STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157668	A. BUILDING 00 B. WING	10/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HOMECARE OF INDIANA	9320 PRIORITY WAY W DR INDIANAPOLIS, IN 46240

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Dates: 10/5/2020-10/8/2020 Facility #: 012581 Provider #: 157668 Medicaid #: 201216760 Census: 66 At this Emergency Preparedness survey, Premier Homecare of Indiana was found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, including staffing and implementing staffing related to the Covid-19 pandemic in accordance with 42 CFR 484.102.	E 0000		
G 0000 Bldg. 00	This visit was for a Federal Recertification and State re-licensure survey of a home health provider. This was a fully extended survey. Survey dates: 10/5/2020-10/8/2020 Facility #: 012581 Provider #: 157668 Medicaid #: 201216760 Records Reviewed: 5 active and 2 discharged	G 0000		

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

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

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	Home visits completed: 2 (two other scheduled visits canceled) Total active census: 66 Active skilled: 63 Active aide only: 2 Unduplicated admissions within the last 12 months: 263 This deficiency reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Quality Review completed 11/19/2020 Area 1			
G 0374 Bldg. 00	484.45(b) Accuracy of encoded OASIS data Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review, the agency failed to ensure the outcome and assessment information set (OASIS) questions were answered accurately at the time of the assessment for 1 of 5 active records reviewed, out of a total of 7 clinical records reviewed. (Patient #3) Findings Include: Review of the clinical record for patient #3, start of care 8/17/20, included an OASIS start of care comprehensive assessment dated 8/17/20, in which M1005 asked about the most recent inpatient discharge date, in which the answer was "Unknown." M2001 Drug Regimen Review asked if "Did a complete drug regimen review identify potential clinically significant medication issues?" the answer was "0 _ No - No issues found during	G 0374	G0374 - An OASIS inservice to be done by SMc, the OASIS consultation company, in order to better educate the nursing staff on how to answer the OASIS questions appropriately based on the initial assessment (Exhibit B-1). The Director of Nursing to review all OASIS completed prior to submission to CMS to ensure that they are filled in accurately. The Director of Nursing, SHP, and OASIS Consultation company to continue to monitor OASIS on an on-going basis, until further notice.	12/28/2020

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	review." These questions were answered inaccurately as evidenced by the following: Review of an agency document titled "Referral/ Intake Form" dated 8/6/20, indicated the patient was referred from a skilled nursing facility. The anticipated discharge date from the facility indicated 8/11/20. Review of the medication profile upon admission and the plan of care for certification period 8/17/2020 to 10/15/2020 indicated, but was not limited to, Amitriptyline, Baclofen, Morphine, Hydroxyzine, Levothyroxine, and Duloxetine. Review of the above medications through Drug.com drug interaction website, revealed major drug interactions between Morphine and Hydroxyzine; Morphine and Baclofen; and Amitriptyline and Duloxetine. The website also indicated moderate drug interactions between Amitriptyline and Levothyroxine; Amitriptyline and Morphine; Amitriptyline and Hydroxyzine; Hydroxyzine and Baclofen; Amitriptyline and Baclofen; Morphine and Duloxetine; Hydroxyzine and Duloxetine; and Baclofen and Duloxetine. The finding was reviewed with the Director of Nursing on 10/6/20 at 12:30 p.m., in which no further information or documentation was provided.			
G 0434 Bldg. 00	484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in care Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the			

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	comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure patients were informed about the frequency of visits and the care to be furnished prior to the start of care for 1 of 5 active records reviewed, out of a total of 7 clinical records reviewed. (Patients 3) Findings include: Review of an undated agency policy titled "Home Care Client Bill of Rights" indicated, " ... 1. A designated Regestered Nurse/ Therapist shall provide the client verbally and with a written notice ... 6. Clients will be informed of their right to particpate in planning care, or treatment and in planning changes in the care of treatment. This includes the right to be informed in advance of the care to be furnished, the discipline, the frequency of visits, the type of care, and any changes in the plan of care or care to be furnished .... " Review of clinical record for patient #3, start of care (SOC) 8/17/20, included consent forms signed by the patient upon admission. Review of the agreement indicated " ... Treatment: PT/OT/SN [physical therapy/occupational therapy/skilled nursing].... " The consents/ clinical record failed to establish the care to be furnished based on the comprehensive assessment and the frequency of	G 0434	G434 Updated Admission (Exhibit A-3). The admission booklet has been updated to include all current and accurate information. Admission consent form updated. All staff updated with current information regarding notifying patient on frequency via EMR communicator. DON to mail all current patients an updated admission booklet to ensure they have the most accurate information. With mailing all patients the information, the agency will cover any deficiencies in the legal documentation that was not accurate or up to date. The DON will make sure that the patient has a signed copy of their frequency. The Director of Nursing to complete bi-weekly admission consent audit to ensure that the frequency of services is included, filled in, and signed by the patient.	12/28/2020

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	visits anticipated by the PT/OT/SN upon admission. During a home visit on 10/7/20 at 10:30 a.m., when asking the patient about how the care was going with skilled nursing and therapy, the patient responded the nurse came and did the admission and never returned for several weeks and wondered what happened, but was thankful for the HHA [home health aide] coming into the home and helping her relay messages to the nurse. The findings were reviewed with the Director of Nursing on 10/6/20 at 12:30 p.m., in which she had no further information or documentation to provide.		This is to ensure that moving forward the patients have accurate information.	
G 0440 Bldg. 00	484.50(c)(7)(i, ii, iii, iv) Payment from federally funded programs Be advised, orally and in writing, of- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f).	G 0440	Updated admission paperwork	12/28/2020

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	Based on record review, the agency failed to ensure patients were advised orally and in writing of the extent to which payment for services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the home health agency and the potential charge for services that may not be covered by these programs for 1 of 5 active records reviewed, out of a total of 7 clinical records reviewed. (Patient 3) Findings include: Review of an undated agency policy titled "Client Admission Process" indicated, " ... 10. The admission professional will ... g. Advise the client/ caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client/ caregiver financial liability, and other methods of payment .... " The clinical record of patient #3 was reviewed and included an agency consent document dated 8/17/20, which revealed the Liability for payment section was left blank for Medicare, Medicaid, Private Insurance, Other Third Party Payer, and the Client Responsibility if applicable. The findings were reviewed with the Director of Nursing on 10/6/20 at 12:30 p.m., in which she had no further information or documentation to provide.		(Exhibit A-2). All current patient are to receive a letter with a copy of their financial responsibility and the services that have been authorized by their insurance. Admission paperwork updated to including extent of which payment for services may be expected. Now and moving forward, once patient has been accepted as a referral, the biller to contact patient and go over insurance information, including patient responsibility if there is one. Biller to update nursing staff and to upload form into EMR so that nursing staff can add information to the admission consent form. The billing manager to monitor that patient financial responsibility form on a bi-weekly basis to ensure it is complete prior to admission. Once 100% accuracy is achieved and maintained, the audit will be decreased to a quarterly basis.	
G 0452 Bldg. 00	484.50(d) Transfer and discharge Standard: Transfer and discharge. The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only			

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	transfer or discharge the patient from the HHA if: Based on record review and interview, the agency failed to inform the patient and representative (if any) in advance of their intent to discharge the patient from home health services in 1 of 2 closed records reviewed, out of a total of 7 clinical records reviewed. (Patient #7) Findings include: During a record review of the Primier Homecare of Indiana policy, " #3. Be given reasonable discharge notice, at least (5) calendar days prior to service being stopped." The clinical record for patient #7, reviewed 10/05/2020, revealed a plan of care for the certification period of 5/12/20 to 7/10/20 with orders for skilled nursing 1 time a week for 9 weeks and home health aide services 2 times a week for 9 weeks. The record evidenced the patient was discharged on 7/8/20. Review of the clinical record failed to evidence that the patient/ representative was informed in advance of the agency's intent to discharge the patient on 7/8/20. The finding was reviewed with the Administrator and Director of Nursing on 10/5/20 at approximately 3:00 p.m., in which the Director of Nursing could not identify where the notice was documented. 410 IAC 17-12-3 (b)(2)(D)(iii)	G 0452	Updated Discharge policy (exhibit A-1). New admission packets will be mailed to patient's home address on/before 12/28/2020 for any patient prior to updated information being placed in admission packet. All updated information communicated to all staff done via communicator in EMR. If a patient meets any of the four criteria listed as not needed to be informed 15 days prior with a 15 day notice, the nurse will place communication in the patient's chart stating why they were discharged without 15 days notice. This information will be monitored by the Director of Nursing on a monthly basis to ensure that the notices are given to the patient in a timely manner. If it is found the a nurse is not giving her patients a 15 notice letter, the DON will reach out to the patient and nurse to address the discharge. Updated admission book (Exhibit A-2).	12/28/2020
G 0514	484.55(a)(1) RN performs assessment			

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Bldg. 00	A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on record review and interview, the agency failed to ensure the Registered Nurse conducted an initial visit within 48 hours of the patient's return home for 1 of 5 active records reviewed in a sample of 7. (Patient #3) Finding include: Review of an undated agency policy titled "Client Admission Process" indicated, " ... 6. The initial assessment will be completed within forty-eight (48) hours of referral or within forty-eight (48) hours of the client's return home, or on the physician ordered/ client requested start of care date ... " The clinical record of patient #3 was reviewed and included a referral document dated 8/6/20, which indicated the patient's projected discharge date from a skilled nursing facility was 8/11/20. Review of the start of care assessment and consents upon admission revealed the patient was admitted on 8/17/20. Review of the coordination notes failed to evidence any documentation explaining why the patient was not assessed within the 48 hours. Review of the physician orders revealed an order to admit the patient on 8/14/20. The record failed	G 0514	Updated referral process (Exhibit C-1). For patient cited, the primary physician will be called and a verbal order will be sent regarding delayed start of care. A complete audit will be preformed by the assistant director of nursing to determine all current patient's who had a start of care outside the 48 hour window. Any patient determined to be delayed SOC, their primary physician will be contacted and a verbal order sent to the office regarding delay of care. New referral process put into place to ensure communication with patient is included in the chart. When patient is accepted as a referral, patient is contacted to verify all demographic information and insurance information. Communication is then placed in patient's chart with verification of information. Communication is placed in patient's chart with	12/28/2020

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	to evidence an order to delay the admission to 8/17/20. The finding was reviewed on 10/6/20 at 12:30 p.m. with the Director of Nursing, in which she stated she would look for documentation for the reason of the delay. The Director of Nursing indicated she believed the patient was not answering the phone and thought a physician order was obtained to delay the admission and she would need to look for documentation to support this. As of the exit conference on 10/8/20 at 2:30 p.m., no documentation to support the Director of Nursing's claim was received. During a home visit on 10/7/20 at 10:30 a.m., when discussing the patient's stay at the skilled nursing facility and the timing of her admission from the discharge, the patient indicated they were wondering why it took so long for the agency to call to set up an appointment for the admission then later indicated how the agency has to contact their room mate since they do not watch their phone closely and happened to be playing a game when the agency called to schedule.		reason and physician notification of extension of Start of Care. Assistant Director of Nursing to continue referral audits on a bi-weekly basis to ensure accuracy of SOC within the 48 hour window/documentation of delayed start of care. If it is found that a patient was admitted outside the 48 hour window, the admitting nurse will contact the primary physician and write a verbal order stating delayed SOC. This audit will continue until 100% accuracy is obtained and maintained monthly.	
G 0526 Bldg. 00	484.55(c) Content of the comprehensive assessment Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: Based on observation, record review and interview, the agency failed to ensure comprehensive assessments accurately reflect the patient's status at the time of admission for 1 of 4 (Patient 3) active records reviewed and 1 of 1 record reviewed of a patient who was recertified in	G 0526	G526 - Comprehensive assessment For the cited patient, the staff will be inservice on the companies policy specific to the	12/28/2020

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	a total sample of 7 clinical records reviewed. (Patient #1) Findings include: 1. Review of an undated agency policy titled "Client Reassessment/ Update of Comprehensive Assessment" indicated, " ... Purpose. To identify decline or improvement in health status, modify the plan of car and document changes that may affect care...." 2. Review of an undated agency policy titled "Comprehensive Client Assessment" indicated, " Policy. A thorough, well-organized, comprehensive and accurate assessment, consistent with the client's immediate needs will be completed for all clients ... The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals, and the care treatment and services provided ... Purpose. To determine the appropriate care, treatment and services to meet client initial needs and his/ her changing needs. To collect data about the client's health history [physical, functional and psychological] ... and their needs as appropriate to the home care setting .... " 3. Review of an undated agency policy titled "Pain Assessment/ Management" indicated, " Special Instructions. 1. Pain assessment is an integral part of the initial comprehensive assessment and the client's right to expect appropriate assessment and management is explained ... 2. ... The assessment include a measure of pain intensity and quality (character, frequency, location, and duration) ... 3. Pain is		comprehensive assessment of the clients. The staff will also be inservice on the specific information of the EMR documentation. 50% of the current patient's will have a complete audit of their comprehensive assessment to ensure accuracy. If it is found that the comprehensive assessment is inaccurate or incomplete, the DON will reject the documentation back to the nurse and have her correct the information. The Director of Nursing will audit 25% of all admission to ensure accuracy and completion of the comprehensive assessment on a bi-weekly basis. If the assessment is found to be inaccurate or incomplete, the DON will reject the comprehensive assessment back to the nurse for correction of documentation. When the DON find 100% accuracy of the comprehensive assessment audit, the audits will be done on a monthly basis.	

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	assessed on every home visit and documented on a pain or symptom flow sheet. Documentation will include the effectiveness of all pain interventions or modalities. 4. The nurse ... will use a standardized agency accepted pain assessment tool that evaluates the location, duration, severity (rating scale), alleviating factors, exacerbating factors, current treatment ... and response to treatment. 5. The follow-up assessments will address effectiveness of the pain management program and identify if there is a need for referral for additional or alternative therapy. If the established plan is ineffective and the pain management needs cannot be met within the agency pain management parameters, a referral will be made to an alternative provider .... " 4. Review of the clinical record for patient #3, evidenced a start of care comprehensive assessment dated 8/17/20. The comprehensive assessment failed to be completely and accurately completed as evidenced by the following: Support System: "Not Assessed" Pain Assessment - Location #1, Pain Management stated "Please refer to intervention documentation." The pain assessment indicated the patient had pain to their back with a frequency of "daily; intermittently" and it did interfere with activity or movement. The assessment indicated chronic pain but failed to include an acceptable level of pain. Musculoskeltal System, Safety Issues Identified; DME/ Assistive Device Assessment/ Instruction; DME/ Assistive Device Assessment/ Ambulation Devices; Use of Ambulation Devices; DME Assistive Device Assessment/ Wheelchair/ Exercise Equipment; Use of Wheelchair/ Exercise			

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	Equipment all were answered stating: "Please refer to intervention documentation." The areas identified failed to include a complete assessment. The endocrine assessment failed to include information of the patient history of blood sugars, treatment, and what their current levels had been running, what is an acceptable level of blood sugars, and frequency of daily checks. Glucose Monitoring: Blood sugar results within expected/ normal range: "No, results higher than expected." The note failed to include what the blood sugar result have been running in case there is a need to notify the physician. Medication Interventions Performed this visit: "See care plan documentation" During an interview on 10/6/20 at 12:30 p.m., when queried about the start of care assessment being incomplete due to the answers documented, the Director of Nursing indicated that these questions needed complete answers and should not be referring to other areas.5. Review of patient #1's clinical record was completed 10/5/2020 and revealed a SOC [start of care] date of 3/25/2019. The recertification comprehensive assessment dated 9/11/2020 revealed wound care and dressing change orders, which stated " ...per care plan ..." The recertification comprehensive assessment failed to evidence any specific wound care orders. Review of the plan of care (POC) dated 9/15/2020, for the certification period of 9/15/2020-11/13/2020, revealed wound care orders from a visit to the Veterans Administration (VA) wound clinic on 1/17/20, and failed to evidence wound care orders received from the VA wound clinic on 9/14/2020. Wound care orders dated 1/17/2020 were"			

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	...cleanse wounds with ¼ strength Dakins. Apply dry 2x2's (two inch gauze pads) between all toes on bilateral feet. Paint right plantar callosing [sic] with Betadine. Fill and cover all wounds with Acticoat. Paint right second toe scab with Betadine. Apply UNNA (gauze compression dressing) boots to bilateral lower extremities. Apply ABD [large gauze pads] pads cupped over toes and feet. Secure all dressings with Kerlix from toes to knees, on Monday, Wednesday, and Friday ..." During a home visit on 10/7/2020, patient #1's plan of care was observed and evidenced the wound care orders were from 1/17/2020. Observation of the patient's plan of care in the home failed to evidence the current wound care orders as a result of the comprehensive assessment not being updated and current. The findings were reviewed with the DON [Director of Nursing] on 10/07/20 at 3:44 p.m., in which she agreed the orders were incorrect. The DON had no further information or documentation to provide. 410 IAC 17 17-15-1(a)			
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;			

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	Based on record review and interview, the agency failed to ensure the start of care comprhensive assessment included the patient's strengths, goals, and care preferences for 1 out of 5 active records reviewed in a sample of 7. (Patient #3) Findings include: Review of the clinical record for patient #3, evidenced a start of care comprehensive assessment dated 8/17/20. The "Medical History - Patient Goals" section indicated "Patient's perceived impact of current illness: Inability to be caregiver." The pain management assessment indicated to "Please refer to intervention documentation." The assessment failed to include the patient's self stated goals/ care preferences and failed to include an acceptable level of pain as described by the patient. During an interview on 10/07/20 at 3:44 p.m., the DON [director of nursing] indicated the assessment failed to include the patient self-assessed and pain management goals.	G 0530	A comprehensive assessment inservice to be held in order to better educate the nursing staff on how to fill in the initial assessment and how to use the initial assessment to formulate the patient's plan of care. All current patients will be audited on bi-weekly basis, for accuracy of care plan documentation. If a care plan needs to be resolved, it will be resolved. If a care plan needs to be added, it will be sent to the nurse to add the appropriate care plan documentation and a verbal order sent to the doctor for signature. The DON to review all comprehensive assessments and plan of care's to ensure accuracy based on patient status at time of assessment. QAPI program to audit all current assessments for accuracy on a bi-weekly and have nursing staff make required adjustments. Once 100% accuracy is achieved and maintained the audit frequency will decrease to monthly.	12/28/2020
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which			

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	is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure visits were made per the plan of care, vital sign parameters were individualized/ patient specific with measurable outcomes and goals, for 1 of 5 active clinical records reviewed (Patients #3) and failed to ensure daily weights were obtained as ordered per the plan of care in 1 of 7 clinical records reviewed. (Patient #2). Findings include: 1. Review of an undated agency policy titled "Plan of Care" indicated, " ... Purpose. To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... Special Instructions. 1. An Individualize Plan of Care signed by a physician shall be required for each client receiving home health ... 2. The Plan of Care shall be completed in full to include the client's assessed needs: ... l. Medications, treatments, and procedures ... p. Treatment goals .... " 2. The clinical record of patient #3 was reviewed and contained start of care comprehensive assessment dated 8/17/20, which revealed a blood pressure of 160/98 [normal blood pressure is 120/80]. The note stated "Vital Sign entered is outside the acceptable range for this patient [95/60 - 140/90]. Action taken: RN [registered nurse] Case Manager notified/ specify: Me." The	G 0572	G572 - updated admission booklet (Exhibit A-3). For the patient cited, the care plans were updated to include a PAIN AID be done during the visit. This would allow for the nurse to assess the pain and determine when to notify the doctor. The doctor will be notified when the patient is outside the patient specific pain frequency and when their vital signs are outside the patient specific window. The ADON will audit 25% of the patients charts, on a bi-weekly basis, to ensure that patient specific care plans are placed in the system. Patient specific vital sign parameters will be entered when an order from the doctor is obtained with patient specific parameters. All missed visits are to be discussed in morning standup and reported on the form, once nurse has identified a missed visit that cannot be made up in the time frame allowed, nurse to contact	12/28/2020

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	pain assessment indicated the patient had pain to their back with a frequency of "daily; intermittently" and it did interfere with activity or movement. The assessment indicated chronic pain but failed to include an acceptable level of pain. The endocrine assessment failed to include information of the patient history of blood sugars, treatment, and what their current blood sugar levels had been running, what is an acceptable level of blood sugars, and frequency of daily blood sugar checks. The plan of care for the certification period of 8/17/2020 - 10/15/20 was reviewed. The plan of care included, but was not limited to, the following diagnoses: hypertension, type 2 diabetes mellitus, spondylosis with radiculopathy, chronic pain syndrome, and fibromyalgia. The orders/ treatments on the plan of care indicated "agency parameters to report: Temperature > 101.1 or < 97.1, Respiration's >20 or <12, Blood pressure >160/100 or <90/55, Pulse rate >100 or <60, Blood sugar >350 or <60, Pulse oximetry < 90. The vital sign parameter failed to be individualized/ patient specific and the goals for pain, blood pressure, and diabetes failed to be measurable. The plan of care failed to be supported by the comprehensive assessment. Review of the physician orders revealed an order dated 9/13/20, which indicated home health aide visits 2 times a week for 5 weeks. Review of the visit notes evidenced the patient was not seen on 9/17, 9/21, 9/23/2020. The record failed to evidence the patient was contacted and an attempt to reschedule missed visits the other 4 days of the work week. The record also failed to evidence the physician was notified and approved the visits could be missed and not made up.		doctor of frequency change for the week due to missed visit. Verbal order placed in EMR of doctor notification. All missed visits to be review on a bi-weekly basis. ADON to monitor for missed visits/change in frequency and to monitor for patient specific parameters bi-weekly to ensure doctor notification is occurring appropriately. ADON to audit 25% of the charts on a bi-weekly basis until 100% accuracy is achieved and maintained, then the frequency will decrease to monthly. All current patient's doctors to be contacted for patient specific parameters. All patient specific parameters to be entered into EMR in other orders.	

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	During an interview on 10/6/20 at 12:30 p.m., when asked if the parameters on the plan of care were individualized/ patient specific or if they are the agency's parameters, the Administrator and Director of Nursing stated the vital sign and blood sugar parameters were agency parameters created by their computer program. When asked about the pain goal not being measurable, the Director of Nursing was in agreement. The clinical record for patient #2 was reviewed on 10/5/2020 at 11:00 am. The clinical record had an established plan of care signed by the physician for certification periods 9/18/2020 to 11/16/2020. Patient #2's primary diagnosis was Hypertensive heart disease with heart failure. The plan of care orders stated daily weights for patient #2 with start date 9/18/2020. Record review evidenced a skilled nursing visit note dated 9/23/2020, timed 1400 and signed by employee C (registered nurse). This document failed to evidence daily weights for patient #2 from 9/19/2020 - 9/23/2020. The skilled nurse failed to follow the physician orders on the plan of care. Record review evidenced a skilled nursing visit note dated 9/29/2020, timed 1515 and signed by employee B (registered nurse/ Director of Nursing). This document failed to evidence daily weights for patient #2 from 9/24/2020- 9/29/2020. The skilled nurse failed to follow the physician orders on the plan of care. During an interview on 10/05/2020 at 11:30 a.m., employee B stated that weights should be recorded in patient #2's chart at skilled nursing visit. 410 IAC 17-13-1(a)			

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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 record review, the agency failed to ensure the plan of care included interventions to ensure patient goals are achieved for 1 of 5 active records reviewed, out of a total of 7 clinical records reviewed. (Patient #3) Findings include:	G 0574	G574 For patient cited - In-service to be provided to discuss patient specific interventions, including teachable intervention and obtainable goals (Exhibit D-1).	12/28/2020

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	Review of an undated agency policy titled "Medical Supervision" indicated, " ... The physician-signed Plan of Care will include ... Client's goals. Description of specific services to be provided ... A list of actions to be taken for delivery of care .... " The clinical record for patient #3 was reviewed and included a plan of care for the certification period of 8/17/20 to 10/15/20, with orders for skilled nursing to "Teach pain management and comfort measures and teach patient/ caregiver regarding medications and medication management." Patient goals include, but not limited to, "Patient/ caregiver understand signs/ symptoms of complications related to diabetes and when to report ... Patient/ caregiver will verbalize understanding of falls/ injury prevention and home safety measures ... Patient/ caregiver can identify signs and symptoms of hypoglycemia and hyperglycemia and appropriate actions to take .... " The plan of care failed to include teaching interventions in order for the patient to achieve these goals. The findings were reviewed with the Director of Nursing on 10/06/20 at 1:00 p.m., and no further documentation was provided. 410 IAC 17-13-1(a)(1)(D)(xiii)		All current patients to have teachable intervention to obtain goals entered into EMR, when found to be deficient by ADON on bi-weekly audit. ADON to monitor comprehensive assessment, including plan of care to ensure interventions are patient specific, goals are obtainable, and care plan is completed in conjunction with comprehensive assessment. ADON to monitor all patient's assessment and plan of care on a bi-weekly basis until 100% accuracy is achieved and maintained, then frequency of audits will decrease to monthly.	
G 0580 Bldg. 00	484.60(b)(1) Only as ordered by a physician Drugs, services, and treatments are administered only as ordered by a physician. Based on record review, the agency failed to ensure orders were complete and included interventions to be provide and goals to achieve for 1 of 5 active records reviewed in a sample of 7	G 0580	G580 - Only as ordered by a physician An inservice to be provided on how	12/28/2020

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	clinical records. (Patient # 3) Findings include: Review of an undated agency policy titled "Medical Supervision" indicated, " ..The physician-signed Plan of Care will include ... Client's goals. Description of specific services to be provided ... A list of actions to be taken for delivery of care .... " The clinical record for patient #3 was reviewed and included a case conference note dated 9/16/20, which indicated the patient stated they were having difficulty performing their ADLs (activities of daily living), "spoke with PCP [primary care physician], verbal order obtained to start HHA [home health aide] visits 2 x/ week." Review of a physician's order dated 9/11/20, which indicated "Aide 2 wk 5 wk [2 times a week for 5 weeks] read back and confirmed. Start Date: 9/13/2020 End Date: 10/15/2020." The physician order failed to include the interventions the aide was to provide and the measurable goals. The findings were reviewed with the Director of Nursing and the Administrator on 10/6/20 at 12:30 p.m., in which they had no further information or documentation to provide. 410 IAC 17-13-1(a)		to generate a verbal order in the EMR with patient specific interventions to be done by the agency employee. The agency will review all current patients charts to ensure that the care plan documentation is included on the Plan of Care. If it is found that the information is not included on the plan of care, signed by the doctor, the agency will generate a verbal order to be signed off by the doctor with the specific interventions to be provided to the patient. The ADON will monitor all patient charts, on a bi-weekly basis, to ensure that the care plan interventions are included in an order to be signed by the doctor. If the ADON finds that there is a discrepancy in the documentation, the case managing nurse will be notified to have the information updated to include communication with the doctor via a verbal order/phone call.	
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that			

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	the plan of care should be altered. Based on record review and interview, the agency failed to ensure the physician was notified of a patient's delay for an admission and failed to notify the physican of an abnormal blood pressure for 1 of 5 active records reviewed in a sample of 7 clinical records reviewed. (Patient 3) Findings include: Review of an undated agency policy titled "Plan of Care" indicated, " ... Special Instructions ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of care .... " During a home visit with patient #3 on 10/7/20 from 10:00 a.m. to 11:30 a.m., the patient indicated they did not hear from the agency during their first week home after being discharged from the facility. The patient indicated calls must go through their room mate and how they do not see calls coming in, for they don't keep their phone plugged in, volume up, or close by at all times. The patient indicated they were playing a game on their phone when they received a call from the Director of Nursing. The patient also indicated they have had blisters on their feet and legs and how they were red and the home health aide called the doctor office to get them an appointment, uses a steroid cream on her legs, their roommate wraps their legs daily, and use to go to the wound clinic for their legs. During this time, the home health aide indicated she had informed the Director of Nursing of the doctor appointment and how they couldn't get the patient in for 2 weeks, then stated the Director of Nursing stressed how important it was for the patient to be seen immediately, so the aide called the doctors office back and was able to convince them to to get the patient in sooner after	G 0590	G590 - Promptly alert relevant physician of changes The referral process has been updated to include communication with the doctor when a patient is not able to be admitted with the 48-hour window from referral. An audit of all current patients will be completed by the DON to ensure that there are no delayed SOC orders that are missing, if it is found there needs to be communication with the doctor, the DON will reach out to the nurse and have them enter a verbal order to be submitted to the doctor. The admitting nurse will contact the doctor of patient delay in start of care to obtain a verbal order with the new start of care. The DON will monitor all charts on a monthly basis to ensure that the nurse is notifying the doctor of an prompt changes in the patient. The documentation of such conversations will be entered into the patient medical record.	12/28/2020

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	describing the patient's legs and symptoms. The clinical record of patient #3, was reviewed and included a physician order dated 8/5/20, indicating "Resident to d/c [discharge] home 8/11/20. SN [skilled nurse] to eval for home health [SN/PT/OT [SN/physical therapy/occcupational therapy]." Review of a referral document dated 8/6/20, indicated the patient's projected discharge date would be 8/11/20. Review of an administrative communication document dated 8/11/20, indicated the patient was contacted to verify information and to determine who the patient's primary care physician was. A voicemail was left and awaiting call back. The clinical record revealed admission consents and a start of care assessment dated 8/17/2020. The clinical record failed to evidence documentation of agency attempts to contact the patient, physician of skilled facility, or discharge planner of skilled facility between 8/12/20 to the admission date of 8/17/20, to verify if patient had been discharged or another phone number of where the patient could be reached. The clinical record failed to evidence an order from a physician, approving the delay of home health services. Review of a skilled nursing visit note dated 9/11/20, revealed a blood pressure of 160/98. The note stated "Vital Sign entered is outside the acceptable range for this patient [95/60 - 140/90]. Action taken: RN [registered nurse] Case Manager notified/ specify: Me." The endocrine assessment questioned if blood sugar results within expected/ normal range, in which the			

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	answer was "No, results higher than expected." The clinical record also failed to evidence the primary care physician was informed of the patients abnormal blood pressure and high blood sugars and failed to obtain patient specific ranges for which the physician wished to be notified. Review of a skilled nursing visit note dated 9/23/20, revealed in the narrative notes the patient had fallen when getting up from the kitchen table, lost balance and went forward. The patient's bilateral lower extremities were red, warm to touch, and the patient stated they were sore to touch. The note indicated the nurse notified the Director of Nursing. The visit note/ clinical record failed to evidence the physician was notified of the patient's fall and the condition of the bilateral lower extremities. During an interview on 10/6/20 at 12:30 p.m., when asked about the delay of the start of care, the Director of Nursing indicated she would look for documentation and orders in regards to the delay. The Director of Nursing stated she believed the patient requested a delay to readjust to being home. The Director of Nursing stated she would look for documentation of their delay, but none was provided by the end of the exit conference on 10/8/20. 410 IAC 17-13-1(a)(2)			
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			

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	identified by the HHA and patient in the plan of care. Based on observation and clinical record review, the agency failed to update the plan of care to reflect the most current information for 1 of 2 records reviewed of patients with recertifications, in a sample of 7 clinical records reviewed. (Patient #1) Findings include: Review of patient #1's clinical record revealed a start of care (SOC) date of 3/25/2019, included a comprehensive assessment dated 9/11/2020, which revealed wound care and dressing change orders " ...per care plan ..." The comprehensive assessment failed to evidence specific wound care orders to support the plan of care. The clinical record revealed the patient had been seen at the VA [veterans administration] wound care clinic on 9/14/2020 and received updated orders to " ...fill and cover wound with prisma moistened with Blastx and cover with 2x2 gauze ..." The POC [plan of care] failed to evidence the most current wound care orders, and the POC failed to be supported by the comprehensive assessment and failed to include updated orders from the VA clinic. Review of the plan of care dated 9/15/2020, for the certification period of 9/15/2020-11/13/2020, with diagnoses of, but not limited to, peripheral venous insufficiency, non-pressure chronic ulcer of the right heel, ankle, and midfoot, hypertensive heart and kidney failure. The POC revealed wound care orders from a visit to the Veterans Administration wound clinic on 1/17/20. Wound care orders were " ...cleanse wounds with ¼ strength Dakins. Apply dry 2x2's (two inch gauze pads) between all	G 0592	G592 - Revised plan of care Care plans to be discussed on a bi-weekly basis. Any new orders need to be added will be discussed at this time as well. All orders to be reviewed at case conference and discontinued/updated. At case conference, the staff will discuss any new care plans to be added or care plans to be resolved. If new care plans are added after the initial Plan of care is created, a verbal order will be written to include the new care plans. DON to monitor plan of cares, care plans, and orders to ensure that all staff and disciplines have accurate care plans and orders entered into the EMR. DON to audit the care plans and plan of care for specific orders on a bi-weekly basis. DON to audit this on a b-weekly basis until 100% accuracy is achieved and maintained and then the frequency can be distressed. All current patient's care plans to be reviewed and updated as determined by the DON. All current orders to be reviewed and updated/discontinued as needed.	12/28/2020

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	toes on bilateral feet. Paint right plantar callosing (sic) with Betadine. Fill and cover all wounds with Acticoat. Paint right second toe scab with Betadine. Apply UNNA [gauze compression dressing] boots to bilateral lower extremities. Apply ABD (large gauze pads) pads cupped over toes and feet. Secure all dressings with Kerlix from toes to knees, on Monday, Wednesday, and Friday ..." During a home visit on 10/7/20 from 9:45 a.m. to 10:45 a.m., patient #1's plan of care was observed and reviewed, and revealed the wound care orders from 1/17/2020. The plan of care failed to be supported by the comprehensive assessment and the plan of care failed to evidence an accurate wound treatment order from 9/14/20. The findings were reviewed with the DON [director of nursing] on 10/07/20 at 3:44 p.m., in which she agreed the orders were incorrect. The DON had no further information or documentation to provide. 410 IAC 17-14-1(a)(1)(C)			
G 0606 Bldg. 00	484.60(d)(3) Integrate all services Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to ensure agency staff/ clinicians collaborated amongst themselves to ensure the patient needs are being met for 1 of 5 active patient records reviewed in a sample of 7 clinical	G 0606	G606 - Integrate all services Morning stand-up form updated to include, patient changes, adverse events (falls, hospitalizations,	12/28/2020

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	records reviewed. (Patient #3) Findings include: Review of an undated agency policy titled "Coordination of Client Services C-360" indicated, " All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively ... Interdisciplinary care conferences shall be conducted as often as necessary to respond to changes in the client's needs, services, care, or goals .... " During an interview while on a home visit on 10/07/20 at 10:20 a.m., the home health aide stated the patient had been on antibiotics for approximately a week for cellulitis. The home health aide stated the patient's legs were red and the patient had a low grade fever. During this time, the patient stated they had blisters on their feet and legs, both legs appeared red. The patient went on to state that their legs have been getting wrapped daily by their roommate after an application of steroid cream. The clinical record of patient #3 was reviewed on 10/7/20, which evidenced out of 5 skilled nursing visits (8/17, 9/11, 9/18, 9/23, and 10/2/20) the patient had 4 different nurses. Review of a skilled nursing visit note dated 9/23/20, which revealed within the narrative note that the patient bilateral lower extremities were red, warm to touch, patient indicated the bilateral lower extremities were sore to touch, and how the patient has a history of cellulitis. The narrative note went on to state that the visiting nurse collaborated with the Director of Nursing. Review of a skilled nursing visit note dated		deaths, etc), new infections, new orders, missed visits, and discharges. Morning stand-up, all nurses present to discuss current patient needs and new changes. All staff to be present at this meeting to ensure that everyone is updated on patient status and needs. ADON to monitor morning stand-up reports to ensure that they are accurate and that the information is transposed on to the appropriate forms for further monitoring. All current patients to be discussed at next case conference and information updated in EMR as necessary to ensure all staff are meeting patient's needs and physician is updated as needed.	

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	10/2/20, the infection assessment indicated "non noted or verbalized." When another question asked if the medication profile has been reviewed for new or changed medications and identification of possible issues with both prescription and non-prescription medications, the answer given was "No new or changed medications." The visit note failed to evidence that a skin assessment had been conducted. Review of coordination notes failed to evidence the collaboration between all nursing staff who provided services to the patient, especially in regards to the patient's cellulitis. During an interview on 10/07/20 at 12:30 p.m., when asked if the agency staff communicated when there are more than one nurse in the home, the Director of Nursing and Administrator indicated staff should be communicating with each other or reviewing previous visit notes. 410 IAC 17-12-2(g)			
G 0644 Bldg. 00	484.65(b)(1),(2),(3) Program data Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's			

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	governing body. Based on agency document review, the agency failed to implement, evaluate, and maintain an effective, ongoing, and agency-wide, data-driven quality assurance program; failed to ensure they measured, analyzed, and tracked quality indicators, including adverse events that would improve health outcomes, patient safety, and quality of care; failed to utilize quality indicator data, including measures from OASIS, or other relevant data in the design of its program; failed to ensure performance improvement activities focused on high-risk, high-volume, or problem-prone areas; failed to consider incidence, prevalence, and severity of problems in those areas; failed to lead to an immediate correction of any identified problems that directly or indirectly threatened the health and safety of patients; failed to track adverse patient events, analyze their causes, and implement preventative actions; failed to take action related to performance improvement, and, after implementing actions measure success and track performance to ensure that improvements are sustained; failed to conduct performance improvement projects that reflect the scope, complexity, and past performance of the agency's services and operations; the governing body failed to ensure that the agency's quality assessment and improvement efforts address priorities for improved quality of care and patient safety, that improvement actions are evaluated for effectiveness, and that clear expectations for patient safety are established, implemented, and maintained. Findings include: 1. The undated agency policy B-260, titled	G 0644	G644 There has been a change in the QAPI coordinator position. The agency has also developed a new QAPI program based on the Foundation Management Services QAPI manual established in 2015. The agency has also placed many PIPs in place to make sure that audits are being done to ensure accuracy of data. Infection control logs have been updated to include agency acquired versus present on admission infections. Adverse event logs put into place to monitored and updated after bi-weekly case conference based on the morning standup reports discussed in the weeks prior to case conference. All current infection control and adverse event logs updated to include all patients as determined by the ADON.	12/28/2020

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	"Performance Improvement," evidenced the statement "the agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes ..." and that " ...data that may be used for data collection include the following " ...adverse events/outcomes of process or services ..." but failed to define an adverse event. The agency's "Performance Improvement," policy failed to evidence the need to conduct performance improvement projects that reflect the scope, complexity, and past performance of the agency's services, and the need to identify, assess, and monitor quality indicators that focus on high risk, high volume, and/or problem-prone areas. An undated agency document titled "Indiana HomeCare QAPI Program 2020" also fails to address the need to identify high risk, high volume, or problem-prone areas, 2. "Infection Control Logs" for each month from January 2020 through June 2020 revealed the statement " ...all patients were treated with antibiotics for their infections ..." No information was included. "Infection Control Reports" for each individual patient revealed inconsistent completeness in relation to type, organism, if hospital acquired, indications of infection, follow up and outcomes. 3. Review of the agency's quarter 1 (Q1) and quarter 2 (Q2) "Indiana HomeCare Services QAPI" worksheets evidenced a table that included "Indicators, Tracking, Criteria, Result, and Comments." a. Q1 and Q2 worksheets included "Clinical" as an "Indicator," with "Tracking" listed as being "on-going,"and "Criteria" as "33% admission audits," with Q1 "Result" as "this quarter showed			

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	an improvement from January to March in terms of admission completeness," and "Comments" of "conducted by QAPI RN, DON, ADON, and Designee." Q2 "Clinical Indicator Result" revealed the statement " ...May showed to be a time of growth and the need to admission audits (sic) continues ..." "Comments" revealed the same statement as Q1 "conducted by QAPI RN, DON, ADON, and Designee." The agency's Q1 and Q2 QAPI worksheets failed to define clinical indicator, to include specific, measurable goals, actions taken and outcomes. b. Q1 and Q2 QAPI worksheets included "Infection Control" as an "Indicator," that "Tracking" is done "Monthly," and "Criteria" as: "all infections for patients are tracked in infection flowsheets and analyzed for patterns. Employee infections are tracked to monitor for trends in relation to the patient." Q1 "Infection Control Result" revealed that "infection control audits showed that all but 1 patient was being treated with an antibiotic. Q2 "Infection Control Result" revealed that "infection control audits showed all three patients with active infections were being treated with antibiotics. Will continue to monitor and audit." The agency's Q1 and Q2 QAPI worksheets failed to: define infection Control Indicator, patterns related to infections in both patients and employees, specific, measurable goals, actions taken and outcomes. c. Q1 and Q2 QAPI worksheets included "Adverse Events" as an "Indicator." The "Criteria" for adverse events was listed as "Determined by each event," and that there were "No adverse events but will continue (sic). The agency failed to clearly define adverse events and also failed to include specific, measurable goals, taken and outcomes.			

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	6. Review of Q1 and Q2 2020 QAPI Committee Minutes failed to reveal detailed discussion of ongoing performance improvement measures, and also failed to address any new performance improvement needs related to clinical or other agency processes. 7. The agency's governing body failed to ensure that an ongoing program for quality improvement was implemented and maintained, as evidenced by the absence of any quality improvement projects or event reporting during Q1 and Q2 2020. 8. The findings were reviewed with the Director of Nursing and the Administrator on 10/8/2020 at 11:00 a.m., in which they had no further documentation to provide. 410 IAC 17-12-2(a)			
G 0654 Bldg. 00	484.65(c)(2) Track adverse patient events Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review, the agency failed to ensure they appropriately tracked adverse events and analyzed their cause for the month of September 2020. Findings include: "Adverse Events" was listed as an "Ongoing Quality Assurance Project," in the undated agency document "Indiana HomeCare QAPI [quality assurance performance improvement] Program 2020," but was limited to staff education related to " ...safety management, emergency	G 0654	G654 - Tack adverse patient events. There has been a change in the QAPI coordinator position. The agency has also developed a new QAPI program based on the Foundation Management Services QAPI manual established in 2015. The morning stand-up tracking sheet has been updated to include	12/28/2020

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	management, and infection control ..." "Adverse Event" logs in the agency's 2020 QAPI binder evidenced the statement "No adverse events were reported" in each month, January 2020 through June 2020. The agency failed to define what an adverse event was in relation to patient safety and outcomes in both their "Performance Improvement" policy as well as the "Indiana HomeCare QAPI Program 2020" document. Review of an agency document titled "Adverse Events - September 2020" revealed there were no adverse events reported. Upon review of patient #3's clinical record, a skilled nurse visit note dated 9/23/2020, indicated the patient had lost their balance and fell forward when getting up from the kitchen table. The Adverse Events tracking log failed to accurately identify a reported fall. The findings were reviewed with the Director of Nursing and the Administrator on 10/8/2020 at 11:00 a.m., in which they had no further documentation to provide. 410 IAC 17-12-2(a)		an adverse events to the patient to be monitored on a daily basis. When an adverse event occurs, the DON and ADON will work together to complete the appropriate paperwork to ensure that the patient is safe and their needs are being met. Adverse event logs put into place to monitored and updated after bi-weekly case conference based on the morning standup reports discussed in the weeks prior to case conference. All current adverse event logs updated to include all patients as determined by the ADON. QAPI book to be updated on a monthly basis with overview of information from the months prior audits.	
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			

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	communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the agency failed to maintain a coordinated, agency-wide infection control program that includes surveillance, identification, prevention, control, and investigation of infections and communicable diseases. The agency also failed to incorporate an infection control program into their QAPI [quality assurance performance improvement] program. Findings include: Review of the undated policy B-401 "Infection Control Plan" revealed the statement " ... the Infection Control Surveillance Plan shall be based on the assessment of the population served by the agency ..." and " ... high risk, high volume indicators...." The agency failed to evidence an assessment of the population served as well as what defines a high risk, high volume indicator. In the undated document "Indiana HomeCare QAPI Program 2020," "Infection Control" is listed as an "Ongoing quality assurance project" that is to be completed on a daily or monthly basis, that patient infections are identified when an antibiotic order is written, and that " ... 100% of infections are tracked to monitor for trends and to ensure clinicians are completing proper documentation for infection {i.e. infection flowsheet}. The agency failed to ensure that 100% of infection are tracked and monitored for trends as evidenced by patient specific "Infection Control Reports" that were incomplete, and failed to consistently evidence whether the infection was hospital or	G 0684	G684 - Infection control There has been a change in the QAPI coordinator position. The agency has also developed a new QAPI program based on the Foundation Management Services QAPI manual established in 2015. The agency has also placed many PIPs in place to make sure that audits are being done to ensure accuracy of data. Infection control logs have been updated to include agency acquired versus present on admission infections. Infection control log put into place to monitored and updated on bi-weekly based off the morning standup reports discussed in the weeks prior to case conference. All current infection control logs updated to include all patients as determined by the ADON.	12/28/2020

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	facility acquired, related to a surgery or an implant, indications of infection, follow up and outcomes, type of organism, and staff member(s) involved. Review of an undated agency document titled "Infection Control Log," revealed detailed instructions on how to complete the infection control logs, and what information should be listed including " ... Hospital admission required (sic), was infection within 30 days of surgery, within one year of an implant, and within 72 hours of admission to agency services ..." "Infection Control Logs," for each month from January 2020 through June 2020 were found in the QAPI binder, and evidenced the statement " ... all patients were treated with antibiotics for their infections ..." No information further information was included. Review of the documents "Indiana HomeCare Services QAPI" for Q1 and Q2 2020 revealed "Infection Control" as an"Indicator," "Criteria" for infection control being " all infections for patients are tracked in infection flowsheets and analyzed for patterns. Employee infections are tracked to monitor for trends in relation to patient." "Result" for Q1 was " ...all but one patient was being treated with an antibiotic. Will continue to monitor." No further information included. The agency failed to define "Criteria" in relation to patterns or trends, and also failed to evidence whether trends or patterns were or were not identified. Q2 evidenced the same information with the exception that " ...all patients were treated with an antibiotic ..." The agency again failed to define "Criteria" and also failed to evidence whether trends or patterns were identified. Q1 2020 QAPI Committee minutes list Infection Control as a "Topic." "Discussion" for infection			

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	control revealed the statement "1st quarter summary." "Decision" revealed the statement "Continue," and "Follow up due date" revealed "Action: Employee F to continue monthly." The minutes failed to evidence that trends, patterns, or analysis were discussed. Q2 2020 QAPI Committee minutes list Infection Control as a "Topic." "Discussion" and "Decision" were blank, and "Follow up due date" revealed "Action: Employee F to continue monthly." The minutes failed to evidence that trends, patterns, or analysis were discussed. 410 IAC 17-12-2(a)			
G 0710 Bldg. 00	484.75(b)(3) Provide services in the plan of care Providing services that are ordered by the physician as indicated in the plan of care; Based on record review and interview, the home health agency failed to ensure all skilled nursing assessments were completed and documented per the plan of care for 2 of 5 active records reviewed, out of a total of 7 clinical records reviewed. (Patient # 2 and 3) Findings include: 1. Review of an undated agency policy titled "Pain Assessment/ Management" indicated, " ... 2. ... The assessment includes a measure of pain intensity and quality [character, frequency, location, and duration] ... 3. Pain is assessed on every home visit and documented on a pain or symptom flow sheet. Documentation will inclue the effectiveness of all pain interventions or modalities ... 5. The follow up assessments will address effectiveness of the pain management	G 0710	G710 - Provide Services in the plan of care An inservice will be provided to the nursing staff by the DON to cover the development and charting of the care plan for each patient. Nurses to be educated on entering a detailed narrative note and communication note to each patient's chart to cover all services provided during visit. The ADON will review all current charts for deficiencies in care plan and communication of the patients needs. If it is found that there are charts lacking accurate information, the ADON will reach	12/28/2020

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	program and identify if there is a need for referral for additional or alternative therapy ... 6. Assessment of presence of pain and treatment response will be incorporated into all agency assessment/ reassessment tools." 2. Review of an undated agency policy titled "Skin Assessment" indicated, " ... Procedure ... 4. Perform physical assessment note skin color, moisture, temperature, texture, mobility and turgor ... 7. Assess any wounds for evidence of healing or signs of infection. 8. Assess overall skin condition .... " 3. The clinical record for patient #2 was reviewed on 10/05/20. Review of the plan of care for certification period 9/18/20 to 11/16/20, included periodic discussions among the team regarding health status and recommendations for the plan of care to meet patient #2's needs. Patient #2's clinical record failed to evidence documentation of adherence to treatment regimen, weight monitoring, diet nutrition, fluid intake, alcohol and smoking cessations, and physical activity. Review of a skilled nursing visit note dated 9/29/2020 at 3:15 p.m., indicated employee B, a registered nurse/ Director of Nursing failed to document the patient's response and action taken for patient #2 regarding current knowledge of congestive heart failure. Review of a skilled nursing note dated 9/29/2020 at 3:40 p.m., evidenced vital signs by employee B, a registered nurse/ Director of Nursing. The note evidenced the patient's blood pressure was 73/55 [average blood pressure is 120/80] mmHg. Employee B failed to reassess patient #2 or notify MD.		out to the case manager and have them update the information as necessary. On bi-weekly basis, all disciplines will discuss care plan documentation is completed for accuracy. The ADON will audit 25% of all charts on a bi-weekly basis to ensure that the care plan documentation is accurate, that the staff are charting against the care plans developed, and that the staff are communicating patient needs in the chart. Once 100% accuracy is achieved and maintained the audits will decrease as necessary.	

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	Surveyor: Ford, Shannon 4. During a home visit interview on 10/7/20 around 10:30 a.m., the patient indicated they had been treated with antibiotics for cellulitis to their bilateral lower extremeties since the previous week. The clinical record for patient #3 was reviewed and contained a plan of care for the certification period of 8/17/20 to 10/15/20, with orders for skilled nursing 1 time a week for 4 weeks starting 9/8/20. The patient's past medical history and diagnoses includes, but not limited to, diabetes mellitus type 2, hypertension, arthritis, fibromyalgia, neuropathy, spondylosis with back pain, weakness, and compression fractures to L1/ L4/ and L5. Interventions included, but not limited to: assess current pain management regimen including effectiveness, relief measures, and side effects; assess pain levels, contributing factors, and relief modalities; assess for diabetic complications; assess for signs/ symptoms of hypglycemia and hyperglycemia. Review of a skilled nursing visit note dated 9/11/20, indicated the patient had chronic, daily but intermittent back pain but failed to evidence the pain level and the description of the type of pain the patient was experiencing (sharp, dull, stabbing, numbing). The visit note also indicated the patient's diabetes was assessed but failed to evidence what the patient's blood sugars were running since last visit and if a diabetic foot exam had been performed. Review of a skilled nursing visit note dated 9/18/20, failed to evidence that the endocrine system/ diabetes and integumentary system (skin)			

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	had been assessed. Review of a skilled nursing visit note dated 9/23/20, failed to evidence that the pain, endocrine, and integumentary system had been assessed. Review of a skilled nursing visit note dated 10/2/20, indicated the patient had chronic, daily but intermittent back pain but failed to evidence the pain level and the description of the type of pain the patient was experiencing (sharp, dull, stabbing, numbing). The visit note also indicated the patient's diabetes was assessed but failed to evidence what the patient's blood sugars were running since last visit and if a diabetic foot exam had been performed. The assessment note failed to evidence that the integumentary system (skin) had been assessed, especially to the bilateral lower extremeties. 5. The findings were reviewed with the Director of Nursing and the Administrator on 10/6/20 at 1:00 p.m., in which neither had any further information or documentation to provide. 410 IAC 17-14-1(a)(1)(H)			
G 0714 Bldg. 00	484.75(b)(5) Patient and caregiver education Patient and caregiver education; Based on record review, skilled nursing failed to ensure they educated patients per the plan of care for 1 out of 5 active clinical records reviewed, out of a total of 7 clinical records reviewed. (Patient #3) Findings include: Review of an undated policy titled "Client/ Family	G 0714	G714 - Patient and caregiver education Bi-weekly audits to be done to check for patient specific education materials needed and care plans are accurate to the patient's needs.	12/28/2020

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	Education" indicated, "Clients and their families will be provided with information necessary to make decisions and to take responsibility for self-management activities related to their need.... ' The clinical record for patient #3 was reviewed and included a plan of care for the certification period of 8/17/20 to 10/15/20, with orders for skilled nursing to "Teach pain management and comfort measures and teach patient/ caregiver regarding medications and medication management." Review of skilled nursing visit notes dated 9/18/20 and 9/23/20, failed to evidence education / interventions had been provided as ordered. The findings were reviewed with the Director of Nursing on 10/06/20 at 1:00 p.m., in which she acknowledged the lack of education and had nothing further to provide. 410 IAC 17-14-1(a)(1)(G)		Patient educational material and patient monitoring logs to be provided to the patient for patient specific problems (Including diabetes, weight, blood sugar checks, heart disease, etc). Patient educational material given to the patient and scanned into the EMR for auditing purposes. All current patient's have been given educational materials to discuss their medical needs. All current patient's audited to ensure that care plans are accurate and educational material completed for each patient.	
G 0802 Bldg. 00	484.80(g)(3) Duties of a HH aide The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered. Based on observation, record review, and interview, the agency failed to ensure home health aide duties included hands on personal care for 1 of 1 home health aide clinical records reviewed, out of a total of 7 clinical records reviewed.	G 0802	G802 - Duties of a HH Aide Patient cited, the aide was given hands on interventions to be done with the patient and an order will	12/28/2020

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	(Patient #3) Findings include: During a home visit with patient #3 on 10/07/20 between 10:00 a.m. to 11:30 a.m., while waiting on the arrival of the home health aide, a caregiver in the home was observed going in and out of the patient's bedroom providing items the patient was heard requesting, which included cleansing wipes, so she could clean themselves and get dressed before the home health aide arrived. During this time, the caregiver was asked if they were family, friend, or worked with another agency in which they replied they were a family member of the roommate and helped the patient throughout the week. Review of the home health aide care plan printed on 10/6/20 evidenced interventions/ duties of " ... Assist patient with home exercise program, Assist with positioning, repositioning, alignment, Assist with transfers, ROM [range of motion] exercises, Incontinent Care, Clean bathroom after patient care, Clean living area of the patient, Do patient laundry, Make patient bed, Assist patient with dressing, Oral care, Shampoo, Skin care .... " On 10/7/20 at approximately 10:20 a.m., the home health aide arrived and the patient walked out into the living room and had the aide assist them with a plastic vest that was worn after the patient had back surgery a few months ago. Review of the patient's agency folder, failed to evidence any patient care instructions for the home health aide or any ROM exercises that the aide may be permitted to do. During this time, the patient was asked if therapy had left them with any exercise to be done with the aide, the patient stated the therapist hasn't left anything and how they have memorized what needs to be done. The aide was interviewed and was asked what services she		be sent to the doctor to cover what interventions the HHA will be providing for the patient. All charts will HHA will be reviewed to check for hands on duties of the HHA are documented and that they are signed off by the ordering physician. If it is found that there are charts without the doctors signature on the HHA interventions, an order will be written and communication done with the doctor to cover the interventions that are needed for patient care. The ADON will audit all charts requiring an HHA on a bi-weekly basis to make sure that the aide is providing hands on care and that the documentation is being done as ordered by the physician. The ADON will audit them on a bi-weekly basis until 100% accuracy is achieved and maintained. If the ADON finds that a patient does not have interventions signed off by the doctor and hands on care is not being provided, the ADON will reach out to the case managing nurse to correct this information.	

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	provided to the patient. The aide replied that she obtains the patient's vital signs, listens to any concerns the patient may have, washes the patient's hair with shower caps (when able), fixes the patient's breakfast, watch the patient take their insulin and other medications, watch the patient eat, offers to assist with bathing and dressing. During this interview, the caregiver was observed taking clean sheets into the patient's bedroom and coming out with dirty sheets and putting them in the washer. When asked about the home exercise program, the home health aide stated she had not been provided or notified of any home exercise program by therapy and that the patient was dismissive on care. The aide was observed cooking the patient's breakfast, watching the patient eat, take their meds (including insulin), and obtaining vital signs. The aide asked the patient if they have obtained any shower caps to wash hair, then proceeded to use a foam/ mousse and washed the patient's hair. The clinical record of patient #3 was reviewed and included a physician's order dated 9/11/20 for home health aide services 2 times a week for 5 weeks. The order failed to include any hands on care/ duties. The order was signed on 9/28/20. Review of the unsigned, updated plan of care for the certification period of 8/17/20 to 10/15/20, the home health aide interventions that were ordered indicated was as follows: "Assist patient with home exercise program; Assist with positioning, repositioning, alignment, Assist with transfers, ROM [range of motion] exercised, Incontinent Care, Clean bathroom after patient care, Clean living area of the patient, Do patient laundry, Make patient bed, Assist patient with dressing, Oral care, Shampoo, Skin care, Emergency call system, Fall precautions, and Remove throw			

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	rugs." Review of the home health aide visit notes dated 9/14 and 9/28 and 10/5/20, revealed the home health aide obtained vital signs and documented a pain level and last bowel movement. The home health aide failed to provide hands on personal care. Review of a home health aide visit note dated 9/30/20 stated "No patient visit ... collaborated with staff ...In bed: rails up .. Notified hospice nurse .... " The visit note not only failed to evidence that the home health aide provided hands on personal care, but the aide inappropriately documented hospice information when the patient is a home health patient. During an interview on 10/7/20 at 2:30 p.m., when questioned about the home health aide not providing hands on care, the Director of Nursing indicated the aide had informed her this morning that the care plan was not showing up in the computer in order for the aide to document the tasks that were / were not done, so she had to fix the problem. The Director of Nursing and the Administrator agreed that the aide should be performing hands on personal care. 410 IAC 17-14-1(g)			
G 0808 Bldg. 00	484.80(h)(1)(i) Onsite supervisory visit every 14 days If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient,			

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	the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit. Based on record review and interview, the agency failed to ensure home health aide supervisory visits were conducted every 14 days during skilled nursing visits for 1 of 1 records reviewed of skilled patients receiving home health aide services, out of a total of 7 clinical records reviewed. (Patient #3) Findings include: The clinical record for patient #3 was reviewed and revealed the patient was receiving skilled nursing, physical therapy, occupational therapy, and home health aide services weekly between 9/13/20 to 10/5/20. Review of the clinical record failed to evidence home health aide supervisory documentation during this time frame. During an interview on 10/6/20 at 1:10 p.m., when asked how often skilled supervisory visits were to be conducted, the Director of Nursing initially indicated every 60 days with recertification and 30 days with skilled services. The Director of Nursing confirmed this patient record did not contain supervisory documentation.	G 0808	G808 - Onsite supervisory visits every 14 days For cited patient - a Nursing in-service to be provided to educate staff on how to document supervisory visits in EMR in order to stay compliant. All current patient charts reviewed to ensure that the appropriate supervisory visits are documented. If it is found that a chart does not have a supervisory visit conducted in the last 14 days, the DON will reach out to the case managing nurse and have them conduct a supervisory visit at the next scheduled visit. The DON will audit all charts on a bi-weekly basis to ensure that the a supervisory visit has been conduct in the previous two weeks. If the DON find that the visits have not been completed, she will reach out to the case manager and ensure that the supervisory visit is completed. The DON will continue to monitor for supervisory visits until 100% accuracy is achieved and maintained, once it is achieved and maintained, the frequency will	12/28/2020

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			be decreased.	
G 1014 Bldg. 00	484.110(a)(2) Interventions and patient response All interventions, including medication administration, treatments, and services, and responses to those interventions; Based on record review and interview, the agency failed to document all interventions, including medication administrations, treatments, services, and responses to those interventions for 2 of 5 active clinical records reviewed, out of a total of 7 clinical records reviewed. (Patient #2 and 3) Findings include: 1. Review of an undated agency policy titled "Medical Supervision" indicated, " ... The physician-signed Plan of Care will include ... Description of specific services to be provided ... A list of actions to be taken for delivery of care .... " 2. Review of an undated agency policy titled "Pain Assessment/ Management" indicated, " ... 2. ... The assessment includes a measure of pain intensity and quality [character, frequency, location, and duration] ... 3. Pain is assessed on every home visit and documented on a pain or symptom flow sheet. Documentation will inclue the effectiveness of all pain interventions or modalities ... 5. The follow up assessments will address effectiveness of the pain management program and identify if there is a need for referral for additional or alternative therapy ... 6. Assessment of presence of pain and treatment response will be incorporated into all agency assessment/ reassessment tools."	G 1014	G1014 - Interventions and patient response An inservice to be provided by the DON to discuss documentation in the chart regarding the patient's response to the interventions provided. All current patients to be audited to ensure that the documentation regarding patient response to interventions is included in the charting. If it is found that the patient response is not included in the charting, the nurse will be asked to add an addendum to the documentation to ensure that she includes the patient documentation information. The DON will audit 25% of all charts to ensure that the documentation of patient response to interventions is included in the documentation in the patient's charting. The DON will audit this on a monthly basis and continue until 100% accuracy is achieved and maintained.	12/28/2020

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	3. The plan of care included, but not limited to the following skilled nursing interventions: Teach disease process, infusion therapy, pain management and comfort measures, anticoagulation medications, medication management, compliance with CHF treatment, education on cardiotonics, vasodilators, and diuretics, use of pump for IV administration, settings, alarms, and troubleshooting, administration of intermittent IV therapy using the SASH [saline flush, medication administration, saline flush, heparin] method, daily weights, educate the patient on congestive heart failure management, and teach Advance Directives.. Review of skilled nursing visit note dated 9/23/2020 at 14:00 by employee C, a registered nurse, failed to document patient #2 response regarding knowledge of advance directives, pain management, congestive heart failure, anticoagulation therapy, and knowledge of disease process. Review of skilled nursing visit note dated 9/29/2020 at 15:15 employee B, a registered nurse/ DON, a failed to document patient #2 response regarding knowledge of advance directives, pain management, congestive heart failure, anticoagulation therapy, and knowledge of disease process. During an interview on 10/7/20 at 1:30 p.m., employee B stated the patient's understanding and response should be documented in the record. 4. The clinical record for patient #3 was reviewed and included a plan of care for the certification period of 8/17/20 to 10/15/20, with orders for skilled nursing to "Teach pain management and			

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	comfort measures and teach patient/ caregiver regarding medications and medication management." Review of a skilled nursing visit note dated 10/2/20, indicated the patient was instructed on pain management and medication management. The visit note failed to evidence the patient's response to the education/ instruction. The findings were reviewed with the Director of Nursing on 10/06/20 at 1:00 p.m., in which she acknowledged the lack of patient response to the education provided and had nothing further to provide.			
G 1016 Bldg. 00	484.110(a)(3) Goals in the patient's plans of care Goals in the patient's plans of care and the patient's progress toward achieving them; Based on record review and interview, the agency failed to document the patient's progress towards goals in the patient's in 3 of 5 active records reviewed. (Patient #2, 3, and 6) Findings include: 1. Review of an undated agency policy titled "Pain Assessment/ Management" indicated, " ... 2. ... The assessment includes a measure of pain intensity and quality [character, frequency, location, and duration] ... 3. Pain is assessed on every home visit and documented on a pain or symptom flow sheet. Documentation will inclue the effectiveness of all pain interventions or modalities ... 5. The follow up assessments will address effectiveness of the pain management program and identify if there is a need for referral for additional or alternative therapy ... 6. Assessment of presence of pain and treatment	G 1016	G1016 - Goals in the patient's plans of care An inservice will be provided to the nursing staff to review the documentation on charting status toward goals on each visit. All current patient charts will be reviewed to check for accuracy in terms of charting related to goals on care plans. Any patient found to not have documentation related to goals documentation, the DON will reach out to the nurse and educate them on the appropriate documentation related to patient's goals on their care plans. The DON will audit 25% of the	12/28/2020

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	response will be incorporated into all agency assessment/ reassessment tools." 2. The clinical record for patient #2 was reviewed on 10/5/2020 at 11:00 a.m. The clinical record had an established plan of care signed by the physician for certification periods 9/18/2020 to 11/16/2020. Patient #1 primary diagnosis is Hypertensive heart disease with heart failure. Goals included, but not limited to: Patient/ caregiver will be independent with care of venous access device, be free from infection, verbalize understanding of Advanced Directives, demonstrate understanding of meds for pain management, verbalize understanding/ demonstrate compliance and independence of medication regimen and s/s adverse reaction to report; verbalize understanding of disease process; patient will be free from adverse side effects of anticoagulation therapy; verbalize understanding of anticoagulant precautions and side effects; verbalize understanding of bleeding and what to report; state side effects of treatment and measure to take, demonstrate procedure for IV therapy and verbalize complication of infusion therapy. Review of skilled nursing visit note dated 9/23/2020 at 14:00 by employee C, a registered nurse, failed to document patient #2 progress towards goals. Review of skilled nursing visit note dated 9/29/2020 at 15:15 by employee B, a registered nurse/ DON, failed to document patient #2 progress towards goals. 3. The clinical record for patient #6 was reviewed on 10/7/2020 at 12:00 a.m. The clinical record had an established plan of care signed by the		charts to ensure that the staff have documented against the care plan and the goals, if the DON finds that the staff are not charting against the care plans and the goals she will reject the documentation and require that the staff chart appropriately toward the goals. The DON will audit 25% of the charts monthly until 100% accuracy is achieved and maintained.	

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	physician for certification periods 9/9/2020 to 11/07/2020. Patient #6 primary diagnosis is Myelodysplastic Syndrome/ adjustment and management of VAD. The skilled nursing notes dated 9/23/2020 and 9/29/2020 failed to document patient #6 response to pain management, infusion therapy, knowledge of disease process, and medication management. Review of skilled nursing visit note dated 9/30/2020 at 12:12 by employee B, a registered nurse/ DON,failed to document patient #6 progress towards goals. During an interview on 10/7/20 at 1:30 p.m., employee B stated the patient's understanding, response and percent towards goal should be documented in the record. 4. The clinical record for patient #3 was reviewed and included a plan of care for the certification period of 8/17/20 to 10/15/20, with orders for skilled nursing to "Teach pain management and comfort measures and teach patient/ caregiver regarding medications and medication management." Patient goals include "Patient will verbalize understanding/ demonstrate compliance and independence of medication regimen and signs and symptoms of adverse reactions to report. Patient will be pain free or verbalize an acceptable pain level with current pain management regimen ... patient will demonstrate understanding of appropriate use of meds for pain management .... " Review of a skilled nursing visit note dated 10/2/20, indicated the patient was instructed on pain management and medication management. The visit note failed to evidence the patient's progress towards those goals.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157668	A. BUILDING 00 B. WING	10/08/2020

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	The findings were reviewed with the Director of Nursing on 10/06/20 at 1:00 p.m., in which she acknowledged the lack of progress toward goals and had nothing further to provide.			
N 0000 Bldg. 00	This visit was for a State re-licensure survey of a home health provider. Survey dates: 10/5/2020-10/8/2020 Facility #: 012581 Provider #: 157668 Records Reviewed: 5 active and 2 discharged Home visits completed: 2 (two other scheduled visits canceled) Total active census: 66 Active skilled: 63 Active aide only: 2	N 0000		
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home			

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	health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.			
	Based on record review and interview, the agency failed to develop and implement a policy requiring a notice of discharge of service to the patient at least fifteen (15) calendar days before the services are stopped and failed to ensure a patient was informed 15 days in advance of the agencies intent to discharge for 1 of 2 closed clinical records reviewed, out of a total of 7 clinical records reviewed. (Patient #7) Findings include: Review of an undated policy titled "Premier Homecare of Indiana" #3, indicated " ... Be given reasonable discharge notice, at least (5) calendar days prior to service being stopped .... " On January 29, 2017, the Indiana State Department of Health updated Article 17 to state patients are to be given a 15 day notice prior to discharge. The clinical record for patient #7, reviewed 10/05/2020, revealed a plan of care for the certification period of 5/12/20 to 7/10/20 with orders for skilled nursing 1 time a week for 9	N 0488	Updated ABN and Discharge policy (exhibit A-1). New Discharge policy and ABN to be mailed to patient's home address on/before 12/8/2020 for any patient prior to updated information being placed in admission packet. All updated information communicated to all staff done via communicator in EMR. If a patient meets any of the four criteria listed as not needed to be informed 15 days prior with a 15 day notice, the nurse will place communication in the patient's chart stating why they were discharged without 15 days notice. This information will be monitored by the DON on a bi-weekly basis until it is determined that the staff are meeting the requirements and 100% accuracy is achieved and	12/28/2020

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	weeks and home health aide services 2 times a week for 9 weeks. The record evidenced the patient was discharged on 7/8/20. Review of the clinical record failed to evidencethe patient/ representative (if any) was informed 15 days in advance of the agency's intent to discharge the patient on 7/8/20. During an interview on 10/5/20 at 3:00 p.m., the administrator indicated the current policy and the agency's Client Bill of Rights and Responsibilities in the admission packet indicated the clients will be given at least 5 days notice.		maintained. Updated admission book (Exhibit A-2).	