| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15K164 | A. BUILDING _____ B. WING _____ | R-C 03/30/2021 |

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| {G 000} | INITIAL COMMENTS<br><br>This was a federal and state revisit for a survey originally conducted on 11/20/21.<br><br>Survey Dates: March 25, 26, 29, 30; 2021<br><br>Facility number: 014207<br>Provider number: 15K164<br><br>Current census: 17<br><br>Apple tree Home Health Care Services, LLC continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning March 30, 2021 to March 30, 2023 for being found out of compliance with the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment of Patients and 484.65 Quality assessment and performance improvement.<br><br>These deficiencies reflects State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings. | {G 000} | | |
| {G 374} | Accuracy of encoded OASIS data<br>CFR(s): 484.45(b)<br><br>Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment.<br>This Standard is not met as evidenced by:<br>Based on observation, record review, and interview, the registered nurse (RN) failed to ensure outcome and assessment information set (OASIS) questions were answered accurately for 3 of 3 patients with observed home visits (#1, 2, 3).<br><br>Findings include: | {G 374} | | |

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

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| {G 374} | Continued From page 1<br>1. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformity of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy, and constipation; and orders for the skilled nurse to visit 8 hours per day, 7 days per week through the certification period.<br><br>A home visit observation was completed on 3/26/21 at 8:47 AM with patient #1 and licensed practical nurse (LPN) E. The patient was observed lying in bed, not guarded, no facial grimaces, or moaning to indicate discomfort, and was non-verbal and unable to respond to the LPN during care.<br><br>The start of care comprehensive assessment dated 3/13/21 indicated OASIS question M1242, that the patient had pain daily, but not constant; question M1311 was left blank"; and questions M1710, M1720, and M1730 required the patient to respond and assign a number that coincided with the answer, (patient was non-verbal and could not have answered).<br><br>During an interview with patient #1's mother on 3/29/21 at 7:52 PM, she indicated the patient non-verbal.<br><br>2. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (nut not limited to) pneumonia, pressure ulcer of the sacrum, | {G 374} | | |

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| {G 374} | Continued From page 2<br>Huntington's disease, dementia, and other malaise.<br><br>A home visit observation was completed on 3/26/21 at 10:15 AM with patient #3 and licensed home health aide (HHA) F. The patient was observed having a G-tube with feeding pump and enteral feeding (introducing nutrients through a tube into the stomach or small intestine) running and a foley catheter.<br><br>The start of care comprehensive assessment dated 3/13/21 indicated OASIS question M1030 (therapies patient receives at home) that the patient had "None of these," but should have marked "enteral nutrition" as the patient has a G-tube. Additionally, OASIS question 1610 indicated the patient was incontinent, but should have marked that the patient had a catheter.<br><br>During an interview during the home visit on 3/26/21 at 10:16 AM, the spouse of patient #2 stated the patient was NPO and the only liquid by mouth was when brushing teeth or sponging mouth.<br><br>3. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified health status, and BMI of 60-69 and orders for home health aide (HHA) services 2 hours per day, 7 days per week to "assist patient with light housekeeping, meal prep, and laundry ...assist patient with safe ambulation ... assist pt [patient] to maintain a safe comfortable home environment." Lastly, the plan of care stated, | {G 374} | | |

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| {G 374} | Continued From page 3<br>"mobilizes with the assist of his cane."<br><br>A home visit observation was completed on 3/26/21 at 11:45 AM with registered nurse (RN) G and patient #3. The patient's residence was observed in a group home (housing for adults with intellectual and developmental disabilities live as independently as possible). There were stairs to the entrance of the house. A narrow doorway was observed from the living area to the kitchen area and another stairway. The patient was observed ambulating unassisted without persons or equipment, and was able to sit, stand, take shoes off all independently.<br><br>The start of care comprehensive assessment dated 3/13/21 stated on OASIS question M1100 that the patient lived alone around the clock (should have been marked that lived in a congregate situation around the clock). OASIS question M1840 regarding the ability for the patient to get to and from the toile safely and transfer on and off was answered "when reminded, assisted, or supervised by another person," but should have been marked "able to get to and from the toilet and transfer independently with or without a device.<br><br>During an interview on 3/30/21 at 3:12 PM person F (behavior analyst for patient #3) stated the patient lives in the group home as the patient can be very manipulative at times with occasional behaviors. Person F stated that the patient did most bathing by self, had a fear of falling, and would require assistance with hard-to-reach areas as the patient is large in size.<br><br>4. During an interview on 3/30/21 at 1:35 PM, the administrator was asked if the comprehensive assessment and OASIS info should be complete | {G 374} | | |

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| {G 374} | Continued From page 4<br>and accurate, she stated "very much so." | {G 374} | | |
| {G 484} | Document complaint and resolution<br>CFR(s): 484.50(e)(1)(ii)<br><br>(ii) Document both the existence of the complaint and the resolution of the complaint; and<br>This Element is not met as evidenced by:<br>Based on record review and interview, the agency failed to document both the existence and resolution of all complaints made to the agency for 2 of 4 interviews conducted patient families (#2, 4).<br><br>Findings include:<br><br>1. An undated agency policy titled "Client/Family Complaint/Grievance Policy," stated "... Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file...."<br><br>2. The complaint log was reviewed on 3/29/21 at 9:14 AM. The complaint log contained 1 (one) complaint from February of 2020. The complaint log failed to evidence any complaints from the families of patient's #2 and #4.<br><br>3. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21.<br><br>During an interview on 3/26/21 at 10:15 AM, the spouse of patient #2 stated he has called and complained about things from time to time, always speaks to and gets immediate resolution from RN G.<br><br>4. The clinical record of patient #4 was reviewed on 3/29/21 and indicated a start of care date of | {G 484} | | |

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| {G 484} | Continued From page 5<br>2/14/20 and a tentative discharge date of 3/31/21.<br><br>5. During an interview on 3/25/21 at 10:54 AM, HHA L (patient #4's daughter) stated she had made a complaint with the alternate administrator and the director of nursing about the agency not providing skilled nursing care for patient #4. She indicated the complaint was made approximately 2/22/21.<br><br>17-12-3(c)(2) | {G 484} | | |
| {G 510} | Comprehensive Assessment of Patients<br>CFR(s): 484.55<br><br>Condition of participation: Comprehensive assessment of patients.<br>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.<br>This Condition is not met as evidenced by:<br>Based on observation, record review, and interview, the registered nurse (RN) failed to ensure all components were present on the comprehensive assessment.<br><br>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.<br><br>Findings include:<br><br>The RN failed to ensure the comprehensive assessment reflected the patient's current health | {G 510} | | |

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| {G 510} | Continued From page 6<br>psychosocial, functional, and cognitive status (See Tag G 528).<br><br>The RN failed to ensure the comprehensive assessment contained the patient's goals, and care preferences, as well as information to demonstrate progress toward achievement of goals identified by the patient and measurable outcomes identified by the agency (See Tag G 530).<br><br>The RN failed to ensure the comprehensive assessment contained information regarding the patient's medical, nursing, rehabilitative, social, and discharge planning needs (See Tag G 534).<br><br>The RN failed to ensure the comprehensive assessment contained information regarding the patient's primary caregiver, or lack of one, and their willingness and ability to provide care, availability, and schedule (See Tag G 538).<br><br>The RN failed to ensure the comprehensive assessment reflected the patient's representative, if any (See Tag G 540). | {G 510} | | |
| {G 528} | Health, psychosocial, functional, cognition<br>CFR(s): 484.55(c)(1)<br><br>The patient's current health, psychosocial, functional, and cognitive status;<br>This Element is not met as evidenced by:<br>Based on observation, record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment reflected the patient's current health psychosocial, functional, and cognitive status for 3 of 3 patients with observed home visit observations (#1, 2, 3).<br><br>Findings include: | {G 528} | | |

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| {G 528} | Continued From page 7<br>1. An undated agency policy titled "Comprehensive client assessment," Policy # C-145 stated, "...The comprehensive assessment must accurately reflect the client's status, and must include at minimum, the following information: The client's current health, psychosocial, functional, and cognitive status ...."<br><br>2. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; and orders for the skilled nurse to visit 8 hours per day, 7 days per week through the certification period.<br><br>A home visit observation was completed on 3/26/21 at 8:47 AM with patient #1 and licensed practical nurse (LPN) E. The patient was observed lying in bed, not guarded, no facial grimaces, or moaning to indicate discomfort, and was non-verbal, had contractures (fixed tightening of muscle, tendons, ligaments, or skin which prevents normal movement of the associated body part) of extremities, had a gastrostomy tube (G-tube- surgically placed device used to give direct access to your child's stomach for supplemental feeding, hydration or medications) and jejunostomy tube (J-tube-plastic tube placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine), and the patient was unable to respond to the LPN during care. | {G 528} | | |

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| {G 528} | Continued From page 8<br><br>The start of care comprehensive assessment dated 3/13/21 failed to list contractures as one of the patient's functional limitations, stated the patient was independent with finances, left allergies, the nutritional risk, and musculoskeletal assessments blank, marked the presence of edema but failed to indicate where the edema was located, marked the nutritional status as "WNL [within normal limits]" but patient had G-tube and J-tube, documented patient was on a regular no concentrated sweets heart healthy diet, and mental orientation was marked as oriented to person, place, and time (yet patient had cognitive disabilities and was non-verbal).<br><br>During an interview with patient #1's mother on 3/29/21 at 7:52 PM, she indicated the patient was NPO (nothing by mouth), received all fluids and medications in the G-tube, and enteral feedings by feeding pump to the J-tube at 75 milliliters (ml) per hour, was non-verbal and made noises like that of a baby, had allergies to beestings only, and has never had a catheter or cystostomy.<br><br>3. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (nut not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise.<br><br>The start of care comprehensive assessment dated 3/13/21 identified the patient had at least 2 pressure ulcers but failed to indicate a detailed assessment of the patient's wounds (measurements, staging, wound characteristics, orders, wound odor ect.). | {G 528} | | |

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| {G 528} | Continued From page 9<br><br>During an interview on 3/29/21 at 8:02 PM, the spouse of patient #2 stated the patient had several wounds and skin issues which were managed by Hospice E.<br><br>4. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified health status, and BMI of 60-69 and orders for home health aide (HHA) services 2 hours per day, 7 days per week to "assist patient with light housekeeping, meal prep, and laundry ...assist patient with safe ambulation ... assist pt [patient] to maintain a safe comfortable home environment." Lastly, the plan of care stated, "mobilizes with the assist of his cane."<br><br>A home visit observation was completed on 3/26/21 at 11:45 AM with registered nurse (RN) G and patient #3. The patient's residence was observed in a group home (housing for adults with intellectual and developmental disabilities live as independently as possible). There were stairs to the entrance of the house. A narrow doorway was observed from the living area to the kitchen area and another stairway. The patient was observed ambulating unassisted without persons or equipment, and was able to sit, stand, take shoes off all independently.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to check the boxes "Stairs" and "Narrow of obstructed walkway" in the safety/sanitation section. The assessment of the endocrine system failed to evidence if the patient | {G 528} | | |

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| {G 528} | Continued From page 10<br>was independent with a glucometer, if blood sugar checks were obtained by himself or group home staff. Additionally, it stated the patient was on an oral medication for the control of diabetes. The fall assessment was blank and did not identify (per assessment choices) Incontinence, cognitive impairment, 3 or more existing diagnoses, or poly pharmacy which all should have been checked. The section titled "orders for discipline & treatment," were left blank (to document which discipline, and frequencies needed). The assessment failed to evidence if the patient required skilled intervention.<br><br>5. During an interview on 3/30/21 at 2:56 PM person F (behavior analyst for patient #3) stated the patient lives in the group home as the patient can be very manipulative at times with occasional behaviors. Person F stated that the patient had not been on an oral glycemic for 2 or 3 years, doesn't use or have a cane, has only occasional incontinence and usually it is behavioral, and do most bathing by self, but had a fear of falling and would require assistance with hard-to-reach areas as the patient is large in size.<br><br>6. During an interview on 3/30/21 at 1:35 PM, the administrator was asked if the comprehensive assessment and OASIS info should be complete and accurate, she stated "very much so."<br><br>IAC 410 17-14-1(a)(1)(b) | {G 528} | | |
| {G 530} | Strengths, goals, and care preferences<br>CFR(s): 484.55(c)(2)<br><br>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 | {G 530} | | |

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| {G 530} | Continued From page 11<br>by the HHA;<br>This Element is not met as evidenced by:<br>Based on record review and interview, the registered nurse (RN), failed to ensure the comprehensive assessment contained the patient's goals, and care preferences, as well as information to demonstrate progress toward achievement of goals identified by the patient and measurable outcomes identified by the agency for 3 of 3 patients with observed home visit observations (#1, 2, 3).<br><br>Findings include:<br><br>1. An undated agency policy titled "Comprehensive client assessment," Policy # C-145 stated, "...The comprehensive assessment must accurately reflect the client's status, and must include at minimum, the following information: ... The client's strengths, goals, and care preferences, including information that may be used to demonstrate the client's progress toward achievement of the goals identified by the client and the measurable outcomes identified by the agency...."<br><br>2. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheostomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; and orders for the skilled nurse to visit 8 hours per day, 7 days per week through the certification period. | {G 530} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15K164 | A. BUILDING _____ B. WING _____ | R-C 03/30/2021 |

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| APPLE TREE HOME HEALTH CARE SERVICES, LLC | 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220 |

| (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 |
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| {G 530} | Continued From page 12<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's/caregivers' goals, care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.<br><br>3. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (nut not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's/caregivers' goals, care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.<br><br>4. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified health status, and BMI of 60-69.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's/caregivers' goals, care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency. | {G 530} | | |

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| {G 530} | Continued From page 13<br>5. During an interview on 3/30/21 at 1:35 PM, the administrator stated the comprehensive assessment should contain the patients' strengths, care preferences, and goals they have set for themself. | {G 530} | | |
| {G 534} | Patient's needs<br>CFR(s): 484.55(c)(4)<br><br>The patient's medical, nursing, rehabilitative, social, and discharge planning needs;<br>This Element is not met as evidenced by:<br>Based on record review and interview, the registered nurse (RN), failed to ensure the comprehensive assessment contained the patient's goals, and care preferences, as well as information to demonstrate progress toward achievement of goals identified by the patient and measurable outcomes identified by the agency for 3 of 3 patients with observed home visit observations (#1, 2, 3).<br><br>Findings include:<br><br>1. An undated agency policy titled "Comprehensive client assessment," Policy # C-145 stated, "...The comprehensive assessment must accurately reflect the client's status, and must include at minimum, the following information: ... The client's strengths, goals, and care preferences, including information that may be used to demonstrate the client's progress toward achievement of the goals identified by the client and the measurable outcomes identified by the agency...."<br><br>2. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, | {G 534} | | |

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| {G 534} | Continued From page 14<br>Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheostomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; and orders for the skilled nurse to visit 8 hours per day, 7 days per week through the certification period.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's/caregivers' goals, care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.<br><br>3. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (nut not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's/caregivers' goals, care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.<br><br>4. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified | {G 534} | | |

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| {G 534} | Continued From page 15<br>health status, and BMI of 60-69.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's/caregivers' goals, care preferences, information to demonstrate progress toward achievement of goals identified by the patient, or measurable outcomes identified by the agency.<br><br>5. During an interview on 3/30/21 at 1:35 PM, the administrator stated the comprehensive assessment should contain the patients' strengths, care preferences, and goals they have set for themself. | {G 534} | | |
| {G 536} | A review of all current medications<br>CFR(s): 484.55(c)(5)<br><br>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.<br>This Element is not met as evidenced by:<br>Based on observation, record review, and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained a complete review of medications and medication lists were accurately maintained for 3 of 3 patients with observed home visit observations (#1, 2, 3).<br><br>Findings include:<br><br>1. An undated agency policy titled "Comprehensive client assessment," Policy # C-145 stated, "...The comprehensive assessment must accurately reflect the client's status, and must include at minimum, the following information: ...A review of all medications the | {G 536} | | |

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| {G 536} | Continued From page 16<br>client is currently...."<br><br>2. MCCONNELL, E., 2002. Administering medication through a gastrostomy tube, Nursing 2002: December 2002 - Volume 32 - Issue 12 - p 22, stated "...Give liquid medications whenever possible to prevent clogging and enhance absorption. Dilute with at least 30 ml [milliliters] of water. ... If a tablet can be safely crushed, use a pill crusher to grind it to a fine powder and mix it with 30 to 50 ml of warm water. ... Don't use a GT to administer ... sustained-release tablets or capsules ...."<br><br>3. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; orders for the skilled nurse to visit 8 hours per day, 7 days per week for (but not limited to) "SN to administer medications through G tube." Additionally, medications listed on the plan of care included: albuterol sulfate (inhaled), clonazepam (by mouth), "diazepam 5 mg [milligram]- 7.5 mg-10 mg rectal kit once as needed for prolongue [sic] seizure per rectum," dulcolax laxative (per rectum), loratadine (by mouth), "miralax 17 gram/dose oral powder take 17G [gram] daily mixed with 8 oz. [ounce] water, juice, soda, coffee or tea by mouth," montelukast (by mouth), Phenobarbital (by mouth), pulmicort (inhaled), tegretol (by mouth), and topiromate (by mouth), | {G 536} | | |

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| {G 536} | Continued From page 17<br>and failed to evidence if the patient had any drug allergies.<br><br>A home visit observation was completed on 3/26/21 at 8:47 AM with patient #1 and licensed practical nurse (LPN) E. The patient was observed lying in bed, had a gastrostomy tube (G-tube- surgically placed device used to give direct access to your child's stomach for supplemental feeding, hydration or medications) and jejunostomy tube (J-tube-plastic tube placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine). LPN was observed prepping and administering medications into the G-tube.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to delineate the route medications were to be given, allergies to medications, or the interventions the SN was responsible for related to medication administration.<br><br>During an interview with patient #1's mother on 3/29/21 at 7:52 PM, she indicated the patient was NPO (nothing by mouth), received all fluids and medications in the G-tube, and enteral feedings by feeding pump to the J-tube, and the only known allergy for the patient was beestings.<br><br>4. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (but not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and medication orders (but not limited to) "dextroamphetamine 20 mg oral capsule, extended-release Admin [administer] 1 cap [capsule] daily per GT [g-tube] | {G 536} | | |

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| {G 536} | Continued From page 18<br>... Pantoprazole 40 mg oral delayed release tablet Admin 1 tab daily per GT...." The record failed to evidence the skilled nurse sought out clarification from the physician for extended release (sustained release) medications to be crushed and put into G-tube.<br><br>5. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified health status, and BMI of 60-69 with as needed (PRN) medication orders (but not limited to) cetirizine, loperamide, lorazepam, nystatin bicarbonate, and promethazine all which failed to evidence an indication for use.<br><br>6. During an interview on 3/30/21 at 1:35 PM, the administrator stated that all PRN medications should have an indication for their use. | {G 536} | | |
| {G 538} | Primary caregiver(s), if any<br>CFR(s): 484.55(c)(6)(i,ii)<br><br>The patient's primary caregiver(s), if any, and other available supports, including their:<br>(i) Willingness and ability to provide care, and<br>(ii) Availability and schedules;<br>This Element is not met as evidenced by:<br>Based on record review the registered nurse (RN) failed to ensure the comprehensive assessment contained information regarding the patient's primary caregiver, or lack of one, and their willingness and ability to provide care, availability, and schedule 3 of 3 patients with observed home visit observations (#1, 2, 3).<br><br>Findings include: | {G 538} | | |

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| {G 538} | Continued From page 19<br><br>1. An undated agency policy titled "Comprehensive client assessment," Policy # C-145 stated, "...The comprehensive assessment must accurately reflect the client's status, and must include at minimum, the following information: ...The client's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, and their availability and schedules...."<br><br>2. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; and orders for the skilled nurse to visit 8 hours per day, 7 days per week through the certification period.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's primary caregiver, their willingness and ability to provide care, availability, and schedules.<br><br>3. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (nut not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise, and orders for home health aide (HHA) services 8 hours per day, 7 days per week. | {G 538} | | |

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| {G 538} | Continued From page 20<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's primary caregiver, their willingness and ability to provide care, availability, and schedules.<br><br>4. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified health status, and BMI of 60-69.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence the patient's primary caregiver, their willingness and ability to provide care, availability, and schedules. | {G 538} | | |
| {G 540} | The patient's representative (if any); CFR(s): 484.55(c)(7)<br><br>The patient's representative (if any);<br>This Element is not met as evidenced by:<br>Based on record review, the registered nurse (RN) failed to ensure the comprehensive assessment reflected the patient's representative, if any, for 5 of 5 records reviewed (#1, 2, 3, 4, 5).<br><br>Findings include:<br><br>1. An undated agency policy titled "Comprehensive client assessment," Policy # C-145 stated, "...The comprehensive assessment must accurately reflect the client's status, and must include at minimum, the following information: ...The client's representative, if any...."<br><br>2. The clinical record of patient #1 was reviewed | {G 540} | | |

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| {G 540} | Continued From page 21<br>on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence if the patient had a patient representative or not.<br><br>3. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses as pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise.<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence if the patient had a patient representative or not.<br><br>4. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 and stated patient "lives in a congregate setting."<br><br>A home visit observation was completed on 3/26/21 at 11:45 AM with registered nurse (RN) G and patient #3. The patient's residence was observed in a group home (housing for adults with intellectual and developmental disabilities live as independently as possible). | {G 540} | | |

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| {G 540} | Continued From page 22<br><br>The start of care comprehensive assessment dated 3/13/21 failed to evidence if the patient had a patient representative or not.<br><br>An authorization to release medical information was completed and signed by the patient and RN G on 3/13/21 which listed the group home manager and program coordinator as able to receive all information regarding patient #3.<br><br>During an interview on 3/30/21 at 3:12 PM person F (behavior analyst for patient #3) stated the patient lives in the group home as the patient can be very manipulative at times with occasional behaviors.<br><br>5. The clinical record of patient #4 was reviewed on 3/29/21 and indicated a start of care date of 2/14/20 and a tentative discharge date of 3/31/21. The last plan of care in the record was dated 12/21/20-2/18/21 (no current plan of care) which indicated diagnoses of (but not limited to); Hypertension and Diabetes.<br><br>The recertification comprehensive assessment dated 12/18/20 failed to evidence if the patient had a patient representative or not.<br><br>The clinical record of patient #5 was reviewed on 3/29/21 and indicated a start of care date of 2/14/20 and a discharge date of 3/20/21. The record contained a plan of care for the certification period of 2/8/21-4/8/21 which indicated a primary diagnoses of heart failure.<br><br>The recertification comprehensive assessment dated 12/9/20 failed to evidence if the patient had a patient representative or not. | {G 540} | | |
| G 564 | Discharge or Transfer Summary Content | G 564 | | |

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| (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 |
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| G 564 | Continued From page 23<br>CFR(s): 484.58(b)(1)<br><br>Standard: Discharge or transfer summary content.<br>The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.<br>This Standard is not met as evidenced by:<br>Based on record review, the agency failed to ensure a transfer/discharge summary was sent to the patient's healthcare practitioner post discharge for 1 of 1 discharged patient records reviewed (#5).<br><br>Findings include:<br><br>The clinical record of patient #5 was reviewed on 3/29/21 and indicated a start of care date of 2/14/20 and a discharge date of 3/20/21. The record contained a plan of care for the certification period of 2/8/21-4/8/21 which indicated a primary diagnoses of heart failure.<br><br>A comprehensive discharge assessment was completed by the registered nurse on 3/20/21 but failed to evidence any transfer/discharge summary. | G 564 | | |
| {G 574} | Plan of care must include the following<br>CFR(s): 484.60(a)(2)(i-xvi)<br><br>The individualized plan of care must include the following:<br>(i) All pertinent diagnoses;<br>(ii) The patient's mental, psychosocial, and cognitive status;<br>(iii) The types of services, supplies, and equipment required; | {G 574} | | |

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| {G 574} | Continued From page 24<br>(iv) The frequency and duration of visits to be made;<br>(v) Prognosis;<br>(vi) Rehabilitation potential;<br>(vii) Functional limitations;<br>(viii) Activities permitted;<br>(ix) Nutritional requirements;<br>(x) All medications and treatments;<br>(xi) Safety measures to protect against injury;<br>(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.<br>(xiii) Patient and caregiver education and training to facilitate timely discharge;<br>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;<br>(xv) Information related to any advanced directives; and<br>(xvi) Any additional items the HHA or physician may choose to include.<br>This Element is not met as evidenced by:<br>Based on observation, record review and interview, the agency failed to ensure the plan of care contained complete and accurate information regarding all the patient's pertinent diagnoses, allergies, measurable goals and outcomes established by the agency and patient, durable medical equipment (DME) and supplies, the patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific interventions and education, and advance directive information for 3 of 3 patients with observed home visit observations (#1, 2, 3).<br><br>Findings include: | {G 574} | | |

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| {G 574} | Continued From page 25<br>1. An undated agency policy titled "Plan of care," Policy # C-580 stated "...An individualized plan of care signed by the physician shall be required for each client ... The plan of care shall be completed in full to include a. all pertinent diagnosis(es)...specific dietary or nutritional requirements ...medications, treatments, and procedures ...medical supplies and equipment ... treatment goals ... instructions for timely discharge ...."<br><br>2. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21.<br><br>The plan of care failed to evidence accurate diagnoses, accurate cognitive status, all DME and supplies, complete and correct medication information, all functional limitations, complete nutritional requirements, all treatments, allergies (left blank), patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors (completely missing), patient and caregiver education to facilitate timely discharge (completely missing), patient specific interventions and education, measurable goals to meet the needs of the patient, and advance directive information (completely missing) as evidenced by:<br><br>A home visit observation was completed on 3/26/21 at 8:47 AM with patient #1 and licensed practical nurse (LPN) E. The patient was observed lying in bed, not guarded, no facial grimaces, or moaning to indicate discomfort, and was non-verbal unable to communicate or make needs known or answer questions, had contractures (fixed tightening of muscle, tendons, ligaments, or skin which prevents normal movement of the associated body part) of | {G 574} | | |

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| {G 574} | Continued From page 26<br>extremities, had a gastrostomy tube (G-tube-surgically placed device used to give direct access to your child's stomach for supplemental feeding, hydration or medications) and a jejunostomy tube (J-tube-plastic tube placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine), and the patient was non-verbal and unable to respond to the LPN during care. There was no wound dressing was observed on leg, no catheter in place. LPN E was observed prepping and administering medications into the G-tube. DME observed in the home were (but not limited to): hospital bed, suction machine, oxygen concentrator, percussion vest, track system on the ceiling for transfers, kangaroo feeding pump and supplies, syringes, tracheotomy supplies, and gauze.<br><br>The record contained a plan of care for the certification period of 3/13/21-5/12/21. The plan of care listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation. The admission summary on the POC stated "Patient has DX [diagnosis] of Lissencephaly the oldest living patient with this dx in the world." The POC failed to evidence the diagnosis of Lissencephaly (often called smooth brain, is a set of rare brain disorders where the whole or parts of the surface of the brain appear smooth) and evidenced the inaccurate diagnosis of cystostomy (per interview below from caregiver) on the ICD-10 diagnoses. | {G 574} | | |

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| {G 574} | Continued From page 27<br>The plan of care for the certification period of 3/13/21-5/12/21 indicated orders for the skilled nurse to visit 8 hours per day, 7 days per week for "skilled assessment of vital signs, pain management, assess knowledge deficits and teach accordingly. Trach Care and NG [nasogastric] Feeding administration. Assess G tube and J tube potency [sic- should be patency meaning open] daily, skin status, instruct on measures to improve skin integrity. SN to administer medications through G tube. SN to administer feeding through J tube SN to assess clients for hypo/hyperglycemia [low and high blood sugar levels]. SN to evaluate safety concerns and interventions. SN to assess and evaluate patient's mental and emotional status. Evaluate caregiver ability to provide patient's needs. SN to develop individualized plan of care with medication safety and emergency information. SN for wound assessment and management of the laceration wound on left leg ... Manage patients oxygen level on 3 liters of oxygen per mask ... perform trach care and percussions once daily ... percussion machine is set for stimulating cough ... skilled nurse to verify setting during each shift ... feed patient through G-tube/J-tube Continuous feeding for 19 hours daily ... flush G/J tube before and after use ...." Additionally the plan of care listed The orders on the plan of care failed to evidence accurate feeding administration orders (patient did not have an NG tube, nor a G/J tube (together as one)), failed to identify the specific feeding amount, rate, and caloric intake of the enteral feeding, identify medications with accurate routes to be administered, identify reasoning for assessing for hypo/hyperglycemia (no diagnosis of diabetes), specific wound care orders, specific oxygen orders (continuous or as needed), specific percussion vest settings, specific fluid | {G 574} | | |

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| {G 574} | Continued From page 28<br>orders to flush G-tube and J-tube before and after use, and orders for placement check of G-tube prior to use.<br><br>The plan of care for the certification period of 3/13/21-5/12/21 listed the following DME and supplies: "Hospital bed, oxygen, wheelchair ... Chux/underpads, exam gloves, NG tube." The POC failed to evidence all DME observed in the home.<br><br>The plan of care for the certification period of 3/13/21-5/12/21 listed the patient's nutritional requirements as "regular. Heart Healthy. No Concentrated Sweets." The nutritional requirements failed to be accurate as the patient has enteral feedings with a feeding pump into the J-tube, the nutrition type, rate, amount, and caloric intake, as well as fluid/flush amounts and frequency failed to be evidenced on the POC.<br><br>The plan of care for the certification period of 3/13/21-5/12/21 listed the patient's mental status as "Oriented, forgetful." The POC failed to evidence that the patient was non-verbal/unable to communicate thus the nurse would be unable to assess mental orientation or if the patient was forgetful.<br><br>The plan of care for the certification period of 3/13/21-5/12/21 indicated a goal that stated "Client will have absence or control of pain as evidenced by optimal mobility and activity necessary for functioning and performing ADLs...." The goal failed to be measurable and failed to be specific to the patient's needs.<br><br>The start of care comprehensive assessment dated 3/13/21 stated "Patient has Dx of Lissencephaly the oldest living patient with this dx | {G 574} | | |

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| {G 574} | Continued From page 29 | {G 574} | | |

in the world" in the narrative. The assessment failed to evidence the diagnosis of Lissencephaly and evidenced the inaccurate diagnosis of cystostomy, failed to list contractures as a functional limitation, stated the patient had a medical power of attorney, and stated the patient had pain "daily, but not constantly" but failed to evidence what type of pain scale used to determine pain. The assessment failed to evidence a skin/wound assessment with measurements, characteristics, and treatment to be completed and by whom. The assessment listed the patient's nutritional risk (choices were high, moderate, good) as "NaN [sic]," and failed to evidence enteral feedings with patient specific orders. The assessment listed the supplies/DME as: NG tube, hospital bed, oxygen, and wheelchair. The assessment failed to complete an entry for "Orders for Discipline & Treatment ... Conclusions [need for care] ... " and failed to evidence the reason for home care services in order to create the plan of care.

During an interview with patient #1's mother on 3/29/21 at 7:52 PM, she indicated the patient was NPO (nothing by mouth), received all fluids and medications in the G-tube, and enteral feedings by feeding pump to the J-tube at 75 milliliters (ml) per hour, was non-verbal and made noises like that of a baby, patient had a high pain tolerance and that she was the one that could tell (as his mother) if he had pain since he is nonverbal, had allergies to beestings only, and has never had a catheter or cystostomy. Additionally, the mother stated that LPN E cared for the patient at 3 different agencies and was aware of the care that he needed and worked very well with the patient. Lastly, the mother stated the patient received percussion vest treatment twice per day, 10 minutes at 10 MHz

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| {G 574} | Continued From page 30<br>(megahertz) followed by 10 minutes at 12 MHz.<br><br>3. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21.<br><br>The plan of care failed to evidence all diagnoses, accurate cognitive status, all DME and supplies, all functional limitations, complete nutritional requirements, all treatments and orders, allergies (left blank), patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors (completely missing), patient and caregiver education to facilitate timely discharge (completely missing), patient specific interventions and education, measurable goals to meet the needs of the patient, and advance directive information (completely missing) as evidenced by:<br><br>A home visit observation was completed on 3/26/21 at 10:15 AM with patient #2 and licensed home health aide (HHA) F. The patient was observed having a G-tube with feeding pump and enteral feeding (introducing nutrients through a tube into the stomach or small intestine) running and a foley catheter, a hospital bed with air mattress and a nebulizer machine. The patient had wound dressings covering the left hip, right buttock (observed to be a Stage III pressure ulcer when dressing came off and wound was visualized), right lateral ankle, bilateral big toes, left inner foot below the big toe, and left inner foot.<br><br>The record contained a plan of care for the certification period of 3/13/21-5/12/21. The plan of care listed the patients diagnoses as: pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other | {G 574} | | |

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| {G 574} | Continued From page 31 | {G 574} | | |

malaise. The admission summary on the POC stated "[patient #2] also has a diagnosis of GERD [gastroesophageal reflux], Huntington's chorea [hereditary condition that stops parts of the brain working properly over time], dysphagia [difficulty swallowing], anxiety all end stage ...." The POC failed to evidence the diagnosis of dysphagia, GERD, and anxiety.

The plan of care for the certification period of 3/13/21-5/12/21 listed the patient's nutritional requirements as "regular. Heart Healthy. No Concentrated Sweets." The nutritional requirements failed to be accurate as the patient has enteral feedings with a feeding pump into the G-tube, the nutrition type, rate, amount, and caloric intake, as well as fluid/flush amounts and frequency failed to be evidenced on the POC.

The plan of care for the certification period of 3/13/21-5/12/21 listed the following DME and supplies: "Chux/underpads, exam gloves." The POC failed to evidence all DME observed in the home.

The plan of care for the certification period of 3/13/21-5/12/21 listed the patient's mental status as "Oriented, forgetful, disoriented." The POC failed to evidence that the patient was non-verbal/unable to communicate thus the nurse would be unable to assess mental orientation or if the patient was forgetful or oriented/disoriented.

The plan of care for the certification period of 3/13/21-5/12/21 indicated a goal (but not limited to) that stated "Patient receive assist with wound care evidenced by signs of healing." The goal failed to be measurable and failed to be specific to the patient's needs as the agency has no skilled wound care orders.

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| {G 574} | Continued From page 32<br><br>The start of care comprehensive assessment dated 3/13/21 indicated in the nutrition section that the patient had a "fair" appetite and had enteral feedings through a "PEG [percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach]." The assessment also stated the patient had 2 stage II pressure ulcers.<br><br>During an interview during the home visit on 3/26/21 at 10:16 AM, the spouse of patient #2 stated the patient was NPO and the only liquid by mouth was when brushing teeth or sponging mouth, had several wounds which Hospice E managed.<br><br>4. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21.<br><br>The plan of care failed to evidence any cognitive or developmental delay diagnosis, any personal care orders for the HHA to complete, allergies (left blank), patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors (completely missing), patient and caregiver education to facilitate timely discharge (completely missing), patient specific interventions and education, measurable goals to meet the needs of the patient, and advance directive information (completely missing) as evidenced by:<br><br>The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified health | {G 574} | | |

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| {G 574} | Continued From page 33 | {G 574} | | |

status, and BMI of 60-69 and orders for home health aide (HHA) services 2 hours per day, 7 days per week to "assist patient with light housekeeping, meal prep, and laundry ...assist patient with safe ambulation ... assist pt [patient] to maintain a safe comfortable home environment."

A home visit observation was completed on 3/26/21 at 11:45 AM with registered nurse (RN) G and patient #3. The patient's residence was observed in a group home (housing for adults with intellectual and developmental disabilities live as independently as possible). The patient was observed ambulating unassisted without persons or equipment, and was able to sit, stand, take shoes off all independently.

During an interview on 3/26/21 at 11:45 AM, RN G stated the patient has "MR [mental retardation]." This diagnosis failed to be on the plan of care.

During an interview on 3/30/21 at 3:12 PM person F (behavior analyst for patient #3) stated the patient lives in the group home as the patient can be very manipulative at times with occasional behaviors, doesn't use or have a cane, had only occasional incontinence (usually it is behavioral), and did most bathing by self, but had a fear of falling and would require assistance with hard-to-reach areas as the patient is large in size.

5. During an interview on 3/30/21 at 1:35 PM, the administrator stated the plan of care should have everything completed and should contain (but not limited to) the patient's allergies and DME in the home.

IAC 410 17-13-1(a)(1)(C)

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| {G 574} | Continued From page 34<br>IAC 410 17-13-1(a)(1)(D)(ii-xiii) | {G 574} | | |
| G 602 | Communication with all physicians<br>CFR(s): 484.60(d)(1)<br><br>Assure communication with all physicians involved in the plan of care.<br>This Element is not met as evidenced by:<br>Based on record review the agency failed to ensure communication with all physicians involved in 3 of 4 active records reviewed (#1, 2, 4).<br><br>Findings include:<br><br>1. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; and orders for the skilled nurse to visit 8 hours per day, 7 days per week.<br><br>During an interview with patient #1's mother on 3/29/21 at 7:52 PM, she indicated the patient was NPO (nothing by mouth), received all fluids and medications in the G-tube, and enteral feedings by feeding pump to the J-tube, was non-verbal and made noises like that of a baby, had allergies to beestings only, and has never had a catheter or cystostomy. Additionally, the mother stated the patient had several physicians that were involved in his care, including but not limited to, Physicians A (primary care physician), B (neurologist), C | G 602 | | |

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| G 602 | Continued From page 35<br>(pulmonologist), and D (for management of gastric tubes).<br><br>The record failed to evidence that physician's B, C, or D were notified that the patient was admitted to services, or regarding any care orders.<br><br>2. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise and indicated the patient was on hospice. The record failed to evidence any communication with the hospice physician regarding the patient's care.<br><br>3. The clinical record of patient #4 was reviewed on 3/29/21 and indicated a start of care date of 2/14/20 and a tentative discharge date of 3/31/21. The last plan of care in the record was dated 12/21/20-2/18/21. The calendar in the electronic medical record indicated a visit was last completed by home health aide (HHA) L on 3/27/21 for personal care assistant, but no documentation had been completed. The record failed to evidence communication with the physician after that certification period. | G 602 | | |
| {G 608} | Coordinate care delivery<br>CFR(s): 484.60(d)(4)<br><br>Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.<br>This Element is not met as evidenced by:<br>Based on observation and record review, the agency failed to ensure coordination of care was | {G 608} | | |

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| {G 608} | Continued From page 36<br>completed with the group homes where the patients resided for 1 of 1 active patients who lived in a group home (#1).<br><br>Findings include:<br><br>The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 and stated patient "lives in a congregate setting." The record failed to evidence coordination of care between the group home and agency staff.<br><br>A home visit observation was completed on 3/26/21 at 11:45 AM with registered nurse (RN) G and patient #3. The patient's residence was observed in a group home (housing for adults with intellectual and developmental disabilities live as independently as possible).<br><br>An authorization to release medical information was completed and signed by the patient and RN G on 3/13/21 which listed the group home manager and program coordinator as able to receive all information regarding patient #3. | {G 608} | | |
| {G 622} | Name/contact information of clinical manager<br>CFR(s): 484.60(e)(5)<br><br>Name and contact information of the HHA clinical manager.<br>This Element is not met as evidenced by:<br>Based on record review and interview the agency failed to ensure the name and contact information of the director of nursing (clinical manager) was given to the patients in writing for 3 of 3 home visit observations completed (#1, 2, 3).<br><br>Findings include: | {G 622} | | |

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| {G 622} | Continued From page 37<br>1. An undated policy titled "Statement of Rights," Policy C-380 stated, "...If you need assistance, have questions, or have a complaint about our agency, staff or services ... Contact: [employee A], administrator, [employee D], RN, MSN [registered nurse, masters of science in nursing]...." The policy failed to have the name of the newly reported director of nursing (clinical manager).<br><br>2. A home visit observation was conducted with licensed practical nurse (LPN) E on 3/26/21 at 8:47 AM, with patient #1 (start of care 3/13/21). The home folder was viewed and failed to identify employee C's name and contact information as the director of nursing/clinical manager.<br><br>3. A home visit observation was conducted with home health aide (HHA) F on 3/26/21 at 10:15 AM, with patient #2 (start of care 3/13/21). The home folder was viewed and failed to identify employee C's name and contact information as the director of nursing/clinical manager.<br><br>4. A home visit observation was conducted with registered nurse (RN) G on 3/26/21 at 11:45 AM, with patient #3 (start of care 3/13/21). The home folder was viewed and failed to identify employee C's name and contact information as the director of nursing/clinical manager.<br><br>5. During an interview on 3/25/21 at 3:29 PM, RN C stated that she started with the agency in November 2020 as a nurse and the alternate director of nursing, but as of 3/20/21 she was the clinical supervisor. | {G 622} | | |
| {G 640} | Quality assessment/performance improvement CFR(s): 484.65<br><br>Condition of participation: Quality assessment | {G 640} | | |

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| {G 640} | Continued From page 38<br>and performance improvement (QAPI).<br><br>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.<br>This Condition is not met as evidenced by:<br>Based on record review and interview, the agency failed to develop, implement, evaluate, and maintain an effective, ongoing, agency wide, data-driven quality assurance performance improvement program (QAPI), failed to indicate the frequency and method in which quality indicators were to be measured, analyzed, and tracked, failed to show measurable improvement for the quality indicators to improve health, safety, and quality of care, failed to ensure the frequency and detail of the data collection was approved by the governing body, and failed to implement performance improvement projects all with an emphasis on infection control due to the public health emergency related to COVID-19. These practices had the potential to affect all patients.<br><br>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. | {G 640} | | |

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| {G 640} | Continued From page 39<br><br>Findings include:<br><br>An undated agency policy titled "Quality Assessment and performance improvement (QAPI," Policy # B-260 stated "Policy: Agency will develop, implement, evaluate, and maintain an effective, ongoing agency wide, data driven QAPI program ... The agency will maintain documentation of its QAPI program and be able to demonstrate its operation to CMS [Centers for Medicare and Medicaid] ... The program will be capable of showing measurable improvement in indicators that will improve health outcomes, client safety, and quality of care... The frequency and detail of the data collection must be approved by the governing body. ...Performance improvement projects ... The agency must document the quality imp<br><br>During an interview on 3/30/21 at 11:27 AM, the administrator was asked if the agency had any performance improvement projects. The administrator stated the agency was "just doing the audits." When queried if they were doing anything with the data collected, she stated RN D (alternate clinical manager) was supposed to have fixed the errors, and there was no written plan. Lastly, she stated they will use the audit info to compile a list for the QAPI meeting.<br><br>During an interview on 3/30/21 at 10:42 AM, the administrator was queried about the QAPI program changes, she stated that she had not had another meeting since the last survey, but the agency had been doing chart audits to collect information. | {G 640} | | |
| {G 682} | Infection Prevention<br>CFR(s): 484.70(a) | {G 682} | | |

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| {G 682} | Continued From page 40<br>Standard: Infection Prevention.<br>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.<br>This Standard is not met as evidenced by:<br>Based on observation, record review, and interview, the agency failed to ensure all staff followed standard precautions and infection control policies for 3 of 3 home visits observed (# 1, 2, 3).<br><br>Findings include:<br><br>1. An undated agency policy titled "Handwashing/Hand Hygiene," stated "...PURPOSE: To improve hand hygiene practices of agency staff and reduce transmission of pathogenic microorganisms to clients and personnel in the home care setting. ...SPECIAL INSTRUCTIONS ... r. Decontaminate hands after removing gloves ... HAND HYGIENE TECHNIQUE: 1. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry ...."<br><br>2. A home visit observation was conducted with licensed practical nurse (LPN) E on 3/26/21 at 8:47 AM, with patient #1 (start of care 3/13/21). The patient was observed lying in bed and had (but not limited to) a tracheotomy (creating an opening in the neck in order to place a tube into a person's windpipe. The tube is inserted through a cut in the neck below the vocal cords which allows air to enter the lungs.). LPN E was observed providing skilled care. LPN E completed hand hygiene and donned gloves. Patient #1 had copious amounts of secretions | {G 682} | | |

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| {G 682} | Continued From page 41<br>leaking from the tracheotomy and audible secretions. LPN E removed soiled gauze dressing from around the tracheotomy, cleaned secretions off with the soiled gauze and immediately applied a new gauze dressing around the tracheotomy. LPN E failed to remove gloves, complete hand hygiene, and don new gloves prior to placing new dressing.<br><br>3. A home visit observation was conducted with home health aide (HHA) F on 3/26/21 at 10:15 AM, with patient #2 (start of care 3/13/21). HHA F initially donned gloves (but failed to complete hand hygiene first). Then, HHA F washed the patient's back, then rectal area cleaning bowel movement, cleaned the rag in the basin water, and then used the same rag to wash the perineum (dirty to clean, instead of clean to dirty). Lastly, when soiled gloves were removed HHA F failed to complete hand hygiene before donning new gloves.<br><br>4. A home visit observation was conducted with registered nurse (RN) G on 3/26/21 at 11:45 AM, with patient #3 (start of care 3/13/21). During the visit RN G was observed completing hand hygiene with hand sanitizer. RN G rubbed the hand sanitizer in hands some and then shook and flung hands outwards to dry it and failed to rub hands vigorously together until hands were dry. Additionally, glove was dropped on the floor and then donned and patient assessment completed. RN G failed to throw the glove in the trash and obtain a new one.<br><br>5. During an interview on 3/30/21 at 1:35 PM, the administrator stated staff should complete hand hygiene of either hand washing or use of hand sanitizer before donning gloves, and if gloves were dropped on the floor, they should be thrown | {G 682} | | |

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| {G 682} | Continued From page 42<br>away and not used. | {G 682} | | |
| {G 706} | Interdisciplinary assessment of the patient<br>CFR(s): 484.75(b)(1)<br><br>Ongoing interdisciplinary assessment of the patient;<br>This Element is not met as evidenced by:<br>Based on observation, record review, and interview the skilled nurse (SN) failed to complete a thorough and complete assessment of the patient for 2 of 2 skilled nursing assessments observed (#1, 3).<br><br>Findings include:<br><br>1. Constantine, L., MSN, RN, C-FNP. (2004, June 15). Overview of Nursing Health Assessment. Retrieved March 30, 2021, from rn.com<br>"... PULMONARY ASSESSMENT: When examining the pulmonary system ... Inspect the thoracic cage, palpate the thoracic cage, Auscultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth, Auscultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds. ...."<br><br>2. The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for | {G 706} | | |

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| {G 706} | Continued From page 43<br>catheterization), and constipation. The plan of care additionally stated "Respiratory orders for trach [tracheotomy] care: ... Skilled nurse to assess and manage patient's oxygen level. On 3 liters of oxygen per mask ...."<br><br>A home visit observation was completed on 3/26/21 at 8:47 AM with patient #1 (start of care 3/13/21) and licensed practical nurse (LPN) E. The patient was observed lying in bed, not guarded, no facial grimaces, or moaning to indicate discomfort, and was non-verbal, had contractures (fixed tightening of muscle, tendons, ligaments, or skin which prevents normal movement of the associated body part) of extremities, had a gastrostomy tube (G-tube-surgically placed device used to give direct access to your child's stomach for supplemental feeding, hydration or medications) and jejunostomy tube (J-tube-plastic tube placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine), and the patient was unable to respond to the LPN during care. During LPN E's physical assessment, she auscultated the lungs posteriorly (on back) in 4 areas, then anteriorly (in front) in 1 area and then auscultated heart sounds. LPN E failed to auscultate lung sounds in all lung fields and failed to verify oxygen settings. The oxygen concentrator was observed, and setting was set between 3.5 and 4 liters, not 3 liters per order.<br><br>3. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21.<br><br>A home visit observation was completed on 3/26/21 at 11:45 AM with registered nurse (RN) G | {G 706} | | |

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| {G 706} | Continued From page 44<br>and patient #3. The patient's residence was observed in a group home (housing for adults with intellectual and developmental disabilities live as independently as possible). RN G took the patient's vital signs, then auscultation anterior chest in 1 area before auscultating in 4 areas posteriorly. RN G failed to auscultate the lung fields in all areas.<br><br>4. During an interview on 3/30/21 at 1:35 PM, the administrator stated during a nursing assessment all lung fields should be auscultated.<br><br>IAC 17-12-2(g) | {G 706} | | |
| {G 710} | Provide services in the plan of care<br>CFR(s): 484.75(b)(3)<br><br>Providing services that are ordered by the physician as indicated in the plan of care;<br>This Element is not met as evidenced by:<br>Based on record review the skilled nurse (SN) failed to follow the written plan of care for 1 of 1 record review of patients observed with skilled nursing orders (#1).<br><br>Findings include:<br><br>The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; orders for the skilled nurse to visit 8 hours per day, 7 days per | {G 710} | | |

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| {G 710} | Continued From page 45<br>week and SN for (but not limited to) wound assessment and management of the laceration wound on left leg.<br><br>A home visit observation was completed on 3/26/21 at 8:47 AM with patient #1 and licensed practical nurse (LPN) E. LPN E failed to assess or complete any wound care to the patient's leg.<br><br>The record failed to evidence any visits were completed on 3/14/21, 3/20/21, 3/21/21, 3/27/21, and 3/18/21 (did not follow the frequency).<br><br>During an interview on 3/30/21 at 1:35 AM, the administrator stated the skilled nurse should follow the plan of care.<br><br>IAC 17-14-1(a)(2)(F) | {G 710} | | |
| G 726 | Nursing services supervised by RN<br>CFR(s): 484.75(c)(1)<br><br>Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k).<br>This Element is not met as evidenced by:<br>Based on record review and interview, the registered nurse (RN) failed to supervise the licensed practical nurse (LPN) and the agency failed to have a policy for LPN supervision for 1 of 1 record review of patients observed with skilled nursing orders (#1).<br><br>Findings include:<br><br>The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal | G 726 | | |

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| G 726 | Continued From page 46<br>distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; orders for the skilled nurse to visit 8 hours per day, 7 days per week and SN for (but not limited to) wound assessment and management of the laceration wound on left leg.<br><br>Skilled nurse visits were completed on 3/15/21-3/19/21 and 3/22/21-3/26/21 by LPN E. The record failed the evidence communication or supervision between the LPN and RN.<br><br>During an interview on 3/28/21 from 8:02 AM-8:40 AM, the clinical manager (director of nursing) stated LPN supervisory visits were completed every 14 days.<br><br>During an interview on 3/30/21 at 1:35 PM, the administrator stated LPN supervisory visits were completed every 6 months. | G 726 | | |
| G 772 | Documentation of competency evaluation<br>CFR(s): 484.80(c)(5)<br><br>The HHA must maintain documentation which demonstrates that the requirements of this standard have been met.<br>This Element is not met as evidenced by:<br>Based on record review and interview, the agency failed to ensure all home health aides (HHA) had completed a competency evaluation and test which was maintained in the personnel record for 2 of 2 HHA personnel files reviewed (F, H).<br><br>Findings include:<br><br>1. An undated agency policy titled "Home health | G 772 | | |

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| G 772 | Continued From page 47<br>aide services," Policy C-220 stated, "...All individuals providing home health services will be qualified trough training and/or competency evaluations ... Only aides who meet required standards will provide direct care ...."<br><br>2. A review of HHA F's personnel file on 3/30/21 (unknown hire date), failed to evidence a skills competency evaluation or written test.<br><br>3. A review of HHA H's personnel file on 3/30/21 (unknown hire date), failed to evidence a skills competency evaluation or written test.<br><br>4. During an interview on 3/30/21 at 1:35 PM, the administrator stated HHA competency skills evaluation and tests should be present in the personnel record.<br><br>IC 17-14-1(I)(2) | G 772 | | |
| {G 798} | Home health aide assignments and duties<br>CFR(s): 484.80(g)(1)<br><br>Standard: Home health aide assignments and duties.<br>Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).<br>This Standard is not met as evidenced by:<br>Based on record review, and interview, the registered nurse (RN) failed to ensure home health aide (HHA) care plans were appropriate and specific to the needs of the patient for 2 of 2 patient records reviewed with HHA services (#2, 3). | {G 798} | | |

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| {G 798} | Continued From page 48<br><br>Findings include:<br><br>1. An undated agency policy titled "Home Health Aide Care Plan," Policy C-751 stated, "A complete and appropriate care plan, identifying duties to be performed by the home health aide shall be developed by a registered ...All home health aide staff will follow the identified plan ...<br><br>2. The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (nut not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise and orders for home health aide (HHA) services 8 hours a day, 7 days per week for light housekeeping, safe ambulation, and assist patient to maintain a safe comfortable environment.<br><br>The admission summary on the plan of care stated "...The patient lives with her husband who is elderly with multiple medical issues ... The patient is non-verbal but yells out when in pain or uncomfortable. The patient is bed-bound and in bed all the day... The patient receives food through her g-tube. She is on continuous feeding and is unable to feed through her mouth... the patient is to be turned every 2 hours ...."<br><br>A home visit observation was conducted with home health aide (HHA) F on 3/26/21 at 10:15 AM, with patient #2. The patient was observed in a hospital bed, non-verbal and not able to make needs known, a gastrostomy tube (G-tube) for all nutrition was present. While at the home visit the husband stated the patient took nothing by mouth | {G 798} | | |

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| {G 798} | Continued From page 49<br>and remained in bad all day.<br><br>The agency document titled "HHA Care Plan," evidenced tasks (but not limited to) "Proper position during meals ... Support during transfer/ambulation ... use of assistive devices," the tasks included (but not limited to) "shower with chair, hair care, shampoo, skin care, apply barrier cream, nail care, oral care/denture, assist with dressing, assist with ambulation, walker, assist with transfers, meal set up, assist with feeding, encourage fluids."<br><br>During an interview on 3/29/21 at 8:02 PM, the spouse of patient #2 stated the patient did not take in any food/fluids by mouth, only through G-tube and was bed-bound.<br><br>3. The clinical record of patient #3 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed diagnoses of Diabetes, heart failure, abnormal electrocardiogram, obstructive sleep apnea, arthsclerotic heart disease, other specified health status, and BMI of 60-69 and orders for home health aide (HHA) services 2 hours per day, 7 days per week to "assist patient with light housekeeping, meal prep, and laundry ...assist patient with safe ambulation ... assist pt [patient] to maintain a safe comfortable home environment."<br><br>The agency document titled "HHA Care Plan," evidenced tasks (but not limited to) "... hair care, shampoo, skin care, nail care, assist with dressing, assist with ambulation, walker, stand by assist, meal set up, assist with feeding."<br><br>4. During an interview on 3/30/21 at 1:35 PM, the | {G 798} | | |

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| {G 798} | Continued From page 50<br>administrator stated that the tasks on the aide care plan should be specific to the needs of the patient.<br><br>IAC 17-13-2(a) | {G 798} | | |
| {G 800} | Services provided by HH aide<br>CFR(s): 484.80(g)(2)<br><br>A home health aide provides services that are:<br>(i) Ordered by the physician;<br>(ii) Included in the plan of care;<br>(iii) Permitted to be performed under state law; and<br>(iv) Consistent with the home health aide training.<br>This Element is not met as evidenced by:<br>Based on observation, record review, and interview, the home health aide (HHA) failed to follow the aide care plan tasks as assigned for 1 of 1 aide observed during home visits (#2).<br><br>Findings include:<br><br>An undated agency policy titled "Home Health Aide Care Plan," Policy C-751 stated, "...All home health aide staff will follow the identified plan ...."<br><br>The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (nut not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise and orders for home health aide (HHA) services 8 hours a day, 7 days per week for light housekeeping, safe ambulation, and assist patient to maintain a safe comfortable environment.<br><br>The agency document titled "HHA Care Plan," | {G 800} | | |

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| {G 800} | Continued From page 51<br>evidenced tasks to be completed daily (but not limited to) "... Support during transfer/ambulation ... use of assistive devices," the tasks included (but not limited to) "shower with chair, hair care, shampoo, assist with dressing, assist with ambulation, walker, assist with transfers, meal set up, assist with feeding, encourage fluids."<br><br>A home visit observation was conducted with home health aide (HHA) F on 3/26/21 at 10:15 AM, with patient #2. The patient was observed in a hospital bed, non-verbal and not able to make needs known, a gastrostomy tube (G-tube) for all nutrition was present. While at the home visit the husband stated the patient took nothing by mouth and remained in bad all day. HHA F failed to shower the patient (did bed bath), complete hair care, shampoo, assist with ambulation, use walker, transfer in any fashion, set up meals, assist with feeding, or encourage fluids all per the aide care plan.<br><br>During an interview on 3/29/21 at 8:02 PM, the spouse of patient #2 stated the patient did not take in any food/fluids by mouth, only through G-tube and was bed-bound.<br><br>During an interview on 3/30/21 at 1:35 PM, the administrator stated that the aides should be following the aide care plan. | {G 800} | | |
| {G 804} | Aides are members of interdisciplinary team<br>CFR(s): 484.80(g)(4)<br><br>Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures.<br>This Element is not met as evidenced by: | {G 804} | | |

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| {G 804} | Continued From page 52<br>Based on observation, record review, and interview, the home health aide (HHA) failed to report a change with the patient to the registered nurse (RN) for 1 of 1 aide home visits observed (#2).<br><br>Findings include:<br><br>The clinical record of patient #2 was reviewed on 3/25/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which indicated diagnoses (but not limited to) pneumonia, pressure ulcer of the sacrum, Huntington's disease, dementia, and other malaise and orders for home health aide (HHA) services 8 hours a day, 7 days per week for light housekeeping, safe ambulation, and assist patient to maintain a safe comfortable environment.<br><br>A home visit observation was conducted with home health aide (HHA) F on 3/26/21 at 10:15 AM, with patient #2. The patient was observed in a hospital bed, non-verbal and not able to make needs known, a gastrostomy tube (G-tube) for all nutrition was present. HHA F was assisting the patient with personal care. While turning the patient during the bed bath, HHA F pulled on the G-tube. Tissue around the G-tube started bleeding. The husband was upset and told HHA that she had to be careful and could not pull on the tube. At the end of the home visit HHA F asked the patient's spouse if she needed to call and report the bleeding from her pulling on it to the nurse. The husband stated that it should be fine.<br><br>During an interview on 3/30/21 at 1:35 PM, the administrator was asked if it was acceptable for | {G 804} | | |

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| {G 804} | Continued From page 53<br>the HHA to pull on the G-tube, even accidentally. She stated the HHA should never pull on it. | {G 804} | | |
| {G 960} | Make patient and personnel assignments,<br>CFR(s): 484.105(c)(1)<br><br>Making patient and personnel assignments,<br>This Element is not met as evidenced by:<br>Based on interview, the clinical manager failed to make patient and personnel assignments.<br><br>Findings include:<br><br>During an interview on 3/28/21 from 8:02 PM-8:40 PM, the clinical manager was asked who assigned the aides to each patient. She stated "That would be [name of administrator]" (non-clinical). | {G 960} | | |
| G 972 | Report all branch locations to SA<br>CFR(s): 484.105(d)(1)<br><br>The parent HHA is responsible for reporting all branch locations of the HHA to the state survey agency at the time of the HHA's request for initial certification, at each survey, and at the time the parent proposes to add or delete a branch.<br>This Element is not met as evidenced by:<br>Based on observation and interview, the agency failed to report a branch location that was being used for training purposes.<br><br>Findings include:<br><br>A home visit observation was conducted with licensed practical nurse (LPN) E on 3/26/21 at 8:47 AM, with patient #1 (start of care 3/13/21). At the time of the observation LPN E was asked about her initial training with the agency. She stated the clinical manager did her training at the "Fort Wayne office." When asked if she knew the address to the office, she looked in her | G 972 | | |

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| G 972 | Continued From page 54<br>documents and stated "5812 W Hills Road."<br><br>After completion of the home visit, the surveyor drove to 5812 W. Hills Road and went into the establishment. Staff were present at the door. I asked if this was an office for Apple tree. The staff at the door stated this was the office of the home health agency entity G. The entity had cubicles in the office, at least 2 staff people were present, and medical signs posted. At that time RN G arrived at entity G. She informed surveyor that she had to transfer her patients to another home health agency and the office was entity G. Additionally, RN G stated on 3/13/21 she moved 5 patients from entity G to Apple tree until she is given a full home health license. She stated that in addition to the patients she brought all her aide staff with her and the administrator of Apple tree used entity G's office to complete training and orientation. Additionally, she stated apple tree staff do use entity G's office to chart. | G 972 | | |
| G 984 | In accordance with current clinical practice CFR(s): 484.105(f)(2)<br><br>All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. This Element is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure nurses completed skilled care per professional standards for 1 of 1 home visit observed with skilled care observation (#1).<br><br>Findings include:<br><br>MCCONNELL, E., 2002. Administering medication through a gastrostomy tube, Nursing 2002: December 2002 - Volume 32 - Issue 12 - p 22, stated "...Give liquid medications whenever | G 984 | | |

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| G 984 | Continued From page 55 | G 984 | | |

possible to prevent clogging and enhance absorption. Dilute with at least 30 ml [milliliters] of water. ... If a tablet can be safely crushed, use a pill crusher to grind it to a fine powder and mix it with 30 to 50 ml of warm water. ... Put your patient in semi-Fowler position [positioned on their back with the head and trunk raised to between 15 and 45 degrees, although 30 degrees is the most frequently used bed angle] ... attach a 30-60 ml piston syringe ... To verify placement and patency, aspirate for gastric contents, note the residual volume, and follow your facility's policy for reinstilling it ... Pinch the tubing to seal it and add 30 ml of water to the syringe. Release the tubing, let the water flow by gravity to flush it ... Pour the diluted medication into the syringe and release the tubing to administer it. If you're giving more than one drug, flush between each dose with 15 to 30 ml of water, clamp ...."

The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation.

A home visit observation was completed on 3/26/21 at 8:47 AM with patient #1 and licensed practical nurse (LPN) E. The patient was observed lying in bed a gastrostomy tube (G-tube- surgically placed device used to give direct access to your child's stomach for supplemental feeding, hydration, or medications)

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| G 984 | Continued From page 56<br>and jejunostomy tube (J-tube-plastic tube placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine) were observed. LPN E was observed prepping medications for administration. All liquid medications were placed in a medication cup, then all pills were crushed and placed into another medication cup, and syringes of liquid medication were prepped as well. All medications were taken to bedside. LPN E attached a 60 milliliter (ml) piston syringe to the end of the G-tube. LPN E then added all liquid medications to the piston syringe to be administered via gravity into the G-tube. Then, LPN E dumped the crushed medication powder (by itself) into the piston syringe then added a red liquid and shook the tube. This was completed 3-4 times until all powder had been administered into the patient's stomach. LPN E then clamped the G-tube off. | G 984 | | |
| {G1024} | Authentication<br>CFR(s): 484.110(b)<br><br>Standard: Authentication.<br>All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.<br>This Standard is not met as evidenced by:<br>Based on record review and interview, the agency failed to ensure that all start of care documents, assessment, and plan of care documents were completed, authenticated, and signed upon admission for 1 of 3 records reviewed of patients admitted after plan of correction date (#1).<br><br>Findings include: | {G1024} | | |

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| {G1024} | Continued From page 57 | {G1024} | | |

The clinical record of patient #1 was reviewed on 3/29/21 and indicated a start of care date of 3/13/21. The record contained a plan of care for the certification period of 3/13/21-5/12/21 which listed the patients diagnoses as: Quadriplegia, Other reduction deformities of brain, Abdominal distention (Gaseous), encounter for attention to tracheotomy, unspecified convulsions, severe intellectual disabilities, encounter for attention to cystostomy (general term for the surgical creation of an opening into the bladder most commonly for catheterization), and constipation; orders for the skilled nurse to visit 8 hours per day, 7 days per week.

The start of care comprehensive assessment was dated as completed on 3/13/21 by registered nurse (RN) G.

During an interview with patient #1's mother on 3/29/21 at 7:52 PM, she indicated the patient had been on services a couple weeks or so.

The Patient agreement titled, "Apple tree home health care service," was dated 3/14/21 by RN G and the family of patient #1.

The receipt of bill of rights was dated 3/14/21 and signed by the family of patient #1.

The document titled "Authorization to release medical information to friends/family," was dated by RN G and the patient's family on 3/14/21.

The transfer and discharge policy were signed by RN G and the patient's mother on 3/14/21.

A document regarding translation and communication assistance was completed and signed by patient #1's mother and was not dated

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| APPLE TREE HOME HEALTH CARE SERVICES, LLC | 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220 |

| (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 |
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| {G1024} | Continued From page 58<br>(was placed with consents in medical record).<br><br>The patient consent form and authorization were signed and dated by RN G and the patient's mother on 3/14/21.<br><br>The document titled "Home health services Medicare supply/services benefit election form stated, "...8. Apple Tree Home Hewalth [sic] Care Supplies benefit coverage will begin on 03/14/21" and was signed by the patient's mother and dated 3/14/21.<br><br>The document titled "Patient Emergency Preparedness Plan," was signed by RN G (on 3/14/21) and patient #1's mother (on 3/14/21).<br><br>The home safety assessment was completed and signed by RN G and the patient's mother on 3/14/21.<br><br>The document titled "Clinical records/Medical record retention," policy was signed and dated by RN G and the patient's mother on 3/14/21.<br><br>IAC 17-15-1(a)(6) | {G1024} | | |