agency responsibility to govern independently patient services, care coordination requirements and is to be reviewed and signed between each entity. **The Administrator will complete the MOA between the Agency and other service providers by 12.31.2020** The Administrator or designee will ensure ongoing compliance with this plan of correction.	12/31/2020

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	The clinical record failed to evidence a shared patient agreement with Entity D. 3. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." The clinical record contained a plan of care for the certification period of 7/28/20 - 9/25/20, which indicated the patient received attendant care services from Entity D. The clinical record failed to evidence a shared patient agreement with Entity D. 4. An interview was conducted with the administrator on 9/28/20 at 4:15 PM. During the interview, the administrator indicated the agency did not have shared patient agreements with other home care agencies that delineated their roles. 17-12-2(e)			
G 0980 Bldg. 00	484.105(e)(3) Primary HHA is responsible for patient care The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients. Based on record review and interview, the home health agency failed to ensure a shared patient agreement which indicated who the primary home health agency was created for 3 of 3 patients who received care from another agency (#1, 4, 5), in a total sample of 7 records. Findings include: 1. The clinical record of Patient #1 was reviewed on 9/23/20 and 9/28/20, and indicated a start of care of 4/26/19, with the primary diagnosis of quadriplegia. The clinical record included a plan of	G 0980	G0980 Agency has implemented a MOA that outlines a agreement is in place with other service providers whom the agency has a shared patient with this agreement is to be used to outline services each agency provides to ensure no conflict in services, service hours occur, to designate which providers service hours are dominate to meet patients needs, to set the requirement for each agency responsibility to govern	12/31/2020

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	care for the certification period of 8/18/20 - 10/16/20, which indicated the patient received attendant care services from Entity D, an attendant-care services agency. The clinical record failed to evidence a shared patient agreement with Entity D, which indicated the primary agency. 2. The clinical record of Patient #4 was reviewed on 9/25/20 and 9/30/20, and indicated a start of care date of 6/21/18, with the primary diagnosis of schizoaffective disorder. The clinical record included a plan of care for the certification period of 8/9/20 - 10/7/20, which indicated the patient received attendant care services from Entity D. The clinical record failed to evidence a shared patient agreement with Entity D, which indicated the primary agency. 3. The clinical record of Patient #5 was reviewed on 9/29/20 and 9/30/20, and indicated a start of care of 12/11/17, with a primary diagnosis of "Generalized anxiety disorder." The clinical record contained a plan of care for the certification period of 7/28/20 - 9/25/20, which indicated the patient received attendant care services from Entity D. The clinical record failed to evidence a shared patient agreement with Entity D, which indicated the primary agency. 4. An interview was conducted with the administrator on 9/28/20 at 4:15 PM. During the interview, the administrator indicated the agency did not have shared patient agreements with other home care agencies that indicated the primary agency. 17-12-2(e)		independently patient services, care coordination requirements and is to be reviewed and signed between each entity. The Administrator will complete the MOA between the Agency and other service providers by 12.31.2020 The Administrator or designee will ensure ongoing compliance with this plan of correction.	

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N 0000 Bldg. 00	This was a State relicensure and complaint survey of a home health agency. Complaint #IN00328386; Substantiated with findings Survey Dates: September 23, 24, 25, 28, 29, 30; 2020 Facility Number: 014003 Provider Number: 15K151 Unduplicated admissions past 12 months: 48 Skilled patients: 4 Home Health Aide Only Patients: 13 Personal Service Only Patients: 0 Total Active Patients: 15 Sample selection: Records with home visits: 3 Records without home visits: 2 Discharge records: 2 Total records reviewed: 7	N 0000	The Administrator conducted a in-service with the Clinical Supervisor and Client Service Director on the statement of deficiencies and COP's 11.21.2020. In service focused on COP's and Agencies policies associated with survey report. In addition a in service with the interdisciplinary team was conducted on the statement of deficiencies. The following are our Agencies Plan of Corrections to address all findings. This Agency has began a full scale audit on all current census and personnel charts to address findings and bring Agency to compliance with CMS regulation and State licensure. A mandatory in service will be conducted with all agency staff by 12.31.2020 to educate and competency staff on deficiencies findings.	
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and			

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	shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure personnel records contained a signed receipt of the employee's job description for 1 of 8 personnel files reviewed (Employee B), and failed to ensure personnel records contained annual performance evaluations for 2 of 8 personnel files reviewed (Employees A, B). Findings include: 1. An undated agency policy titled "Personnel Records," policy number B-235, stated " ... Policy. Personnel files will be established and maintained for all personnel ... Special Instructions. 1. Personnel Records - the employee personnel record will include, but not limited to: ... b. Employment Information: ...Signed job description ... c. Ongoing Employment: Performance appraisals ...." 2. The personnel file of Employee A, Administrator, was reviewed on 9/29/20, and indicated a date of hire of 1/27/14. The employee file failed to evidence an annual evaluation had been completed since 1/27/17. 3. The personnel file of Employee B, Alternate Director of Nursing and Alternate Administrator, was reviewed on 9/29/20, and indicated a date of hire of 5/5/17. The personnel file contained a	N 0458	N0458 All employee files were audited 10/1/2020-10/24/2020 by the Administrative Assistant. All personnel files will be brought up to date by 12/31/2020 assuring that all forms are completed, signed, and dated. On 11/22/2020 Employee B received a current Annual Performance Review which was signed and dated for her file. Employee B has a signed and dated Job description for 9/18/2020 that has been place in her file. To ensure ongoing compliance with plan of correction the following process have been implemented. Upon employee's completion of orientation Administrative Assistant will complete a chart audit assuring that all forms have been completed, signed, and dated. Annual review dates will be inputted into EMR system for tracking purposes. EMR will alert 30 days prior to due date. All upcoming annual reviews will be discussed during daily meeting to assure they are	12/31/2020

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	document titled "Performance Evaluation," dated and signed by Former Employee A, Registered Nurse, on 5/4/20. The Performance Evaluation indicated the evaluation was a "3 yrs [year]" evaluation, and was not signed by Employee B, but instead the document stated "face to face discussion" on the line that was indicated for the employee's signature. The personnel file failed to evidence an annual performance evaluation was completed prior to 5/4/20. The employee file also failed to evidence a signed and dated job description for the employee's roles as Alternate Administrator and Alternate Director of Nursing. 4. An interview was conducted with the administrator and Employee W, Home Health Aide (HHA) on 9/29/20 at 4:45 PM. During the interview, the administrator indicated an employee's personnel file should include a signed and dated copy of the job description for each role assigned to the employee. The administrator also indicated an annual performance review should be completed every year for every employee.		completed timely and per Agency policy. Employee files will be 100% audited monthly by Administrative Assistant for the next 90 days. If after the 90 days all charts are found to be 100% in compliance, then 10% of the employee files (no less than 5 employee files) will be audited monthly going forward. If files are not found to be in compliance at any time 100% of the employee files will be audited and staff will be re-educated on Agency and State policies and procedures. Training on this process was completed with all administrative staff 11/24/2020. The Client Services Director will be responsible to assure that this process is followed going forward.	
N 0466 Bldg. 00	410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review, and interview, the home health agency failed to ensure the separation of personnel and employee medical files for 3 of 8	N 0466	N0466 All employee files were audited 10/1/2020-10/24/2020 by the Administrative Assistant. As of	11/23/2020

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	personnel and medical files reviewed (Employees D, F, V). Findings include: 1. An undated agency policy titled "Personnel Records," policy number B-235, stated " ... Policy. Personnel files will be established and maintained for all personnel ... Special Instructions. 1. Personnel Records - the employee personnel record will include, but not limited to: ... d. Medical History/Health Status - Maintained Confidentially: Pre-employment physical, if required ... TB [Tuberculosis] screening (2-step Mantoux), Drug screening, if required ...." 2. The personnel and medical file of Employee D, Home Health Aide (HHA), was reviewed on 9/29/20, and indicated a date of hire as 5/7/20. The employee's personnel file contained the employee's on-hire physical exam, on-hire 2-step TB test results, and on-hire drug screen results, but failed to evidence these documents were kept in a separate, confidential medical file. 3. The personnel and medical file of Employee F, Registered Nurse (RN) was reviewed on 9/29/20, and indicated a date of hire as 9/2/20. The employee's personnel file contained the employee's on-hire physical exam and 2-step TB test results but failed to evidence these documents were kept in a separate, confidential medical file. 4. The personnel and medical file of Employee V, Home Health Aide, was reviewed on 9/29/20, and indicated a date of hire as 7/2/20. The employee's personnel file contained the employee's on-hire 1-step TB test results but failed to evidence this document were kept in a separate, confidential		11/23/2020 all evidence of physical exam, TB evaluation and clinical follow-ups, Drug Screens, Hepatitis B Vaccine and any other medical documentation has been removed from the personnel files and is being stored separately in a medical file for each employee including Employee D, F and V in the statement of deficiencies report. To ensure ongoing compliance with plan of correction the following process have been implemented. Upon employee's completion of orientation the Administrative Assistant will complete a chart audit assuring that all evidence of physical exam, TB evaluation and clinical follow-ups, Drug Screens and Hepatitis B Vaccine documentation are being stored separately in a medical file. Employee files will be 100% audited monthly by the Administrative Assistant for the next 90 days. If after the 90 days all charts are found to be 100% in compliance, then 10% of the employee files (no less than 5 employee files) will be audited monthly going forward. If files are not found to be in compliance at any time 100% of the employee files will be audited and staff will be re-educated on Agency and State policies and procedures. Training on this process was completed with all administrative	

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	medical file. 5. An interview was conducted with the administrator and Employee W, HHA, on 9/29/20 at 4:45 PM. During the interview, the administrator indicated the employee health files should be kept separate from personnel files. The administrator also indicated the agency was "in transition trying to get [personnel and health files] all electronic."		staff on 11/24/2020. The Client Services Director will be responsible to assure that this process is followed going forward.	