STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15K150	A. BUILDING 00 B. WING	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MY CARE AT HOME, HOME HEALTH CARE SERVICES, LLC	1516 S HARRISON STREET SHELBYVILLE, IN 46176

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G 0000 Bldg. 00	This visit was a federal re-certification and a state licensure survey in conjunction with a complaint investigation for a home health agency. This survey was a partially extended survey. Complaint #IN00287117: substantiated with state and federal findings Complaint #IN00240557: unsubstantiated due to lack of evidence Survey dates: 11/6, 11/7, 11/8, 11/12, and 11/13/19 Facility #: 13957 Provider #: 15K150 Medicaid #: 201208600A Unduplicated census: 17 Active census: 8 These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Quality Review completed on 12/9/19 CS	G 0000		
G 0434 Bldg. 00	484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in care Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits;			

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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	(vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure that the patient received home health aide service frequencies as indicated on the signed consent for 1 of 6 patients who received home health aide care services only, in a sample of 7 records reviewed. (#6) Findings include: A patient admission binder, titled, "Patient Orientation for Home Health Care", stated, "....decision making - you have the right to ... be informed in advance about your care/service ... any changes in the care to be provided ...." Record review for patient #6 included a plan of care with the start of care on 7/19/18 for the certification period of 1/15/19 to 3/15/19 with orders for home health aide (HHA) 5-7 times per week, 7 hours per day, may be divided into 2 visits per day - 4 hours in the morning and 3 hours in the evening per the patient's request. Duties included, but were not limited to, report changes to the RN (registered nurse), document level of function every visit (QV), assist with dusting QV, assist with dishes QV, clean bathrooms QV, assist with laundry, floor cleaning, safety, perineal care, partial bath, shampoo, oral care, dressing, skin care, foot care, meal planning, and companionship. An agency admission consent form was signed, but not dated, by patient #6 and a registered	G 0434	Director of Nursing/designee will audit all active patient charts to ensure consent form is dated. (Complete by 12/27/19) Administrator will in-service aides on proper conduct when with patients. Any aide found not conducting themselves properly will be disciplined following agency disciplinary policy. (Complete by 1/7/2020) Director of Nursing/designee will in-service nurses on requirement MD must be notified when there is a change in patient's plan of care. That includes when frequency/duration of a discipline is not met. (Complete by 12/27/19) Director of Nursing/designee will audit all visit notes submitted weekly to ensure if there is a change in the patient's plan of care, including frequency/duration of a discipline, there is documentation MD was notified of that change. (Begin immediately) Once 100% compliance is achieved 10% of visit notes will audited quarterly to ensure compliance is maintained. Director of Nursing/designee will instruct patients that if unable to meet their needs, including	01/07/2020

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	nurse, which stated, ".... HHA (home health aide) 7 days a week, 4-7 hrs per day ...." A HHA visit was missed on 2/4/19. A missed visit note stated, "Unable to send staff to the client. The client was notified that agency was having difficulty with staffing. The client was notified that if the staffing situation doesn't improve, we may have to consider the 15-day discharge notice. Offered to refer client to another provider but client refused". During a HHA visit on 2/7/19, the aide was sent home early. A missed visit note stated, "Pt sent caregiver [employee C] home early prior to end of shift. Per [employee C] was being "kicked out". Per pt, she caught [employee C] dozing off in the bathroom and when she confronted [employee C], [employee C] stated she didn't feel good and didn't mean to doze off. The pt sent client [sic] home for showing up "sick". [Employee C] reported she doesn't have temperature but she was put on antibiotic and has been making her in and out [sic] of the bathroom". A HHA visit was missed on 2/14/19. A missed visit note stated, "Shortened visit due to staffing availability ... " A HHA visit scheduled for 2/24/19 recorded a 3-hour visit, 11:00 AM-2:00 PM. A missed visit note stated, "Shortened visit due to staffing availability ... " A HHA visit scheduled for 2/28/19 recorded a 3-hour visit, 6:00 PM-9:00 PM. There was no morning visit. A missed visit note stated, "Shorter visit due to staffing availability". The agency failed to evidence that the patient received HHA services 7 days per week as stated		ordered frequency/duration of visits, patient will be given 15 day notice of discharge. Agency will continue to attempt to staff patient as ordered. Agency will provide patient will list of other agencies they can contact. Agency will assist with finding another agency if patient requests they assist. MD will notified that patient is to be discharged due to inability to meet their needs. (Begin immediately) Director of Nursing/designee will instruct nurses on need to discharge patient if agency is unable to meet their needs which includes providing ordered frequency/duration for a discipline. (Complete by 12/27/19)	

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	on the signed consent. During an interview on 11/12/19 at 12:18 PM, patient #6 stated that HHAs were often late or did not show up at all. The patient stated she was in need of help 7 days per week. 17-12-3(b)(2)(D)(i)(BB) 17-12-3(b)(2)(D)(ii)(AA) 17-12-3(b)(2)(D)(iii)			
G 0484 Bldg. 00	484.50(e)(1)(ii) Document complaint and resolution (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to ensure the complaint log binder was kept up to date and failed to ensure complaints were investigated and resolved for 1 of 1 agency. Findings include: During the entrance conference on 11/6/19 at 10:00 AM, the complaint log was requested from the administrator. The administrator stated that there were no complaints, and stated, "We never get complaints. Our clients are happy". When queried if there had been any complaints in 3 years, the administrator stated, "No". The complaint log binder was reviewed on 11/13/19. It contained a blank form for complaints and resolutions. The only summary log was dated 2017, without any monthly summary explaining that there were no reported complaints. No identified log had been established for 2018 or	G 0484	Administrator/designee will maintain a compliant log. It will be kept current. If there are no complaints that month there will be signed/dated entry that says "No reported complaints this month." (Begin immediately) Administrator/designee will in-service staff on what constitutes a complaint – including patient unhappy with service, schedule or care giver. Will be instructed to fill out agency complaint form and give to Administrator. It will be written on the complaint log. (Complete 1/7/2020) Administrator/designee will investigate the complaint and document findings and resolution of complaint. (Begin immediately)	01/07/2020

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	2019. During review of patient #6's clinical record, on 11/7/19, a plan of care for the certification period of 1/15/19 to 3/15/19 included orders for a home health aide (HHA) for 5-7 times per week, 7 hours per day, may be divided into 2 visits per day - 4 hours in the morning and 3 hours in the evening per the patient's request. Duties included, but were not limited to: report changes to the RN (registered nurse), document level of function every visit (QV), assist with dusting QV, assist with dishes QV, clean bathrooms QV, assist with laundry, floor cleaning, safety, perineal care, partial bath, shampoo, oral care, dressing, skin care, foot care, meal planning, and companionship. During an HHA visit on 2/7/19, the aide was sent home early. A missed visit note stated, "Pt sent caregiver [employee C] home early prior to end of shift. Per [employee C] was being "kicked out". Per pt, she caught [employee C] dozing off in the bathroom and when she confronted [employee C], [employee C] stated she didn't feel good and didn't mean to doze off. The pt sent client [sic] home for showing up "sick". [Employee C] reported she doesn't have temperature but she was put on antibiotic and has been making her in and out [sic] of the bathroom". The agency failed to evidence any documentation of the complaint, or its resolution. 17-12-3(c)(2)			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses;			

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	(ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Based on record review and interview, the agency failed to ensure the frequency and duration of visits were specific to the needs of the individual patient (#2, 3, and 7) in 3 of 7 records reviewed; and failed to ensure that goals were individualized and measurable for the patient's needs (#7) in 1 of 7 records reviewed. Findings include: 1. An undated agency policy, titled, "Plan of Care", stated that the purpose was to provide	G 0574	Director of Nursing/designee will review all active patients plans of care to ensure the plan is individualized to that specific patient. If plan isn't specific for that patient nurse will talk with patient on what needs added or change to make plan specific to patient. Once that is done nurse will contact MD and review changes needed to individualize the care plan. If MD agreeable, nurse will write a verbal order to	01/07/2020

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	guidelines for agency staff to develop a plan of care individualized to meet specific identified needs of the patient, and to include type, frequency, and duration of all visits/service, and treatment goals. 2. Records were reviewed for patient #2 for the certification period of 8/28/19 to 10/26/19. The plan of care stated that the principle diagnosis was Parkinson's disease. Orders for the home health aide were for 7 days per week up to 8 hours per day and included the following duties: assist with hair care, skin care, dressing, light laundry, bed linen change, light housekeeping, take out trash, report change in condition to RN (registered nurse), assist with meal preparation, use of mechanical lift, provide incontinence care, fall precautions, and transfer safety. The agency failed to indicate specific hours to individualize care of the patient as evidenced by: Home health aide visits for the certification period indicated 3 hour visits on 8/29, 9/5, 9/29, and 10/5/19, while all other visits ranged from 4-8 hours. During an interview on 11/6/19 at 4:10 PM, the administrator stated that the duration of up to 8 hours was a mistake and would be fixed. 3. Records were reviewed for patient #3 and included a plan of care for the certification period of 9/28/19 to 11/9/19. The principle diagnosis was dementia, with orders for home health aide 2 times per week up to 7 hours per visit and included the following duties: assistance with major ADL's (activities of daily living), encourage fluids, remind meal time, toileting/hygiene, report changes to RN, report wandering behaviors, assist with ambulation, assist with meal		reflect those changes. This includes ensuring the duration of visits is appropriate to meet patient's needs. (Complete by 1/7/2020) Director of Nursing/designee will review all admission and re-certification plans of care submitted each week to ensure they are individualized to meet that patient's specific needs. (Begin immediately) Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is being maintained. Director of Nursing/designee will in-service aides on need to follow the aide plan of care. (Complete by 1/7/2020) Director of Nursing/designee will audit all aide visit notes submitted weekly against patient's aide care plan to ensure aide is following the plan. If aide is not following plan of care they will rein-serviced one on one. (Begin immediately) Once 100% compliance is achieved 10% of aide visit notes will be audited against patient's plan of care quarterly to ensure compliance is being maintained. Director of Nursing/designee will instruct nurses that there must be goals for the ordered disciplines on the plan of care. (Complete by 12/27/19) Director of Nursing/designee will audit all admission and re-certification plans of care	

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	preparations, fall precautions, and safety supervision. Home health aide visits for the certification period indicate that the aide was in the patient's home for 7 hours each visit. A visit on 10/2/19 noted that the patient refused a bath or help with dressing. The aide cleaned the home and assisted with meal preparation. A visit on 10/4/19 noted that the patient's bed was "already made" and that the patient and wife perform perineal care, bath, and dressing of the patient. The aide did light housekeeping and assisted with meal preparation. Visits on 10/9/19 and 10/11/19 indicated no bathing or toileting assistance was needed. The aide assisted with meal preparation and provided companionship only. Additionally, visits on 10/16, 10/18, 10/23, 10/24, 10/25, and 10/30/19 indicated no bathing or toileting assistance. The aide assisted with meal preparation and companionship only. The agency failed to evidence specific hours to individualize the patient's care. During an interview on 11/7/19 at 4:35 PM, the administrator reiterated that visit frequencies and durations would be made more specific. The administrator stated that the office needs help with filing and checking that aides follow through {with duties}. 4. Record review of patient #7 included a plan of care for the certification period of 5/28/19 to 7/26/19 with the primary diagnosis of COPD, including contracture of the right knee, arthritis, and chronic pain. A home health aide was ordered for 4 times per week for 1 week, then 5 times per week for up to 8 hours per day.		submitted weekly to ensure there are goals stated for each discipline ordered. If goals are missing nurse will be instructed to add them. (Begin immediately) Once 100% compliance is achieved 10% of plans of care will be audited quarterly to ensure compliance is maintained.	

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	An aide plan of care, dated 3/28/19, included, but was not limited to, the following duties: assistance for major adls (activities of daily living), take out trash, report changes to the RN, document condition, make bed, assist with dusting and dishes, clean bathroom, assist with laundry, floor cleaning safety, perineal care, partial bath or shower, shampoo, dressing, skin care, foot care, oral care, standing, meal planning and preparation, record LBM (last bowel movement), turn and reposition, and companionship. A home health aide visit, dated 5/27/19, stated, "off holiday", so no visit was made. A visit was missed on 5/28/19, as well, with a missed visit note, dated 6/24/19, that the physician was notified that it was missed, per the patient's request. The patient only had 3 visits that week. Visits made 6/17-6/21/19 stated, "Not needed" for dusting, making the bed, partial bath, shower, denture care, skin care, back rub, helping client to stand, meal planning, assisting with deep breathing exercises, lotion, and incontinence care. The aide recorded visits for 7-8 hours. Visits made 6/24-6/27/19 stated, "Not needed" for making the bed, partial bath, shower, skin care, back rub, assisting with deep breathing, lotion, and incontinence care. The aide recorded visits for 4-8 hours. A missed/shortened visit note stated that the following visits were shortened: 5/29, 6/13, 6/19, 6/23, 6/25, 6/26, and 6/27/19. Reason stated, "Shortened visit per pt's [patient's] request to accommodate some errands, MD appts [medical doctor appointments], trip to wound care clinic and spouse coming home earlier. Pt also requesting no visit to be made on 6/28/19 and the visit to be made on 6/23/19 but a shorter one due to visiting mother-in-law".			

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	The plan of care clinical summary stated, ".... pt reported had a recent fall when alone and has seen the doctor and was not treated for any broken bones or injuries. Pt was not able to recollect exact time and date ... goals are being met ...." Goals for the skilled nurse and home health aide were left blank with no other goals stated on the plan of care. The agency failed to evidence that the visit duration was specific to the individualized needs of the patient and failed to evidence any goals on the plan of care for improvement of the patient's condition or safety. 17-13-1(a)(1)(D)(iii)			
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery 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. Based on record review, observation, and interview, the agency failed to ensure the coordination of medication delivery so that all medications ordered on the plan of care were made available to the patient for 1 of 7 records reviewed. (#1) Findings include: An agency policy, reviewed on 5/5/16, titled, "Coordination of Patient Services", stated, ".... all personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care ... to ensure appropriate, quality care is being provided to patients ... to establish	G 0608	Director of Nursing/designee will in-service nurses on requirement to assess their meds, ensure they have ordered medications, understand their meds and how to take. If patient is using multiple pharmacies educate patient on trying to use just one pharmacy to decrease potential of getting medications mixed up, having too many of one med or not enough of another med. (Complete by 12/27/19) Director of Nursing/designee will review all nursing notes submitted weekly to ensure if there is something documented regarding	12/27/2019

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	effective interchange, reporting, and coordination of patient care does occur ... to ensure continuity of care .... " Record review of patient #1 included a plan of care with a start of care on 10/25/19 for the certification period of 10/25/19 to 12/23/19. Medications listed on the plan of care included, but were not limited to, the following: Lidocaine external patch 4 %, as needed for pain; Lorazepam (Ativan) as needed for anxiety; Fluoxetine Hydrochloride (Prozac, an antidepressant); and, Flunisolide nasal solution (Qnasl, steroid for nasal congestion). The agency failed to evidence coordination of care for medication delivery as evidenced by: A communication note, dated 10/25/19, stated, ".... notified MD [medical doctor] office POC [plan of care] will be faxed for review ... reason for client confused [sic] because receiving meds from 2 different pharmacies ... MD office confirmed will only send orders from now on to [2nd pharmacy] ...." A communication note, dated 11/4/19, stated, ".... contacted [2nd pharmacy] due to pt [patient] reported out of fluoxetine and ativan ... per [2nd pharmacy] pt discharged on 10/21/19 per pt's request ... per pt, they were confusing her [with medication sent] ... per MD, they will send order to [1st pharmacy] ... per MD, ativan should have not been out ... notified that pt has been taking them regularly and when asked reason ... per pt, having speech difficulty ...." A home visit was conducted with the skilled nurse (SN) and patient on 11/7/19 (the only SN visit since the start of care) at 3:25 PM. The patient was confused about medications. The		medications – confusion, missing meds, meds not avail, etc that there is documentation MD has been notified and patient has been educated on the issue, issue has been resolved and patient voices understanding. (Begin immediately) Once 100% compliance has been achieved 10% of nursing notes will be reviewed quarterly to ensure compliance is being maintained. Director of Nursing/designee will instruct nurses to review patient's meds at each visit to determine if there any issues which may include don't have medication yet, ran out of med, using a substitute that MD may/may not be aware of, etc. If there are issues noted nurse to contact MD and inform patient of any orders/instructions from MD and whether patient verbalizes understanding. (Complete by 12/27/19) Director of Nursing/designee will audit all nursing notes submitted weekly to ensure there is documentation meds were reviewed. If any problems are noted there should be documentation MD was notified and patient informed of any orders/instructions from MD and whether patient verbalizes understanding. (Complete by 12/27/19) Once 100% compliance is achieved 10% of nursing notes will be reviewed quarterly to ensure	

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MY CARE AT HOME, HOME HEALTH CARE SERVICES, LLC	1516 S HARRISON STREET SHELBYVILLE, IN 46176

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	patient identified medications by color and stated, "Sometimes they look different". During an interview, the SN stated that the patient was admitted after discharge from a nursing home, and that the patient had been out of the Ativan and Prozac since then. The patient stated she is also out of the lidocaine patch and nasal spray. The SN attempted to educate the patient about medications and encouraged her to fill her own medication planner box, the patient remained confused about the color of the medications and their uses. The patient remained without medications 2 weeks after admission. 17-12-2(g)		compliance is maintained.	
G 0660 Bldg. 00	484.65(e)(1)(2)(3)(4) Executive responsibilities for QAPI Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained; (2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness; (3) That clear expectations for patient safety are established, implemented, and maintained; and (4) That any findings of fraud or waste are appropriately addressed. Based on record review and interview, the agency	G 0660	Administrator/DON will implement a QAPI program that meets	01/07/2020

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	failed to ensure the governing body maintained a quality assessment and performance improvement (QAPI) program to evaluate its effectiveness of patient care for all 8 active patients of the agency. Findings include: An undated agency policy, titled, "Corporate Compliance Policy", stated, ".... agency will develop and implement evaluation tools to monitor compliance and assist in reducing problem areas ... will have ongoing evaluation and reporting of performance improvement ...." Review of the agency's QAPI binder indicated that a program had been developed by the administrator with evaluation of its effectiveness for the year 2017 but had not been maintained for 2018 and 2019. A patient communication log included in the QAPI notebook, dated 4/1/18, stated, "No issues". A patient communication log, dated 4/2019, stated, "No issues". Fall tracking logs were blank (see G574, patient #4). There were no patient satisfaction survey forms included in the binder after 12/2016. The agency failed to provide any evidence that a QAPI program had been ongoing; failed to measure improvement of patient safety and quality of care; failed to analyze and track adverse patient events to assess agency care and services; failed to use data from quality indicators to help develop a program to monitor its effectiveness for improvement; failed to identify any problems in order to improve its performance; failed to conduct any performance improvement projects; and, failed to evidence that the governing body ensured that a QAPI program was ongoing to provide improvement for patient safety and quality of care.		State/Federal regulations. QAPI will include monitoring of falls, infections, complaints, patient satisfaction surveys. Administrator will create/utilize appropriate forms that capture the information needed to conduct trending, analysis, interventions, etc. (Complete by 1/7/2020) Administrator/DON will in-service field staff on the QAPI program and what they need to report to Administrator/designee as well as what forms may need to be completed. (Complete by 1/7/2020) Administrator/designee will ensure patient satisfaction surveys are sent to 20% of agency's active patients quarterly. (To begin immediately) Administrator/designee will be responsible to tabulate results of survey responses quarterly and implement any actions needed to correct/improve areas of concern. These will be incorporated into the QAPI program. (To begin immediately) Administrator/designee will in-service nurses on the need to create a patient specific fall prevention program for any patient who is a fall risk. This will be updated minimally at re-certification/resumption AND anytime there is a change in patient's situation. (Complete by 1/7/2020) Administrator/DON will audit all	

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	During an interview on 11/7/19 at 4:35 PM, the administrator agreed that the QAPI program started in 2017 had not been maintained, and stated, "I'm really behind on that". The administrator was queried if the governing body was involved with the development of a QAPI program, and stated, "No". "We are not having quarterly meetings at this time". 17-12-1(e)		current patient charts to determine if patient has been deemed a fall risk. If they have Administrator will instruct the nurse to create a patient specific fall prevention program, notify MD of program and implement with patient at next visit. (Complete by 12/27/19) Administrator/DON will audit all admissions, re-certs and resumptions and if patient is a fall risk will ensure there is a patient specific fall prevention program in place. If program not documented Administrator will instruct nurse to implement one. (To begin immediately) Administrator/designee will instruct nurses that MD must be notified of changes in patient's condition. That would include issues of pain, not having ordered meds, etc. (Complete by 12/27/19) Administrator/designee will audit all weekly visits notes to ensure if there is a change in patient condition or situation there is documentation MD has been notified. (Begin immediately) Once 100% compliance is achieved 10% of visit notes will be audited quarterly to ensure compliance is maintained. Administrator/DON will ensure Governing Body approves scope of QAPI program yearly. Will ensure there is documentation in meeting minutes indicating GB has approved the QAPI program for the	

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			next year. (Being immediately) Administrator/DON will ensure QAPI meetings are held quarterly and there are minutes kept for those meetings. (Begin immediately)	
G 0710 Bldg. 00	484.75(b)(3) Provide services in the plan of care Providing services that are ordered by the physician as indicated in the plan of care; Based on record review, observation, and interview, the agency failed to ensure the patient had all medications ordered on the plan of care for 1 of 1 patient requiring skilled services in a sample of 7 records reviewed. (#1) Findings include: 1. An undated agency policy, titled, "Medication Management", stated, ".... agency has a medication management system that supports patient safety and improves quality of care treatment and services by reducing practice variation, errors and misuse of medications ... comprehensive patient assessment performed at the start of care and other defined points in time include review of all medication the patient is taking ... medications in the home are reviewed with the patient to determine current medications and patient understanding of the medications' actions ... specific instructions for how and when to take the medications will be reviewed and documented ...." 2. Record review of patient #1 with a start of care on 10/25/19 for the certification period 10/25/19 to 12/23/19, included a plan of care with orders for skilled nursing once every other week to instruct	G 0710	Director of Nursing/designee will in-service nurses on requirement to assess their meds, ensure they have ordered medications, understand their meds and how to take. If patient is using multiple pharmacies educate patient on trying to use just one pharmacy to decrease potential of getting medications mixed up, having too many of one med or not enough of another med. (Complete by 12/27/19) Director of Nursing/designee will review all nursing notes submitted weekly to ensure if there is something documented regarding medications – confusion, missing meds, meds not avail, etc that there is documentation MD has been notified and patient has been educated on the issue, issue has been resolved and patient voices understanding. (Begin immediately) Once 100% compliance has been achieved 10% of nursing notes will be reviewed quarterly to ensure	12/27/2019

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	and teach medications, dosages, schedules, purpose, side effects, importance of complying with medications and the consequences of not complying. Orders for the home health aide included medication reminders every visit. Goals listed for the patient stated, "Patient will verbalize understanding of medication regimen, actions, side effects, and adverse reactions within". The skilled nurse failed to ensure the patient had access to all medications ordered for consistency of care as evidenced by the following: Medications listed on the medication profile and plan of care included, but were not limited to, the following: Lidocaine external patch 4 %, 1 patch, once a day, "po" (orally), ongoing, apply on intact skin as needed for pain; Lorazepam (Ativan) oral tablet, 0.5 mg (milligrams), once a day, po, ongoing, as needed for anxiety; Fluoxetine Hydrochloride (Prozac, an antidepressant) oral capsule 20 mg, 1 capsule, once a day, po, ongoing; and, Flunisolide nasal solution (Qnasl, steroid for nasal congestion) 25 mcg (micrograms) 1 spray daily, ongoing. Drugs.com stated that Prozac should not be stopped suddenly due to unpleasant withdrawal symptoms. A home visit was conducted with the skilled nurse and patient on 11/7/19 at 3:25 PM. During an interview at this time, the skilled nurse stated that the patient was admitted after discharge from a nursing home, and explained that the patient had been out of the Ativan and Prozac since then. The patient stated she was also out of the lidocaine patch and had been using an over-the-counter lidocaine roll-on that the nurse gave her [in the nursing home] but continued to have shoulder pain. The patient stated, "I don't have my nasal spray and am really stuffy". The skilled nurse stated that the patient was not		compliance is being maintained. Director of Nursing/designee will instruct nurses to review patient's meds at each visit to determine if there any issues which may include don't have medication yet, ran out of med, using a substitute that MD may/may not be aware of, etc. If there are issues noted nurse to contact MD and inform patient of any orders/instructions from MD and whether patient verbalizes understanding. (Complete by 12/27/19) Director of Nursing/designee will audit all nursing notes submitted weekly to ensure there is documentation meds were reviewed. If any problems are noted there should be documentation MD was notified and patient informed of any orders/instructions from MD and whether patient verbalizes understanding. (Complete by 12/27/19) Once 100% compliance is achieved 10% of nursing notes will be reviewed quarterly to ensure compliance is maintained.	

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	having any side effects from the missed medications and that the doctor was aware. The skilled nurse's last visit with the patient was 12 days prior. A communication note, dated 11/4/19, stated, "....per MD (medical doctor), ativan should have not been out ...." 17-14-1(a)(1)(C)			
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 governing body failed to ensure the agency maintained a quality assessment and performance improvement program (QAPI) or that a frequency for data collection had been established. Findings include: Review of the agency's QAPI binder indicated that a program had been developed by the administrator for the year 2017 but had not been maintained for 2018 and 2019. During an interview on 11/7/19 at 4:35 PM, the administrator was queried if the governing body was involved with the development of a QAPI program, and stated, "No".	G 0942	Administrator/DON will ensure Governing Body approves scope of QAPI program yearly. Will ensure there is documentation in meeting minutes indicating GB has approved the QAPI program for the next year. (Complete by 12/27/2019)	12/27/2019

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	17-12-1(b)			
N 0000 Bldg. 00		N 0000		
	This visit was a state re-licensure survey for a home health agency. Survey dates: 11/6, 11/7, 11/8, 11/12, and 11/13/19 Facility #: 13957 Provider #: 15K150 Active census: 8 IDR Committee met on 01/17/2020. Tag N458 deleted.			
N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be			

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	administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on personnel record review, the agency failed to ensure that documentation was present in an employee's file for a first step tuberculin skin test (employee D) for 1 employee from a sample of 7 reviewed, or that documentation was obtained	N 0464	Administrator/designee will audit all current field employee files to ensure there is proof of a negative PPD in the past twelve months prior to being hired. If no proof of negative PPD then employee will	12/27/2019

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	for a prior tuberculin skin test (employee G) for 1 employee from a sample of 7 reviewed. Findings include: 1. Indiana requirements for tuberculin skin testing, titled, "Recommendations for Implementation of the Indiana State Department of Health's Tuberculin Shortage Guidelines for Acute and Long Term Care Facilities in the State of Indiana -- September 20, 1013", stated, ".... the following recommendations are based on earlier health advisories from the Centers for Disease Control and Prevention ... a) tuberculin skin test (TST). A two step screening is required unless the applicant had a TST within the past 12 months and can provide documentation of date given and read, results in millimeters and interpretation (positive or negative), then only a single (one step) follow-up TST is needed ...." 2. Personnel record review for employee D included a pre-employment request and authorization for tuberculin skin test. The form queried, "Have you ever had a TB test? ... answer: Yes, Oct or Nov 2018 ... Have you ever had a reaction? answer: Yes ...." A one step tuberculin skin test was administered on 9/18/19 without evidence of a prior negative test. 3. Personnel record review for employee G included a second step tuberculin skin test administered on 4/4/19. There was no evidence of a first step skin test. 4. No additional information was supplied from the administrator by the end of the exit conference on 11/13/19.		be required to have another PPD. (Complete by 12/27/19) Administrator/designee will audit all new field staff employee files before they are permitted to see patients to ensure there is proof of a negative PPD in past twelve months. If no proof of negative PPD in past twelve months employee will be required to have a 2step. (Complete by 12/27/19)	

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N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the agency failed to ensure a program was maintained to evidence improvement of patient safety, health, and quality of care; failed to ensure information obtained from the start of care assessment, which identified needs for improvement for the patient, was included in a QAPI (quality assessment performance improvement) program for 1 of 1 patient who required skilled nurse services in a sample of 7 records reviewed (#1); failed to ensure a performance improvement program was developed for high-risk patients prone to falls for 3 of 7 records reviewed (#1, 2, 7); and failed to ensure an infection control program was developed, maintained, and/or included in a quality assessment and performance improvement (QAPI) program for 1 of 1 agency. Findings include: 1. An undated agency policy, titled, "Corporate Compliance Policy", stated, ".... agency will develop and implement evaluation tools to	N 0472	Administrator/DON will implement a QAPI program that meets State/Federal regulations. QAPI will include monitoring of falls, infections, complaints, patient satisfaction surveys. Administrator will create/utilize appropriate forms that capture the information needed to conduct trending, analysis, interventions, etc. (Complete by 1/7/2020) Administrator/DON will in-service field staff on the QAPI program and what they need to report to Administrator/designee as well as what forms may need to be completed. (Complete by 1/7/2020) Administrator/designee will ensure patient satisfaction surveys are sent to 20% of agency's active patients quarterly. (To begin immediately) Administrator/designee will be	01/07/2020

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	monitor compliance and assist in reducing problem areas ... will have ongoing evaluation and reporting of performance improvement ...." 2. An undated agency policy, titled, "Infection Prevention /Control", stated, ".... the agency will have an infection prevention and control component to the Infection program ... this program will evaluate those patient/populations to be at risk and implement processes as needed ...." 3. During the agency's QAPI (quality assessment performance improvement) review on 11/6/19 at 10:09 AM, records failed to evidence QAPI activity after April 2017. Patient communication logs within the binder were blank. 4. A status update/weekly audit report binder contained the following: 1/1/18-3/31/18 - "no issues". The blank page was signed by the administrator. 4/1/18-6/30/18 - one incident listed for 5/26/18, no further information 7/1/18-9/30/18 - no incidents listed 10/1/18-12/31/18 - no incidents listed 1/25/19 - one incident, no information A fall tracking log was blank. There were no patient satisfaction survey forms completed since December 2016. The agency failed to evidence maintenance of a QAPI program to include any agency processes to monitor. 5. Record review for patient #1 included a start of		responsible to tabulate results of survey responses quarterly and implement any actions needed to correct/improve areas of concern. These will be incorporated into the QAPI program. (To begin immediately) Administrator/designee will in-service nurses on the need to create a patient specific fall prevention program for any patient who is a fall risk. This will be updated minimally at re-certification/resumption AND anytime there is a change in patient's situation. (Complete by 1/7/2020) Administrator/DON will audit all current patient charts to determine if patient has been deemed a fall risk. If they have Administrator will instruct the nurse to create a patient specific fall prevention program, notify MD of program and implement with patient at next visit. (Complete by 12/27/19) Administrator/DON will audit all admissions, re-certs and resumptions and if patient is a fall risk will ensure there is a patient specific fall prevention program in place. If program not documented Administrator will instruct nurse to implement one. (To begin immediately) Administrator/designee will instruct nurses that MD must be notified of changes in patient's condition. That would include issues of pain, not having ordered	

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	care comprehensive assessment, dated 10/25/19, for the certification period of 10/25/19 to 12/23/19. The clinical summary stated, ".... received a referral for SN [skilled nurse] for medication set-up ... due to reported increased confusion/forgetfulness, physical debilitation ... recent major fall ... broke her spine ... patient lives alone ... can get easily confused ... feeling overwhelmed and confused with medication at this time ... patient's stated goals ... I just want somebody with me as I go about my day, I have fallen before and I don't want to be back in the nursing home ...." A patient summary stated, ".... per pt, approximately 4 months ago she fell and broke her spine ...." During a home visit on 11/7/19 at 3:25 PM, the SN stated that the patient was admitted after discharge from a nursing home, and that the patient had been out of the Ativan and Prozac since then. The patient stated she was also out of the lidocaine patch and had been using an over-the-counter lidocaine roll-on that the nurse gave her [in the nursing home] but continued to have shoulder pain. The patient stated, "I don't have my nasal spray and am really stuffy". During an interview at this time, the skilled nurse stated that the patient was not having any side effects from the missed medications and that the doctor was aware. The skilled nurse's last visit with the patient was 12 days prior. The agency failed to evidence improvements for the patient's care or fall prevention in a QAPI plan and failed to evidence a performance improvement plan for this high-risk patient. 6. Record review of patient #2 included a plan of care with a start of care on 4/30/19 for the		meds, etc. (Complete by 12/27/19) Administrator/designee will audit all weekly visits notes to ensure if there is a change in patient condition or situation there is documentation MD has been notified. (Begin immediately) Once 100% compliance is achieved 10% of visit notes will be audited quarterly to ensure compliance is maintained. Administrator/DON will ensure Governing Body approves scope of QAPI program yearly. Will ensure there is documentation in meeting minutes indicating GB has approved the QAPI program for the next year. (Being immediately) Administrator/DON will ensure QAPI meetings are held quarterly and there are minutes kept for those meetings. (Begin immediately)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K150	A. BUILDING 00 B. WING	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MY CARE AT HOME, HOME HEALTH CARE SERVICES, LLC	1516 S HARRISON STREET SHELBYVILLE, IN 46176

(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
	certification of 8/28/19 to 10/26/19 with a primary diagnosis of Parkinson's disease and a history of falling. The clinical summary stated, ".... pt lives alone ... sitting in her wheelchair ... patient has received new shower chair, educated daughter on need for staff to be checked off until then will continue bed bath ...." The agency failed to evidence that this high-risk patient was included in a performance improvement program. 7. Record review of patient #7 included a plan of care for the certification period of 5/28/19 to 7/26/19 with the primary diagnosis of COPD, including contracture of the right knee, arthritis, and chronic pain. A re-certification assessment, dated 5/27/19, stated in the clinical summary, ".... pt reported had a recent fall when alone and has seen the doctor and was not treated for any broken bones or injuries. Pt was not able to recollect exact time and date ...." The agency failed to evidence that this high-risk patient was included in a performance improvement program. 8. Record review of the agency's QAPI program indicated the program failed to be maintained or to evidence any infection control program. 9. During an interview on 11/7/19 at 4:35 PM, the administrator agreed that the QAPI program had not been maintained. The administrator was queried if the governing body was involved with the development of a QAPI program, and stated, "No". "We are not having quarterly meetings at this time." 10. During an interview on 11/7/19 at 4:35 PM, the administrator confirmed that the QAPI program was not maintained, stating, "I'm behind on that."			