STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157571	A. BUILDING 00 B. WING	01/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARETENDERS	1724 STATE STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 418.102. Survey Dates: January 4th, 5th, 6th, and 7th of 2021. Facility Number: 004701 Unduplicated Census=1599 At this Emergency Preparedness Survey, Caretenders was found to be in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 418.102.	E 0000		
G 0000 Bldg. 00	This visit was for a Federal Recertification and State Licensure Survey in conjunction with an Infection Control Focused COVID-19 Survey . Survey Dates: January 4th, 5th, 6th, and 7th of 2021 Facility Number: 004701 Unduplicated Census: 1599 Records Reviewed: 18 Home Visits: 7 On January 5th, 2021 at 4:45 p.m. a partially extended survey was announced. These deficiencies reflects State Findings cited in	G 0000		

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

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

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	accordance with 410 IAC 17. Refer to Sate Form for additional State Findings. Quality Review completed on 1/14/2021 A4			
G 0616 Bldg. 00	484.60(e)(2) Patient medication schedule/instructions Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to provide patients with a written medication list for 4 of 7 home visit observations. (Patients 6, 10, 11 and 12) Findings include: 1. A 2/1/18 policy titled Medication Administration was provided by the Administrator on 1/6/21 at 1:00 p.m. The policy indicated, but was not limited to, "The clinician will instruct the patient/ family/caregiver in an understandable format and language regarding the following: a. Name(s) and classifications of medications ordered (i.e., the reason why the medications have been ordered) b. Manner in which to administer the medications, including appropriate frequency, dosage and route of administration c. Expected actions and side effects of the medications to be administered d. Special instructions about the medication administration (i.e., to take with/without food...to crush or not crush tablets, and to monitor the patient's pulse before administration)...f. Potential side effects of the medications that may occur." 2. During a home visit for patient 10 on 1/6/21 at	G 0616	On 1-21-21 and 1-22-21 the Executive Director conducted mandatory education with all staff using policy 2.1.017 Coordination of Care, From Admit Through Discharge and 10.002 Medication Administration to ensure that all patients have Patient Instruction Sheets listing all home meds are present and in the home folder. Beginning week of 1-18-21, Executive Director or designee will print 100% of all active patients' Patient Instructions Sheets. These will be given to clinicians to take to the patient on their next home visit and ensure the form is reviewed with the patient/caregiver and placed in the home folder. Once placed in the home folder the clinician will then be responsible for documenting and making a call to the office to let the provider know the form has been successfully delivered, placed in the home folder, and reviewed with the patient/caregiver. Beginning week of 1-18-21, on	02/05/2021

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	9:30 a.m., the patient's admission packet was reviewed. The packet failed to evidence a written copy of the patient's medication administration list provided by the facility. 3. During a home visit for patient 6 on 1/6/21 at 1:00 p.m., the patient's admission packet was reviewed. The packet failed to evidence a written copy of the patient's medication administration list provided by the facility. 4. During a home visit for patient 11 on 1/8/21 at 9:00 a.m., the patient's admission packet was reviewed. The packet failed to evidence a written copy of the patient's medication administration list provided by the facility. 5. During a home visit for patient 12 on 1/8/21 at 10:00 a.m., the patient's admission packet was reviewed. The packet failed to evidence a written copy of the patient's medication administration list provided by the facility. When the patient was asked if they had received a medication list from the facility, employee K then provided the medication list and stated that "Since they're (the patient) so new to us (the facility), it (medication administration list) just hasn't made it into the folder yet." 6. During an interview with the administrator on 1/4/21 at 4:00 p.m., the administrator stated that "Some (patients) have written medication lists from us (the agency), and some (patients) have a medication list from the hospital." Administration acknowledged that each patient should have a written copy of their medication list provided by the agency.		Start of Care if the patient has a hospital discharge med list the clinician will reconcile all medications, make any necessary changes, educate the patient./caregiver, sign and date the med list, and confirm with the physician. If the patient does not have a discharge medication list, the clinician will hand write a medication list to leave in the home until the Plan of Care with the approved medications is finalized and the Patient Instruction Report arrives at the patient's home. The clinician will educate the patient/caregiver that a Patient Instruction Sheet will be mailed to them and ask that they put it in the home folder. This education will be documented as part of the Start of Care visit. The medication list will be updated/revised as physician orders. Beginning week of 1-18-21 Executive Director or designee will perform 4 random home visits each week to ensure that Patient Instruction Sheets with the patients' current medications are in the home folders. This process will be ongoing until 100% compliance is achieved x 8 consecutive weeks	

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G 0620 Bldg. 00	484.60(e)(4) Other pertinent instructions Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs. Based on record review and interview, the agency failed to provide written information describing the services the patient would be receiving as ordered on the plan of care on 5 of 7 admission packets reviewed. (Patients 6, 8, 10, 11, and 12) Findings include: 1. A policy dated 8/1/19 titled Coordination of Care, From Admit Through Discharge was provided by the Administrator on 1/6/21 at 1:00 p.m.. The policy indicated, but was not limited to, "Coordination of care with patient and caregiver: Written information obtained from the plan of care will be provided to the patient and caregiver outlining: a. Visit schedule including frequency of visits by agency staff and contract workers b. Medication schedule/ instructions including: medication name, dosage and frequency, and which medications will be administered by agency staff and/ or contract workers...d. Pertinent instructions related to the patient's care and treatments that the agency will provide, specific to the patient's needs." 2. During a home visit for patient 10 on 1/6/21 at 9:30 a.m., the admission packet was reviewed. The packet failed to contain a written copy of the patient's plan of care provided by the agency. 3. During a home visit for patient 6 on 1/6/21 at 1:00 p.m., the admission packet was reviewed. The packet failed to contain a written copy of the	G 0620	On 1-21-21 and 1-22-21 the Executive Director conducted mandatory education with all staff using policy 2.1.017 Coordination of Care, From Admit Through Discharge to ensure that all patients have Patient Instruction Sheets including home meds, visit schedule and frequency, treatments and disciplines ordered, in the home. Beginning week of 1-18-21, Executive Director or designee with print 100% of all active patients' Patient Instructions Sheet. These will be given to clinicians to take to the patient on their next home visit and ensure the form is reviewed with the patient/caregiver and placed in the home folder. Once placed in the home folder the clinician will then be responsible for documenting and making a call to the office to let the provider know the form has been successfully delivered, placed in the home folder and reviewed with the patient/caregiver. Beginning 1-18-21 on Start of Care, the clinician will educate the patient/caregiver that a Patient Instruction Sheet will be mailed to them and ask they put it with the home folder. This education will be	02/05/2021

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	patient's plan of care provided by the agency. 4. During a home visit for patient 8 on 1/5/21 at 8:45 a.m., the admission packet was reviewed. The packet failed to contain a written copy of the patient's plan of care provided by the agency. 5. During a home visit for patient 11 on 1/7/21 at 9:00 a.m., the admission packet was reviewed. The packet failed to contain a written copy of the patient's plan of care provided by the agency. 6. During a home visit for patient 12 on 1/7/21 at 10:00 a.m., the admission packet was reviewed. The packet failed to contain a written copy of the patient's plan of care provided by the agency. Patient 12 was asked if he/she was provided a written plan of care from the facility. The patient stated that "If she had been given one, she didn't know what it was or where to find it." 7. During an interview on 1/7/21 at 2:00 p.m., the administrator stated that every admission packet should contain a written copy of the patient's plan of care provided by the agency.		documented as part of the Start of Care. The clinicians will check for it on subsequent visits to ensure the patient has notice of the visit schedule and frequency, treatments and disciplines ordered in the home. Beginning week of 1-18-21 Executive Director or designee will be making 4 random home visits each week to ensure that Patient Instruction Sheets are in the home folder. This process will be ongoing until 100% compliance is achieved x 8 consecutive weeks.	
G 0942 Bldg. 00	484.105(a) Governing body Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the agency failed to evidence all policies had been approved	G 0942	On 1-22-21 education was provided to the Executive Director on the policy transmittal, review,	02/05/2021

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	or adopted by the Governing Body for 1 of 1 home health agency's reviewed. Findings Include: 1. A revised 04/01/2020 policy titled Organizational Responsibilities and Organizational Charts was provided by the Executive Director/Administrator on 1/04/2021 at 11:40 a.m. The policy indicated, but was not limited to, "The Executive Director, appointed by the Board of Directors through Senior Management delegation serves as the designated person so functioning as the governing body. The Executive Director thus assumes full legal authority and responsibility for the agency's overall management and operation, provision of all home health services, fiscal operations, review of the agency's budget and operational plans ..." 2. A review of the agency's policies on 01/07/2021 evidenced the "Policy Committee" had approved the following policies: Infection Control Plan last revised 01/01/2021 Medication Administration last revised 02/01/2018 Wound Assessment, Documentation, and Photography last revised 01/01/2021 Hand Hygiene last revised 05/01/2019 Quality Assessment & Performance Improvement (QAPI) Team last revised 01/01/2021 Notice of Non-Coverage Expedited Determination For Discharge last revised 05/01/2019 Grievance Procedure, Patient Complaints last revised 01/01/2021 Admission Process last revised 01/01/2021 Coordination of Care, From Admit Through Discharge last revised 08/01/2019 Infection Control Plan last revised 01/01/2021 Staff Screening, New Hire, and Annual last		and adoption process. As the Governing Body, the Executive Director is responsible for reviewing and determining adoption of any policy distributed by LHC Group. After review and adoption, the Executive Director is responsible for educating staff of any new or revised policy. Beginning with the February 2021 policy transmittal distribution, the Executive Director as the Governing Body will review the transmittal in its entirety and review the specific policy referenced. The Executive Director will determine adoption of the policy and acknowledge adoption by signing and dating the transmittal. The policy transmittals will be filed in the agency for reference. Quarterly, all policy transmittals distributed in the last quarter will be reviewed by the QAPI team to ensure adoption of the new or revised policies and documentation of that review reflected in meeting minutes.	

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	revised 06/01/2020 Patient Discharge/Transfer Process last revised 06/01/2020 3. During an interview on 11/04/2020 at 2:30 p.m. when asked for a copy of the Governing Body meeting minutes, to verify the agency policies had been adopted by the Governing Body, the Executive Director stated she did not have meeting minutes for the Governing Body as she was the sole member. 4. During an interview on 11/06/2020 at 2:55 p.m. the Executive Director stated the policy committee was made up of all LHC Group members, the indirect owners of the agency through a limited liability company. The Executive Director, also serving as the Governing Body, stated she was not part of the policy committee. 17-12-1(b)			
G 0948 Bldg. 00	484.105(b)(1)(ii) Responsible for all day-to-day operations (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to maintain responsibility for all day to day operations of the home health agency and failed to ensure all policies were specific to the home health agency for 1 of 1 agency. Findings include: 1. A revised 04/01/2020 policy titled Organizational Responsibilities and Organizational Charts was provided by the Executive	G 0948	On 1-22-21 education was provided to the Executive Director on the policy transmittal, review, and adoption process. As the Governing Body, the Executive Director is responsible for reviewing and determining adoption of any policy distributed by LHC Group. After review and adoption, the Executive Director is responsible for educating staff of any new or revised policy. Beginning with the February 2021 policy transmittal distribution, the	02/05/2021

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	Director/Administrator on 1/04/2021 at 11:40 a.m. The policy indicated, but was not limited to, "The Executive Director, appointed by the Board of Directors through Senior Management delegation serves as the designated person so functioning as the governing body. The Executive Director thus assumes full legal authority and responsibility for the agency's overall management and operation, provision of all home health services, fiscal operations, review of the agency's budget and operational plans ..." 2. A review on 11/07/2021 evidenced the following policies, contained information specific to states unrelated to the agency: Quality Assessment & Performance Improvement (QAPI) Team last revised 01/01/2021 Notice of Non-Coverage Expedited Determination For Discharge last revised 05/01/2019 Grievance Procedure, Patient Complaints last revised 01/01/2021 Admission Process last revised 01/01/2021 Coordination of Care, From Admit Through Discharge last revised 08/01/2019 Infection Control Plan last revised 01/01/2021 Staff Screening, New Hire, and Annual last revised 06/01/2020 Patient Discharge/Transfer Process last revised 06/01/2020 3. During an interview on 01/06/2021 at 2:55 p.m. the Executive Director stated the policy committee was made up of all LHC Group members, the indirect owners of the agency through a limited liability company. The Executive Director, also serving as the Governing Body, stated she was not part of the policy committee and was unable to make modifications or updates to the agency policies. She stated if changes were needed they		Executive Director as the Governing Body will review the transmittal in its entirety and review the specific policy referenced. The Executive Director will determine adoption of the policy and acknowledge adoption by signing and dating the transmittal. The policy transmittals will be filed in the agency for reference. Quarterly, all policy transmittals distributed in the last quarter will be reviewed by the QAPI team to ensure adoption of the new or revised policies and documentation of that review reflected in meeting minutes.	

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	would have to be directed up through LHC Group. 4. During an interview on 01/06/2021 at 3:00 p.m. the Administrator/Executive Director stated she was not aware the policies needed to be specific to Indiana only. 17-12-1(b)(3) 17-12-1(c)(1)			
N 0000 Bldg. 00	This visit was for a State Licensure Survey in conjunction with an Infection Control Focused COVID-19 Survey. Survey Dates: January 4th, 5th, 6th, and 7th of 2021 Facility Number: 004701 Unduplicated Census: 1599 Record Reviews: 18 Home Visits: 7	N 0000		
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances:			

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	(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the agency failed to develop a discharge policy requiring a notice of at least 15 days prior to discharging a patient for 1 of 1 home health agencies reviewed. Findings include: A revised 06/01/2020 policy titled Patient Discharge/Transfer Process indicated, but was not limited to, "Policy: 1. Any of the following reason may be criteria for patient discharge or transfer ... 2. Discharge Planning is initiated upon admission ... 3. The patient participates in the transfer process." The policy fails to evidence that the state requires the agency to provide the patient or the patient's legal representation at least fifteen calendar days notice before the services are stopped. A review of the agency's admission packet on	N 0488	The Agency revised Policy 1.003 (attachment 1) to clarify the discharge notice requirement of at least 15 days notice prior to discharge to reflect the need for the notice for all patients except in the following circumstances: ·Health, safety, or welfare of the agency's employees would be at immediate and significant risk if the agency continued to provide services to the patient; ·Patient refuses services; ·Services are no longer reimbursable and agency informs patient of available community resources; or ·Patient no longer meets regulatory criteria (i.e. lack of	02/05/2021

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	01/04/2021 evidenced a document titled Transfer & Discharge Policy. The document fails to evidence the state's requirement to provide the patient or the patient's legal representation at least fifteen calendar days notice before the services are stopped. During an interview on 01/06/2021 concerning the missing notice the Administrator/Executive Director reviewed the policies provided and was unable to find a 15 day notice requirement. During an interview on 01/07/2021 at 11:18 p.m. the administrator provided a policy titled Notice of Non-Coverage, Expedited Determination and Reconsideration for Discharge and stated that it included for Indiana a 15 day notice was required. The document does contain the required 15 notice but only pertains to cases of non-coverage and expedited determination and reconsideration. The agency's specific discharge policy for all agency related discharges and patient admission packet discharge policy failed include the 15 day notice requirement.		physician's order) and the agency informs patient of available community resources The Agency also revised the verbiage in the Patient Orientation Booklet (attachment 2) to reflect the same as in Policy 1.003 in reference to the 15 day notice requirement for any patient prior to discharge. The Executive Director will educate all staff on the change in Policy 1.003 and the Patient Orientation Booklet on 1-22-21 to ensure compliance with giving 15 day notice to all patients prior to discharge except in the following circumstances: ·Health, safety, or welfare of the agency's employees would be at immediate and significant risk if the agency continued to provide services to the patient; ·Patient refuses services; · Services are no longer reimbursable and agency informs patient of available community resources; or ·Patient no longer meets regulatory criteria (i.e. lack of physician's order) and the agency informs patient of available community resources Beginning 2/1/21, the agency will begin the new process. Beginning week of 2/14/21,the Executive Director or designee wi11 audit 3 discharge records a	

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			week x 8 weeks and until 100% x 4 consecutive weeks to ensure all patients are receiving at least a 15 day notice of discharge except in the following circumstances: ·Health, safety, or welfare of the agency's employees would be at immediate and significant risk if the agency continued to provide services to the patient; ·Patient refuses services; ·Services are no longer reimbursable and agency informs patient of available community resources; or Patient no longer meets regulatory criteria (i.e. lack of physician's order) and the agency informs patient of available community resources	