STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K159	A. BUILDING 00 B. WING	10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELDER'S JOURNEY HOME CARE	4 W NATIONAL AVENUE BRAZIL, IN 47834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102, for a home health agency. Facility #: 014228 CCN: 15K159 Survey dates: 10-6, 10-7, 10-8, 10-9, and 10-13-2020 At this Emergency Preparedness survey, Elder's Journey Home Care, was found to have been in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 484.102 for Home Health Agencies.	E 0000		
G 0000 Bldg. 00	This visit was for a Federal Recertification, a Focused Infection Control, and a State Licensure survey of a home health agency. Three (3) complaints were investigated in conjunction with the recertification survey. This survey was announced as partial extended on 10-8-2020, at 4:15 p.m. Complaint #: IN00290685: substantiated-without additional findings Complaint #: IN00277830: unsubstantiated-lack of sufficient evidence Complaint #: IN00284431: unsubstantiated-lack of sufficient evidence	G 0000		

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

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	Facility #: 014228 CCN: 15K159 Survey dates: 10-6, 10-7, 10-8, 10-9, and 10-13-2020 Skilled Unduplicated Admissions in prior 12 months: 42 Current Census: Skilled Services: 27 Unskilled: 217 Total: 244 Record Review: Record reviews with home visit: 4 Record review only: 5 Total clinical records reviewed: 9 These deficiencies reflect State Findings in accordance with 410 IAC 17. Refer to state form for additional state findings. Quality Review completed on 10/22/2020 A4			
G 0536	484.55(c)(5) A review of all current medications			

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Bldg. 00	A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the registered nurse failed to ensure clear and accurate medication profiles & failed to ensure medication discrepancies were reconciled with the ordering physician upon resumption of care post hospitalization and next certification period thereafter, for 2 of a total sample of 9 patients. (Patient #3, #5) Findings include: 1. Review of an undated agency policy titled "Medication Reconciliation" stated: ". . . Agency will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, before and after inpatient facility stays. . ." Review of an undated agency policy titled "Medication Profile" stated: ". . . The profile will be reviewed and updated as needed to reflect current medications the client is taking. . . To provide documentation of the comprehensive assessment of all medications the client is currently taking, and identify discrepancies between client profile, prescription bottles, and the physician and/or agency profile. . .The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, when updated and at minimum	G 0536	**G536** **1.** The Director of Clinical Services has corrected errors to pt #3 and #5's charts in order to comply with policies C709, C708, C706, and C700. Pt #3: The Director of Clinical services reviewed pt's discharge orders, contacted MD office for medication order clarification, received verbal orders, and updated pt's medication profile. The Director of Clinical Services forwarded copies of orders and profiles to pt's MD, RNCM, and Nursing Supervisor. **EXHIBIT B.** Patient #5: The Director of Clinical Services contacted pt's physician and pharmacy on 10/9/2020 to obtain clarification regarding intravenous medication dosing. Director of Clinical Services obtained verbal order and updated the medication profile. Notification of order clarification and updated medication profile were forwarded to pt's physician, RNCM, clinical staff, and Nursing Supervisor. **EXHIBIT C** **2.** The Director of Clinical Services to in-service all nursing staff on proper Medication reconciliation, identification of medication	11/06/2020

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	every sixty (60) days thereafter. . ." 2. Patient #3's clinical record included a discharge summary from a hospital dated 8-10-2020. The summary included a list of 17 "Discharge Medications" Benzocaine 20/Docusate NA (sodium) (for constipation) 283 mg (milligrams), enema, Lactobacillus acidophilus (probiotic) tab take 2 tablet, Menthol/M-Salicylate 10-15% topical cream, apply a small amount topically three times a day, Mupirocin 2% (antibiotic ointment) apply ointment topically twice a day, Psyllium SF (sugar free fiber laxative) oral powder mix 1 teaspoonful & drink every day, Hydrocortisone 1/Pramoxine (anti-inflammatory, anesthetic) 1% rectal Foam insert, 1 applicator full into rectum 4 times a day, Hydrocortisone 2.5% (anti-inflammatory) rectal Cream with applicator apply a thin film into rectum twice a day as needed, Nitroglycerin 2% ointment (relaxes blood vessels), apply 1 inch topically three times a day as needed for high blood pressure, Polyethylene glycol (treatment for constipation) 3350 oral powder mix 1 capful (17 gms) and drink every day as needed, Simethicone (antacid) 80 mg chewable tablet, chew and swallow one tablet orally twice a day as needed, Bisacodyl (stimulant laxative) 10 mg rectal suppository, insert 1 suppository into rectum every day for constipation, Cefpodoxime Proxetil (antibiotic) 100 mg tab, take one tablet orally every day, Enoxaparin (Lovenox-prevention of blood clots) 40 mg/0.4 ml (milliliter) injectable syringe 0.4 ml, inject 40 mg subcutaneously every day, Ophthalmic multivitamin AREDS capsule take 1 orally twice a day, Omeprazole (decreases stomach acid) 20 mg Enteric coated capsule, twice a day, Hydrocodone 5 mg/Acetaminophen 325 mg (pain medication) 1 tablet by mouth every 6 hours as needed for pain, not to exceed 3000 mg per day of acetaminophen products.		discrepancies and proper coordination the physician's offices for clarification as stated in the company's policies. The in-service will include the following policies: C-700 Medication Profile (highlighting "the Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication.") , C-706 Medication Orders (highlighting " Any medication discrepancies will be verified with physician"), C-708 Medication Administration (highlighting " Agency staff will verify orders for all drugs and treatments before administering them to clients.") and C-709 Medication Reconciliation (highlighting "When client is discharged from the facility, the medications will be reviewed and the orders updated to reflect changes and/or continuation of previous orders."). **EXHIBIT A** **3**. The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency. Is corrected and will not recur. **4**. The date of corrective action to be completed by 11/6/2020.	

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	Review of Patient #3's plan of care dated 9-22-2020 to 11-20-2020 evidenced five medications of: Omeprazole delayed release 1 tablet daily; Baclofen (muscle relaxer) 20 mg 1 tablet 4 times daily, PreserVision AREDS 1 tablet daily, Cholecalciferol (Vitamin D) disintegrating tablet, 1 tablet daily; and cyanocobalamin (Vitamin B 12) lozenge 1000 mcg, 1 daily. A review of the agency's medication profile for Patient #3 dated 8-12-2020 and 9-22-2020 contained an identical listing of 8 medications which included: Omeprazole delayed release 20 mg daily; Baclofen 20 mg tablet 4 times a day, PreserVision AREDS 1 tablet daily; Cholecalciferol Disintegrating 500 units 1 tablet daily; Cyanocobalamin lozenge 1000 mcg, 1 daily; Lactobacillus 1 tab daily, Docusate Sodium 100 mg capsule, 1 capsule daily; and Nitrobid Transdermal (applied to skin) ointment 2%, 1 dose as needed for chest pain by mouth. A review of the resumption of care comprehensive assessment dated 8-12-2020 by Registered Nurse, Employee D, page 2 indicated the medication list was reviewed and updated by checking a box and with a medication note that ATB (antibiotic) and Lovenox injections x (times) 14 days. The check box indicating a change or new medication was not checked. The Plan/Care Coordination section on page 3 was left blank and the note section failed to evidence contact of the physician for clarification of Patient #3's medication orders. The Registered Nurse failed to identify the discrepancies between the "Continued Medications", "Medication List at Discharge" and "Medication Profile" and failed to reconcile these medications with the ordering physician for an			

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	exact list of current medications, dosage and route of administration. During an interview on 10-13-2020 at 4:00, the Administrator and Clinical Manager acknowledged the above findings and when queried, provided nothing further. 3. Review of Patient #5's clinical record, start of care 8-5-19, a plan of care certification period of 9-28-2020 to 11-26-2020, evidenced a Medication Profile with the following incomplete and unclear medication description of "Methylprednisolone Sodium Succ (succinate-an anti-inflammatory medication) Intravenous Solution Reconstituted 1000 mg - 250 mg/100 ml over 45 min to 1 hour once monthly. This listing failed to evidence clarity regarding the ordered dose, if reconstituted, who was reconstituting and with what and how much, total volume & dose to be administered, route of administration (peripheral IV or port), use of flush solutions such as saline or heparin, and specific mode of administration (pump, free flow etc.). During an interview on 10-13-2020 at 4:00, the Administrator and Clinical Manager acknowledged the above findings and when queried, provided nothing further. 17-14-1(a)(1)(B) 17-15-1(a)(3)			
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;			

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	(iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Based on observation, record review, and interview, the agency failed to ensure the plan of care contained all durable medical equipment, specific bowel regimen orders, diet requirements, an accurate listing of medications and treatments, pertinent diagnosis/surgeries, and an accurate and up-to-date summary of care for 2 (Patient #3 & #5) of 9 records reviewed. Findings included: 1. Review of an undated agency policy titled "Care Plans" stated: ". . . Purpose. . . To provide updated, coordinated document that reflects the current home care services. . . Special	G 0574	**G574** **1.** The Director of Clinical Services received verbal orders for patients #3 and #5 to maintain compliance with policies C660, C580, C635, C706, C709, C700, and C708. Pt #3: Amendment order entered to specify bowel program, HHA orders, wound orders, urostomy care, DME, diagnosis, surgical diagnosis, diet, and clinical summary clarification. The Director of Clinical Services faxed and updated medication profile and verbal order to patient's	11/06/2020

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	Instructions. . . The Care Plan shall be reviewed, evaluated, and revised (minimally) every 60 days and as needed . . ." Review of an undated agency policy titled "Plan of Care" stated: ". . . Patients receive appropriate services based on an assessment of their needs and physician orders. Home Health Agency will develop a plan of care, specific to each patient's needs and containing all required elements. . . The plan of care shall be completed in full to include: all pertinent diagnosis(es) . . . type, frequency, & duration of all visits/services . . . specific procedures . . . surgical procedure(s) . . . medical supplies & equipment required. . . If a physician refers a client under a plan of care that cannot be completed until after an assessment visit, the physician shall be consulted to approve additions or modifications to the original plan. . . Verbal/telephone orders shall be obtained from the client's physician for changes in the plan of care. . ." Review of an undated agency policy titled "Physician Orders" stated: ". . . When the nurse receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. . . When written orders are received from the physician, they will be reviewed to assure the orders are clear and legible. . ." Review of an undated agency policy titled "Medication Orders" stated: ". . . Agency staff will verify with the physician any incomplete, illegible or unclear medication orders prior to administering the medication and/or providing client education about the medication. . ."		physician for signature, then forwarded the order to amend POC and updated medication profile to patient's RNCM, clinical staff, and Nursing Supervisor. **EXHIBIT D.** Patient #5: The Director of Clinical Services obtained a verbal clarification order for patient's intravenous medication and updated patient's medication profile. Copies of the order and medication profile were forwarded to patient's physician, RNCM, clinical staff, and Nursing Supervisor. The Director of Clinical Services obtained a verbal order to amend current plan of care to include an updated list of DME. Verbal order was sent to MD for signature and forwarded to patient's RNCM, clinical staff, and Nursing Supervisor. **EXHIBIT E.** **2**. The Director of Clinical Services to in-service all nursing staff on the correct needed components to Plan of Cares including current and correct DME, medications, diagnosis/surgeries, diet requirements treatments and all care coordination with other companies and updated summary of cares that are not "copy and pasted" from a previous POC. The in-service will include the following polices C-660 Care Plans (highlighting, the POC to "reflect the current home services"), C-580 Plan of Care (highlighting, ("HHA will develop a plan of care, specific to each patient's needs and	

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	Review of an undated agency policy titled "Medication Reconciliation" stated: ". . . Agency will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, before and after inpatient facility stays, and at the time of discharge. . . The agency nurse will contact the physician to resolve any questions about the medication and other related concerns." Review of an undated agency policy titled "Medication Profile" stated: ". . . The profile will be reviewed and updated as needed to reflect current medications the client is taking. . . To provide documentation of the comprehensive assessment of all medications the client is currently taking, and identify discrepancies between client profile, prescription bottles, and the physician and/or agency profile. . . To provide documentation of changes in the medication regime as they happen, and support changes needed to the plan of care. . . If the physician has called a pharmacist with new medication orders. . . The change shall be documented on the Medication Profile and included in the next plan of care. . . The Medication Profile shall be reviewed by a Registered Nurse every 60 days thereafter. . ." 2. Review of Patient #3's clinical record evidenced a local hospital's faxed document dated 8-10-2020 which contained a hospital discharge summary, history & physical, discharge instructions & resumption of care orders/instructions for Patient #3. Review of Patient #3's plan of care dated 9-22-2020 to 11-20-2020 evidenced the following absence or discrepancies compared to the hospital discharge		containing all required elements."" Physician shall be consulted to approve additions or modifications to the original plan." "Verbal/telephone orders shall be obtained from the client's physician for changes in the Plan of Care.") C-635 Physician Orders (highlighting, the entire procedure (1 under Special Instructions) that outline the procedure in taking a verbal order. C-706 Medication Orders (highlighting, "Agency will verify with the physician any incomplete, illegible or unclear medication orders prior to administering the medication and/or providing client education about the medication"). C-709 Medication Reconciliation) highlighting, "Agency will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, before and after inpatient facility stays, and at the time of discharge. "). C-708 Medication Administration (highlighting," The agency will contact the physician to resolve any questions about the medication and other related concerns."). C-700 Medical Profile (highlighting, "The profile will be reviewed and updated as needed to reflect current medications the client is taking." "TO PROVIDE DOCUMENTATIONOF THE COMPREHENSIVE ASSESSMENT OF ALL	

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	documents and the clinical notes failed to evidence clarification of the discrepancies: The plan of care dated 9-21-2020 to 11-20-2020 failed to evidence the clarification/addition of the diagnoses of quadriplegia (paralysis of the body from at least the shoulders down), muscle invasive bladder cancer and surgical procedures of cystectomy (removal of bladder) and creation of a ileal conduit (creation of a small internal bladder using the small intestines with opening through abdominal wall - stoma) on 8-3-2020 The plan of care dated 9-21-2020 to 11-20-2020 failed to evidence the presence of the following medications listed on the said hospital discharge orders/instruction sheet for Patient #3: -Benzocaine 20/Docusate NA (sodium) (for constipation) 283 mg (milligram). enema, instill 1 enema into rectum every other day. -Lactobacillus acidophilus (probiotic) tab (tablet) take 2 tablet orally every day. Menthol/M-Salicylate 10-15% topical cream, apply a small amount topically three times a day for temporary relief of minor aches & pains of muscles and joints. -Mupirocin 2% (antibiotic ointment) apply ointment topically twice a day -Psyllium SF (sugar free fiber laxative) oral powder mix 1 teaspoonful & drink every day (put one dose into an empty glass, mix this product with at least 8 ounces of water, stir briskly and drink promptly) -Hydrocortisone 1/Pramoxine (anti-inflammatory, anesthetic) 1% rectal Foam insert, 1 applicator full into rectum 4 times a day as needed for hemorrhoids. -Hydrocortisone 2.5% (anti-inflammatory) rectal Cream with/ applicator apply a thin film into rectum twice a day as needed for rectal irritation		MEDICATIONS THE CLIENT IS CURRENTLY TAKING, AND IDENTIFY DISCREPANCIES BETWEEN CLEINT PROFILE, PRESCRIPTION BOTTLES, AND THE PHYSICIAN AND/OR AGENCY PROFILE." "To provide documentation of changes in the medication regime as they happen, and support changes needed to the plan of care." "The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication. The Registered Nurse shall sign and date the Medication Profile upon initiation, when updated and, at minimum, every sixty (60) days thereafter."). **EXHIBIT A** **3.** The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency. Is corrected and will not recur. **4**. The date of corrective action to be completed by 11/6/2020.	

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	-Nitroglycerin 2% ointment (relaxes blood vessels), apply 1 inch topically three times a day as needed for high blood pressure associated with autonomic dysreflexia (elevated blood pressure & heart rate). Remove when symptoms are alleviated. If symptoms recur within 24 hours, may reapply but seek medical attention. -Polyethylene glycol (treatment for constipation) 3350 oral powder mix 1 capful (17 grams) and drink every day as needed for constipation (mix in 8 ounces of juice or water). -Simethicone (antacid) 80 mg chewable tablet, chew and swallow one tablet orally twice a day as needed for gas. -Bisacodyl (stimulant laxative) 10 mg rectal suppository, insert 1 suppository into rectum every day for constipation. -Cefpodoxime Proxetil (antibiotic) 100 mg tab, take one tablet orally every day. -Enoxaparin (prevention of blood clots) 40 mg/0.4 ml (milliliter) injectable syringe 0.4 ml, inject 40 mg subcutaneously every day. -Omeprazole oral tablet delayed release 20 mg, 1 tab daily per mouth was listed on said plan of care but with a different dose when compared to the hospital discharge instruction sheet. Hospital discharge instructions evidenced Omeprazole 20 mg EC (enteric coated) cap take two capsules orally every day on an empty stomach before meal, 40 mg compared to plan of care dose of 20 mg. Patient #3's medication profile mirrored the medications on Patient #3's plan of care. Patient #3's clinical record/resumption of care note dated 8-12-2020 by Registered Nurse, Employee D, listed Lovenox (Enoxaparin) and Cefpodoxime Proxetil as daily for 14 days only. The clinical record failed to evidence contact of the physician for clarification of the above hospital discharge medications.			

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	Further review of Patient #3's plan of care dated 9-22-2020 to 11-20-2020 failed to evidence a complete list of DME (durable medical equipment) & supplies. Said plan of care listed a wheel chair, elevated toilet seat, and tub/shower bench. On 10-7-2020 at 10:00, during a home visit with Patient #3, a specially modified wheeled chair used for administration of enemas and bowel program as well as rolling into the shower was observed in use. An electric wheel chair, over-the-bed tables, gel chair mattress, bed air mattress, sliding board, Hoyer lift, and miscellaneous ileal conduit supplies were observed in the home and not listed in the plan of care dated 9-22-2020 to 11-20-2020. Hospital discharge instructions/orders dated 8-10-2020 listed the following DME/supply items for the patient: gauze pad 4 inch x 4 inch, 8-ply nonsterile, for ostomy care as needed; alcohol prep pads, bandage, elastic, adhesive 1 inch x 5 yards as directed; dressing, mepilex border 8.7 x 9.8 inch for wound care to sacrum; dressing mepilex border 9.2 x 9.2 inch for wound care to sacrum as needed; underpad, bed 30 inch x 36 in; bag, urinary drainage for urostomy three times a week; adapter urostomy drain tube; barrier, adaptive ring; barrier ostomy H#7331 as needed; Karaya (skin protectant) powder; skin prep wipes; & gloves. Patient #3's plan of care dated 9-22-2020 to 11-20-2020, failed to evidence the incorporation of these items and/or clarification with the physician regarding their usage. Review of Registered Nurse, Employee D's clinical note dated 8-14-2020 stated Patient #3 utilized CPAP (continuous positive airway pressure breathing device) at HS (night) and wore			

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	15K159	A. BUILDING 00 B. WING	10/13/2020

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	compression stockings on both lower extremities 24 hours/day. The plan of care failed to evidence the inclusion of both of these items into said plan of care. Review of Patient #3's clinical record evidenced Patient #3's use of Enemeez, mini laxative, 1-3 prior to bowel program. The said plan of care failed to evidence the incorporation of Enemeez. Review of Patient #3's plan of care dated 9-22-2020 to 11-20-2020 evidenced orders for SN (skilled nursing) to provide bowel regimen but failed to evidence the specific details of Patient #3's bowel regimen that was included in order dated 8-10-2020 which stated: "Bowel and Bladder 3 x week: Order RN to assist with bowel care that involves Enemeez and digital stimulation x 3 weekly. Veteran to also have urostomy care/change 2 x weekly." This order and specific details related to Patient #3's bowel regiment failed to be incorporated into the plan of care dated 9-22-2020 to 11-20-2020. On 10-7-2020 at 10:00, during a home visit with Patient #3, this order was seen being performed by Registered Nurse, Employee D. Patient #3's plan of care dated 9-22-2020 to 11-20-2020 failed to evidence the additional services of attendant care also being provided by agency of 2 hours per day, 7 days per week, as approved by Indiana Family Social Services Administration. During an interview on 10-13-2020 at 4:00, the Administrator and Clinical Manager acknowledged the above findings and when queried, provided nothing further. 3. Review of Patient #5's clinical record, start of			

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	care 8-5-19, a plan of care certification period of 9-28-2020 to 11-26-2020, diagnosis of multiple sclerosis (nervous system disease affecting vision, balance & muscle control) with orders of "SN (skilled nurse) to administer Methylprednisolone (steroid to reduce inflammation) IV 1 day a month per MD order." The plan of care failed to evidence specific skilled nursing orders related to route of administration, access type, access care, dressings, IV flushes-saline and/or heparin (anticoagulant), and complete medication dose/order that included strength, dilution, solution type, mode & rate of administration, and duration of infusion. Patient #5's said plan of care failed to evidence specific IV supplies and DME (durable medical equipment) and vendor for IV medication and associated supplies such as dressings, needles, tubing, and/or infusion pump. Patient #5's said plan of care evidenced the following unclear, confusing medication order: "Methylprednisolone sodium succ (succinate) solution reconstituted 1000 mg - 250 mg/100 ml - infused - over 45 min - 1 hour once monthly - intravenously - ongoing." This order failed to evidence clarity regarding the ordered dose, if reconstituted, who was reconstituting and with what and how much, total volume & dose to be administered, route of administration (peripheral IV or port), use of flush solutions such as saline or heparin, and mode of administration. On 10-9-2020 at 3:00 p.m., the Clinical Manager was queried to interpret the medication order from Patient #5's plan of care, certification period of 9-28-2020 to 11-26-2020, and stated she could not. On 10-13-2020 at 9:27 a.m., the Clinical Supervisor stated she had contacted Patient #5's primary			

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	physician and clarified Patient #5's IV order and provided the written order documentation. During an interview on 10-13-2020 at 4:00, the Administrator and Clinical Manager acknowledged the above findings and when queried, provided nothing further. 17-13-1(a)(1)			
G 0576 Bldg. 00	484.60(a)(3) All orders recorded in plan of care All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the agency failed to ensure all written/verbal orders were incorporated into the plan of care for 1 (Patient #3) of 9 patient records reviewed. Findings include: Review of an undated agency policy titled: "Plan of Care-CMS #485 and Physician Orders" stated: ". . . Each patent must receive an individualized written plan of care, including any revisions or additions. . ." Review of Patient #3's clinical record evidenced a verbal order dated 8-10-2020 which stated: "Bowel and Bladder 3 x week: Order RN to assist with bowel care that involves Enemeez and digital stimulation x 3 weekly. Veteran to also have urostomy care/change 2 x weekly." On 10-7-2020 at 10:00, during a home visit with Patient #3, the above stated order was seen being performed by Registered Nurse, Employee D. This order dated 8-10-2020, failed to be incorporated into the plan of care dated 9-22-2020	G 0576	**G576** **1.** The Director of Clinical Services received a verbal order to amend current plans of care to include all current orders for patients #3 and #5, in order to maintain compliance with policy C580. **EXHIBIT F.** **2.** The Director of Clinical Services to in-service all nursing staff on the requirement to incorporate all written and verbal orders into the Plan of Care. The in-service will include the following policies C-660 (highlighting, “The Care Plan shall be reviewed, evaluated and revised (minimally every sixty (60) days and as needed.”C-580 Plan of Care (highlighting, “HHA will develop a plan of care, specific to each patient’s needs and containing all required elements.”) **EXHIBIT A** **3**. The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure	11/06/2020

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	to 11-20-2020. During an interview on 10-13-2020 at 4:00, the Administrator and Clinical Manager acknowledged the above findings and when queried, provided nothing further. 17-14-1(a)(1)(C)		that this deficiency. Is corrected and will not recur. **4**. The date of corrective action to be completed by 11/6/2020.	
N 0000 Bldg. 00	This visit was for a State Licensure survey of a home health agency. Three (3) complaints were investigated in conjunction with the re-licensure survey. Complaint #: IN00290685: substantiated-without additional findings Complaint #: IN00277830: unsubstantiated-lack of sufficient evidence Complaint #: IN00284431: unsubstantiated-lack of sufficient evidence Facility #: 014228 CCN: 15K159 Survey dates: 10-6, 10-7, 10-8, 10-9, and 10-13-2020 Skilled Unduplicated Admissions in prior 12 months: 42 Current Census: Skilled Services: 27 Unskilled:	N 0000		

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	217 Total: 244 Record Review: Record reviews with home visit: 4 Record review only: 5 Total clinical records reviewed: 9			
N 0529 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure 60 day summaries were not repetitive and contained an accurate reflection of the patient's treatments & procedures for 1 (Patient 3) of 9 clinical records reviewed. Findings included: Review of Patient #3's clinical record on 10-8-2020, start of care 3-31-2020, evidenced a hospital discharge on 8-10-2020 with the diagnosis of bladder cancer with a procedure of cystoprostatectomy with loop (removal of bladder and creation of an ileal conduit-- creation of a	N 0529	**N529** **1.** The Director of Clinical Services obtained an order to amend patient's current plan of care, explaining the RNCM entered outdated information on the care plan, and specified patient no longer uses catheters, as he had a cystectomy and ileal conduit placement on 8/3/2020. **EXHIBIT G.** **2.** The Director of Clinical Services to in-service all nursing staff on the importance and the requirement of	11/06/2020

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	small internal bladder using the small intestines with opening through abdominal wall - stoma) on 8-3-2020. A review of the plan of care for the certification period of 9-22-2020 to 11-20-2020, included a 60 summary narrative that failed to evidence documentation of patient's hospitalization, surgical incision, condition of ileal conduit stoma and function. The same 60 day summary stated ". . . Client can straight cath (catheter used to empty one's bladder) and uses a Texas catheter (an external catheter device used to contain urine when bladder leaks) during the day with a leg bag and a Foley catheter (indwelling catheter inserted into the bladder) during the night. . ." During an interview with Patient #3, on 10-8-2020 at 2:10 p.m., Patient #3 stated he no longer used any catheters and leg bags for urine control since his bladder was removed (8-3-2020) and the ostomy (artificial opening through abdominal wall for Patient #3's urine) placed. During an interview on 10-13-2020 at 4:00, the Administrator and Clinical Manager acknowledged the above findings and when queried, provided nothing further.		reassessing clients post hospitalization and including and significate changes in their condition, diagnosis or treatments. Instruction not to “copy and paste” from previous 60 day summaries. The in-service will include the following policy C-155 Client Reassessment/Update of Comprehensive Assessment (highlighting, “Reassessments must be done at least: Within forty-eight (48) hours of (or knowledge of) client return from hospital admission of more than twenty-four (24) for any reason other than diagnostic testing.”). **EXHIBIT A** **3.** The Director of Clinical Services will be responsible for monitoring these corrective actions to ensure that this deficiency. Is corrected and will not recur. **4**. The date of corrective action to be completed by 11/6/2020.	