STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was a federal recertification and state re-licensure survey with two complaints, and focused COVID-19 infection control survey of a home health agency. The survey was partially extended on 11/12/20 at 5:01 PM. Complaint #IN00290288; Substantiated with Federal findings Complaint #IN00284680; Substantiated with Federal findings Survey Dates: November 4, 5, 6, 9, 10, 12, 13, 16; 2020 Facility Number: IN005869 Provider Number: 15K002 Unduplicated admissions past 12 months: 14 Skilled patients: 44 Home Health Aide Only Patients: 51 Personal Service Only Patients: 0 Total Active Patients: 68 These deficiencies reflect State findings cited in accordance with 410 IAC 17. Quality review by area 2 on 1/28/21	G 000		
G 478	Investigate complaints made by patient CFR(s): 484.50(e)(1)(i) (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: This Element is not met as evidenced by: Based on record review and interview, the home	G 478		

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

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G 478	Continued From page 1 health agency failed to ensure all patient complaints were thoroughly investigated for 20 of 36 complaints reviewed, which involved 16 patients (#4, 5, 12, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30). Findings include: 1. An agency policy titled "Complaint Process," policy number 2-008.1, last revised 10/28/20, stated " ... Policy: Any difference of opinion, dispute, or controversy between a patient or family/caregiver or patient representative and [home health agency] concerning any aspect of services or the application of policies or procedures will be considered a complaint ... The Agency will investigate complaints made by a patient, the patient's representative (if any), and that patient's caregivers and family ... Procedure ... 2 ... The supervisor or designee may begin to investigate the complaint under the Administrator within five (5) days after receipt of such complaint ... 5. Complaints, investigation, investigation findings, resolution, and actions taken to remove any risks to the patient while the complaint was being investigated will be documented on a complaint form ...." 2. The survey's Entrance Conference was conducted on 11/6/20 at 9:48 AM with the Administrator. During the Entrance Conference, the Administrator indicated when a complaint was received by agency staff, the staff member would complete a "Complaint Form" in the agency's Electronic Medical Record (EMR). The Director of Nursing (DON) would then investigate the complaint, including interviewing all staff involved, and the Administrator would review and "sign off" on all complaint investigations.	G 478		

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G 478	Continued From page 2 3. The agency's complaint log from 1/1/2020 - 11/4/2020 was reviewed on 11/6/20. The complaint log contained a "Complaint Form" documented on 11/2/20 by the Alternate Administrator. The form indicated Person A, group home manager for Patient #18 (start of care 4/27/15) was the complainant, and Employee T, Home Health Aide (HHA), was the employee involved. The complaint stated "[Alternate Administrator] received a call from [Person A] at group home stating they have a complaint regarding HHA [Employee T]. [Person A] states that the client has been having a lot of behaviors [yelling, cussing, throwing wash cloths). Group home staff believe that [Employee T] may be the cause of these behaviors. Group home staff states they have been observing [Employee T] with [Patient #18] for the past month and a half. They have observed [Employee T] putting shampoo on the client's head, not rubbing it in and then just rinsing it off and only using 1 washcloth to clean client when client requests 2 washcloths ... Staff states they have changed [Patient #18]'s bed time from 11pm to 9pm to see if that would make a difference and it has not. Group home staff doesn't want to lose [Employee T] as their aide, but wants these issues resolved." The "Resolution/ Follow-up" stated "Immediate Action/Steps Taken by Supervising Personnel Upon Receipt of Concern/Complaint ... [Alternate Administrator] contacted [Employee T] and discussed behaviors. [Employee T] re-educated on following client's request for wash cloths and other care as time allows. Administrator, Clinical Manager, Alternate Clinical Manager, Scheduling Director, and Human Resources notified. Clinical Manager and / or Alternate Clinical Manager to do a surprise HHA supervisory visit with HHA and client to observe care and behaviors." The complaint form indicated a supervisory visit was	G 478		

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G 478	Continued From page 3 conducted by the DON on 11/3/20, and both Patient #18 and Employee T were present during the visit. The complaint was documented as "Resolved" on 11/3/20. The complaint form failed to evidence the complaint investigation included interviews with Employee T's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 4. The agency's Complaint Log contained a "Complaint Form" documented by the Director of Nursing on 10/30/20. The form indicated Person B, group home supervisor for Patient #19 (start of care 2/20/20), was the complainant and Employee R, HHA, was the employee involved. The "Complaint Details" stated "[Person B], house manager called this date with issues re [regarding] care provided by [Employee R]. [Person B] stated aide has arrived late every day scheduled this week. Today, when aide had not arrived by 0715, [Person B] states she called agency and was told aide would be arriving shortly. At 0730, [Person B] received a call from agency stating aide would not be arriving. [Person B] also stated once [Employee R] finishes getting [Patient #19] dressed and out to breakfast, [the HHA] is on her phone the remainder of the visit ...." The complaint's "Resolution/Follow-up" stated "HR Director, [Employee CC], spoke with [Employee R] about the importance of being on time and re-educated on the cell phone usage policy on 10/30/20 at 4:30pm. [Employee R] acknowledged understanding. Administrator spoke with scheduling to remove [Employee R] from [Patient #19]'s schedule ...." The complaint was documented as "Resolved" on 11/2/20. The complaint form failed to evidence the complaint investigation included staff interviewing Employee R's other patients to assess if they had any	G 478		

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G 478	Continued From page 4 similar issues or concerns with the care received from the HHA. 5. The agency's Complaint Log contained a "Complaint Form" documented by Employee DD, office staff, on 10/28/20. The form indicated Patient #20 (start of care 3/26/13) was the complainant, and Employee EE, HHA, was named as the employee involved. The "Complaint Details" stated "[Patient #20] called in to requested [sic] that we 'get [Employee EE] the [expletive] off my schedule'. [The patient] said that [Employee EE] has a bad attitude and she falls asleep. [The patient] claims he has woken [the HHA] up many times and she gets an attitude with him ...." The complaint "Resolution/ Follow-up" stated "[Employee EE] was removed immediately from [Patient #20]'s schedule as requested. [Employee CC, HR Director] addressed the issues in the clients [sic] home and re-educated the employee regarding policy violations on 10/29/2020 in the office ...." The complaint was documented as "Resolved" on 10/29/20. The complaint form failed to evidence the complaint investigation included interviews of Employee EE's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 6. The agency's Complaint Log included a "Complaint Form" documented by the Administrator on 10/27/20. The form indicated Patient #21 (start of care 4/24/19) was the complainant, and Employee K, HHA, was named as the employee involved. The "Complaint Details" stated "[Patient #21] called in and spoke to [the Administrator] in presence of [Employee DD, office staff]. [Patient #21] stated that she was unhappy with aide [Employee K] because she arrived late for shifts, she was not completing all	G 478		

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G 478	Continued From page 5 the tasks on the care plan, and she talked to the apartment manager about other people in the apartment complex instead of going directly to [Patient #21]'s apartment to provide care. [Patient #21] reported that [the HHA] arrived 15 minutes late on 10/27/2020 am shift and aide arrived 18 minutes late for pm shift while [the patient] was on the phone with the Administrator ...." The complaint form's "Resolution/ Follow-up" stated " ... [Patient #21] stated that she did not want anyone to speak to [Employee K] about the issues and did not want her replaced with a different aide. Administrator explained to [the patient] that the issues would not be corrected if they could not be address [sic]. Administrator asked if she could replace [the HHA] from [the patient's] schedule and speak to [the HHA] about the issues in general once she was removed. [Patient #21] stated that Administrator could replace [Employee K] from next week's schedule, but she wanted her to continue to provide the scheduled visits for the current week ... 10/29/2020 at 9:23 am [Patient #21] called and spoke to [Employee DD] and told [the employee] that she thought about it overnight and did not want [Employee K] removed from her schedule ... 10/28/20 After speaking with [Employee DD], the Administrator met with [Employee FF], RN Case Manager, about the situation. [Employee FF] reported that she watched [Employee K] provide care for [Patient #21] while performing the recertification on 10/13/2020 and that [the HHA] provided good care to client and was following the care plan ... Administrator called [Patient #21] back at 9:48 am ... Administrator explained ... that if [Employee K] was going to remain in the home that agency would need to speak with her about the issues (arriving late, following care plan) so that they could be resolved). [Patient #21] stated that she was in	G 478		

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G 478	Continued From page 6 agreement with the plan ...." The complaint was documented as resolved on 10/28/2020. The administrator failed to thoroughly investigate the complaint, but rather let the patient determine the course of action for the HHA. The complaint form failed to evidence the complaint investigation included review of Employee K's timecards or interview of Employee K's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 7. The agency's Complaint Log included a "Complaint Form" documented by the Alternate Administrator on 10/2/2020. The form indicated Patient #5 (start of care 4/5/19) was the complainant, and Former Employee C, HHA, was the employee named in the complaint. The form's "Complaint Details" stated "10/2/20 ... [Alternate Administrator] received call from [Patient #5] stating that she does not want [Former Employee C] to return to her house ... Patient states that HHA left a mess all over the counter after making breakfast and didn't put appliances away. Patient states didn't [sic] look like the pan had been cleaned. Patient states she didn't feel the HHA cleaned up after herself ...." The complaint's "Resolution/ Follow-up" stated "[Alternate Administrator] notified Clinical Manager, Alternate Clinical Manager, Scheduling Director and Human Resources Director of above concerns. [Alternate Administrator] advised [Patient #5] that [Former Employee C] would be added to non-preferred list and therefore would not be scheduled back in her home. Patient verbalized understanding." The complaint form failed to evidence the complaint investigation included an interview of Former Employee C regarding the visit in question or interviews of Former Employee C's patients to assess if they had any similar issues or concerns with the care	G 478		

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G 478	Continued From page 7 received from the HHA. 8. The agency's Complaint Log included a "Complaint Form" documented on 9/22/20 by Employee GG, RN Case Manager. The form indicated the house supervisor (unnamed) of Patient #19 was the complainant, and Employee HH, HHA, was the employee involved. The "Complaint Details" stated "[Employee GG] was notified by House supervisor that [Employee HH] is not giving appropriate care. She stated that the aide is going into [Patient #19's] room and asking him if he wants a shower rather than telling him that she is there to help him with his shower. She is not shaving him daily, she puts him in a depend [incontinence brief] though he is continent during the day and she is only staying at this home for 30 minutes and leaving." The form's "Resolution/ Follow-up" stated "DON spoke with [Employee GG] re providing care as assigned. Aide stated she was frustrated with the house staff because the third shift worker would not answer her questions and she was new with the client. DON expressed to aide she should contact the office when issues arise instead of leaving without performing duties. Aide voiced understanding. DON left message with house manager requesting a return call." The complaint was documented as "Resolved" on 9/25/20. The complaint form failed to evidence the DON made contact with Patient #19's group home manager regarding Employee GG's concerns with the group home staff and failed to evidence interviews were conducted of Employee GG's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 9. The agency's Complaint Log contained a "Complaint Form" documented on 9/18/20 by	G 478		

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G 478	Continued From page 8 Employee N, HHA. The form indicated Patient #22 (start of care 1/22/19) was the complainant, and Former Employee E, HHA, was the employee involved. The "Complaint Details" stated "[Patient #22] called [Employee N] with a complaint abut [sic] [Former Employee E]. [The patient] stated [Employee N] has not been doing a [sic] the cleaning tasks on the flowsheet unless he asks her to. [The patient] states when [the HHA] does do the cleaning, it is not done very well ...." The form's "Resolution/ Follow-up" stated "HR Director [Employee CC] spoke with [Former Employee E] about the need to follow care plan including all the cleaning tasks. Aide was spoke with that client should not have to direct them to do the tasks but aide should be self motivated to complete the tasks on the flowsheet. Aide acknowledge understanding." The complaint was documented as "Resolved" on 9/24/20. The complaint form failed to evidence the interviews were conducted of Former Employee E's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 10. The agency's Complaint Log contained a "Complaint Form" documented on 7/29/20 by the DON. The form indicated Patient #4 (start of care 10/27/15) as the complainant, and Employees G and K, HHAs, were the employees named in the complaint. The "Complaint Details" stated "[Patient #4] contacted agency this date to report neither [Employee K], HHA, or [Employee G], HHA, are doing her laundry. [The patient] further stated that [Employee K] refuses to clean or take out trash. Client also stated she does not allow [Employee K] to shower her [due to] long nails. Client requested [Employee K] removed from schedule as soon as possible." The Complaint Form's "Resolution/ Follow-up" stated "DON	G 478		

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G 478	Continued From page 9 spoke with [Employee G], HHA, who admitted to not washing laundry 'because I was tired of being the only one to do anything.' DON explained laundry is ordered to be completed on every shift [due to] the amount of soiled laundry client generates. DON also asked if aide did not do laundry the week of 7/6-7/12 [2020], why did flow sheet indicate she did. Aide stated she did not read the flow sheet when completing. Aide instructed on proper documentation. Aide voiced understanding. DON spoke with [Employee K], HHA, who stated she does laundry every visit. DON explained laundry is ordered to be completed on every shift d/t the amount of soiled laundry client generates. Aide was also instructed to cut her fingernails ...." The complaint was documented as "Resolved" on 7/30/20. The complaint form failed to evidence interviews were conducted of Employee G or Employee K's other patients to assess if they had any similar issues or concerns with the care received from the HHAs, or that concerns of false documentation were addressed. 11. The agency's Complaint Log contained a "Complaint Form" documented on 7/16/20 by Employee GG, RN Case Manager. The form indicated the group home manager of Patient #23 (start of care 5/18/17) was the complainant, and Employee II, HHA, was the employee named in the complaint. The form's "Complaint Details" stated "[Group home manager] called and notified us that her 3rd shift staff s [sic] telling her that [Employee II] is showering [Patient #23] and getting him dressed fast then throwing a breakfast at him ... The [HHA] will just go and sit on the coach [sic] and watch TV not engaging with the client. The morning of the complaint [Employee II] took client to bathroom and left him there and told staff [the patient] was sitting on	G 478		

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G 478	Continued From page 10 toilet ... [the HHA] left [the patient] in a stool mess." The "Resolution/ Follow-up" stated "[DON] spoke with [Employee II] on the phone. [The HHA] denies that she rushes or that she just sits and watch TV. [The HHA] was told that she needs to be mindful on how she is spending her time with clients. If the work is done then [Employee II should] engage with the patient. [The HHA] verbalized understanding." The complaint was documented as "Resolved" on 7/20/20. The complaint form failed to evidence interviews were conducted of Employee II's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 12. The agency's Complaint Log contained a "Complaint Form" documented 7/10/20 by the Alternate Director of Nursing (ADON). The form indicated Patient #24 (start of care 2/18/20) was the complainant, and Employee Q, HHA, was the employee named in the complaint. The "Complaint Details" stated "[Patient #24] called stating [Employee Q] cleaned her kitchen and took out her trash. However, when pt [patient] requested she vacuum the floor [the HHA] stated it was not on the careplan [sic] and stepped out to call the office. [The HHA] stepped back into apartment, took her things and left. Pt denies altercation on the subject ...." The complaint form's "Resolution/ Follow-up" stated "7/10/20 ... ADON spoke with [Employee Q] who stated she completed cleaning the kitchen, mopping, taking out the trash, picking up mail, getting out clothes for shower. She was asked to do make the bed [sic], but patient then declined stating HHA would not know how ... HHA states the apartment was clean, and throughout visit patient asked her to do things and then 'made me feel stupid' 'told me I wouldn't know how to do these things.' [Employee Q] states she was preparing to give	G 478		

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G 478	Continued From page 11 patient a shower at which time patient made derogatory remarks toward her abilities again, and she became upset. [Employee Q] states she stepped out and called [the home health agency] ... [the HHA] then left patient residence ...." The complaint was noted to be "Resolved" on 7/10/20. The complaint form failed to evidence an interview was conducted with the agency employee whom Employee Q spoke with during the incident and failed to evidence interviews were conducted of Employee Q's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 13. The agency's Complaint Log contained a "Complaint Form" documented on 6/22/20 by the DON. The form indicated Person F, family member of Patient #25 (start of care 4/27/13), was the complainant, and Former Employee G was the employee named in the complaint. The "Complaint Details" stated "[Person F] ... contacted agency ... with concerns re ... care received from [Former Employee G], HHA. [Patient #25] is scheduled for services 0800 - 1600 [8:00 AM to 4:00 PM] daily during [Person F's] work hours. [Person F] stated around [8:30 AM] she contacted agency to alert that [Former Employee G] had not arrived as scheduled. [Person F] stated she was told by scheduling that aide was scheduled at 8am and they would contact her. Agency sent [Employee N], HHA as a replacement ... [Former Employee G] arrived around [11:15 AM]. During her visit ... [Former Employee G] went to her car twice, once for 27 minutes and a second time for 19 minutes. Daughter also claims aide wiped client with a dry towel then used that same towel to wipe off a table." The form's "Resolution/ Follow-up" stated "DON spoke with [Former Employee G] re visit. Aide admits she went to her car twice to smoke ...	G 478		

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G 478	Continued From page 12 DON explained leaving the client to smoke is not allowed. Aide voiced understanding. Aide denied wiping table with a towel used on client ...." The complaint was documented as "Resolved" on 6/23/20. The complaint form failed to evidence interviews were conducted of Former Employee G's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 14. The agency's Complaint Log included a "Complaint Form" documented on 6/11/20 by Employee FF, RN Case Manager. The form indicated Patient #26 (start of care 2/5/20) was the complainant, and Former Employee H, HHA, was named as the employee involved. The form's "Complaint Details" stated "6/11/20: [Patient #26] reports [Former Employee H] HHA being disrespecttful [sic] and rude, in turn [patient's] feelings are hurt ... [Patient #26 reported Former Employee H said] 'I don't want to talk to anyone today ... I'm having a bad day ... Don't fill your trash can this full again ... Your fridge is a mess ... When I'm done mopping I'm done working today but I'm not leaving early cause I'll lose money. I'm to [sic] tired to do anymore today.' [Patient #26] claims [Former Employee H] ... acted disgusted when [the patient] dropped soup on herself ... 6/17/20 Complaints from [Patient #26] stating [Former Employee H] told her ... the [home health agency] was taking Medicaid hours away related to being short staffed ... but will be making the hours up at the end ... [DON] spoke with [Former Employee H] who stated she did not tell pt this ... [the HHA] denied using or saying anything about Medicaid and hours." The complaint form's "Resolution/ Follow-up" stated " ... 6/17 [2020]: [Former Employee H] removed from [Patient #26's] home and will be placed in other clients	G 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 478	Continued From page 13 home ...." The complaint was documented as "Resolved" on 6/17/20. The complaint form failed to evidence interviews were conducted of Former Employee H's other patients to assess if they had any similar issues or concerns with the care received from the HHA and failed to evidence Former Employee H was interviewed regarding the alleged "disrespectful and rude" statements she made towards Patient #26. 15. The agency's Complaint Log included a "Complaint Form" documented on 5/15/20 by the ADON. The form indicated Person I, family member of Patient #27 (start of care 6/4/19), was the complainant, and Former Employee J, HHA, was the employee named in the complaint. The form's "Complaint Details" stated "[Person I] states [Patient #27] made several remarks ... about [Former Employee J] ... [Patient #27] consistently stated [Former Employee J] was on her phone quite a bit ...." The complaint's "Resolution/ Follow-up" stated "05/15/20 ... ADON placed [Former Employee J] on non-preferred list ...." The complaint was documented as "Resolved" on 5/15/20. The complaint form failed to evidence an interview was conducted with Former Employee J regarding the allegations and failed to evidence interviews were conducted of Former Employee J's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 16. The agency's Complaint Log included a "Complaint Form" documented on 5/4/20 by Employee FF, RN Case Manager. The form indicated Patient #26 (start of care 2/5/20) was the complainant, and Former Employee K, HHA, was named as the employee involved. The form's "Complaint Details" stated "[Patient #26] reports [Former Employee K], HHA is not	G 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 478	Continued From page 14 following aide careplan [sic] stating working is not being completed. Pt states [the HHA] is not sweeping or mopping floors, cooking or cleaning bathroom or dusting. [Patient #26] states she is signing flowsheets because she doesn't want confrontation ...." The complaint "Resolution/ Follow-up" was documented as "[Patient #26] to review HHA careplan flowsheets with HHA prior to signing and call agency immediately if tasks are not compelted [sic]. [Former Employee K], HHA completing tasks appropriately per flowsheets unless pt advises her not to." The complaint form failed to evidence an investigation of inaccurate documentation, or that an interview was conducted with Former Employee K regarding the allegations and failed to evidence interviews were conducted of Former Employee K's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 17. The agency's "Complaint Log" included a complaint documented by Employee FF, RN Case Manager, on 4/8/20. The "Complaint Form" indicated Patient #4 (start of care 10/27/15) was the complainant, and Employee K, HHA, was the employee named in the complaint. The form's "Complaint Details" stated "[Employee FF] took a call from [Patient #4]. [The patient] sent [Employee K], HHA away [from the visit]. [The patient] said [the HHA] refused to make her bed, refused to do her laundry ... [Patient #4] said 'all [the HHA] was doing was playing on her phone'." The complaint's "Resolution/ Follow-up" was documented as "[RN Case Manager] spoke with [Employee K], HHA. [The HHA] stated she made [Patient #4's] bed but didn't have time to do laundry ... 5/11: [RN Case Manager] spoke with ... [Patient #4] for an update on [Employee K], HHA visit. [The patient] denies complaints and said [the HHA] did ok. The complaint was	G 478		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 478	Continued From page 15 documented as "Resolved" on 5/11/20. The complaint form failed to evidence interviews were conducted of Employee K's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 18. The agency's "Complaint Log" included a complaint documented by Employee FF, RN Case Manager, on 3/30/20. The "Complaint Form" indicated Patient #28 (start of care 3/15/13) was the complainant, and Former Employee L, Licensed Practical Nurse (LPN), was the employee named in the complaint. The form's "Complaint Details" stated "[Patient #28] called saying [Former Employee L] did not use hand sanitizer or hand soap after removing her gloves. Also, [the patient] voiced concern of [Former Employee L] not wiping the top of the insulin bottle with alcohol swab prior to filling syringe." The complaint's "Resolution/ Follow-up" stated "DON spoke with [Former Employee L] on 4/1/20. [Former Employee L] stated she did wash her hands when she removed her gloves ... DON reminded nurse of heightened concerns at this time and to be sure to have client's attention when washing hands and wiping insulin vial." The complaint was documented as "Resolved" on 4/1/20. The complaint form failed to evidence an interview was conducted with Former Employee L regarding the allegation of her not cleaning the insulin vial with alcohol prior to injecting and filing a syringe (as proper standard precautions require), failed to evidence a supervisory visit of Former Employee L was conducted to ensure she was following infection control policies and procedures, failed to evidence interviews were conducted of Former Employee L's other patients to assess if they had any similar issues or concerns with the care received from the nurse.	G 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 478	Continued From page 16 19. The agency's "Complaint Log" included a complaint documented by Former Employee M, HHA, on 3/26/20. Former Employee M was also the complainant. The "Report of Concern" form indicated Patient #29 (start of care 3/2/20) was the patient involved in the complaint, and two unnamed employees of Patient #29's group home were named in the complaint. The "Date of Concern" was 3/24/20, and the "Description of Concern" stated "A male and female house staff was very rude towards [Former Employee M] from the moment I walked into the door. Since it was my first day with [Patient #29], I wasn't comforable [sic] with picking up [the patient] to get him in and out of the shower. I asked the [male house employee] to help assist me with [the patient]. [The male house employee] seemed very annoyed ... [The male house employee] forcefully got [Patient #29] out [of the shower], and also forcefully put [the patient] in his scooter. [The male house employee] didn't put [the patient] in all the way, sorta [sic] just put him at the end [of the seat]. Therefore [the patient] started to fall out [of the scooter] ...." The complaint's "Follow Up Investigation by Administrator ..." indicated the complaint was investigated on 4/9/20 by the DON, and indicated "DON contacted [group home] re incident. Voicemail left requesting return call." The complaint's "Resolution" stated "no return call received." The complaint documentation failed to evidence the DON or other agency staff followed up with the patient's group home supervisor to ensure Former Employee M's concerns of potential abuse towards Patient #29 by the group home staff were received and investigated by the group home. 20. The agency's Complaint Log included a complaint documented by Former Employee L,	G 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 478	Continued From page 17 LPN, on 3/2/20. The "Report of Concern" indicated Patient #26 (start of care 2/5/20) was the complainant, and Former Employee K, HHA, was the employee named in the complaint. The form indicated the "Date of Concern" was 3/1/20, and the "Description of Concern" stated "[Former Employee L, LPN] asked [Patient #26] what time [Former Employee K] was scheduled, [the patient] stated [the HHA] just left. [The LPN] asked why client's apartment was not clean and client stated 'I guess because [the HHA] didn't want to clean, just sit in the chair' ... Client's living room was a mess with blankets piled up and clutter all over including the floors. [Patient #26] stated '[The HHA] even complains about the food I ask her to cook for me and now I feel like I shouldn't eat at all.' [The patient] also stated 'I refused my showers all weekend because I felt like I was a burden to [the HHA]'." The complaint's "Follow Up Investigation" was documented on 3/5/20 by Former Employee N, Former Director of Human Resources. The "Investigation Description" stated "HR Director spoke to [Former Employee K] about completing all duties from care plan, and ensuring an attitude-free environment in client's home ...." The complaint form failed to evidence interviews were conducted of Former Employee K's patients to assess if they had any similar issues or concerns with the care received from the HHA. 21. The agency's Complaint Log included a complaint documented by Employee FF, RN Case Manager, on 2/29/20. The "Complaint Form" indicated Person O, family member of Patient #12 (start of care 12/6/19) was the complainant, and Former Employee P, HHA, was the employee named in the complaint. The form's "Complaint Details" stated "... [Person O] said the past few times [Former Employee P] has been	G 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

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G 478	Continued From page 18 scheduled to come at 8am she doesn't show up until 9-930am ... [Person O] said she has shown [the HHA] on numerous occasions how to care for [Patient #12] or how to do things in the home but she said if she walks away [the HHA] doesn't do whats [sic] expected. [Person O] also voiced concern about [Former Employee P] not assisting when [Patient #12] becomes loud and/or hits himself ...." The complaint was documented as "Resolved" on 3/5/20. The complaint form failed to evidence an interview with Former Employee P regarding the allegations, failed to evidence a record review of Former Employee's timesheets was conducted, and failed to evidence interviews were conducted of Former Employee P's other patients to assess if they had any similar issues or concerns with the care received from the HHA. 22. The agency's Complaint Log included a complaint documented by the DON on 2/12/20. The "Complaint Form" indicated Employee I, LPN, was the complainant, and Patient #30 (start of care 3/21/13) was the patient involved. The form's "Complaint Details" stated "[Employee I], LPN, informed agency ... that during visit on 2/6/20 [Patient #30] did not have any clean towels or clothes and dirty laundry was overflowing in client's laundry basket ... Laundry was not done on subsequent days until nurse arrived Sunday 2/9/20 and clean laundry was left on client's bed. Laundry task is listed on client's care plan as daily for the first shift of the day. LPN also stated that client had not showered/changed clothes for five consecutive days." The complaint's "Resolution /Follow-up" stated "HR director addressed issues with Aides [complaint form did not name specific individuals] for [Patient #30] and stressed the importance of following client care plans ... Aides also stated that client is refusing to bathe when they attempted to. HR Director reiterated with	G 478		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

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G 478	Continued From page 19 aides that they need to call and speak to an RN when these things occur." The complaint was indicated as "Resolved" on 2/13/20. The complaint form failed to indicate which HHAs the complaint was regarding and failed to evidence interviews were conducted of the HHAs' other patients to assess if they had any similar issues or concerns with the care received from the HHAs. 23. An interview was conducted with the Administrator and DON on 11/16/20 at 4:01 PM. During the interview, the Administrator indicated all complaints should be investigated thoroughly.	G 478		
G 528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This Element is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment contained a complete and thorough health status for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 17 records. Findings include: 1. An agency policy titled "Initial and Comprehensive Assessment," policy number 4-018.1 and revised 10/28/20, stated "... Policy ... A comprehensive patient assessment ... will be patient-specific and comprehensive ... Procedure: ... 5. The comprehensive assessment will accurately reflect the patient's status, and will include at least the following information ... C. A physical assessment, including ... other relevant data related to pertinent physical findings of common symptoms such as constipation,	G 528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 528	Continued From page 20 dyspnea [difficulty breathing], skin breakdown, sleep disorders, nausea and vomiting, anxiety dehydration [sic], etc. (Head to toe assessment) ...." King, Kingery, and Casey. "Diagnosis and Evaluation of Heart Failure." June 15, 2012. Retrieved 11/19/2020, from www.aafp.org. " ... History and Physical Exam. Patients with heart failure can have ... fluid retention, with peripheral or abdominal swelling ...." 2. The clinical record of Patient #1 was reviewed on 11/4/20 and 11/12/20, and indicated a resumption of care date of 9/26/17, with patient diagnoses including but not limited to schizoaffective disorder, Type 2 Diabetes, personality disorder, "arthropathy [diseases of the joint]," and high blood pressure. The clinical record contained a comprehensive assessment completed on 10/21/20 by Employee FF, Registered Nurse (RN), for the recertification period of 10/22/2020 - 12/20/2020. A home visit observation with Patient #1 was conducted on 11/4/2020 at 3:50 PM. During the visit, the patient was noted to have all medications and blood glucose monitor locked in a medication lock box by the home health agency staff. The DON (director of nursing), present at the home visit, indicated the patient had her medications locked by the agency because the patient would "overtake" her medications and check her blood sugar frequently throughout the day if she had access to her medications and glucose monitor. The DON also indicated the patient's provider "agreed to" the agency locking the patient's medications and glucose monitor, and the patient did not have access to the lock box. The patient's comprehensive assessment failed to evidence the patient's need for her	G 528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 528	Continued From page 21	G 528		

medications to be locked without her ability to access them.

A plan of care for the certification period of 8/23/20 - 10/21/2020 included physician orders which stated "SN [Skilled Nurse] to assess weight every visit."

The comprehensive assessment indicated presence of "short term memory deficit," but failed to evidence further details regarding this deficit (extent of deficit, if it is at baseline, improving, or worsening, etc). The comprehensive assessment failed to evidence presence of an assessment of the patient's arthropathy. The comprehensive assessment indicated a "reported" patient weight of 210 pounds, but failed to indicate if this weight was higher, lower, or no change compared to the patient's previous weight measurement.

3. The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated a start of care date of 4/30/2020, with patient diagnoses including but not limited to cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. The clinical record contained a comprehensive assessment completed on 10/23/2020 by Employee C, RN, for the recertification period 10/27/2020 - 12/25/2020.

A home visit observation with Patient #2 was conducted on 11/5/2020 at 9:50 AM. During the home visit, the patient was noted to receive respiratory support from a ventilator through a tracheostomy (surgically placed opening through the neck into the trachea for breathing assistance) and received enteral feedings through a MIC-KEY gastrostomy tube (medical

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

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G 528	Continued From page 22 tube surgically inserted into the stomach for enteral feedings). The comprehensive assessment failed to evidence assessment of the tracheostomy and gastrostomy tube sites (is site clean, dry, any redness or drainage, etc.). The patient's comprehensive assessment contained a section titled "Neuro [Neurological] / Emotional / Behavioral Status," which indicated the patient "verbalizes but is unable to make needs known." The "Pain Assessment" section of the assessment indicated the patient had "no pain." The comprehensive assessment failed to evidence the method of pain assessment (medically recognized pain scale for non-verbal patients or presence or absence of nonverbal clues of pain, such as grimacing, bracing, guarding, etc). The "Respiratory Status" section of the comprehensive assessment indicated the patient exhibited "Accessory muscles used ... Ineffective breathing pattern ... Abnormal breath sounds" as symptoms related to his diagnosis of chronic respiratory failure, however the assessment failed to evidence if these symptoms were improved, worsened, or at baseline. The respiratory assessment also indicated the patient's breath sounds were "clear" to all lung lobes upon auscultation, however the "Head to Toe assessment," documented within the "Goals / Interventions Summary" section of the assessment, indicated "Lung sounds course throughout." The comprehensive assessment included a medication list with the orders for " ... Midodrine [given for low blood pressure or systolic heart failure] ... Onfi [given to prevent seizures] ... Polyethylene glycol [Miralax, given for constipation] ... Senna [given for constipation] ...	G 528		

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G 528	Continued From page 23 Vimpat [given to prevent seizures] ... Glycerin adult rectal suppository [given for constipation ..." The comprehensive assessment failed to evidence assessment of diseases or conditions related to these medications. 4. The clinical record of Patient #3 was reviewed on 11/5/2020 and 11/12/2020, and indicated a start of care date of 5/20/2020, with patient diagnoses including, but not limited to rheumatoid arthritis, fibromyalgia, chronic pain syndrome, history of squamous cell cancer, history of drug use, and Chronic Obstructive Pulmonary Disease (COPD, chronic inflammatory disease of the lungs). The clinical record contained a comprehensive assessment completed on 9/16/2020 by Employee C, RN, for the recertification period 9/17/2020 - 11/15/2020. The comprehensive assessment stated "... Nutritional Status ... Meals Prepared By: Self. Formula via PEG [Percutaneous endoscopic gastrostomy, surgically placed feeding tube] 4-5 times/day ... Current and Medical Health Status ... Patient has a trach related to a tracheostomy from throat and tongue cancer ...." The comprehensive assessment failed to evidence assessment of the tracheostomy and PEG tube sites (is site clean, dry, any redness or drainage, etc), and failed to evidence which tube feeding the patient received. The comprehensive assessment stated "Neuro/Emotional/Behavioral Status ... Patient shows no s/s [signs and symptoms] of depression, Depression is managed well with GTube (PEG tube) medication ... Patients Head to Toe Assessment ... Patient reports 10 out of 14 days feeling depressed ... Pt [Patient] states she feels med aren't helping ...." The comprehensive assessment failed to evidence a consistent	G 528		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 528	Continued From page 24 assessment of the patient's depression or interventions to help with mitigation. The comprehensive assessment stated " ... Patients Head to Toe Assessment ... Patient reports chronic pain related to back. Patient states she sees pain management and is prescribed oral medication and a transdermal patch that is changed every 3 days to manage the pain. Patient claims pain level is always at a 7 or 8 and that is a tolerable level however rating pain is an 8 today ...." The comprehensive assessment failed to evidence a more thorough pain assessment (if pain radiates to other locations, what makes pain better or worse, if there is any improvement from the pain medications, if any side effects from chronic pain medications, etc). The comprehensive assessment contained a medication list which included the medication (but not limited to) Lamotrigine (given to prevent and treat seizures) and Pilocarpine (used to decrease secretions). The comprehensive assessment failed to evidence diagnoses or conditions related to these medications. 5. The clinical record of Patient #4 was reviewed on 11/6/2020, and indicated a start of care date of 10/27/2015, with patient diagnoses including, but not limited to, dementia, stress incontinence, tremor, asthma, and chronic pain. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager, on 9/25/2020, for the recertification period 9/30/2020 - 11/28/2020. A home visit observation with Patient #4 was conducted on 11/6/2020 at 8:50 AM. During the visit, the patient was noted to have all	G 528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 528	Continued From page 25	G 528		

medications locked in a medication lock box by the home health agency staff. The patient's comprehensive assessment failed to evidence the patient's need for her medications to be locked without her ability to access them.

The comprehensive assessment contained a medication list which included the medications, but not limited to, Atenolol (given to lower blood pressure), Bisacodyl (given for constipation), Colace (given for constipation), Ferrous sulfate (iron supplement given for low-iron related conditions), Furosemide (given to remove excess fluid in the body), Levothyroxine (given for low thyroid function), Prilosec (given for Gastroesophageal Reflux Disease (GERD), Risedronate (given to treat osteoporosis), and Spironolactone (given to remove excess fluid in the body). The comprehensive assessment failed to evidence diagnoses or conditions related to these medications.

6. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, and indicated a start of care date of 4/5/19, with patient diagnoses including, but not limited to heart failure, COPD, history of transient ischemic attack (TIA, temporary loss of blood flow to the brain), left above the knee amputation, generalized muscle weakness, history of deep vein thrombosis (blood clot formed within a vein deep in the body), and depression. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager, on 9/22/2020, for the recertification period 9/26/2020 - 11/24/2020.

The "Cardiac Status" section of the comprehensive assessment stated, "Educated patient on keeping leg elevated and following low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 528	Continued From page 26 sodium diet to reduce/prevent swelling." The comprehensive assessment failed to evidence if edema was present or absent. The comprehensive assessment contained a medication list which included, but not limited to, the medications "Famotidine (given for GERD), Lotrimin AF (given to treat fungal infections of the skin), Mupirocin (given to treat bacterial infections of the skin), Narcan (given to reverse narcotic overdose), Pregabalin (given for nerve pain), and Oxycodone-Acetaminophen (narcotic given for pain relief). The comprehensive assessment failed to evidence diagnoses or assessments related to these medications. 7. An interview was conducted with the Alternate Administrator and Director of Nursing (DON) on 11/12/2020 at 4:06 PM. During the interview, the Alternate Administrator indicated the comprehensive assessment should include an accurate and thorough health status of the patient. 17-14-1(a)(1)(A)	G 528		
G 530	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment included the patient's progress towards goals and care preferences for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total	G 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 530	Continued From page 27 sample of 17 records. Findings include: 1. An agency policy titled "Initial and Comprehensive Assessment," policy number 4-018.1 and revised 10/28/20, stated "... Procedure ... The comprehensive assessment will accurately reflect the patient's status, and will include at least the following information ... H. Patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals idenfied [sic] by the patient and the measurable outcomes identified by the agency ...." 2. The clinical record of Patient #1 was reviewed on 11/4/20 and 11/12/20, and indicated a resumption of care date of 9/26/17, with patient diagnoses including, but not limited to, schizoaffective disorder, Type 2 Diabetes, personality disorder, "arthropathy [diseases of the joint]," and high blood pressure. The clinical record contained a comprehensive assessment completed on 10/21/20 by Employee FF, Registered Nurse (RN), for the recertification period of 10/22/2020 - 12/20/2020. The recertification comprehensive assessment failed to evidence the patient's progress towards their goals and care preferences. 3. The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated a start of care date of 4/30/2020, with patient diagnoses including, but not limited to, cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. The clinical record contained a comprehensive assessment completed on 10/23/2020 by Employee C, RN, for	G 530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 530	Continued From page 28	G 530		

the recertification period 10/27/2020 - 12/25/2020. The recertification comprehensive assessment failed to evidence the patient's progress towards their goals and care preferences.

4. The clinical record of Patient #3 was reviewed on 11/5/2020 and 11/12/2020, and indicated a start of care of 5/20/2020, with patient diagnoses including, but not limited to, rheumatoid arthritis, fibromyalgia, chronic pain syndrome, history of squamous cell cancer, history of drug use, and Chronic Obstructive Pulmonary Disease (COPD, chronic inflammatory disease of the lungs). The clinical record contained a comprehensive assessment completed on 9/16/2020 by Employee C, RN, for the recertification period 9/17/2020 - 11/15/2020. The recertification comprehensive assessment failed to evidence the patient's progress towards their goals and care preferences.

5. The clinical record of Patient #4 was reviewed on 11/6/2020, and indicated a start of care date of 10/27/2015, with patient diagnoses including, but not limited to, dementia, stress incontinence, tremor, asthma, and chronic pain. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager, on 9/25/2020, for the recertification period 9/30/2020 - 11/28/2020. The recertification comprehensive assessment failed to evidence the patient's progress towards their goals and care preferences.

6. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, and indicated a start of care date of 4/5/19, with patient diagnoses including, but not limited to, heart failure, COPD, history of transient ischemic attack

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 530	Continued From page 29 (TIA, temporary loss of blood flow to the brain), left above the knee amputation, generalized muscle weakness, history of deep vein thrombosis (blood clot formed within a vein deep in the body), and depression. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager, on 9/22/2020, for the recertification period 9/26/2020 - 11/24/2020. The recertification comprehensive assessment failed to evidence the patient's progress towards their goals and care preferences. 7. An interview was conducted with the Alternate Administrator and Director of Nursing (DON) on 11/12/2020 at 4:06 PM. During the interview, the Alternate Administrator indicated the comprehensive assessment should include a patient's care preferences "if they have preferences."	G 530		
G 534	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the comprehensive assessment included individualized patient nursing and discharge planning needs for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 17 records. Findings include: 1. An agency policy titled "Initial and Comprehensive Assessment," policy number 4-018.1 and revised 10/28/20, stated "... Procedure ... The comprehensive assessment will accurately reflect the patient's status, and will	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 30	G 534		

include at least the following information ... I. Patient's medical, nursing, rehabilitative, social, and discharge planning needs ...."

2. The clinical record of Patient #1 was reviewed on 11/4/20 and 11/12/20, and indicated a resumption of care date of 9/26/17, with patient diagnoses including, but not limited to, schizoaffective disorder, Type 2 Diabetes, personality disorder, "arthropathy [diseases of the joint]," and high blood pressure.

A home visit observation with Patient #1 was conducted on 11/4/2020 at 3:50 PM. During the visit, Employee E (Licensed Practical Nurse, LPN) obtained Patient #1's blood sugar, and reported the reading was 230. The LPN reported this blood sugar level to the patient's physician.

An interview was conducted with the agency's Administrator and Director of Nursing (DON) on 11/6/20 at 11:56 PM. During the interview, the DON indicated the call parameters for an elevated blood sugar was "dependent on the doctor," and there was no agency expectation of all diabetic patients and/or insulin-dependent diabetic patients to have call parameters for high blood sugar. The DON stated, "some doctors haven't issued orders [regarding call parameters for elevated blood sugar]," and indicated if there were not call parameters, the agency nurse was expected to "use nursing judgment" on when to notify the provider for a high blood sugar reading.

The clinical record contained a comprehensive recertification assessment completed on 10/21/20 by Employee FF, Registered Nurse (RN), for the recertification period of 10/22/2020 - 12/20/2020. The comprehensive assessment indicated "Vitals Physician Alert Range: ... Fasting Blood Sugar: <

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 31 [less than]70. Random Blood Sugar: <70 .... Skilled Nursing: ... Diabetes: ... Skilled Nurse to assist patient to perform finger stick blood sugar twice a day ...." The comprehensive assessment failed to evidence nursing needs, such as call parameters for elevated blood sugar levels. The comprehensive assessment included a section titled "Goals/Interventions Summary," which stated "... Interventions ... Skilled Care Discharge Plan: Patient educated on discharge process for when a higher level of care is required." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale. 3. The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated a start of care date of 4/30/2020, with patient diagnoses including but not limited to cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. A home visit observation with Patient #2 (start of care 4/30/2020) was conducted on 11/5/2020 at 9:50 AM. Prior to entrance to the home, the DON indicated the patient's family requested home health staff wear "full PPE [personal protective equipment]," including gown, gloves, N-95 mask, and face shield, to decrease the spread of COVID-19 to the patient and family members. The clinical record contained a comprehensive assessment completed on 10/23/2020 by Employee C, RN, for the recertification period 10/27/2020 - 12/25/2020. The comprehensive assessment failed to evidence the caregivers' request for staff to wear additional PPE, such as gowns, N-95 masks, and face shield. The	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 32	G 534		

comprehensive assessment included a section titled "Goals/Interventions Summary," which stated "... Interventions ... Skilled Care Discharge Plan: Patient educated on discharge process for when a higher level of care is required." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale.

4. The clinical record of Patient #3 was reviewed on 11/5/2020 and 11/12/2020, and indicated a start of care date of 5/20/2020, with patient diagnoses including, but not limited to, rheumatoid arthritis, fibromyalgia, chronic pain syndrome, history of squamous cell cancer, history of drug use, and Chronic Obstructive Pulmonary Disease (COPD, chronic inflammatory disease of the lungs). The clinical record contained a comprehensive assessment completed on 9/16/2020 by Employee C, RN, for the recertification period 9/17/2020 - 11/15/2020. The comprehensive assessment included a section titled "Goals/Interventions Summary," which stated "... Skilled Care DC [Discharge] Plan: Discharge when skilled care is no longer needed/goals met ... Patient educated on discharge process for when a higher level of care is required ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning which included if/when the patient could be discharged with rationale.

5. The clinical record of Patient #4 was reviewed on 11/6/2020, and indicated a start of care date of 10/27/2015, with patient diagnoses including, but not limited to, dementia, stress incontinence, tremor, asthma, and chronic pain. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 33 on 9/25/2020, for the recertification period 9/30/2020 - 11/28/2020. The comprehensive assessment included a section titled "Goals/Interventions Summary," which stated "... Skilled Care DC [Discharge] Plan: Patient educated on discharge process for when a higher level of care is required ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharged with rationale. 6. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, and indicated a start of care date of 4/5/19, with patient diagnoses including, but not limited to, heart failure, COPD, history of transient ischemic attack (TIA, temporary loss of blood flow to the brain), left above the knee amputation, generalized muscle weakness, history of deep vein thrombosis (blood clot formed within a vein deep in the body), and depression. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager, on 9/22/2020, for the recertification period 9/26/2020 - 11/24/2020. The comprehensive assessment stated "... Cardiac Status: ... PT/INR [laboratory test used to test the speed in which blood clots] ... Is Patient Taking an Anticoagulant? Yes ...." The medication list included with the comprehensive assessment indicated that patient's medication orders included "... Warfarin [medication used to thin the blood, dosed and monitored by a physician or Coumadin clinic according to PT/INR blood work testing] 5 mg oral tablet. Comment: As directed by [Coumadin clinic] ..." The comprehensive assessment failed to evidence the date and test results of the patient's most recent PT/INR result, and failed to evidence the patient's current orders for	G 534		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 534	Continued From page 34 frequency of PT/INR testing. The comprehensive assessment included a section titled "Goals/Interventions Summary," which stated " ... Skilled Care Discharge Plan: Discharge when higher level of care is needed. Patient will verbalize understanding to education provided on discharge process by end of recertification period ... Interventions ... Patient educated on discharge process for when a higher level of care is required ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharged with rationale. 7. An interview was conducted with the Alternate Administrator and Director of Nursing on 11/12/2020 at 4:06 PM. During the interview, the Alternate Administrator indicated the comprehensive assessment should include all patient nursing and discharge needs. 17-14-1(a)(1)(B)	G 534		
G 536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This Element is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained a complete review of medications which maintained the medication list accurately for 4 of 5 active records reviewed (#2, 3, 4, 5), in a total sample of	G 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 536	Continued From page 35 17 records. Findings include: 1. An agency policy titled "Initial and Comprehensive Assessment," policy number 4-018.1 and revised 10/28/20, stated "... Procedure ... The comprehensive assessment will accurately reflect the patient's status, and will include at least the following information ... U. Review of medication history, as applicable to care and service and current medication use, including prescription, over-the-counter medications and herbal medications ...." 2. The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated a start of care date of 4/30/2020, with patient diagnoses including but not limited to, cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. The clinical record contained a comprehensive assessment completed on 10/23/2020 by Employee C, RN, for the recertification period 10/27/2020 - 12/25/2020. The comprehensive assessment contained a medication list which included the orders for, but not limited to, "Zinc oxide [given to treat skin irritations] 10% topical cream, 10% [dosage], topically, Frequency: BID [twice a day] - AM/PM and as needed ... Bacitracin zinc [given to treat bacterial skin infections] 500 units/g [gram] topical ointment, scant amount, topical, Frequency: Three times a day as needed ...." The medication list failed to evidence indications for administering the Bacitracin and failed to evidence clear directions on the amount and location to apply the topical medications Zinc oxide and Bacitracin zinc. 3. The clinical record of Patient #3 was reviewed	G 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 536	Continued From page 36 on 11/5/2020 and 11/12/2020, and indicated a start of care date of 5/20/2020, with patient diagnoses including, but not limited to, rheumatoid arthritis, fibromyalgia, chronic pain syndrome, history of squamous cell cancer, history of drug use, and Chronic Obstructive Pulmonary Disease (COPD, chronic inflammatory disease of the lungs). The clinical record contained a comprehensive assessment completed on 9/16/2020 by Employee C, RN, for the recertification period 9/17/2020 - 11/15/2020. The comprehensive assessment contained a medication list, which included an order for Ipratropium-albuterol [given for shortness of breath] 0.5mg [milligram] - 2.5 mg / 3 ml [milliliter], 3 ml inhalation three times a day "as needed." The medication list failed to evidence indication for administration of this medication. 4. The clinical record of Patient #4 was reviewed on 11/6/2020, and indicated a start of care date of 10/27/2015, with patient diagnoses including, but not limited to, dementia, stress incontinence, tremor, asthma, and chronic pain. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager, on 9/25/2020, for the recertification period 9/30/2020 - 11/28/2020. The comprehensive assessment contained a medication list which included orders for, but not limited to, "Clear Eyes + Redness Relief [eye drops given for temporary relief of eye irritation] 0.012% ophthalmic [related to the eye] gel forming solution ... 1 drop both eyes, Ophthalmic, Frequency: Four times as day as needed ... Hydrocortisone AC 1% topical cream [given to treat itching related to several skin conditions], Scant amt [amount], Topical, Frequency: Twice a day as needed ... Mucinex D [given to treat cough] Max Strength 120 mg - 1200 mg oral tablet, extended release, 1200 mg -	G 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 536	Continued From page 37 120 mg, Oral, Frequency: Every 12 hours as needed ... Mupirocin [given to treat bacterial skin infection] 2% topical ointment, scant amount, topical, Frequency: Three times per day AM, Noon, PM as needed ... Nystatin [given to treat fungal infection on the skin] 100,000 units/g [gram] topical powder, Scant amt, Topical, Frequency: Twice a day as needed ... Nystatin-triamcinolone [given to treat fungal infection on the skin]100,000 units/g - 0.1% topical cream, Scant amt, Topical, Frequency: Once a day as needed ... Tobramycin [given to treat eye infections] 0.3% ophthalmic solution, 2 drops, Eye Drops, Frequency: every 4 hours as needed for 7 days to affected eye ... Tramadol [given for pain relief] 50 mg oral tablet, 50 mg, Oral, Frequency: Every 8 hours as needed ... Triple Antibiotic Plus [given to treat or prevent bacterial skin infection] topical ointment, Scant amt, Topical, Frequency: Once daily as needed ... Ventolin HFA [given for shortness of breath] 90 mcg/inh [micrograms per inhalation] inhalation aerosol, 1 puff, Inhalation, Frequency: Every 6 hours as needed ...." The medication list failed to evidence indications for administering the above medications and failed to evidence clear directions on the amount and location to apply the topical medications Hydrocortisone, Mupirocin, Nystatin, Nystatin-triamcinolone, and Triple Antibiotic Plus. 5. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, and indicated a start of care date of 4/5/19, with patient diagnoses including, but not limited to heart failure, COPD, history of transient ischemic attack (TIA, temporary loss of blood flow to the brain), left above the knee amputation, generalized muscle weakness, history of deep vein thrombosis (blood clot formed within a vein deep	G 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 536	Continued From page 38 in the body), and depression. The clinical record contained a comprehensive assessment completed by Employee FF, RN Case Manager, on 9/22/2020, for the recertification period 9/26/2020 - 11/24/2020. The comprehensive assessment contained a medication list which included orders for "... Lotrimin AF 1% topical cream, scant [dosage], topical, Frequency: Twice a day ... Mupirocin 2% topical cream, scant, by mouth [sic], Frequency: three times a day ... Narcan [given to reverse opioid overdose] 4 mg / 0.1 mL nasal spray, 4 mg / 0.1 mL, nasal spray, Frequency: 1 spray into nares as needed ... Nystatin 100,000 units / g topical powder, 100000 units/g, topical, Frequency: Four times per day -as needed ... Oxycodone-acetaminophen [opioid given for pain relief] 10 mg - 325 mg oral tablet ... 325 mg - 10 mg, Oral, Frequency: 1 tablet every 6 hours as needed ... Tessalon [given to treat cough] 200 mg oral capsule, 200 mg, by mouth, Frequency: three times a day as needed ...." The medication list failed to evidence indications for administering Narcan, Nystatin, Oxycodone-acetaminophen, and Tessalon; and failed to evidence clear directions on the amount and location to apply topical medications Lotrimin and Mupirocin. 6. An interview was conducted with the Alternate Administrator and Director of Nursing (DON) on 11/12/2020 at 4:06 PM. During the interview, the Alternate Administrator indicated the medication list should include indications for when to administer "as needed" medications. 17-14-1(a)(1)(B)	G 536		
G 538	Primary caregiver(s), if any CFR(s): 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and	G 538		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

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G 538	Continued From page 39 other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the comprehensive assessment included the primary caregiver's willingness and ability to provide care, availability, and schedules for 1 of 1 active records of patients with primary caregivers reviewed (#2), in a total sample of 17 records. Findings include: An agency policy titled "Initial and Comprehensive Assessment," policy number 4-018.1 and revised 10/28/20, stated "... Procedure ... The comprehensive assessment will accurately reflect the patient's status, and will include at least the following information ... V. Patient and family/caregiver and other available support systems and the type of care the family/caregiver is available, capable, and willing to provide ... X. Assess availability and schedules ...." The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated a start of care date of 4/30/2020, with patient diagnoses including but not limited to cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. The clinical record contained a comprehensive assessment completed on 10/23/2020 by Employee C, RN, for the recertification period 10/27/2020 - 12/25/2020. The comprehensive assessment indicated " ... Psychosocial Status: Patient resides in a tri-level home with caregivers: mother, step-father, and brothers. Patient's caregivers provide care for client when agency is not in home. Father works a full time job, and brother attends school	G 538		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 538	Continued From page 40 therefore are not available to care for patient 24/7. Patient's mother ... cannot have direct contact with client [due to health condition] ...." The clinical record failed to evidence Patient #2's primary caregivers' willingness and ability to provide care, availability, and schedules. An interview was conducted with the Alternate Administrator and Director of Nursing (DON) on 11/12/2020 at 4:06 PM. During the interview, the Alternate Administrator indicated the comprehensive assessment should include information regarding the primary caregiver(s).	G 538		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and 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	G 574		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 574	Continued From page 41 HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the plan of care (POC) included all pertinent diagnoses, the patient's nutritional requirements, a complete list of the patient's medications, patient and caregiver education, training to facilitate timely discharge, and patient-specific and measurable goals for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 17 records. Findings include: 1. An agency policy titled "Care Planning Process," policy number 4-001.1 and revised 10/28/20, stated " ... Procedure. 1. Individualized Plan of Care: Based on the assessment and conclusions, the plan of care will include, but will not be limited to: ... C. All pertinent primary and secondary diagnoses ... I. Measurable outcomes and goals identified by the organization and the patient anticipated to occur as a result of implementing and coordinating the plan of care ... N. Nutritional requirements. O. Medications including dose/frequency/route ... S. Discharge or referral plans ... Y. Patient and caregiver education and training to facilitate timely discharge ...." 2. The clinical record of Patient #1 was reviewed on 11/4/20 and 11/12/20, and indicated a resumption of care date of 9/26/17, with patient diagnoses including but not limited to, schizoaffective disorder, Type 2 Diabetes,	G 574		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 574	Continued From page 42 personality disorder, "arthropathy [diseases of the joint]," and high blood pressure. The clinical record included a plan of care for the certification period of 10/22/2020 - 12/20/2020. The recertification comprehensive assessment completed by Employee FF, Registered Nurse (RN), on 10/21/2020, indicated the patient had urinary "urgency/frequency" and incontinence (inability to control bladder) and short-term memory loss. The comprehensive assessment included a medication list which listed (but not limited to) the medication "Simvastatin [given for elevated cholesterol]." The POC failed to evidence patient diagnoses of elevated cholesterol, short-term memory loss or urinary urgency, frequency, or incontinence. A home visit observation with Patient #1 was conducted on 11/4/2020 at 3:50 PM. During the visit, the patient was noted to have all medications and blood glucose monitor locked in a medication lock box by the home health agency staff. The Director of Nursing (DON), present at the home visit, indicated the patient's provider "agreed to" having the agency lock the patient's medications and glucose monitor, and the patient did not have access to the lock box. The POC failed to evidence a physician's order for the patient's medication and glucose monitor to be locked in a medication lock box. The POC contained a section titled "Rehabilitation Potential/Discharge Plans/Goals," which stated, "Skilled Care Discharge Plan: Patient will verbalize understanding to education provided on discharge process by end of recertification period." The POC failed to evidence patient-specific and individualized patient discharge planning was conducted to	G 574		

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G 574	Continued From page 43 facilitate a timely discharge. The POC contained patient goals including "Patient will be free from pain through next recertification period ... Patient/Caregiver will be able to recall/demonstrate Signs/Symptoms of the following disease processes: diabetes for self-management of disease process by end of certification period ... Patient Fast Blood Sugar or Resting Blood Sugar will remain Within Normal Limits through next recertification period ... Patient/caregiver will demonstrate no complications from obtained lab(s) when performed ... Patient will continue to maintain weight during this certification period ... Patient will continue to remain compliant with medications this certification period ..." The POC failed to evidence all goals were individualized, patient-specific, and measurable. 3. The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated a start of care date of 4/30/2020, with patient diagnoses including but not limited to, cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. The clinical record contained a plan of care for the recertification period of 10/27/2020 - 12/25/2020. The clinical record contained a comprehensive assessment for Patient #2 on 10/23/2020 by Employee C, RN. The comprehensive assessment indicated the patient had dyspnea (feeling of shortness of breath) at "rest." The plan of care failed to evidence the patient's dyspnea at rest within the patient's functional limitations. The POC contained the orders for medications "... Acetaminophen [given for pain relief and/or fever] 500 mg [milligram] oral tablet, 500 mg,	G 574		

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G 574	Continued From page 44 every 4 hours as needed ... Bacitracin zinc [given to treat or prevent skin bacterial infections] 500 units/g [gram] topical ointment, scant amount, Three times a day as needed ... Midodrine [given for low blood pressure or systolic heart failure] ... Onfi [given to prevent seizures] ... Polyethylene glycol [Miralax, given for constipation] ... Senna [given for constipation] ... Vimpat [given to prevent seizures] ... Glycerin adult rectal suppository [given for constipation] .... Zinc oxide 10% topical cream [used to prevent or treat skin irritations] ... 10% ... as needed ...." The plan of care failed to evidence diagnoses related to the medications Midodrine, Onfi, Miralax, Senna, Vimpat, and Glycerin suppository; failed to evidence indications for when to administer the Acetaminophen, Bacitracin zinc, and Zinc oxide; and failed to evidence a clear dosage or administration instructions for Zinc oxide. The POC contained a section titled "Rehabilitation Potential/Discharge Plans/Goals," which stated, "Discharge Plan: Discharge when higher level of care and/or hospice is required ... Skilled Care Discharge Plan: Patient/caregiver will verbalize understanding to education provided on discharge process by end of recertification period." The POC failed to evidence patient-specific and individualized patient discharge planning and education was conducted to facilitate a timely discharge. The POC contained patient goals including " ... Client's bathing needs will be met with the assistance of the Skilled Nurse by the end of this recertification period ... Client's grooming needs will be met with assistance of the Skilled Nurse by the end of this recertification period ... Client's elimination needs will be met with the assistance of the Skilled Nurse by the end of this	G 574		

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G 574	Continued From page 45 recertification period ... Client's nutritional needs will be met with the assistance of the Skilled Nurse by the end of this recertification period ... Client's [sic] will remain safe in the home when primary caregiver is not available with the supervision of the Skilled Nurse by the end of this recertification period ... Patient/caregiver will demonstrate stable pain with Activities of Daily Living as evidenced by pain scale, and or improvement in [sic] by end of recertification period ... Patient/caregiver will demonstrate no complications from obtained lab(s) when performed ... Patient will tolerate Ventilator settings during this recertification period ...." The POC failed to evidence all goals were individualized, patient-specific, and measurable. 4. The clinical record of Patient #3 was reviewed on 11/5/2020 and 11/12/2020, and indicated a start of care of 5/20/2020, with patient diagnoses including, but not limited to, rheumatoid arthritis, fibromyalgia, chronic pain syndrome, history of squamous cell cancer, history of drug use, and Chronic Obstructive Pulmonary Disease (COPD, chronic inflammatory disease of the lungs). The clinical record contained a plan of care for the recertification period 9/17/2020 - 11/15/2020. The POC contained a medication list with orders for but not limited to, "Lamotrigine [given to prevent and treat seizures] 100 mg oral tablet, 100 mg, two times a day ... Pilocarpine [used to decrease secretions] 5 mg oral tablet ... 5 mg - 10 mg (patient discretion r/t [related to] salivation), two times a day ...." The POC failed to evidence diagnoses or conditions related to these medications. The POC's medication list also contained orders for "Acetaminophen [Tylenol, given for pain or fever] 325 mg oral tablet ... 650 mg, Every 4 hours as needed ... Dilaudid [opioid	G 574		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 574	Continued From page 46 given for pain relief] 8 mg oral tablet ... 8 mg, Every 6 hours as needed ... Ipratropium-albuterol [given for shortness of breath] 0.5 mg - 2.5 mg / 3 ml inhalation solution ... 2.5mg - 0.5 mg / 3 ml, Three times a day as needed ..." The medication list failed to evidence indications or directions for when to administer these medications. A comprehensive assessment for Patient #3 was completed on 9/16/2020 by Employee C, RN. The comprehensive assessment indicated the patient received tube feeding through her percutaneous gastrostomy tube (PEG, tube surgically placed into the stomach for enteral feedings) "4-5 times/day." The POC's "Nutritional Req. [Requirements]" stated "Mechanical [Soft, Hi-Fiber, etc.], PEG tube, thickened liquids." The POC failed to evidence the specific type of tube feeding the patient received. The POC contained a section titled "Rehabilitation Potential/Discharge Plans/Goals," which stated, " ... Discharge Plan: Patient educated on discharge process for when a higher level of care is required ... Skilled Care Discharge Plan: Discharge when skilled care is no longer needed/goals met. Patient will verbalize understanding to education provided on discharge process by end of recertification period ...." The POC failed to evidence patient-specific and individualized patient discharge planning and education was conducted to facilitate a timely discharge. The POC contained patient goals including " ... Patient will demonstrate decreased pain using wong baker pain scale [method of pain rating where the patient picks one of 6 pictures of faces to represent their pain] through next recertification ... Patient will demonstrate no complications from	G 574		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 574	Continued From page 47 obtained lab(s) when performed ... Patient will decrease risk for pressure ulcer as evidenced by standardized test score by the end of recertification period ... Clinician will assist in changing trach weekly through the recertification period ... Caregiver will be able to state care that is required for patient by end of recertification period [Patient is her own primary caregiver] ... Aide: Patient will be satisfied with care provided by HHA [Home Health Aide]. Client will remain safe in the home with the assistance of the the [sic] HHA. Client's bathing needs will be met with the assistance of the HHA. Client's grooming needs will be met with the assistance of the HHA ... Client's elimination needs will be met with the assistance of the HHA. Client will be complaint with medication with the reminders of the HHA. Client will transfer/ambulate safely with the assistance of the HHA. Client's nutritional needs will be met with the assistance of the HHA. Client's home environment will be maintained in a safe manner with the assistance of the HHA. Client's will remain safe in the home when primary caregiver is not available with the supervision of the HHA." The POC failed to evidence all goals were individualized, patient-specific, and measurable. 5. The clinical record of Patient #4 was reviewed on 11/6/2020, and indicated a start of care date of 10/27/2015, with patient diagnoses including, but not limited to, dementia, stress incontinence, tremor, asthma, and chronic pain. The clinical record contained a plan of care for the recertification period 9/17/2020 - 11/15/2020. The POC contained a medication list which included orders for "Atenolol [given to treat high blood pressure] ... Bisacodyl [given to treat constipation] ... Clear Eyes + Redness Relief [eye	G 574		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

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G 574	Continued From page 48	G 574		

drops given for temporary relief of eye irritation] 0.012% ophthalmic [related to the eye] gel forming solution ... 1 drop both eyes, Ophthalmic, Frequency: Four times as day as needed ... Colace [given to treat constipation] ... Ferrous Sulfate [iron supplement given for conditions related to low iron] ... Furosemide [given to decrease excess fluid in the body] ... Hydrocortisone AC 1% topical cream [given to treat itching related to several skin conditions], Scant amt [amount], Topical, Frequency: Twice a day as needed ... Levothyroxine [given to treat underactive thyroid] ... Melatonin [given for insomnia] ... Mucinex D [given to treat cough] Max Strength 120 mg - 1200 mg oral tablet, extended release, 1200 mg - 120 mg, Oral, Frequency: Every 12 hours as needed ... Mupirocin [given to treat bacterial skin infection] 2% topical ointment, scant amount, topical, Frequency: Three times per day AM, Noon, PM as needed ... Nystatin [given to treat fungal infection on the skin] 100,000 units/g [gram] topical powder, Scant amt, Topical, Frequency: Twice a day as needed ... Nystatin-triamcinolone [given to treat fungal infection on the skin] 100,000 units/g - 0.1% topical cream, Scant amt, Topical, Frequency: Once a day as needed ... Prilosec [given for Gastroesophageal Reflux Disease (GERD)] ... Spironolactone [given to decrease excess fluid in the body] ... Tobramycin [given to treat eye infections] 0.3% ophthalmic solution, 2 drops, Eye Drops, Frequency: every 4 hours as needed for 7 days to affected eye ... Tramadol [given for pain relief] 50 mg oral tablet, 50 mg, Oral, Frequency: Every 8 hours as needed ... Trazodone [given for pain relief] ... Triple Antibiotic Plus [given to treat or prevent bacterial skin infection] topical ointment, Scant amt, Topical, Frequency: Once daily as needed ... Ventolin HFA [given for shortness of breath] 90

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 574	Continued From page 49 mcg/inh [micrograms per inhalation] inhalation aerosol, 1 puff, Inhalation, Frequency: Every 6 hours as needed ...." The POC failed to evidence diagnoses related to Atenolol, Bisacodyl, Colace, Ferrous Sulfate, Furosemide, Hydrocortisone, Levothyroxine, Melatonin, Mucinex, Mupirocin, Nystatin, Prilosec, Spironolactone, and Trazodone; failed to evidence indications for administering the "as needed" medications Clear Eyes, Hydrocortisone, Mucinex, Mupirocin, Nystatin, Nystatin-triamcinolone, Tobramycin, Tramadol, Triple Antibiotic Plus, and Ventolin; and failed to evidence clear directions on the amount and location to apply the topical medications Hydrocortisone, Mupirocin, Nystatin, Nystatin-triamcinolone, and Triple Antibiotic Plus. The POC stated " ... Skilled Care Discharge Plan: Patient educated on discharge process for when a higher level of care is required ... Goals ... Skilled Care Discharge Plan: Patient will verbalize understanding to education provided on discharge process by end of recertification period ...." The POC failed to evidence patient-specific and individualized patient discharge planning and education was conducted to facilitate a timely discharge. The POC contained patient goals including "... Patient/caregiver will demonstrate decreased pain with ambulation as evidenced during this recertification period ... Patient will be free of adverse s/s [signs and symptoms] of anticoagulant therapy during this recertification period ... Patient/caregiver will demonstrate no complications from obtained lab(s) when performed ... Patient will have decrease [sic] risk for pressure ulcer as evidenced by standardized test during this recertification period ... Patient will demonstrate improvement in ADL/IADL [Activities	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 50 of Daily Living/Instrumental Activities of Daily Living] ... Client will remain safe in home during this recertification period ... Aide: Patient will be satisfied with care provided by HHA 7 days/week during this recertification period. Client will remain safe in the home with the assistance of the the [sic] HHA during this recertification period. Client's bathing needs will be met with the assistance of the HHA during this recertification period. Client's grooming needs will be met with the assistance of the HHA during this recertification period ... Client's elimination needs will be met with the assistance of the HHA during this recertification period. Client will be complaint with medication with the reminders of the HHA during this recertification period. Client will transfer/ambulate safely with the assistance of the HHA during this recertification period. Client's nutritional needs will be met with the assistance of the HHA during this recertification period. Client's home environment will be maintained in a safe manner with the assistance of the HHA during this recertification period. Client's [sic] will remain safe in the home when primary caregiver is not available with the supervision of the HHA during this recertification period." The POC failed to evidence all goals were individualized, patient-specific, and measurable. 6. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, indicated a start of care date of 4/5/19, with patient diagnoses including, but not limited to heart failure, COPD, history of transient ischemic attack (TIA, temporary loss of blood flow to the brain), left above the knee amputation, generalized muscle weakness, history of deep vein thrombosis (blood clot formed within a vein deep in the body), and depression. The clinical record contained a plan of care for the recertification period 9/26/2020 -	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 51 11/24/2020. The POC contained a medication list which included orders for "Atorvastatin [given for elevated cholesterol] ... Famotidine [given for GERD] ... Lotrimin AF 1% topical cream, scant [dosage], topical, Frequency: Twice a day ... Mupirocin 2% topical cream, scant, by mouth [sic], Frequency: three times a day ... Narcan [given to reverse opioid overdose] 4 mg / 0.1 mL nasal spray, 4 mg / 0.1 mL, nasal spray, Frequency: 1 spray into nares as needed ... Nystatin 100,000 units / g topical powder, 100000 units/g, topical, Frequency: Four times per day -as needed ... Oxycodone-acetaminophen [opioid given for pain relief] 10 mg - 325 mg oral tablet ... 325 mg - 10 mg, Oral, Frequency: 1 tablet every 6 hours as needed ... Tessalon [given to treat cough] 200 mg oral capsule, 200 mg, by mouth, Frequency: three times a day as needed ...." The POC failed to evidence diagnoses or conditions related to the medications Atorvastatin, Famotidine, Lotrimin, Mupirocin, Nystatin, and Lyrica; failed to evidence indications for administering Narcan, Nystatin, Oxycodone-acetaminophen, and Tessalon; and failed to evidence clear directions on the amount and location to apply topical medications Lotrimin and Mupirocin. The POC stated " ... Skilled Care Discharge Plan: Patient educated on discharge process for when a higher level of care is required ... Goals ... Skilled Care Discharge Plan: Discharge when higher level of care is needed. Patient will verbalize understanding to education provided on discharge process by end of recertification period ...." The POC failed to evidence patient-specific and individualized patient discharge planning and education was conducted to facilitate a timely	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 52 discharge. The POC contained patient goals including, but not limited to "... Patient/caregiver will demonstrate decreased pain with ambulation as evidenced by wong baker pain scale, and or improvement in ADL/IADL during this recertification period ... Patient will be free of adverse s/s of anticoagulant therapy during this recertification period ... Patient/caregiver will demonstrate no complications from obtained lab(s) when performed ... Patient will have decrease risk for pressure ulcer as evidenced by standardized test score during this recertification period ... Patient/caregiver will show improvement in compliance with medication regimen by end of certification period ... Aide: Patient will be satisfied with care provided by HHA. Patient will be clean and comfortable and safe during this recertification period. Client will remain safe in the home with the assistance of the the [sic] HHA during this recertification period. Client's bathing needs will be met with the assistance of the HHA during this recertification period. Client's grooming needs will be met with the assistance of the HHA during this recertification period ... Client's elimination needs will be met with the assistance of the HHA during this recertification period. Client will be complaint with medication with the reminders of the HHA during this recertification period. Client will transfer/ambulate safely with the assistance of the HHA during this recertification period. Client's nutritional needs will be met with the assistance of the HHA during this recertification period. Client's home environment will be maintained in a safe manner with the assistance of the HHA during this recertification period. Client's [sic] will remain safe in the home when primary caregiver is not available with the supervision of the HHA	G 574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 574	Continued From page 53 during this recertification period." The POC failed to evidence all goals were individualized, patient-specific, and measurable. 7. An interview was conducted with the Alternate Administrator and Director of Nursing (DON) on 11/12/2020 at 4:06 PM. During the interview, the Alternate Administrator indicated the POC should include all pertinent diagnoses, all patient nutritional requirements, and patient and/or caregiver discharge education. The Alternate Administrator also indicated all "as needed" medications should include indications for when to administer the medication, and all goals should be patient-specific and measurable on the POC. 17-13-1(a)(1)(C)(viii, ix, xi)	G 574		
G 580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician. This Element is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the skilled nurse did not provide services absent a physician order for 2 of 4 home visit observations (Patients #1, 4). Findings include: 1. An agency policy titled "Care Planning Process," policy number 4-001.1 and revised 10/28/20, stated " ... Individualized Plan of Care: Based on the assessment and conclusions, the plan of care will include, but will not be limited to: ... E. All patient care orders including verbal orders ...." 2. An agency job description titled "Field Nurse	G 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 54 [Licensed Practical Nurse or Registered Nurse (RN)] Job Description," revised 5/1/16, stated " ... Job Summary: ... Follow the plan of care according to physician orders ...." 3. The clinical record of Patient #1 was reviewed on 11/4/20 and 11/12/20, and indicated a resumption of care date of 9/26/17, with patient diagnoses including but not limited to schizoaffective disorder, Type 2 Diabetes, personality disorder, "arthropathy [diseases of the joint]," and high blood pressure. The clinical record included a plan of care (POC) for the certification period of 10/22/2020 - 12/20/2020. The POC contained an order for Skilled Nurse services 0.5 - 1.5 hours per visit, 2 visits per day, 7 days per week; and included the Skilled Nurse interventions "Clinician to administer all medications ... Skilled Nurse to set medications once a week ...." A home visit observation with Patient #1 was conducted on 11/4/2020 at 3:50 PM. During the visit, the patient was noted to have all medications and blood glucose monitor locked in a medication lock box by the home health agency staff. The Director of Nursing (DON), present at the home visit, indicated the patient's provider "agreed to" having the agency lock the patient's medications and glucose monitor, and the patient did not have access to the lock box. The clinical record failed to evidence a physician's order to lock the patient's medications and blood glucose monitor without the patient's ability to access the lock box. 4. The clinical record of Patient #4 was reviewed on 11/6/2020, and indicated a start of care date of 10/27/2015, with patient diagnoses including, but not limited to, dementia, stress incontinence,	G 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 580	Continued From page 55 tremor, asthma, and chronic pain. The clinical record contained a plan of care for the recertification period 9/17/2020 - 11/15/2020. The POC contained an order for Skilled Nurse services 0.5 - 1.5 hours per day, 7 days a week; and included the Skilled Nurse interventions " ... Clinician to administer AM medication daily. Clinician to set medications as follows: 1x/weekly ...." A home visit observation with Patient #3 was conducted on 11/6/2020 at 8:50 AM. During the visit, the patient was noted to have all their medications locked in a medication lock box by the home health agency staff. The clinical record failed to evidence a physician's order to lock the patient's medications without the patient's ability to access the lock box. 5. An interview was conducted with the Alternate Administrator and Director of Nursing on 11/12/2020 at 4:06 PM. During the interview, the Administrator indicated the use of a lock box to hold patient's medications and/or medical supplies was enacted on a case-by-case basis, and was "usually a patient safety issue ... typically [used for] a dementia patient." The Administrator indicated whether the patient has access to the lock box was also determined on a case-by-case basis. The Administrator also indicated the plan of care "should talk about" patient diagnoses which could indicate the need for a medication lock box. 17-13-1(a)	G 580		
G 590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's	G 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 56	G 590		

condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.
This Element is not met as evidenced by:
Based on record review and interview, the home health agency failed to notify the patient's medical provider for a change in the patient's condition for 1 of 2 active records with a noted change in patient condition, in a total sample of 17 records.

Findings include:

An agency policy titled "Care Planning Process," policy number 4-001.1 and revised 10/28/20, stated "... Procedure ... 9. The Agency will promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest the outcomes are not being achieved and/or that the plan of care should be altered ..."

An agency job description titled "Field Nurse [Licensed Practical Nurse or Registered Nurse (RN)] Job Description," revised 5/1/16, stated "... Responsibilities/essential functions: ... 11. Report to physician and RN Case Manager of adverse findings ...."

The clinical record of Patient #3 was reviewed on 11/5/2020 and 11/12/2020, and indicated a start of care of 5/20/2020, with patient diagnoses including, but not limited to, rheumatoid arthritis, fibromyalgia, chronic pain syndrome, history of squamous cell cancer, history of drug use, and chronic obstructive pulmonary disease (COPD). The clinical record contained a plan of care (POC) for the recertification period 9/17/2020 - 11/15/2020. The POC was revised on 10/15/2020, and stated "10/15/20 ... [Patient's physician] notified of Significant Change of Condition assessment on 10/15 at 1500

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 57 [10/15/2020 at 3:00 PM]. [Employee FF, RN Case Manager] ... in home to coordinate care with physician, client/caregiver, due to cellulitis [infection of the skin] to abdominal wall requiring biweekly surgical wound measurements ... [Patient] Discharged home 10/14/20 with instructions to: -keep insicion [sic] clean and dry, -change percutaneous endoscopic gastrostomy dressing every day ...." The POC update noted 5 wounds, including "... Patient has stoma for percutaneous endoscopic gastrostomy covered with ABD [abdominal pad, type of dressing] and 4 x 4 gauze. Upon assessment of area there is dark brown, green and yellow, thick drainage from site. Stoma is red and tender ...." A skilled nurse visit was documented by Employee FF on 10/21/2020. During this visit, the RN documented the presence of 5 wounds, with wound #4 indicated to be the patient's PEG tube site. The nurse documented wound #4's measurements to be 2 centimeters (cm) in length by 2 cm in width by 0.1 cm in depth (2 x 2 x 0.1), with no drainage or odor noted. Wound #4's wound bed color was noted to be "healing, gray, pink," and the surrounding tissue was noted to be "healthy, pink." Employee FF also completed Patient #3's skilled nurse visit on 10/28/2020. During the visit, the RN documented wound #4's measurements to be 2.0 cm x 2.0 cm x 0.5 cm, with no drainage or odor noted. Wound #4's wound bed color was noted to be "healing, pink, green, gray," and the surrounding tissue was noted to be "healthy, pink." The clinical record failed to evidence the RN notified the patient's provider of the increase in depth measurement and change in wound bed color to wound #4.	G 590		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 590	Continued From page 58 An interview was conducted with the Alternate Administrator and Director of Nursing (DON) on 11/12/2020 at 4:06 PM. During the interview, the DON indicated the nurse should notify the patient's physician for an increase in wound measurement. 17-13-1(a)(2)	G 590		
G 592	Revised plan of care CFR(s): 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the revised plan of care (POC) contained the patient's progress towards their goals for 5 of 5 active records reviewed (#1, 2, 3, 4, 5), in a total sample of 17 records. Findings include: 1. An agency policy titled "Care Planning Process," policy number 4-001.1 and revised 10/28/20, stated "... Procedure ... 10. A revised plan of care will reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the agency and patient in the plan of care ...." 2. The clinical record of Patient #1 was reviewed on 11/4/20 and 11/12/20, and indicated a	G 592		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 592	Continued From page 59	G 592		

resumption of care date of 9/26/17. The clinical record included a plan of care for the recertification period of 10/22/2020 - 12/20/2020. The POC failed to evidence the patient's progress towards their goals and outcomes.

3. The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated a start of care date of 4/30/2020. The clinical record contained a plan of care for the recertification period 10/27/2020 - 12/25/2020. The POC failed to evidence the patient's progress towards their goals and outcomes.

4. The clinical record of Patient #3 was reviewed on 11/5/2020 and 11/12/2020, and indicated a start of care date of 5/20/2020. The clinical record contained a plan of care for the recertification period 9/17/2020 - 11/15/2020. The POC failed to evidence the patient's progress towards their goals and outcomes.

5. The clinical record of Patient #4 was reviewed on 11/6/2020, and indicated a start of care date of 10/27/2015. The clinical record contained a plan of care for the recertification period 9/17/2020 - 11/15/2020. The POC failed to evidence the patient's progress towards their goals and outcomes.

6. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, and indicated a start of care date of 4/5/19. The clinical record contained a plan of care for the recertification period 9/26/2020 - 11/24/2020. The POC failed to evidence the patient's progress towards their goals and outcomes.

7. An interview was conducted with the Alternate Administrator and Director of Nursing (DON) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 592	Continued From page 60 11/12/2020 at 4:06 PM. During the interview, the Alternate Administrator indicated the recertification plan of care was updated by the agency with "all the orders that [the agency] has added on."	G 592		
G 682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This Standard is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all employees followed agency infection control policies and procedures and standard precautions for 3 of 4 home visit observations (#1, 2, 4). Findings include: 1. An agency policy titled "Hand Hygiene," policy number 6-006.1 and revised 10/23/2020, stated "... Procedure. Hand decontamination with an alcohol-based hand rub ... 1. Apply alcohol-based hand rub product to palm of one (1) hand and rub hands together, covering all surfaces of hands and fingers (including under nails) until hands are dry ... Hand Washing with Soap and Water ... 1. Wet hands with clean, running water (warm or cold), and apply soap ... 3. Scrub your hands for at least 20 seconds ...." An agency policy titled "Exposure to Coronavirus (2019-NCOV) Disease Response and Management," policy number 6-040.1 and revised 10/21/2020, stated "... Employee Protection in homes with 2019-NCOV [COVID-19] positive	G 682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 682	Continued From page 61 cases or suspcision [sic]. 1. Staff providing care in a home with a positive 2019-NCOV case or suspected 2019-NCOV case must wear the following PPE [Personal Protective Equipment]: N-95 mask [specialty mask which filters out small particles] or higher, Face shield or eye protection, Isolation gown, Gloves ...." 2. Case-Lo. Updated 9/17/18. "What Is A Subcutaneous Injection?" Obtained 11/23/2020 from www.healthline.com. "... How to administer a subcutaneous injection ... 3. Clean and inspect the injection site. Before injecting medication, inspect your skin ... Then you should clean the skin with an alcohol swab. Let the alcohol dry thoroughly before doing the injection ...." 3. A home visit observation was conducted on 11/4/2020 at 3:50 PM with Patient #1 (resumption of care 9/26/17) and Employee E (Licensed Practical Nurse, LPN). During the visit, Employee E obtained a verbal order from the patient's physician to give the patient a one-time dose of Lantus [insulin given to lower blood sugar] 35 units subcutaneous [injection into the fatty tissue directly underneath the top layers of skin]. The LPN applied alcohol to a gauze pad, cleaned the injection site (the lower left quadrant of the patient's abdomen) with the alcohol gauze pad, and applied the pen needle to the Lantus pen. The patient's shirt fell on top of the injection site, the LPN lifted the patient's shirt up and injected the medication subcutaneously. The LPN failed to clean the injection site, which had been dirtied with the patient's shirt falling onto the site after it had been cleansed with alcohol, prior to giving the injection. 4. A home visit observation was conducted on 11/5/2020 at 9:50 AM with Patient #2 (start of	G 682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 682	Continued From page 62 care 4/30/2020) and Employee F, LPN. Prior to entering the home, the agency's Director of Nursing (DON) indicated the patient's family requested staff wear PPE according to the agency policy for suspected COVID-19 cases, due to the patient and family member's immunocompromised status. Prior to entering the patient's home, Employee F donned a new gown, gloves, N-95 mask, and face shield. The LPN began to set up supplies to clean the patient's tracheostomy (surgically placed opening through the neck into the trachea for breathing assistance) site, and his N-95 mask was noted to have moved down to below his nose. The LPN completed the patient's tracheostomy care, MIC-KEY gastrostomy tube (medical tube surgically inserted into the stomach for enteral feedings) care, and enteral feeding with his N-95 mask below his nose. After the nurse completed the patient's care, the LPN adjusted his mask to the proper position (covering both his nose and mouth) and stated, "I'm sorry, but I have to fix this [mask]." The LPN failed to ensure a correct fit of his PPE throughout the home visit. 5. A home visit observation was conducted on 11/6/2020 at 8:50 AM with Patient #4 (start of care 10/27/2015) and Employee G, Home Health Aide (HHA). During the visit, Employee G was noted to remove her gloves, perform hand hygiene using alcohol-based hand sanitizer, waved her hands in the air to dry them, then rubbed her hands together. Later during the visit, the HHA was noted to wash her hands for soap and water, scrubbing her hands outside of the water for 6 seconds then rinsing and drying her hands. The HHA failed to appropriately perform hand hygiene with both alcohol-based hand sanitizer and hand washing according to agency policy.	G 682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 682	Continued From page 63 6. An interview was conducted on 11/6/2020 at 11:56 AM with the Administrator and DON. During the interview, the DON indicated the nurse should clean an injection site with alcohol prior to an injection, and a mask should cover both the employee's nose and mouth during the entire home visit. The Administrator indicated when using alcohol-based hand sanitizer, staff should rub their hands until dry rather than wave their hands in the air to dry. 17-12-1(m)	G 682		
G 684	Infection control CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This Standard is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure an agency-wide infection control program was maintained for the surveillance, identification, prevention, control, and investigation of patient and staff infections for 1 of 8 active patient infection reports (#31), 3 of 5 discharged patient infection reports (#32, 33, 34),	G 684		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 684	Continued From page 64 8 of 9 active employee infection reports (B, E, F, O, Q, V, JJ, KK), and 7 of 7 terminated employee infection reports (Former Employees Q, R, S, T, U, W, V) noted with agency tracking and log records, which had the potential to effect all agency patients and employees. Findings include: 1. An agency policy titled "Exposure to Coronavirus (2019-NCOV): Disease Response and Management," policy number 6-040.1 and revised 10/21/2020, stated " ... Procedure: 1. Employees must immediately report any concerns regarding exposure to 2019-nCoV to a supervisor, whether the potential exposure has occurred through providing patient care, travel, assisting an ill traveler or other person, handling a contaminated object, or cleaning a contaminated environment ... 5. Patients are screen [sic] by telephone screening, supervisory visits, recertification ... start of care, employees, and resumptions of care [visits] ... Employees with Symptoms: 1. Employees who have a measured body temperature higher than 99.5 (armpit) or 100 (oral), a new cough, new onset of shortness of breath, chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, or vomiting, diarrhea should be separated from other employees and clients, and sent home immediately until they have recovered ... 3. Any employee with the above symptoms that have not been tested for 2019-NCOV or have tested positive for 2019-NCOV, should stay home until they are fever free (without the use of medication) for at least 72 hours (three full days) AND symptoms have improved for at least 72 hours AND at least ten days have passed since symptoms first began ... 2019-NCOV Tracking:	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 684	Continued From page 65 1. 2019-NCOV positive employees and clients will be tracked in agency's infection control report/log. Data is analyzed as part of QAPI program to ensure proper infection control guidelines are being followed and to help prevent the spread of 2019-NCOV. 2. A list will be kept of all 2019-NCOV positive clients ...." 2. The Entrance Conference was conducted on 11/4/2020 at 9:48 AM with the Administrator and the Director of Nursing (DON). During the Entrance, the DON indicated she oversaw tracking all patient and employee infections. All patient and employee infections were documented by the DON on an "Infection Control" tracking form and included as part of the agency's infection control log. Patients with COVID-19 symptoms or who were exposed to someone with COVID-19 symptoms or a positive test result were assessed and tracked by the DON daily. Employees were advised to "self-monitor" for COVID-19 symptoms, and were to immediately report any signs or symptoms of COVID-19, as well as exposure to someone with COVID-19 symptoms or a positive test result, to the agency. The DON indicated Person DD, Director of Office Staff, oversaw tracking of employees with reported symptoms of COVID-19 or exposure to someone with suspected or confirmed COVID-19. Employees were monitored for signs and symptoms daily for 10 days after the start of symptoms or 14 days after exposure. 3. The agency's Infection Control Log from 1/1/2020 to 11/4/2020 was reviewed on 11/9/2020. The log contained an "Infection Control" report for Patient #31 (start of care 5/9/15) documented by the Director of Nursing on 3/25/2020. The report stated " ... Others: During supervisory visit on 3/25/20, it was noted [group	G 684		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
G 684	Continued From page 66 home] staff recorded cough w/o [without] other sx [symptoms] 03/16/20 - 03/24/2020 on their symptom log. All other sx negative, no fever ... All staff wearing PPE [Personal Protective Equipment, such as masks, gowns, etc] ...." The infection report failed to evidence if a COVID-19 screening was performed on the patient on the day the visit was made, if the patient's physician was notified of the reported symptoms, and if any follow-up or tracking of the patient was conducted. The log contained an "Infection Control Form" for Former Employee Q documented on 4/11/2020 by the DON. The form stated " ... Others: At 2:50 pm on 4/10/20 [Former Employee Q] reported sore throat and headache but no fever. [Employee was] immediately removed from schedule ... [Employee] returned to schedule 4/21/2020 ...." The form failed to evidence patients or other employees who were potentially exposed to Former Employee Q were notified of the potential exposure and tracked for symptoms. The log contained an "Infection Control Form" for Employee O documented on 4/14/2020 by the DON. The form stated " ... Others: [Employee O] called off for being sick 4/12/20 ... Negative COVID Test 4/19/20. Returned to schedule following negative test results 4/20/2020 ...." The form failed to evidence patients or other employees who were potentially exposed to Employee O were notified of the potential exposure and tracked for symptoms until the patient received a negative COVID-19 test result. The log contained an "Infection Control Form" for Former Employee R documented on 4/25/2020 by DON. The form indicated the former employee was " ... Others: Taken off schedule	G 684		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 684	Continued From page 67 4/25/2020 due to fever 100.3 ... [Employee] returned to schedule 5/5/2020 ...." The form failed to evidence patients or other employees who were potentially exposed to Former Employee R were notified of the potential exposure and tracked for symptoms. The log contained an "Infection Control Form" for Former Employee S documented on 4/26/2020 by the DON. The form stated " ... Others: [Former Employee R] called in at 1:55 PM on 4/26/2020 to report she had a fever of 100.00 [sic]. [Employee] immediately removed from Schedule. Employee refused to go get tested. Taken off schedule 04/26/2020 ... 5/17/2020 - [Employee's family member] was exposed. [Employee] told to quarantine for 14 days. Employee showed no symptoms during 14 [sic] days and [returned] to schedule 06/05/2020 ...." The form failed to evidence patients or other employees who were potentially exposed to Former Employee S were notified of the potential exposure and tracked for symptoms. The log contained an "Infection Control" report for Patient #32 (discharge date 8/24/2020) documented on 5/2/2020 by the DON. The form stated " ... Signs / Symptoms ... Fever, chills ... Physician Order: MD ordered client to be tested for COVID, client refused ... Treatment / Intervention: Staff in full PPE ..." The form failed to evidence if the patient was monitored further for symptoms, which employees were potentially exposed to Patient #32, and if these employees were tracked for symptoms. The log contained an "Infection Control Form" for Former Employee T documented on 5/13/2020 by the DON. The form stated " ... Others: [Former Employee T] taken off schedule 5/13/2020	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 684	Continued From page 68 reported sore throat and fever 99.6 [Fahrenheit. Employee] instructed to get tested ... Returned to schedule 5/20/2020 following negative test results on 5/19/2020 ...." The form failed to evidence patients or other employees who were potentially exposed to Former Employee T were notified of the potential exposure and tracked for symptoms. The log contained an "Infection Control Form" for Employee JJ documented on 5/12/2020 by the DON. The form stated " ... Others ... Employee reported sore throat on 5/14/2020 at 12:45pm. Immediately removed from schedule and instructed to get tested ... Returned to schedule 5/18/2020 following negative test results ...." The form failed to evidence patients or other employees who were potentially exposed to Employee JJ were notified of the potential exposure and tracked for symptoms until the employee received a negative COVID test result. The log contained an "Infection Control Form" for Employee Q documented on 5/19/2020 by the DON. The form stated " ... Others: Employee [Q] reported a slight cough on 5/19 [2020] at 12:15 pm. [Employee was] immediately removed from schedule and instructed to get tested. 5/20/20- no symptoms. [Employee was] instructed to report immediately if symptoms occurred or fever. [Employee Q] returned to schedule 5/25/2020 following negative COVID test results ...." The form failed to evidence Employee Q was tracked for symptoms on 5/21/2020, 5/22/20, 5/23/20, and 5/24/20; and failed to evidence patients or other employees who were potentially exposed to Employee Q were notified of the potential exposure and tracked for symptoms until the employee received a negative COVID test results.	G 684		

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	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 684	Continued From page 69 The log contained an "Infection Control Form" for Employee V documented on 5/25/2020 by the DON. The form indicated " ... Others: Employee [V] reported not feeling well at 3:00 pm on 5/25/20. [Employee was] immediately removed from schedule. Had a fever of 99.7. 5/30/20 - no symptoms. 6/2-20 [sic] - no symptoms. 6/5/20- no symptoms. [Employee V] returned to schedule 05/06/2020 following negative COVID results ...." The form failed to evidence Employee V was tracked for symptoms on 5/31/2020, 6/1/20, 6/3/20, and 6/4/20; and failed to evidence patients or other employees who were potentially exposed to Employee V were notified of the potential exposure and tracked for symptoms until the employee received a negative COVID test results. The log contained an "Infection Control" report for Patient #33 (discharge date 6/18/2020) documented ON 6/1/2020 by the DON. The form stated " ... Reported Infection / Condition: Respiratory ... Signs / Symptoms: Other SOB [Shortness of Breath] ... Pathogens Identified: unknown - client swabbed prior to admission to hospice, results not received prior to client's discharge ...." The infection report failed to evidence if any follow-up on the patient's test results was conducted after the patient's discharge and failed to evidence if any employees who were potentially exposed to Patient #33 were notified of the potential exposure and tracked for symptoms until the agency received the patient's test results. The log contained an "Infection Control Form" for Former Employee U documented on 6/16/2020 by the DON. The form stated " ... Others: On 6/16 [2020, Former Employee U] reported a fever 100.3 [sic]. [Employee] immediately removed	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 70	G 684		

from schedule ... [Employee] resigned 6/18/2020 ...." The form failed to evidence patients or other employees who were potentially exposed to Former Employee U were notified of the potential exposure and tracked for symptoms.

The log contained an "Infection Control Form" for Employee E documented on 7/17/2020 by the DON. The form stated " ... Others: [Employee E] removed from schedule following notification of possible exposure 07/17/2020 0815. [The employee] returned to schedule 7/20/20 following negative COVID screen ...." The form failed to evidence the employee was tracked for symptoms on 7/18/20 and 7/19/20 and failed to evidence the date the employee was exposed, and failed to evidence the test result of the person Employee E was exposed to (was the exposed person's test result negative, therefore ending the quarantine?).

The log contained an "Infection Control Form" for Employee B documented on 7/13/2020 by the DON. The form stated " ... Signs/Symptoms of Infection ... Headache ... Others: [Employee B] removed from schedule 07/13/2020 due to possible exposure to [ill family member] ... Returned to schedule 07/22/2020. [Employee B's ill family member] received negative results 07/21/2020 ...." The form failed to evidence the employee was tracked for symptoms on 7/14/2020, 7/15/20, 7/16/20, 7/17/20, 7/18/20, 7/19/20, and 7/20/20.

The log contained an "Infection Control Form" for Former Employee W documented on 8/10/2020 by the DON. The form stated "... Others: [Former Employee W] removed from schedule 08/10/2020 due to reporting fever and vomiting. Employee instructed to get tested. 8/11/20 -no fever,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 71 vomiting, runny nose, fatigue. 8/12/2020-no symptoms. 8/14/20-no symptoms. 08/16/20-reported that she had received negative COVID test results. [Former Employee W] returned to schedule 08/17/2020 following negative results ...." The form failed to evidence Former Employee W was tracked for symptoms on 8/13/20 and 8/15/20 and patients or other employees who were potentially exposed to Former Employee W were notified of the potential exposure and tracked for symptoms. The log contained an "Infection Control Form" for Former Employee V documented on 8/16/2020 by the DON. The form stated " ... Others: [Former Employee V] notified agency on 8/16/20 that she was possibly exposed to COVID ... She was removed from schedule [sic]. [Former Employee V] requested a leave of absence ...." The form failed to evidence the employee was tracked for signs and symptoms of COVID and/or a result from a COVID-19 test. The log contained an "Infection Control Form" for Employee F documented on 8/31/2020 by the DON. The form stated " ... Pathogens Identified: Positive COVID results received 09/03/2020 ... Physician Order: [Employee F] removed from schedule 08/31 [2020]. [The employee] returned to schedule 09/16 following CDC guidelines/negative COVID screen ... Others: ... Negative COVID test 09/18/2020 ...." The form indicated the employee returned to work on 9/16/20 after a negative COVID test result, however the date of the negative test result was documented as 9/18/2020. The form failed to evidence patients or other employees who were potentially exposed to Employee F were notified of the potential exposure and tracked for symptoms.	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 684	Continued From page 72 The log contained an "Infection Control Form" for Employee KK documented on 09/04/2020 by the DON. The form stated " ... Signs/Symptoms of Infection: ... Others: asymptomatic, possible exposure ... Others: ... [Employee KK] removed from schedule 09/04/2020. Returned to schedule 09/09/2020 following negative COVID screen results 09/08/2020 ...." The infection tracking form failed to evidence the test results of the person which Employee KK was exposed. The log contained an "Infection Control" report for Patient #34 (discharge date 10/24/2020) documented on 10/17/2020 by the DON. The form stated " ... Signs/Symptoms: [Patient #34] found down in home ... Pathogens Identified: ... [Local hospital] indicated client is positive for COVID ...." The infection tracking form failed to evidence employees who were potentially exposed to Patient #34 were tracked for symptoms. 4. An interview was conducted on 11/16/2020 with the Administrator and DON. During the interview, the Administrator indicated all patients exposed to employees or other persons with suspected or confirmed COVID-19 were to be monitored. The Administrator also indicated the agency had contacted their local health department regarding the requirements for tracking of employees with exposure to patients or other persons with suspected or confirmed COVID-19, and were advised by the health department employees who were wearing PPE at the time of the exposure were able to "monitor themselves" for signs and symptoms of COVID-19. The agency staff failed to evidence documentation of this recommendation from the local health department.	G 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 686	Continued From page 73	G 686		
G 686	Infection control education CFR(s): 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). This Standard is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all staff received infection control education in relation to daily self-monitoring for COVID-19 for 4 of 4 employees interviewed regarding self-monitoring for COVID-19 symptoms (F, G, L, LL), which had the potential to impact all employees and patients of the agency. Findings include: 1. An agency policy titled "Exposure to Coronavirus (2019-NCOV): Disease Response and Management," policy number 6-040.1 and revised 10/21/2020, stated " ... Employees with Symptoms: 1. Employees who have a measured body temperature higher than 99.5 (armpit) or 100 (oral), a new cough, new onset of shortness of breath, chills, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, or vomiting, diarrhea should be separated from other employees and clients, and sent home immediately until they have recovered ...." 2. The agency's Entrance Conference was conducted on 11/4/2020 at 9:48 AM with the Administrator and DON. During the Entrance Conference, the Administrator indicated all employees were advised to self-screen for COVID-19 symptoms and to report all symptoms to the agency, including a temperature greater than or equal to "99.5 or 100" degrees	G 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 686	Continued From page 74 Fahrenheit. 3. An interview was conducted with Employee F on 11/5/2020 at 10:49 AM. During the interview, the employee indicated when conducting COVID-19 self-screenings, the temperature value to report to the agency was "within fever range." 4. An interview was conducted with Employee G on 11/6/2020 at 9:32 AM. During the interview, the employee indicated when conducting COVID-19 self-screenings, the temperature value to report to the agency was "greater than 99.0" degrees Fahrenheit. 5. An interview was conducted with Employee L on 11/6/2020 at 12:25 PM. During the interview, the employee indicated when conducting COVID-19 self-screenings, the temperature value to report to the agency was "I'm not exactly sure, above 99 or 100 [degrees Fahrenheit]?" 6. An interview was conducted with Employee LL on 11/6/2020 at 12:39 PM. During the interview, the employee indicated when conducting COVID-19 self-screenings, the temperature value to report to the agency was "102" degrees Fahrenheit.	G 686		
G 768	Competency evaluation CFR(s): 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 768	Continued From page 75 paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. This Standard is not met as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure home health aides (HHA) were oriented and competency checked on the proper use of Hoyer lifts for 4 of 6 HHAs interviewed (Employees L, LL, P, MM) and were trained on patient-specific Hoyer lifts via manufacturer's instructions for use in 10 of 10 active patients with Hoyer lifts (5, 6, 7, 8, 9, 10, 11, 12, 13, 35), which had the potential to affect the safety of all 10 patients who used a Hoyer lift in their home. Findings include: 1. An agency policy titled "Home Health Aide Training," policy number 1-029.1 and revised 10/28/2020, stated " ... Purpose: To outline a home health aide training program to ensure the competence and skills of home care aides ... Training Program ... 2. The home health aide training program must include each of the following subject areas (basic checklist): ... j.	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
G 768	Continued From page 76 Safe transfer techniques and ambulation ... 4. The competency evaluation will address each of the following skills. The bolded skills will be evaluated by observing the aide's performance of the task with a patient or pseudo-patient ... j. Safe transfer techniques and ambulation [item bolded, indicating the task was to be evaluated by observation] ...." An agency job description titled "Clinical Manager Job Description," revised 10/25/18, stated " ... Responsibilities/essential functions: 1. Provide oversight of all patient care services and personnel ... 8. The direction, coordination and overall supervision of all services provided by direct care staff ...." An undated agency job description titled "Home Health Aide Job Description," policy number P-46.00, stated " ... Responsibilities/essential functions: 2. Performs personal care as assigned by plan of care, including but not limited to: ... M. Transfers ... 3. Demonstrates competency in use of transfer devices Invacare. (2013). Invacare Reliant 450 RHL450-I, Invacare Reliant 450 RPL450-I, Invacare Reliant 600 RPL600-I: Manual/Electric Mobile Patient - User Manual. Received 11/10/2020 from the DON and indicated as the manufacturer's instructions for Patients #5, 7, 9, 10, and 12's Hoyer, stated " ... Do NOT attempt any transfer without approval of patient's ... nurse ... observe a trained team of experts perform the lifting procedures and then perform the entire lift procedures and then perform the entire lift procedure several times with proper supervision and capable individual acting as a patient ...." Joerns Healthcare Inc (2013). Joerns Hoyer: User	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

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G 768	Continued From page 77 Instruction Manual: Hoyer Advance. Received 11/10/20 from DON and indicated as the manufacturer's instructions for Patient #6's Hoyer, stated " ... Always familiarize yourself with operating control and safety features of a lift before lifting patient ... Do NOT lift a patient unless you are trained and competent to do so ...." Invacare. (9/4/18). Owner's Operator and Maintenance Manual: Portable Patient Lift and Sling. Received 11/9/20 from the DON and indicated as the manufacturer's instructions for Patient #7, stated " ... Lifting the Patient: ... When the sling is elevated a few inches of the surface of the bed and before moving the patient, check again to make sure the sling is properly connected to the hooks of the swivel bar ... 8. When moving the patient lift away from the bed, turn patient so that he/she faces assistant operating the patient lift. 9. Turn crank handle ... lowering patient so that his feet rest on or over the base of the lift, straddling the mast ...." 2. A home visit observation with Patient #7 (start of care 1/31/2020) and Employee H, HHA was conducted on 11/10/2020 at 9:02 AM. During the visit, the HHA positioned the Hoyer sling underneath the patient, moved the Hoyer to next to the patient's bed, lowered the swivel bar to directly above the patient, and hooked the sling's straps to the swivel bar. The HHA repositioned the patient's wheelchair and locked the wheels, then raised the patient out of the bed with the Hoyer, moved the patient's legs to the side of the Hoyer, and transferred the patient from the bed to the wheelchair. During the visit, Employee H failed to double check the connections between the swivel bar and the Hoyer pad before transferring, when the patient was slightly	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 768	Continued From page 78 elevated from the bed, and failed to reposition Patient #7 when moving her away from the bed so the patient faced the Hoyer operator (HHA) and her legs rested on the base of the lift and straddled the mast. 3. The agency's Complaint Log was reviewed on 11/6/2020 and included a "Complaint Form" documented by the Alternate Director of Nursing (ADON) on 6/11/2020. The complaint form indicated Patient #10 (start of care 1/15/19) was the patient involved, Former Employee U was the employee involved, and the complainant was the patient's group home staff. The "Complaint Details" stated "[Patient #10's group home staff member] called ... stating she helped [Former Employee U] with the loops on Hoyer ...." The "Resolution / Follow-up" stated "6/11/20 ... [ADON] spoke with Program Coordinator [for patient's group home] ... [ADON and Program Coordinator] discussed HHAs are trained generally on hoyers and transfers, but not specifically on any one patient's type or comfort. HHAs many need assistance from [group home employees] for loops, specifics on use of particular belts and that type of thing. If they do not feel comfortable with general hoyer they can be retrained [at the agency] at any time ...." 4. A list of all agency patients with Hoyer lifts was reviewed on 11/6/2020. The list indicated patients 5 (start of care 4/5/19), 6 (start of care 8/24/17), 7 (start of care 1/31/2020), 8 (start of care 3/11/13), 9 (start of care 7/2/20), 10, 11 (start of care 10/1/20), 12 (start of care 12/6/19), 13 (start of care 11/11/19), and 35 (start of care 4/22/19) currently had a Hoyer lift in their home. 5. An agency document titled "QAPI Indicator," dated 10/23/2020, stated " ... Aspect of Care:	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 768	Continued From page 79 Improvement of Hoyer and lift specific training for home health aides. All aides are currently competency checked on Hoyers and Sara lifts by an RN [Registered Nurse]. Aides will be specifically competency checked in the home on Hoyer and Sara lifts on individual clients by an RN prior to proving care using Hoyer or Sara lift. To improve care, manuals for Hoyer and Sara lifts will be kept in the client's home folder and client's medical records ... Reason/Need for Indicator: Medical record chart and employee file audits showed: Competency checks on hovers and Sara lifts by RN, but no documentation of Hoyer or Sara lift competency by RN on specific patients. Lack of documentation in medical record and home folder of Hoyer and Sara lift manuals ...." The agency's performance improvement project failed to evidence the agency competency checked HHAs on the use of Hoyers according to the specific Hoyer's manufacturer's instructions. 6. An interview was conducted with Employee L, HHA, on 11/6/2020 at 12:31 PM. During the interview, the HHA indicated she did provide services to 2 patients with Hoyers (Patients #6 and #7). The HHA stated "one of the other aides taught me" how to use Patient #6's Hoyer in the home, and she was not competency checked on the patient's specific Hoyer by an agency RN. The HHA indicated prior to use of Patient #7's Hoyer she was not trained or competency checked by an RN in the home. The HHA also indicated she was "not sure" if Patients #6 and #7 had the manufacturer's instructions in their homes. 7. An interview was conducted with Employee LL, HHA, on 11/6/2020 at 12:39 PM. During the interview, the HHA indicated she did provide care to a patient with a Hoyer, but could not recall	G 768		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 768	Continued From page 80	G 768		

which patient. The HHA also indicated prior to use of the Hoyer she was not trained or competency checked by an RN in the home.

8. An interview was conducted with Employee P, HHA, on 11/6/2020 at 5:05 PM. During the interview, the HHA indicated she did provide care to a patient with a Hoyer, but could not recall which patient. The HHA also indicated prior to use of the Hoyer she was not trained or competency checked by an RN in the home.

9. An interview was conducted with Employee MM, HHA, on 11/6/2020 at 5:11 PM. During the interview, the HHA indicated she did provide care to multiple patients with Hoyers, but could not recall which patients. The HHA also indicated prior to use of the Hoyer she was not trained or competency checked by an RN in the home.

10. An interview was conducted with the Administrator and DON on 11/10/2020 at 12:03 PM. During the interview, the Administrator indicated all specialty equipment training, including use of Hoyers, was conducted in the agency office by the Director of Nursing (DON) and ADON. Agency RNs also conducted in-home competencies of the HHAs use of specialty equipment. The Administrator stated the agency enacted the PIP regarding conduction of competencies of HHAs on patient-specific Hoyers and Sara lifts after "going through [agency] files ... reviewing [home health agency association]'s recommendations on competencies." The Administrator denied any adverse incident occurred which led to enacting this PIP. The Administrator also indicated the agency "held a QAPI meeting ... updated [transfer of patients] policy the same day the PIP was enacted, however the agency was unable to perform all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 768	Continued From page 81 in-home competencies immediately due to staffing shortages. The Administrator also indicated all patients with a Hoyer had the manufacturer's instructions in the home. 17-14-1(l)(A)	G 768		
G 946	Administrator appointed by governing body CFR(s): 484.105(b)(1)(i) (i) Be appointed by and report to the governing body; This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the administrator reported to the governing body. Findings include: An agency policy titled "Governing Body," policy number 1-002.1 and revised 9/1/20, stated " ... Purpose: To outline the roles and responsibilities of the Governing Body ... Procedure ... The Governing Body will appoint a qualified Executive Director/Administrator and establish procedures of systemic communication between the two. Performance of the Executive Director/Administrator will be monitored annually through a procedure established by the Governing Body ...." An agency job description titled "Administrator Job Description," revised 10/25/18, stated " ... Position: Administrator ... Reports to: Governing Body ...." The survey's Entrance Conference was conducted on 11/4/20 at 9:48 AM with the Administrator and the Director of Nursing (DON).	G 946		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
G 946	Continued From page 82 During the Entrance Conference, the Administrator indicated she is the sole member of the agency's Governing Body. The Administrator's personnel record was reviewed on 11/16/2020, and indicated a date of hire of 4/9/2012. The personnel record contained a yearly evaluation for the Administrator completed on 2/26/13. The Administrator's personnel record failed to evidence the Administrator had received a yearly evaluation from the Governing Body since 2013. The agency's Governing Body minutes were reviewed on 11/16/2020. The Governing Body minutes failed to evidence a yearly evaluation of the Administrator had been conducted at any point. An interview of the agency's Administrator and DON was conducted on 11/16/2020 at 4:01 PM. During the interview the Administrator indicated all agency employees should receive a yearly evaluation. When questioned why the Administrator did not have yearly evaluation conducted since 2013, the Administrator stated, "I don't give myself annual evals [evaluations]." 17-12-1(b)(1)	G 946		
G 978	Must have a written agreement CFR(s): 484.105(e)(2)(i-iv) An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or	G 978		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 978	Continued From page 83 individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure written agreements were in place which delineated the services each agency was to provide for 2 of 2 active records reviewed (#2, 5), in a total sample of 24 patients who received care from another agency and 17 records reviewed. Findings include: 1. An agency job description titled "RN Case Manager Job Description," revised 10/31/17, stated " ... Job Summary: The RN Case Manager plans, organizes, and directs home care services. The RN Case Manager builds from the resources of the community to plan and direct services to meet the needs of individual and families ... Responsibilities/essential functions: ... 7. Prepares clinical and progress notes, coordinates services ... 18. Regularly conducts Case Care Conferences ...." 2. The entrance conference interviews were conducted on11/4/2020 at 9:48 AM with the agency's Administrator and Director of Nursing (DON). During the Entrance Conference, the Administrator indicated the agency did share patients with other agencies. The Administrator also indicated care was coordinated with shared patient agencies through the Registered Nurse	G 978		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
G 978	Continued From page 84 (RN) Case Managers. The Administrator stated the agency did not have a shared patient contract with shared patient agencies which delineated the services each agency was to provide. 3. A list of all patients who received care from multiple agencies was reviewed on 11/5/20. The list included 24 patients (Patient #2 (start of care 4/30/20), #5 (start of care 4/5/19), #6 (start of care 8/24/17), #7 (start of care 1/31/20), #8 (start of care 3/11/13), #20 (start of care 3/26/13), #22 (start of care 1/22/19), #25 (start of care 4/27/13), #26 (start of care 2/5/20), #27 (start of care 6/4/19), #28 (start of care 3/15/18), #30 (start of care 3/21/13), #36 (start of care 1/3/17), #37 (start of care 9/16/20), #38 (start of care 6/11/20), #39 (start of care 11/26/18), #40 (start of care 2/25/19), #41 (start of care 8/21/18), #42 (start of care 9/26/19), #43 (start of care 10/3/18), #44 (start of care 8/27/20), #45 (start of care 9/18/19), #46 (start of care 6/24/16), and #47 (start of care 3/19/18)) who received care from 3 separate home care agencies (Entities X, Y, and Z). 4. The clinical record of Patient #2 was reviewed on 11/9/2020 and 11/12/2020, and indicated patient diagnoses including but not limited to cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. The clinical record contained a plan of care for the recertification period 10/27/2020 - 12/25/2020. The plan of care stated " ... Other Services Received: ... Support services through [Entity Y, a personal services agency] ...." Patient #2's clinical record failed to evidence a shared patient agreement was enacted with Entity Y. 5. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, and indicated a start of care date of 4/5/19, with patient	G 978		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE HOME HEALTH CARE	302 E JEFFERSON BLVD FORT WAYNE, IN 46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 978	Continued From page 85 diagnoses including, but not limited to heart failure, Chronic Obstructive Pulmonary Disease (COPD, chronic inflammatory disease of the lungs), history of transient ischemic attack (TIA, temporary loss of blood flow to the brain), left above the knee amputation, generalized muscle weakness, history of deep vein thrombosis (blood clot formed within a vein deep in the body), and depression. The clinical record contained a plan of care for the recertification period 9/26/2020 - 11/24/2020. The plan of care stated " ... Other Services Received: ... [Entity X, a personal services agency] attendant 14 hours a week ...." Patient #5's clinical record failed to evidence a shared patient agreement was enacted with Entity Y. 17-12-2(d)	G 978		
G 980	Primary HHA is responsible for patient care CFR(s): 484.105(e)(3) The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients. This Element is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure a shared patient agreement which indicated the primary home health agency was created for 2 of 2 active records reviewed (#2, 5), in a total sample of 24 patients who received care from another agency and 17 records reviewed. Findings include: 1. An agency job description titled "RN Case Manager Job Description," revised 10/31/17, stated " ... Job Summary: The RN Case Manager plans, organizes, and directs home care services.	G 980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

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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
G 980	Continued From page 86 The RN Case Manager builds from the resources of the community to plan and direct services to meet the needs of individual and families ... Responsibilities/essential functions: ... 7. Prepares clinical and progress notes, coordinates services ... 18. Regularly conducts Case Care Conferences ...." 2. The entrance conference interviews were conducted on 11/4/2020 at 9:48 AM with the agency's Administrator and Director of Nursing (DON). During the Entrance Conference, the Administrator indicated the agency did share patients with other agencies. The Administrator also indicated care was coordinated with shared patient agencies through the Registered Nurse (RN) Case Managers. The Administrator stated the agency did not have a shared patient contract which indicated the primary home health agency. 3. A list of all patients who received care from multiple agencies was reviewed on 11/5/20. The list included 24 patients (Patient #2 (start of care 4/30/20), #5 (start of care 4/5/19), #6 (start of care 8/24/17), #7 (start of care 1/31/20), #8 (start of care 3/11/13), #20 (start of care 3/26/13), #22 (start of care 1/22/19), #25 (start of care 4/27/13), #26 (start of care 2/5/20), #27 (start of care 6/4/19), #28 (start of care 3/15/18), #30 (start of care 3/21/13), #36 (start of care 1/3/17), #37 (start of care 9/16/20), #38 (start of care 6/11/20), #39 (start of care 11/26/18), #40 (start of care 2/25/19), #41 (start of care 8/21/18), #42 (start of care 9/26/19), #43 (start of care 10/3/18), #44 (start of care 8/27/20), #45 (start of care 9/18/19), #46 (start of care 6/24/16), and #47 (start of care 3/19/18)), who received care from 3 separate home care agencies (Entities X, Y, and Z). 4. The clinical record of Patient #2 was reviewed	G 980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K002	A. BUILDING _____ B. WING _____	C 11/16/2020

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G 980	Continued From page 87 on 11/9/2020 and 11/12/2020, and indicated patient diagnoses including but not limited to cerebral palsy, moderate intellectual disabilities, and chronic respiratory failure. The clinical record contained a plan of care for the recertification period 10/27/2020 - 12/25/2020. The plan of care stated " ... Other Services Received: ... Support services through [Entity Y, a personal services agency] ...." Patient #2's clinical record failed to evidence a shared patient agreement which indicated the primary agency was enacted with Entity Y. 5. The clinical record of Patient #5 was reviewed on 11/6/2020 and 11/12/2020, and indicated a start of care date of 4/5/19, with patient diagnoses including, but not limited to heart failure, Chronic Obstructive Pulmonary Disease (COPD, chronic inflammatory disease of the lungs), history of transient ischemic attack (TIA, temporary loss of blood flow to the brain), left above the knee amputation, generalized muscle weakness, history of deep vein thrombosis (blood clot formed within a vein deep in the body), and depression. The clinical record contained a plan of care for the recertification period 9/26/2020 - 11/24/2020. The plan of care stated " ... Other Services Received: ... [Entity X, a personal services agency] attendant 14 hours a week ...." Patient #5's clinical record failed to evidence a shared patient agreement which indicated the primary agency was enacted with Entity X. 17-12-2(e)	G 980		