

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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	<p>INITIAL COMMENTS</p> <p>This visit was for a Federal/State Complaint Survey, in conjunction with a focused infection control COVID-19 survey.</p> <p>Survey Dates: 8/2 and 8/3 of 2021</p> <p>Complaint IN00358988 - Unsubstantiated with unrelated findings cited</p> <p>Facility Number: 012972</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 17.</p> <p>QR completed 8/18/2021 A4 Authentication CFR(s): 484.110(b)</p> <p>Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is not met as evidenced by: Based on record review and interview, the agency failed to ensure care was provided and signed off on by the patient prior to documenting in the clinical record for 2 of 4 patients with home health aide visits. (Patients 2 &amp; 3)</p> <p>Findings include:</p> <p>1. A review of the initial training for the Electronic Medical Record Aide Connect in AloraPlus required by all Home Health Aides instructed as</p>	G 000		
G1024		G1024		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 1</p> <p>follows:</p> <p>2) The Pencil Icon - Click on the Pencil Icon. The scheduled visit will open and give the option to start a scheduled visit.</p> <p>b) At the end of the visit, log back in and scroll down to the "Aide Visit Note"</p> <p>c) The visit note will display the items on the Aide Plan of Care for the user to complete</p> <p>d) Check the correct option (completed/not completed/patient refused) save and close</p> <p>e) Obtain patient's signature using the touch screen or mouse</p> <p>f) The patient should sign with actual signature or digital signature</p> <p>g) End the visit</p> <p>2. The clinical record for patient 2 was reviewed on 8/2/2021. The certification period reviewed was 3/16/2021 to 5/14/2021 with 2 Home Health Aides (HHA) providing services per the Plan of Care. The clinical record evidenced the following:</p> <p>On 3/16/2021, HHA B had a scheduled shift for 8:00 a.m.-2:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:57 a.m.</p> <p>On 3/17/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:59 a.m.</p> <p>On 3/18/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:42 a.m.</p> <p>On 3/19/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:57 a.m.</p>	G1024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 2</p> <p>On 3/20/2021, HHA B had a scheduled shift for 8:00 a.m.-12:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 10:19 a.m.</p> <p>On 3/21/2021, HHA B had a scheduled shift for 8:00 a.m.-12:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:53 a.m.</p> <p>On 3/22/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:03 a.m.</p> <p>On 3/23/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:56 a.m.</p> <p>On 3/24/2021, HHA B had a scheduled shift for 8:00 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:25 a.m.</p> <p>On 3/25/2021, HHA B had a scheduled shift for 8:00 a.m.-1:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 9:38 a.m.</p> <p>On 3/26/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 9:33 a.m.</p> <p>On 3/27/2021, HHA D had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA D and patient 2 signed off on the implementation of all completed tasks at 9:09 a.m.</p> <p>On 3/29/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:57 a.m.</p> <p>On 3/30/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed</p>	G1024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 3</p> <p>tasks at 8:55 a.m.</p> <p>On 3/31/2021, HHA B had a scheduled shift for 7:30 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:24 a.m.</p> <p>On 4/1/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:56 a.m.</p> <p>On 4/2/2021, HHA B had a scheduled shift for 9:00 a.m.-5:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:56 a.m.</p> <p>On 4/3/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:54 a.m.</p> <p>On 4/5/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:58 a.m.</p> <p>On 4/6/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:53 a.m.</p> <p>On 4/7/2021, HHA B had a scheduled shift for 7:30 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:27 a.m.</p> <p>On 4/8/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:55 a.m.</p> <p>On 4/9/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:52 a.m.</p> <p>On 4/12/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2</p>	G1024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 4</p> <p>signed off on the implementation of all completed tasks at 8:28 a.m.</p> <p>On 4/13/2021, HHA B had a scheduled shift for 8:00 a.m.-4:0 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:00 a.m.</p> <p>On 4/14/2021, HHA B had a scheduled shift for 7:30 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:24 a.m.</p> <p>On 4/15/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:56 a.m.</p> <p>On 4/16/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:51 a.m.</p> <p>On 4/17/2021, HHA D had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA D and patient 2 signed off on the implementation of all completed tasks at 9:14 a.m.</p> <p>On 4/18/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 9:00 a.m.</p> <p>On 4/19/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:07 a.m.</p> <p>On 4/20/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:49 a.m.</p> <p>On 4/21/2021, HHA B had a scheduled shift for 7:30 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:28 a.m.</p> <p>On 4/22/2021, HHA B had a scheduled shift for</p>	G1024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 5</p> <p>9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:45 a.m.</p> <p>On 4/23/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:49 a.m.</p> <p>On 4/26/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 12:50 p.m.</p> <p>On 4/27/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:54 a.m.</p> <p>On 4/28/2021, HHA B had a scheduled shift for 7:30 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:26 a.m.</p> <p>On 4/29/2021, HHA B had a scheduled shift for 9:00 a.m.-2:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 9:04 a.m.</p> <p>On 4/30/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 12:14 a.m.</p> <p>On 5/1/2021, HHA D had a scheduled shift for 9:00 a.m.-1:30 p.m., but HHA D and patient 2 signed off on the implementation of all completed tasks at 9:16 a.m.</p> <p>On 5/2/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 1:26 p.m.</p> <p>On 5/3/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:58 a.m.</p>	G1024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 6</p> <p>On 5/4/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 9:14 a.m.</p> <p>On 5/5/2021, HHA B had a scheduled shift for 7:30 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:44 a.m.</p> <p>On 5/6/2021, HHA B had a scheduled shift for 9:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 9:09 a.m.</p> <p>On 5/7/2021, HHA B had a scheduled shift for 9:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:36 a.m.</p> <p>On 5/10/2021, HHA B had a scheduled shift for 8:00 a.m.-4:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:01 a.m.</p> <p>On 5/11/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 10:33 a.m.</p> <p>On 5/12/2021, HHA B had a scheduled shift for 7:30 a.m.-12:30 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 7:23 a.m.</p> <p>On 5/13/2021, HHA B had a scheduled shift for 9:00 a.m.-5:00 p.m., but HHA B and patient 2 signed off on the implementation of all completed tasks at 8:55 a.m.</p> <p>3. The clinical record for patient 3 was reviewed on 8/2/2021. The certification period reviewed was 6/15/2021 to 8/13/2021 with 5 Home Health Aides (HHA) providing services per the Plan of Care. The clinical record evidenced the following:</p>	G1024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 7</p> <p>On 6/15/2021, HHA F had a scheduled shift for 2:00 p.m.-4:00 p.m., but HHA F and patient 2 signed off on the implementation of all completed tasks at 1:57 p.m.</p> <p>On 6/20/2021, HHA G had a scheduled shift for 12:00 p.m.-3:00 p.m., but HHA G and patient 2 signed off on the implementation of all completed tasks at 12:43 p.m.</p> <p>On 6/22/2021, HHA H had a scheduled shift for 2:00 p.m.-5:00 p.m., but HHA H and patient 2 signed off on the implementation of all completed tasks at 2:28 p.m.</p> <p>On 6/24/2021, HHA H had a scheduled shift for 2:00 a.m.-5:00 p.m., but HHA H and patient 2 signed off on the implementation of all completed tasks at 2:15 p.m.</p> <p>On 6/26/2021, HHA H had a scheduled shift for 2:00 p.m.-5:00 p.m., but HHA H and patient 2 signed off on the implementation of all completed tasks at 2:32 p.m.</p> <p>On 6/28/2021, HHA H had a scheduled shift for 2:45 p.m.-4:30 p.m., but HHA H and patient 2 signed off on the implementation of all completed tasks at 2:46 p.m.</p> <p>On 7/5/2021, HHA H had a scheduled shift for 1:30 p.m.-4:15 p.m., but HHA H and patient 2 signed off on the implementation of all completed tasks at 2:20 p.m.</p> <p>On 7/7/2021, HHA H had a scheduled shift for 1:30 p.m.-3:45 p.m., but HHA H and patient 2 signed off on the implementation of all completed tasks at 1:30 p.m.</p> <p>On 7/8/2021, HHA H had a scheduled shift for 1:30 p.m.-4:30 p.m., but HHA H and patient 2 signed off on the implementation of all completed tasks at 1:43 p.m.</p> <p>4. During an interview on 8/3/2021 at 12:48 p.m. Director of Clinical Services (DCS) K indicated</p>	G1024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/03/2021	
NAME OF PROVIDER OR SUPPLIER  ELDER'S JOURNEY HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  4211 E 3RD STREET BLOOMINGTON, IN 47401		
(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
G1024	<p>Continued From page 8</p> <p>that aides should not sign off or have the patient sign off on Plan of Care skills performed until the end of the visit.</p> <p>5. During an interview on 8/3/2021 at 3:55 p.m. the Administrator and DCS K indicated the standard expected for aides during visits is to have the patient and the aide to sign off on completion of the plan of care at the end of the visit. DCS K also stated several in-services have been done discussing this as well to reiterate the initial training provided to aides when hired.</p> <p>17-15-1(a)(7)</p>		G1024		