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	15K024	A. BUILDING _____ B. WING _____	R-C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND HOMECARE INC	1304 MAIN STREET ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS This was a Federal home home revisit survey to determine the removal of an Immediate Jeopardy's (IJ) on Conditions of Participation 42 CFR 484.55 Comprehensive Assessment of Patients; 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care; Condition of Participation 42 CFR 484.65 Quality Assessment and Performance Improvement; Condition of Participation 42 CFR 484.75 Skilled Professional Services; and, Condition of Participation 42 CFR 484.105 Organization and Administration of Services that were identified on 4/23/19, 4/25/19, and 5/6/19. Survey date: June 4, 2019 Facility number: 004808 Provider number: 15K024 Total census: 209 Skilled patients: 36 Total records reviewed: 1 An immediate jeopardy was identified on 4/23/19 related to the Comprehensive assessment of patients. The administrator was notified on 4/23/19 at 4:55 PM. The immediate jeopardy remained unremoved after exit on 5/6/19. The agency failed to ensure the comprehensive assessment accurately described the patient's status, and to measure or describe wounds (#3,9); failed to evidence a head-to-toe assessment to include the patient's past and current health status or to address wounds (#3,	{G 000}		

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

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{G 000}	Continued From page 1	{G 000}		

9); failed to evidence progress towards measurable outcomes by describing/measuring wounds in the assessment (#3, 9), failed to evidence medical, nursing, and discharge needs were met by including all pertinent diagnoses and identifying the patient's needs in a comprehensive assessment (#3, 9); failed to evidence a review of all medications, adverse effects, and interactions that could potentially harm the patient (#9,13); failed to update the patient's condition in a re-certification comprehensive assessment to measure progress of wounds and to update changes (#3); and, failed to update the comprehensive assessment after a hospital admission greater than 48 hours which resulted in dressing changes and wound care not being completed (#3).

An immediate jeopardy was identified on 4/23/19 related to Care Planning, Coordination, and Quality of Care. The administrator was notified of the immediate jeopardy on 4/23/19 at 4:55 PM. The immediate jeopardy remained unremoved at the survey exit on 5/6/19. The agency failed to ensure that the plan of care [POC] was established by a physician, but instead by the agency itself, without a physician's signature, affecting dressing changes and visit frequencies (#3, 9, 11, 13); failed to evidence that all treatments and frequency of visits ordered by a physician were included on the POC to ensure wounds were cared for (#3), and failed to ensure that all physician's orders were included on the POC to coordinate wound care with the healthcare team (#3, 9, 11, 13); failed to notify the physician of changes in wounds or the presence of wounds, resulting in deterioration of wounds, and premature amputation (#3, 9); failed to integrate services with all physicians involved in

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{G 000}	Continued From page 2	{G 000}		

the patient's care to provide wound/skin care to the patient (#9, 13); failed to coordinate and communicate with the healthcare team to plan wound care, and to integrate all physicians affecting the effectiveness of treatments for skin and wound care (#3, 9).

An immediate jeopardy was identified on 4/23/19 related to Skilled Professional Services. The administrator was informed of the immediate jeopardy on 4/23/19 at 4:55 PM. The immediate jeopardy remained unremoved at the survey exit on 5/6/19. Skilled nursing failed to provide care in accordance with standards of practice and agency policies, affecting assessments, visits, and quality of care (#3, 9, 13, 15); failed to evidence that ongoing interdisciplinary assessments of the patient were completed to ensure progress in wound care, skin care, all body systems affecting the patient's health and that assessments were not carried over from previous nurses' assessments (#3, 9, 13), that care and services were ordered by a physician to provide continuity of care (#11, 13 14), failed to evidence that clinical notes/assessments were accurate and authenticated, and that supervisory notes were actually in the patient's home as documented (#3, 9), and failed to ensure that skilled professionals, including Administration, were involved in a QAPI [quality assessment performance improvement] program, with the potential of affecting all 307 agency patients.

An immediate jeopardy related to Quality Assurance and Performance [QAPI] was identified on 4/25/19. The administrator was notified of the immediate jeopardy when on 4/25/19 at 4:35 PM. The immediate jeopardy remained unremoved at the survey exit on 5/6/19.

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{G 000}	Continued From page 3	{G 000}		

The agency's 307 patients were at risk for potential harm due to the failure of the administrator and the governing body to ensure measures were in place to monitor patient outcomes and safety, quality of care and the safe delivery of care, failed to ensure focus on high risk, high volume, problem-prone areas were monitored for the effectiveness and safety of care provided, failed to identify, track and trend the prevalence of quality relevant data for improved patient outcomes, failed to implement immediate correction of identified problems, failed to document it had conducted performance improvement projects in relation to data-driven areas of concern and failed to maintain an ongoing program for quality improvement. The above deficiencies created a potential for serious harm to the agency's 307 patients.

An immediate jeopardy related to Administration and Organization of Services was identified on 4/25/19. The administrator was notified of the immediate jeopardy on 4/25/19 at 4:35 PM. The immediate jeopardy remained unremoved at the survey exit on 5/6/19. The governing body failed to ensure Administration managed and organized its resources to deliver optimal care to its patients and to develop a QAPI [quality assessment performance improvement] plan to identify systemic issues potentially affecting all 307 patients, and to manage the daily operations of the agency; failed to ensure that the clinical manager provided oversight of the clinical operations of the agency, ascertaining that all assessments and visits were completed in person, and that chart audits were complete, making patient/personnel assignments, and not assigning schedulers to handle incoming calls related to complaints and patient problems in the

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home, coordinating patient care; failed to coordinate referrals so that the physician was involved in the plan of care, assuring patients' needs were continually assessed, and by the nurse caring for the patient, in person, and assuring plans of care were being developed appropriately/accurately, implemented, and updated with current patient information. These deficiencies created the potential to cause serious harm to all 307 patients.

A removal plan/ plan of correction was accepted on 6/3/19.

After record review and interview during an onsite revisit on 6/4/19, it was determined that the Immediate Jeopardies were not removed for the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment of Patients; 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care; 42 CFR 484.65 Quality Assessment and Performance Improvement; 42 CFR 484.75 Skilled Professional Services; and 42 CFR 484.105 Organization and Administration of Services after the agency failed to follow their removal plan/ plan of correction by failing to ensure Patient #1 had a comprehensive reassessment since the last survey. The last comprehensive assessment dated 3/29/19 contained inaccurate information, failed to evidence a thorough medication review and did not adequately represent the needs of the patient. The plan of care for patient #1 contained inaccurate and incomplete information, and failed to evidence a physician order to provide or resume homecare services. The agency failed to complete chart audits for all active patients to identify actual/ potential problems. The agency registered nurse (RN) failed to reassess patient

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{G 000}	Continued From page 5 #1 to ensure the needs to the patient were addressed, and the skilled nurse (SN) failed to follow the plan of care as well as use the plan of care to direct the care given. The administrator and director of nursing failed to ensure that chart audits were being completed, that verification of discharge notification was received, and that clinical oversight of nurses was being conducted. The administrator were notifed on 6/4/19 at 4:00 PM.	{G 000}		
{G 510}	Quality Review completed 6/17/19 Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This CONDITION is not met as evidenced by: Based on record review, the registered nurse failed to complete an updated comprehensive assessment to reassess the patient's condition (See G 544). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.55 Comprehensive Assessment of Patients.	{G 510}		

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{G 510}	Continued From page 6	{G 510}		

1. An immediate jeopardy was identified on 4/23/19 when record review of patient #13, with a history of sepsis, indicated a new wound was found on 10/3/18. There was no documentation that the MD was notified. A faxed order from a podiatrist on 10/10/18 increased visits from monthly to 3 x week effective 10/10/18. No visit was made until 10/12/18 for wound care and BP was 155/91. A registered nurse visited on 10/15/19 and BP was 86/64, documentation stated that the "pt presents lethargic", and the DON [director of nursing] signed where the patient was supposed to for the visit. No one called the MD and the HHA [home health aide] found the patient deceased on 10/16/18. The failure of the agency to provide quality care for the patient created the serious potential for harm. This also has the potential to affect all patients who receive services within the agency.

2. An immediate jeopardy was identified on 4/23/19 when record review of patient #3 failed to evidence a thorough and accurate assessment. Patient #3's start of care (SOC) comprehensive assessment, completed on 2/18/19, was reviewed and listed "Rt toe amputation" as the principal diagnosis. Review of the patient's past medical history, from VA [veterans administration], records dated 2/15/19, indicated that the patient's 3rd toe amputation was in September of 2018 and that the patient now had a wound on the 2nd right toe. The patient was admitted to home care for help with dressing changes of the right 2nd toe, as evidenced by the physician's notes and orders on 2/15/19. Dressing changes were ordered for MWF/PRN [Monday, Wednesday, Friday/and, as needed].

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{G 510}	Continued From page 7 The comprehensive assessment failed to indicate the location, size, or appearance of the wound and only described it as "Rt lesser toe" in functional limitations with the goal for the patient's "rt toe" site to decrease in size to "0" by the end of the certification period, on 4/18/19. The assessment failed to evidence a baseline measurement for comparison. The failure of the agency to provide a thorough and accurate assessment with specific care instructions, and to update the assessment, created the potential for more serious harm, and possibly infection. 3. An immediate jeopardy was identified on 4/23/19 when clinical record review for patient #9, start of care on 8/24/18, with a principal diagnosis of Type 2 diabetes mellitus (DM), failed to evidence information of previous amputations of the patient's toes, or of a wound. An agency document dated 2/3/19, titled "Supervisory Visit & Phone Call", indicated, "...No new needs. Recent amputation of L [left] pinky toe. Augmentin 875 mg [milligrams] BID [twice daily] x [for] 7 days prophy [prophylactic]...." The subsequent comprehensive assessments, dated 10/18/18, 12/17/18 and 2/15/19, failed to evidence that the patient had wounds or amputations. The medication lists from 8/24/18 to 3/8/19 failed to identify prophylactic antibiotic use status post toe amputation. Skilled nurse visit (SNV) notes, dated 12/2018, 1/7, 14, 21 & 28, 2/19 failed to identify skin deficits/wounds. A SNV note on 2/4/19 identified that the patient was unable to walk due to amputation. The visit note failed to evidence documentation of an assessment of the dressing or wound. A SNV note on 2/11/19 failed to evidence a dressing or wound assessment. SNV's for 2/11/19 and 3/19 failed to evidence any wound documentation.	{G 510}		

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Employee II [doctor of podiatric medicine] indicated in a phone interview on 4/22/19 that the patient had a long hx of contractures of the toes and DM. He indicated DM contributed to the 2nd toe of the left foot ulcer he identified in May of 2018. Employee II indicated the patient previously had toes amputated. The clinical record failed to evidence any documentation that the patient had diabetic foot assessments. The clinical record, comprehensive visit notes, and skilled nursing visit notes failed to evidence documentation of that the patient's dressing was observed or the wound assessed. The clinical record failed to evidence that the agency communicated with the physician, or the Assisted Living facility where the patient resided. The agency failed to provide a thorough assessment of this patient. This failure also has the potential to affect all patients who receive services within the agency.

The administrator was notified of the Immediate Jeopardies for patients #3, 9, and 13 on 4/25/19 at 4:35 PM. The immediate jeopardy failed to be corrected by the end of the exit conference on 5/6/19.

4. An Immediate Jeopardy was identified on 5/6/19 when record review indicated patient #11 did not have a nursing visit for 6 days. The plan of care indicated a skilled nurse frequency of 1-hour visits, 1 to 3 times per day, 5 to 7 days per week for glucometer checks, insulin administration, medication set-up, and compliance. The nurse failed to follow the plan of care to complete any skilled visits from 7/10/17 to 7/15/17. It is undetermined if the patient received any insulin during this time which leads to a significant risk for harm. The record failed to evidence the physician was notified of the lack of

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{G 510}	Continued From page 9 care. The comprehensive assessment failed to have correct and thorough information regarding the patient's endocrine system and diabetic needs to fully address the needs of the patient. The administrator was notified of the Immediate Jeopardy for patient #11 on 5/6/19. The immediate jeopardy failed to be corrected by the end of the exit conference on 5/6/19. 5. After clinical record review and interviews on 6/4/19, it was determined the plan of action had not removed the Immediate Jeopardy. The Immediate Jeopardy in Comprehensive Assessments remains in affect related to Patient #1 did not have a reassessment comprehensive assessment since the last survey. The last comprehensive assessment contained inaccurate information, failed to evidence a thorough medication review and did not adequately represent the needs of the patient. The administrator was notified of the immediate jeopardy not being removed on 6/4/19 at 4:00 PM.	{G 510}		
{G 526}	Content of the comprehensive assessment CFR(s): 484.55(c) 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: This STANDARD is not met as evidenced by:	{G 526}		
{G 528}	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial,	{G 528}		

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{G 528}	Continued From page 10 functional, and cognitive status; This ELEMENT is not met as evidenced by:	{G 528}		
{G 530}	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) 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; This ELEMENT is not met as evidenced by:	{G 530}		
{G 534}	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This ELEMENT is not met as evidenced by:	{G 534}		
{G 536}	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is not met as evidenced by:	{G 536}		
{G 544}	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be	{G 544}		

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{G 544}	Continued From page 11 updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is not met as evidenced by: Based on record review, the registered nurse failed to complete an updated comprehensive assessment to reassess the patient's condition for 1 of 1 records reviewed (#1). Findings include: As part of the immediacy removal plan effectve 5/24/19, the agency stated, in regards to reassessment, "... 100% of all skilled nursing clinical records have been audited to assess for accurate and complete assessments, medication lists, current physician orders, etc. Patients with missing components will either have a reassessment process or a paper discharge/readmission process completed ...." The clinical record of patient #1 was reviewed on 6/4/19 and indicated a start of care date of 12/4/18. The record contained a plan of care for the certification period of 4/3/19-6/1/19. The Registered nurse failed to complete an updated comprehensive assessment to reassess the patient's needs as evidenced by: The last recertification comprehensive assessment was completed on 3/29/19. At 4pm The Don said it was on her desk to complete on 6/5/19.	{G 544}		
{G 548}	Within 48 hours of the patient's return CFR(s): 484.55(d)(2)	{G 548}		

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{G 548}	Continued From page 12 Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered resumption date; This ELEMENT is not met as evidenced by:	{G 548}		
{G 570}	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the plan of care was signed by a physician and services were not rendered in the absence of physician orders (See Tag G572) and failed to ensure the plan of care contained all information pertinent to the care of the patient (See Tag G574).	{G 570}		

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{G 570}	Continued From page 13	{G 570}		

The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care.

1. An Immediate Jeopardy was identified on 5/6/19 when record review indicated patient #15 failed to notify the physician of a change in condition or provide education to the patient regarding oxygen safety. The plan of care indicated a skilled nurse frequency of a 1 hour visit, 1 time per week for vital signs, all body assessment, medication set up, medication teaching, and med compliance. The agency electronic notes stated on 3/17/19 that the patient called the home health aide (HHA) to come to the patient home due to the oxygen machine catching on fire. The aide went to the home and cleaned up and stated that the "floor is still black." The HHA stated concern due to the patient still smoking with the oxygen on. The agency's electronic notes stated on 3/18/19 that the HHA came to the office due to the patient not answering the door. The HHA was concerned about the patient due to the incident with the oxygen machine catching fire the day before. The aide went to the home and got into the home. The patient was unable to get up and face and lips were blue. The patient was admitted to the hospital.

The Administrator was notified of the immediate jeopardy on 5/23/19 at 4:35 PM. The immediate jeopardy failed to be removed by the end of the exit conference on 5/6/19.

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2. An Immediate Jeopardy was identified on 4/25/19 when record review indicated patient #13, start of care date of 5/13/16 with primary diagnosis of quadriplegia. Per the coroner report dated 10/16/18 the patient had a "recent history" of a "serious infection (septic) last year requiring hospitalization." The agency plan of care failed to evidence this information. A skilled nurse visit note completed on 10/3/18 indicated the patient had a new wound on right great toe (laceration) from an aide transfer. The nurse failed to contact the physician for orders. An order faxed by the podiatrist to the agency on 10/10/19 contained wound care orders and increased skilled nurse visits from monthly to 3 x week effective 10/10/18. The skilled nurse failed to make a visit until 10/12/18 for wound care. A skilled nurse visit note completed on 10/12/18 indicated the patient blood pressure was 155/91 (unsure baseline). A skilled nurse visit note completed on 10/15/19 at 4:30 PM -5:15 PM indicated the blood pressure was 86/64 and documented the "pt [patient] presents lethargic," The record failed to evidence anyone called the physician or the power of attorney to report the change in condition.

During an interview on 4/17/19 at 11:45 AM employee M, home health aide (HHA) stated that she was told that employee N, registered nurse (RN) went out on 10/15/18 because the patient was not "acting right, "and that the patient had refused to go to the emergency room, but employee M was not sure how accurate that information was. Employee M stated that upon arrival to the patient's home on 10/16/18 she called 911 and the scheduler because she found the patient deceased at 8:00 AM.

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During an interview on 4/24/19 at 2:27 PM the patient's home podiatrist stated that the agency did not contact her to report any feet wounds but the patient called her and reported it. The podiatrist made a visit on 10/10/18 and faxed an order to the agency. She was aware of the patient having homecare because the patient told her.

The administrator was notified of the immediate jeopardy on 4/25/19 at 4:35 pm. The immediate jeopardy failed to be removed by the end of the exit conference on 5/6/19.

3. An immediate jeopardy was identified on 4/25/19 when the plan of care failed to evidence the visit frequencies ordered by the physician, resulting in deterioration of the patient's wound, and the premature amputation of the right 2nd toe. The clinical record of patient #3, with a start of care on 2/18/19, for the certification period 2/18/19 to 4/18/19, included as the principle diagnosis, traumatic amputation of right toe. (A past medical history of the patient, dated 2/15/19, evidenced that the 3rd right toe had been amputated in September of 2018. The right 2nd toe had a wound but was not amputated until 3/14/19). The POC contained orders for skilled nursing, 1-3 days per week for 1 hour per visit per VA to assess VS [vital signs] and all body systems, knowledge of disease process and its associated care and treatment, med regimen knowledge, s/s [signs and symptoms] complications necessitating medical attention, and wound care on right foot. The POC failed to evidence the location of the wound, or care instructions for the wound. A physician ordered dressing changes on 2/15/19 for Monday, Wednesday, and Friday each week and prn [as

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needed] for soilage, and for care to start on 2/15/19. The failure of the agency to provide a thorough and accurate assessment with specific care instructions included on the plan of care created the potential for more serious harm, and the potential to affect all patients who receive services within the agency.

The administrator was notified of the immediate jeopardy on 4/25/19 at 4:35 pm. The immediate jeopardy failed to be removed by the end of the exit conference on 5/6/19.

4. An immediate jeopardy was identified when record review of patient #9, start of care on 8/24/18, with a principle diagnosis of Type 2 diabetes mellitus (DM), failed to include information of previous amputations of the patient's toes, or of a wound. The subsequent comprehensive assessments, dated 10/18/18, 12/17/18 and 2/15/19 did not reflect wounds or amputations. Plans of care from 8/24/18 - 4/20/19 failed to indicate the presence of a wound or the functional limitation of amputations. The med lists from 8/24/18 to 3/8/19 failed to identify prophylactic antibiotic use status post toe amputation. Review of skilled nurse visit (SNV) notes, dated 12/2018, 1/7, 14, 21, 28, and 2/19 failed to identify skin deficits/wounds. A SNV note on 2/4/19 identified that the patient was unable to walk due to amputation. No assessment of dressing or wound was noted on that visit. A SNV note on 2/11/19 lacked dressing or wound assessment. SNV's for 2/19 and 3/19 lacked any wound documentation. Dr. Dewitt, DPM [doctor of podiatric medicine] indicated in a phone interview on 4/22/19 that the patient had a long hx of contractures of the toes and DM. He indicated DM contributed to the 2nd toe of the lt foot ulcer

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he identified in May of 2018. He indicated the pt had previously had toes amputated. No diabetic foot assessments were found on any patient documentation. No assessment of the patient's dressing was documented in the comprehensive assessment or SNV notes. The agency failed to communicate with the physician, or the Assisted Living facility where the patient resided. The agency failed to provide care planning or quality of care for the patient. This also has the potential to affect all patients who receive services within the agency.

The administrator was notified of the initial Immediate Jeopardy on 4/25/19 at 4:35 PM. The Immediate Jeopardy was not removed by the exit conference on 5/6/19.

5. An Immediate Jeopardy was identified on 5/6/19 when record review indicated patient #11 did not have a nursing visit for 6 days. The plan of care indicated a skilled nurse frequency of 1 hour visits, 1 to 3 times per day, 5 to 7 days per week for glucometer checks, insulin administration, medication set up and compliance. The nurse failed to follow the plan of care to complete any skilled visits from 7/10/17 to 7/15/17. It was undetermined if the patient received any insulin during this time which lead to a significant risk for harm. The record failed to evidence the physician was notified of the lack of care.

The Administrator was notified of the immediate jeopardy on 5/23/19 at 4:35 PM. The immediate jeopardy failed to be removed by the end of the exit conference on 5/6/19.

6. After clinical record review and interviews on

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{G 570}	Continued From page 18 6/4/19, it was determined the plan of action had not removed the Immediate Jeopardy. The Immediate Jeopardy remains in affect in Care Planning, Coordination, Quality of Care related to Patient #'s plan of care contained inaccurate and incomplete information, and failed to evidence a physician order to provide or resume homecare services. The administrator was notified of the immediate jeopardy not being removed on 6/4/19 at 4:00 PM.	{G 570}		
{G 572}	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician 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. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure that the plan of care was signed by a physician and services were not rendered in the absence of physician orders for 1 of 1 records reviewed (#1). Findings include: As part of the removal plan/ plan of correction that was accepted on 6/3/19, the plan indicated effectve 5/24/19, "... 100% of all skilled clinical records have been audited to ensure services are	{G 572}		

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{G 572}	Continued From page 19 being provided in compliance with physician orders ... This will entail contacting the physician and obtaining physician verbal orders ... The POC [plan of care] will be written and sent to the physician for signature .... " The clinical record of patient #1 was reviewed on 6/4/19 and indicated a start of care date of 12/4/18. The record contained a plan of care for the certification period of 4/3/19-6/1/19 that indicated orders for a skilled nurse for tracheotomy care, and orders for a home health aide (HHA), attendant care (ATTC), and homemaker (HMK). The record failed to evidence a signed physician's plan of care. During an interview on 6/4/19 at 3:21 PM, employee I, licensed practical nurse (LPN) stated that she had been a nurse for 42 years and she was aware of how to take care of a patient with a tracheotomy (trach). During visits with patient #1, employee I stated she competed trach care, suctioned trach, assessed patient with a head to toe assessment, and checked vital signs, When asked if employee I utilized the plan of care as a guide on what skill to complete with patient #1 she stated no, she only uses the plan of care to have the physician phone number available if needed.	{G 572}		
{G 574}	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) 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	{G 574}		

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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.
This ELEMENT is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the plan of care contained all information pertinent to the care of the patient for 1 of 1 records reviewed (#1).

Findings include:

As part of the removal plan/ plan of correction that was accepted on 6/3/19, the plan indicated effectve 5/24/19, " ... 100% of all active skilled nursing clinical records have been audited ... All physicians were contacted to clarify the patients' diagnoses listing to ensure the agency has an accurate complete listing of the pertinent and relevant patient diagnoses .... "

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{G 574}	Continued From page 21 The clinical record of patient #1 was reviewed on 6/4/19 and indicated a start of care date of 12/4/18. The record contained a plan of care for the certification period of 4/3/19-6/1/19 that indicated the patient had diabetes and had diabetic supplies in the home. The plan of care failed to evidence accurate durable medical equipment (DME), supplies, diagnoses, and medications as evidenced by: During a interview on 6/4/19 at 2:50 PM, the spouse of patient #1 stated that the patient did not have a catheter and was not a diabetic, but did have a tracheotomy with 6 liters of oxygen utilized continuously, a power wheelchair, and suction machine.	{G 574}		
{G 580}	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician. This ELEMENT is not met as evidenced by:	{G 580}		
{G 590}	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) 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 the plan of care should be altered. This ELEMENT is not met as evidenced by:	{G 590}		
{G 604}	Integrate all orders CFR(s): 484.60(d)(2) Integrate orders from all physicians involved in	{G 604}		

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{G 604}	Continued From page 22 the plan of care to assure the coordination of all services and interventions provided to the patient. This ELEMENT is not met as evidenced by:	{G 604}		
{G 606}	Integrate all services CFR(s): 484.60(d)(3) 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. This ELEMENT is not met as evidenced by: Based on interview, the agency failed to ensure the skilled nurse coordinated care with the case manager and other staff members for 1 of 1 patient records reviewed (#1). Findings include: The clinical record of patient #1 was reviewed on 6/4/19 and indicated a start of care date of 12/4/18. The record contained a plan of care for the certification period of 4/3/19-6/1/19. The record failed to evidence coordination of care between staff members as evidenced by: During an interview on 6/4/19 at 3:21 PM, employee I, licensed practical nurse (LPN) stated she had seen patient #1 for skilled services. Employee I indicated she previously was a nurse in the Muncie branch, the skilled patients were discharged and she now had picked up patients in Anderson. Patient #1 was an Anderson patient. Employee I was not aware who the registered nurse (RN) for patient #1 was to report changes, but would call the Anderson office and report	{G 606}		

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{G 606}	Continued From page 23 needs /changes to the schedulers. Employee I stated on 6/3/19 she called the office scheduler to report sending patient #1 to the hospital for low oxygen saturations. Employee I indicated in Muncie she knew all the nurses phone numbers and would coordinate with the nurses when seeing patients to coordinate changes and needs of the patient, but she knew none of the nurses contact information in Anderson to coordinate.	{G 606}		
{G 640}	17-12-2 (g) Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is not met as evidenced by: Based on record review and interview, the agency failed to complete chart audits on all active patients to self identify potential problems	{G 640}		

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{G 640}	Continued From page 24 for 1 of 1 agency. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.65 Quality assessment and performance improvement. As part of the removal plan/ plan of correction that was accepted on 6/3/19, the plan indicated effectve 5/24/19, "... "...agency immediately conducted a 100% audit of the agency ' s skilled patient caseload to identify additional areas of concern ...." After clinical record review and interviews on 6/4/19, it was determined the plan of action had not removed the Immediate Jeopardy. The Immediate Jeopardy (IJ) remains in affect related to Quality Assurance Performance Improvement (QAPI). The agency failed to complete chart audits for all active patients to self-identify potential problems. During an interview on 6/4/19 at 10:01 AM the administrator stated that the agency had 207 total patients (36 of which were skilled) and 92 patients ad been discharged. The administrator on 6/4/19 at 11:02 AM brought in all chart audits that had been completed. There was 29 chart audits that had been completed.	{G 640}		
{G 642}	Program scope CFR(s): 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of	{G 642}		

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{G 642}	Continued From page 25 showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. This STANDARD is not met as evidenced by:	{G 642}		
{G 644}	Program data CFR(s): 484.65(b)(1),(2),(3) 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 governing body. This STANDARD is not met as evidenced by:	{G 644}		
{G 648}	High risk, high volume, or problem-prone area CFR(s): 484.65(c)(1)(i) (i) Focus on high risk, high volume, or problem-prone areas; This ELEMENT is not met as evidenced by:	{G 648}		
{G 652}	Activities lead to an immediate correction	{G 652}		

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{G 652}	Continued From page 26 CFR(s): 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. This ELEMENT is not met as evidenced by:	{G 652}		
{G 654}	Track adverse patient events CFR(s): 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. This STANDARD is not met as evidenced by:	{G 654}		
{G 656}	Improvements are sustained CFR(s): 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. This ELEMENT is not met as evidenced by:	{G 656}		
{G 658}	Performance improvement projects CFR(s): 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations.	{G 658}		

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{G 658}	Continued From page 27 (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. This STANDARD is not met as evidenced by:	{G 658}		
{G 660}	Executive responsibilities for QAPI CFR(s): 484.65(e)(1)(2)(3)(4) Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained; (2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness; (3) That clear expectations for patient safety are established, implemented, and maintained; and (4) That any findings of fraud or waste are appropriately addressed. This STANDARD is not met as evidenced by:	{G 660}		
{G 700}	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and	{G 700}		

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occupational therapy, as specified in §409.44 of this chapter, and physician and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care.
This CONDITION is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the skilled nurse (SN) did not render services absence of physician orders (See Tag G710).

The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation, 42 CFR 484.75 Skilled Professional Services.

1. An Immediate Jeopardy was identified on 5/6/19 when record review indicated patient #15 failed to notify the physician of a change in condition or provide education to the patient regarding oxygen safety. The plan of care indicated a skilled nurse frequency of a 1 hour visit, 1 time per week for vital signs, all body assessment, medication set up, medication teaching, and med compliance. The agency electronic notes stated on 3/17/19 that the patient called the home health aide (HHA) to come to the patient home due to the oxygen machine catching on fire. The aide went to the home and cleaned up the mess and stated that the "floor is still black." The HHA stated concern due to the patient still smoking with the oxygen on. The agency electronic notes stated on 3/18/19 that the HHA came to the office due to the patient not

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answering the door. The HHA was concerned about the patient due to incident with the oxygen machine catching fire the day before. The aide went to the home and got into the home. The patient was unable to get up and face and lips were blue. The patient was admitted to the hospital. The administrator was notified of the immediate jeopardy on 5/6/19 and failed to be removed by the end of the exit conference on 5/6/19.

2. An Immediate Jeopardy was identified on 4/25/19 when record review indicated patient #13, start of care date of 5/13/16 with primary diagnosis of quadriplegia. Per the coroner report the patient had a history of sepsis. The family reported to coroner patient #11 had serious infection with sepsis last year requiring hospitalization. The agency record failed to evidence this information. The patient had a new wound on right great toe (laceration) from an aide transfer, found on 10/3/18. The record failed to evidence documentation the physician was notified. A faxed order from a podiatrist on 10/10/18. The podiatrist reported the patient called and reported wound and she completed a home visit. The podiatrist gave wound care orders and increased visits from monthly to 3 x week effective 10/10/18. The skilled nurse failed to make a visit until 10/12/18 for wound care. Visit documentation on 10/12/18 indicated the patient blood pressure was 155/91 (unsure baseline). Visit documentation on 10/15/19 at 4:30p-5:15p indicated the blood pressure was 86/64 and documented the "pt [patient] presents lethargic." The record failed to evidence anyone called the physician and the home health aide found the patient deceased on10/16/18 at 8:00a and called 911. The clinical record does not

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indicate the power of attorney was notified of the change in condition. The comprehensive assessment failed to evidence when the patient's last bowel movement was, who managed suprapubic catheter, what size catheter was used and how often it was to be changed, if the oxygen use was continuous or intermittent, if the patient would benefit from therapy services from another agency, or what the discharge potential and goals were. The administrator was notified of the immediate jeopardy on 4/25/19 at 4:35 p.m. and failed to be removed by the end of the exit conference on 5/6/19.

3. An immediate jeopardy was identified on 4/25/19 when the clinical records of patient #3 indicated a right 2nd toe wound with orders for dressing changes, most of which did not occur due to confusion regarding correct orders to follow and missed visits. On 2/15/19, the physician ordered dressing changes for Monday, Wednesday, Friday, and as needed each week. The start of care comprehensive assessment, dated 2/18/19, failed to indicate the location, size, or appearance of a wound and was only described as "Rt lesser toe". The assessment described a goal for the patient's wound as decrease to size "0", without a baseline measurement, or any other information regarding the wound. A skilled nurse (SN) visit on 2/18/19, documented an "approx." measurement. A SN visit on 2/20 indicated, "tx [treatment] done" and failed to evidence the treatment provided. A SN visit on 2/22 documented "area not healing well" failed to evidence documentation of the details of the wound not healing. The clinical record failed to evidence a visit on 2/25 or 2/27. A SN visit on 3/1, indicated the SN measured the wound and documented "much worse and larger" without any

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evidence that the physician was informed. The clinical record evidenced that the patient went to the emergency room on 3/3, returned home on 3/6, the record failed to evidence a resumption of care assessment or any visit until after the right 2nd toe was amputated on 3/14. The failure of the agency to provide a thorough and accurate assessment with specific care instructions created the potential for more serious harm, and possibly infection. The administrator was notified of the immediate jeopardy on 4/25/19 at 4:35 p.m. and failed to be removed by the end of the exit conference on 5/6/19.

4. An Immediate Jeopardy was identified on 4/25/19 when record review of patient #9, start of care on 8/24/18, with a principle diagnosis of Type 2 diabetes mellitus (DM), failed to evidence information of previous amputations of the patient's toes, or of a wound. The subsequent comprehensive assessments, dated 10/18/18, 12/17/18 and 2/15/19 failed to evidence wounds or amputations. Plans of care from 8/24/18 - 4/20/19 failed to evidence the presence of a wound or the functional limitation of amputations. The med lists from 8/24/18 to 3/8/19 failed to evidence the use of prophylactic antibiotics status post toe amputation. A review of skilled nurse visit (SNV) notes, dated 12/2018, 1/7, 14, 21, 28, and 2/19 failed to evidence skin deficits/wounds. A SNV note on 2/4/19 identified the patient was unable to walk due to an amputation. The record failed to evidence the dressing or wound was noted on that visit. A SNV note on 2/11/19 failed to evidence a dressing was present or wound assessment was completed. SNV's for 2/19 and 3/19 failed to evidence wound documentation. Non-Employee II, [doctor of podiatric medicine] indicated in a phone interview on 4/22/19 that the

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patient had a long history of contractures of the toes and DM. Non-Employee II indicated DM contributed to the 2nd toe of the left foot ulcer he identified in May of 2018. He indicated the patient had a history of previous toe amputation. The record lacked evidence of diabetic foot assessments performed by the agency. The record failed to evidence the presence of a foot assessment or the presence of a dressing in the SNV notes. The agency failed to communicate with the primary care physician. The agency failed to evidence coordination of care of the wound with the assisted living facility where the patient resided. The agency failed to provide care planning in regards to wound care or diabetic foot care to achieve the optimal outcome for the patient. This failure to evidence through assessment of the patient had the potential to affect all patients who received services within the agency. The administrator was notified of the Immediate Jeopardy on 4/25/19 at 4:35 PM.

5. An Immediate Jeopardy was identified on 5/6/19 when record review indicated patient #11 did not have a nursing visit for 6 days. The plan of care indicated a skilled nurse frequency of 1 hour visits, 1 to 3 times per day, 5 to 7 days per week for glucometer checks, insulin administration, medication set up and compliance. The nurse failed to follow the plan of care to complete any skilled visits from 7/10/17 to 7/15/17. It is undetermined if the patient received any insulin during this time which lead to a significant risk for harm. The record failed to evidence the physician was notified of the lack of care. The comprehensive assessment failed to have correct and thorough information regarding the patient's endocrine system and diabetic needs to fully address the needs of the patient.

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{G 700}	Continued From page 33 The administrator was notified of the immediate jeopardy on 5/6/19 and failed to be removed by the end of the exit conference on 5/6/19. 6. After clinical record review and interviews on 6/4/19, it was determined the plan of action had not removed the Immediate Jeopardy. The Immediate Jeopardy remains in affect for Skilled Professional Services due to a skilled nurse (SN) rendering services absent of a physician orders. The administrator was notified of the immediate jeopardy not being removed on 6/4/19 at 4:00 PM.	{G 700}		
{G 706}	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This ELEMENT is not met as evidenced by:	{G 706}		
{G 710}	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the skilled nurse (SN) did not render services absence of physician orders for 1 of 1 records reviewed (#1). Findings include: As part of the removal plan/ plan of correction that was accepted on 6/3/19, the plan indicated effectve 5/24/19, "... 100% of all skilled clinical records have been audited to ensure services are being provided in compliance with physician	{G 710}		

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{G 710}	Continued From page 34 ordered services ... This will entail contacting the physician and obtaining physician verbal orders ... The POC [plan of care] will be written and sent to the physician for signature .... " The clinical record of patient #1 was reviewed on 6/4/19 and indicated a start of care date of 12/4/18. The record contained a plan of care for the certification period of 4/3/19-6/1/19 that indicated orders for a skilled nurse to provide tracheotomy care. The plan of care failed to evidence any further information on the specifics of trach care to be provided such as suctioning, frequency of trach collar changes, frequency of trach to be suctioned, size of trach, and frequency/ treatment of trach cleansing. During an interview on 6/4/19 at 3:21 PM, employee I, licensed practical nurse (LPN) stated that she had been a nurse for 42 years and she was aware of how to take care of a patient with a tracheotomy (trach). During visits with patient #1, employee I stated she completed trach care, suctioned trach, assessed patient with a head to toe assessment, and checked vital signs, When asked if employee I utilized the plan of care as a guide on what skill to complete with patient #1, she stated no, she only used the plan of care to have the physician phone number available if needed.	{G 710}		
{G 716}	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is not met as evidenced by:	{G 716}		
{G 718}	Communication with physicians CFR(s): 484.75(b)(7)	{G 718}		

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{G 718}	Continued From page 35 Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; This ELEMENT is not met as evidenced by:	{G 718}		
{G 720}	Participate in the HHA's QAPI program; CFR(s): 484.75(b)(8) Participation in the HHA's QAPI program; and This ELEMENT is not met as evidenced by:	{G 720}		
{G 940}	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is not met as evidenced by: Based on record review and interview, the Administrator failed to ensure they were responsible for all day-today operations (See Tag G 948) and the director of nursing (DON) failed to ensure the skilled nurse (SN) did not render services absence of physician orders (See Tag	{G 940}		

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{G 940}	Continued From page 36	{G 940}		

G968).

The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure the provision of quality of care in a safe environment for the Condition of Participation 42 CFR 484.105 Organization and Administration of Services.

An Immediate Jeopardy was identified on 4/25/19, when it was discovered that patients were being treated without physician's orders, potentiating risk of serious adverse outcomes. The agency was creating its own orders and there is no physician involvement to communicate if significant patient conditions occurred. Patients were found to have inaccurate/ incomplete assessments, assessments documented and signed on visits that did not occur, and skilled nurses trained by the clinical manager to conduct assessments in this manner without orientation of the nurse's skills prior to patient assignments. The agency's governing body and administration did not implement a QAPI program to identify systemic issues that would mitigate potential patient adverse outcomes. These failures resulted in patients being at immediate risk due to lack of a current system in place by the governing body/ administration to ensure policies were developed to address patient care, parameters were set for staff expectations of care delivery, and for clinical oversight to identify improper care. The Administrator was notified of the Immediate Jeopardy on 4/25/19 at 4:35 PM and was unremoved by the end of the exit conference on 5/6/19.

After clinical record review and interviews on 6/4/19, it was determined the plan of action had

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{G 940}	Continued From page 37 not removed the Immediate Jeopardy. The Immediate Jeopardy (IJ) remains in affect related to Administration. The administrator and director of nursing failed to ensure that chart audits were being completed, that verification of discharge notification was received, and that clinical oversight of nurses was being conducted.	{G 940}		
{G 942}	Governing body CFR(s): 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. This STANDARD is not met as evidenced by:	{G 942}		
{G 948}	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is not met as evidenced by: Based on record review and interview, the Administrator failed to ensure they were responsible for all day-today operations for 1 of 1 agency. Findings include: As part of the removal plan/ plan of correction that was accepted on 6/3/19, the plan indicated effectve 5/24/19, " ... agency immediately conducted a 100% audit of the agency's skilled	{G 948}		

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{G 948}	Continued From page 38 patient caseload to identify additional areas of concern .... " During an interview on 6/4/19 at 10:01 AM, the administrator stated that the agency had 207 total patients (36 of which were skilled) and 92 patients ad been discharged. The administrator on 6/4/19 at 11:02 AM brought in all chart audits that had been completed. There were 29 chart audits that had been completed. The administrator failed to ensure that all charts were audited.	{G 948}		
{G 950}	Ensure clinical manager is available CFR(s): 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; This ELEMENT is not met as evidenced by:	{G 950}		
{G 958}	Clinical manager CFR(s): 484.105(c) Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following-- This STANDARD is not met as evidenced by:	{G 958}		
{G 960}	Make patient and personnel assignments, CFR(s): 484.105(c)(1) Making patient and personnel assignments, This ELEMENT is not met as evidenced by:	{G 960}		
{G 962}	Coordinate patient care CFR(s): 484.105(c)(2)	{G 962}		

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{G 962}	Continued From page 39 Coordinating patient care, This ELEMENT is not met as evidenced by:	{G 962}		
{G 964}	Coordinate referrals; CFR(s): 484.105(c)(3) Coordinating referrals, This ELEMENT is not met as evidenced by:	{G 964}		
{G 966}	Assure patient needs are continually assessed CFR(s): 484.105(c)(4) Assuring that patient needs are continually assessed, and This ELEMENT is not met as evidenced by:	{G 966}		
{G 968}	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is not met as evidenced by: Based on record review and interview, the director of nursing (DON) failed to ensure the skilled nurse (SN) did not render services absence of physician orders for 1 of 1 records reviewed (#1). Findings include: As part of the removal plan/ plan of correction that was accepted on 6/3/19, the plan indicated effectve 5/24/19, "... 100% of all skilled clinical records have been audited to ensure services are being provided in compliance with physician ordered services ... This will entail contacting the physician and obtaining physician verbal orders ...	{G 968}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K024	A. BUILDING _____ B. WING _____	R-C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE & BEYOND HOMECARE INC	1304 MAIN STREET ANDERSON, IN 46016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 968}	Continued From page 40 The POC [plan of care] will be written and sent to the physician for signature .... " The clinical record of patient #1 was reviewed on 6/4/19 and indicated a start of care date of 12/4/18. The record contained a plan of care for the certification period of 4/3/19-6/1/19, which indicated orders for a skilled nurse to provide tracheotomy care. During an interview on 6/4/19 at 3:21 PM, employee I, licensed practical nurse (LPN) stated that she had been a nurse for 42 years and she was aware of how to take care of a patient with a tracheotomy (trach). During visits with patient #1, employee I stated she completed trach care, suctioned trach, assessed patient with a head to toe assessment, and checked vital signs, When asked if employee I utilized the plan of care as a guide on what skill to complete with patient #1, she stated no, she only used the plan of care to have the physician phone number available if needed.	{G 968}		
{G 974}	Direct support and administrative control CFR(s): 484.105(d)(2) The parent HHA provides direct support and administrative control of its branches. This ELEMENT is not met as evidenced by:	{G 974}		