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	013400	A. BUILDING: _____ B. WING _____	C 09/21/2020

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PREFERENCE HEALTH SERVICES INC	3026 45TH ST, SUITE 2 E HIGHLAND, IN 46322

(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) COMPLETE DATE
N 000	Initial Comments This was a state license only / complaint survey conducted on 9/15/20 - 9/21/20. Facility ID: 013400 Active Patients: 42 Discharged Patients: 17 Records reviewed with home visits: 2 Records reviewed with no home visits: 6 Home Visit with no record reviewed: 1 Total records reviewed: 8 Total home visits: 3 Complaint #: IN00279004 Complaint was substantiated with related and unrelated findings. Preference Health Services, Inc. entered into an "Agreed Order" with the Indiana Department of Health on 9/17/19. This "Agreed Order" had an area subtitled "Stipulated Facts" which stated "... g. Preference's Administrator, Clinical Supervisor, and the corresponding alternate positions shall each provide a daily verbal report to the Nurse Consultant for six (6) months. This report shall be documented in writing, using a form created by the Nurse Consultant. The Alternate Clinical Supervisor and Alternate Administrator will provide daily reports on the dates they perform work at Preference. After six (6) months from the Effective Date of this Agreed Order, Preference's Administrator, Clinical Supervisor,and the corresponding alternate positions shall each provide a weekly verbal report to the Nurse Consultant for six months. This report shall be documented in writing using a	N 000		

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N 000	Continued From page 1	N 000		

form created by the Nurse Consultant. ... i. Preference shall undergo a one-half day (four or five (4-5) hour) in-person home health aide "bootcamp" performed by the Nurse Consultant. All aides shall be required to attend and pass a related test with a score of 80%. If aides score less than 100% on the "bootcamp" test, Preference shall re-educate and re-train aides on the deficiencies before assigning tasks to the home health aide. ... r. Preference's job descriptions shall be modified to include compliance as a component of job performance. i. Staff shall be in-serviced on these compliance requirements. ii. After six (6) months, all staff shall undergo a performance evaluation to evaluate performance against these new performance standards...."

The following "Stipulated Facts" failed to be evidence as completed:

Record review on 9/21/20 of agency documents titled "Inservice Record Sheet" which indicated it was for "Aide Boot Camp" dated 10/26/19, 11/5/19, and 12/17/19 failed to be evidenced as signed by the nurse consultant. This document had indicated the "bootcamp" was conducted by the nurse consultant, however there was no signature or date from the nurse consultant at the bottom of the agency form.

During an interview on 9/17/20 at 3:35 p.m., employee O indicated he/she received additional training a few months ago on "simple stuff" and "how to deal with clients" and indicated they were trained by employee A.

Record review on 9/16/20 evidenced signed agency job descriptions with "compliance requirements" for the home care scheduler,

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N 000	Continued From page 2	N 000		

billing/payroll manager, office manager, receptionist, human resource coordinator and field investigator. There were no evidenced signed job descriptions for any of the administration or clinical staff with compliance statements.

Record review on 9/16/20 evidenced an agency document titled "Inservice Record Sheet" dated 1/22/20 which indicated the purpose as "New compliance requirements". This document evidenced the inservice was attended by employee Q, employee T, employee S, employee R and employee B. There was no evidence any other Preference employee received this same inservice regarding compliance requirements.

During an interview on 9/16/20 at 2:03 p.m., the administrator indicated she thought only office staff job descriptions needed the compliance statement. The administrator then indicated she was told by counsel and the nurse consultant they only needed compliance statements for office personnel job descriptions.

During an interview on 9/15/20 at 1:36 p.m., the administrator indicated she would speak with employee S about employee job descriptions, employee training, performance evaluations and "bootcamp" documentation.

On 9/21/20 at 1:40 p.m., the administrator submitted forms titled "6 Month Probationary Evaluation".

Record review on 9/21/20 failed to evidence a 6 month probationary evaluation completed for employees V, C, F, G, J, and I.

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N 000	Continued From page 3 Quality review completed on 10/8/20 by area 2 IDR Committee met on 11/25/2020. Tags N0000, N0444, N0446, N0458 & N0542 modified. Tags N0470 & N0480 deleted.	N 000		
N 444	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the administrator organized and directed the home health agency's ongoing functions. (employee A) The findings include: The agency job description titled "Administrator / DON [director of nursing] dated 6/19/20 and signed by employee A stated "... Summary: The health administrator's job is an important one to the overall functioning of a medical facility. This job essentially involves the management and	N 444		

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N 444	Continued From page 4 business side of a hospital or health facility. The administrator acts like a supervisor who is not just responsible for the business functions but also for all the medical staff. The focus is primarily given on the type of health care given, whether the health care is up to date and whether all technological upgrading has been done. All of this is part and parcel of the health administrator's job. He or she is also required to implement the required changes both in the business side of the medical facility and the medical side. It is very important to have experience in various levels within the health care administration before taking up this post. Duties/Responsibilities Supervision and management of each section of the medical facility not just the business operations but also medical ones. Ensuring all employees is placed in the correct post according to their ability. Being aware of the medical innovations and recent medical developments and incorporating them within the medical facility. Since he or she is required to administrate the whole facility, it is important that one is alert and prepared to strategize wherever required. He must be an expert in handling people of different mentalities especially since he is responsible for hiring the medical and other staff members. Ensuring all medical supplies are properly ordered and delivered in time. Training and hiring new staff in different departments of the medical facility. All finances and money transactions are handled by the health administrator. There are also legal issues and complexities that he is required to sort out if necessary. Budgeting and accounting are important skills that he must possess as he is required to produce finance reports periodically. Marketing analysis reports should be constantly done by the health administrator so that the required actions can be taken ...."	N 444		

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N 444	Continued From page 5 The agency job description titled "Administrator / Alt [alternate] Administrator" dated and signed by employee A on 2/4/2020, stated "The Administrator, is a qualified person appointed by the Board of Directors to administer, direct and coordinate all the activities of the Home Health Agency. Qualifications Registered Nurse, Physician, or have an undergraduate degree. Demonstrated ability to supervise and direct professional and administrative personnel and deal tactfully with the community. knowledge of corporate business management. Minimum of one year supervisory or administrative experience in the field of Health. Responsibilities Plans overall development and administration of the Agency as set forth in the Conditions of the Participation and/or applicable state regulations under the direction of the Board of Directors. Develops administrative policies and procedures relating to the Home Health Agency. Directs installation of improved work methods and procedures to ensure achievement of objectives of the program. Reviews and evaluates existing policies and produces by means of periodic studies. Coordinates and integrates the total Agency activities through regular conferences with department supervisors. Interprets and transmits policy to the Board [sic] of Directors, and supervisory staff to ensure compliance with Policies. Develops Standards and methods of measurement of Agency activity and coordinates the annual program evaluation. Prepares an effective yearly budget and accounting system in cooperation with Board of Directors. Approves monthly expenditures, and monitors the financial position of the Agency. Prepares reports on Agency activity for the Board of Directors and Advisory Committee Determines organizational lines of authority and fixes areas of responsibility Employs qualified personnel and ensures	N 444		

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N 444	Continued From page 6 adequate staff evaluations Approves all salary increases and staff promotions in cooperation with Governing body Authorizes purchase of supplies and equipment Participates in coordination and implementation of an on-going community awareness program Acts as official Agency spokesperson and representative Works with local, state, and national associations and participates in meetings, conventions, etc. Cooperates with health and health-related agencies to increase and improve services to the community. Promotes educational awareness to Agency staff. Ensures continuous compliance with all applicable federal and state regulations and Agency policy. Handles client complaints not resolved according to procedure and/or works with the board to resolve it. In cooperation with the Board of Directors, appoints a qualified individual to act in the Administrator's absence. Ensures the development and implementation of a continuing education program to meet identified staff needs. Develops an open, positive rapport with community resources affiliated with home health care services. Maintains high visibility and availability while in the office via telephone to physicians, referral sources, community resources, clients and staff. Actively pursues new and innovative marketing opportunities. Ensures the accuracy of public information materials and activities...." During an interview on 9/15/20 at 2:20 p.m., the administrator indicated she did not have documentation of the trainings that were recently done on agency staff by the nurse consultant. The administrator indicated she talked with the nurse consultant and the nurse consultant indicated she could take pictures of the sign-in sheets and send them to the administrator.	N 444		

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N 444	Continued From page 7 During an interview on 9/15/20 at 2:35 p.m., a request was made to review the personnel records. The administrator indicated they were in employee B's office and the office was locked. The administrator indicated she did not have a key to this office and employee B was currently moving that day and failed to leave her a key. Record review on 9/16/20 failed to evidence a compliance statement (as per agreed order) in all employee job descriptions. The only evidenced signed job descriptions with a compliance statement was for the agency's office personnel. During an interview on 9/16/20 at 2:03 p.m., the administrator indicated she was not "here" during the time the job descriptions with compliance statements were signed. The administrator then asked, "Was it just office staff?" Then the administrator indicated she was told by counsel and the nurse consultant they only needed compliance statements in the job description for office staff. During an interview on 9/16/20 at 2:09 p.m., the administrator indicated they do have a physical therapy contract for the agency and that the therapist was part time. The administrator indicated employee C informed her of the information. Then the administrator indicated the therapist was a direct employee and not contracted. During an interview on 9/16/20 at 2:16 p.m., employee B indicated that employee C revealed the physical therapist was a contracted therapist with the agency. When concerns were voiced about the administrator directing and operating the functions of the agency, employee C indicated she had only been at the agency since February	N 444		

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N 444	Continued From page 8 and she had to put the puzzle pieces together.	N 444		
N 446	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. This RULE is not met as evidenced by: Based on record review and interview the administrator failed to ensure the home health agency had adequate staff education and evaluations. The findings include: The agency job description titled "Administrator/ Alt Administrator" dated and signed by employee A on 2/4/2020, stated "... Employs qualified personnel and ensures adequate staff evaluations ... Ensures continuous compliance with all applicable federal and state regulations and Agency policy ... Ensures the development and implementation of a continuing education program to meet identified staff needs...." The agency job description titled "Administrator / DON [director of nursing]" dated and signed by employee A on 6/19/20, stated "... There are also legal issues and complexities that he is required to sort out if necessary...."	N 446		

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N 446	Continued From page 9 Pre-survey review of an Indiana State document titled "Agreed Order" signed and dated by employee D on 9/17/19 stated "... h. Preference shall undergo an, eight (8) hour, in-person home health nursing "bootcamp" performed by the nurse consultant [person F]. The bootcamp may be performed over two days. The Administrator, Clinical Supervisor, and the corresponding alternates shall attend. All nurses shall be required to attend and pass the related test with a score of 80%. If nurses score less than 100% on the "bootcamp" test, Preference shall re-educate and re-train nurses on the deficiencies before assigning tasks to the nurse. i. Preference shall undergo a one-half day (four or five (4-5) hour) in-person home health aide "bootcamp" performed by the Nurse Consultant. All aides shall be required to attend and pass a related test with a score of 80%. If aides score less than 100% on the "bootcamp" test, Preference shall re-educate and re-train aides on the deficiencies before assigning tasks to the home health aide. ... r. Preference's job descriptions shall be modified to include compliance as a component of job performance. i. Staff shall be in-serviced on these compliance requirements. ii. After six (6) months, all staff shall undergo a performance evaluation to evaluate performance against these new performance standards. iii. Any staff failing to meet standards shall be provided with performance improvement plans (PIPs), training, and education. iv. Staff who fail to meet goals contained in the PIPs shall be terminated. Performance evaluations shall be documented annually...." Record review on 9/21/20 for employee A, evidenced a document titled "Home Health Care Nurses Boot Camp Test" dated 2/25/20. This	N 446		

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N 446	Continued From page 10 document failed to evidence it was graded. It is unknown if employee A passed the "bootcamp" test. During an interview on 9/15/20 at 1:36 p.m., the administrator indicated she would talk with the human resources employee about the job descriptions, employee training, performance evaluations and bootcamp documentation. During an interview on 9/15/20 at 2:20 p.m., the administrator indicated she could not find documentation of the training done by the nurse consultant. The administrator indicated she talked with the nurse consultant and she said she could take pictures of the sign-in sheets and send it. Record review on 9/21/20 of the documents titled "6 Month Probationary Evaluation [required per agreed order]" failed to evidence documents for employee I, employee J, employee G, employee F, employee C, and employee K (not completed).	N 446		
N 450	410 IAC 17-12-1(c)(7) Home health agency administration/management Rule 12 Sec. 1(c)(7) The administrator, who may also be the supervising physician or registered nurse required by subsection (d) of this rule, shall do the following: (7) Upon request, make available to the Commissioner or his or her designated agent all: (A) reports; (B) records; (C) minutes; (D) documentation; (E) information; and (F) files;	N 450		

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N 450	Continued From page 11 required to determine compliance within seventy-two (72) hours of the request or, in the event the request is made in conjunction with a survey, by the time the surveyor exits the home health agency, whichever is sooner. This RULE is not met as evidenced by: Based on record review an interview, the administrator failed to make documents and files available upon request. The findings include: An undated agency policy C-381, titled "Client/Family Complaint/Grievance Policy" stated "Purpose ... To provide a mechanism for clients/ representative to complain and participate in the process without fear of retaliation ... Special Instructions ... Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file ..." An undated agency policy D- 460, titled "Contract Personnel" stated "Policy ... Contract personnel are employees of organizations who contract with Agency, or individuals who contract directly with Agency, on an hourly, per visit, or other basis to provide service to clients per a written agreement ... Purpose ... To ensure sufficient numbers of personnel to safely and adequately meet the client's home care needs ... Special Instructions ... 3. Prior to rendering services to agency clients, all contract personnel shall receive an orientation to the agency's client care policies and procedures and applicable personnel requirements ... 4. Professional personnel under contract with the agency to provide professional services shall have complete personnel files	N 450		

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N 450	Continued From page 12 available for the agency upon request. Individuals who contract individually with the agency will have a complete personnel file in the agency which includes references, licenses/certifications, Mantoux/Health screening, and other documentation required by the agency ... " Record review on 9/15/20, evidenced the agency's complaint log which dated back to 2019. On 9/17/20, at 2:36 PM, the complaint log from June 2018 through December 2018 and employee file of the contracted personnel, person G, physical therapist (PT), was requested. Employee A, indicated person G was a contracted employee and did not have a personnel file. Employee A also expressed that there was not a complaint log when they took over as administrator. The administrator failed to provide the requested complaint log prior to exiting the survey on 9/21/20. During an interview on 9/21/20 at 2:20 PM, employee A indicated a contract employee would shadow with a skilled nurse (SN), and would be oriented to what they need to know. During an interview on 9/21/20 at 2:24 PM, office staff found the personnel record for person G. The employee file failed to evidence requested documents, including but not limited to, a skills competency, job description, and orientation.	N 450		
N 458	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall	N 458		

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N 458	Continued From page 13 be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure all personnel records contained performance evaluations in 1 of 3 registered nurse records, in a total sample of 9 employee records reviewed. (A, D) The findings include: 1. An undated agency policy -260, titled "Performance Evaluations" stated "Policy ... A competency-based performance evaluation may be conducted for all employees after ninety (90) day and then one (1) year of employment and at least annually thereafter ... Purpose ... To establish a consistent process by which competence of each agency employee is assessed, demonstrated, and maintained ... Special Instructions ... 6. The original completed performance evaluation will be retained in the employee's personnel record, and a photocopy will be provided to the employee.... " An undated agency policy D-180, titled "Personnel Records" stated Policy ... Personnel	N 458		

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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) COMPLETE DATE
N 458	Continued From page 14 files will be established and maintained for all personnel ... Purpose ... To provide a mechanism for maintaining accurate, complete, and current personnel information ... Special Instructions ... 1. Personnel records: ... a. The personnel record for an employee will include, but not limited to: ... d. Ongoing Employment: ... Performance appraisals ..." 2. Personnel record review on 9/21/20, for employee A, administrator, date of hire 2/4/20, evidenced a document titled "Employee Performance Evaluation" dated 6/21/19. The employee's personnel file failed to evidence a current performance evaluation at the time of review. 3. During an interview on 9/15/20, at 1:37 PM, employee A indicated performance evaluations were located in the employee files.	N 458		
N 460	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.	N 460		

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N 460	Continued From page 15 This RULE is not met as evidenced by: Based on record review and interview, the agency failed to include documentation of orientation to their job in 1 of 1 administrator's personnel record reviewed. (A) The findings include: An undated agency policy D-180, titled "Personnel Records" stated Policy ... Personnel files will be established and maintained for all personnel ... Purpose ... To provide a mechanism for maintaining accurate, complete, and current personnel information ... Special Instructions ... 1. Personnel records: ... a. The personnel record for an employee will include, but not limited to: ... c. Employment Information: ... Orientation checklist - completed and signed ...." Personnel record review for employee A, administrator, on 9/21/20, failed to evidence documentation of orientation to their job as administrator. During an interview on 9/21/20, at 2:14 PM, employee A indicated that employee B, CEO (chief executive officer), completed most of the orientation for role as administrator. Employee A added that "everyone" has oriented him/her to their job so the administrator would know all the roles. During an interview on 9/21/20, at 2:39 PM, employee A indicated orientation to the role of administrator was included in the two day bootcamp with person F, nurse consultant.	N 460		

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N 484	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure personnel effectively communicated with each other to support patient care in 2 of 2 clinical records reviewed for patients on anticoagulant precautions, out of 8 total clinical records reviewed (#4, #7). The findings include: 1. An undated agency Policy C- 751 titled "Home Health Aide Care Plan" had an area subtitled "Special Instructions" that stated "2. The Care Plan shall be developed in plain, non-technical lay terms and identify the duties to be performed ..." An undated agency policy reviewed on 8/17/20, titled "Coordination of Client Services" stated "...The agency will integrate services, whether they are provided directly or under contract, to assure the identification of client needs and factors that could affect client safety and the effectiveness of treatment...." 2. Clinical record review on 9/21/20, for patient #4, start of care 4/30/18, diagnoses included but were not limited to heart failure and long term use	N 484		

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N 484	Continued From page 17 of anticoagulants (blood thinning medication), evidenced a document titled "Home Health Certification and Plan of Care" for certification period 6/18/20 - 8/16/20. This document had an area subtitled "Safety Measures" which stated "Anticoagulant Precautions ... Instructed on safety measures. Standard Precautions/Infection Control. O2 [oxygen] Precautions ... " Another area subtitled "Medications" stated "Coumadin [anticoagulant medication] Oral 2 MG [milligrams] 1 Tab [tablet](s) Every evening take with 5 mg tab to equal 7 mg every evening ... Coumadin Oral 5 MG Tab(s) Take one tablet by mouth every evening ... Oxygen @ [at] 2 LPM/NC [liters per minute via nasal cannula] AS NEEDED for Shortness of Breath ... " An area subtitled "Orders and Treatments" evidenced a summary written about the patient which stated "Patient becomes SOB [short of breath] with exertion. Patient uses oxygen @ 2 LPM/NC prn [as needed] for SOB ... Patient has functional limitations - decreased endurance, and limited mobility ... Patient is able to ambulate with assistance from rollator with rest periods ..." Record review on 9/21/20, for patient #4, evidenced a document titled "Aide Care Plan" for the period of 6/18/20 - 8/16/20, which had an area subtitled "Functional Limitations" that indicated endurance, dyspnea, bowel/bladder incontinence, and ambulation pertained to this patient. An area subtitled "DME [durable medical equipment]" which indicated the patient had a nebulizer, oxygen, and a walker that was being utilized in the home. Under the area subtitled "Personal Care" indicated the aide would ensure universal precautions each visit. Another area subtitled "Additional Comment" stated "Fall Prevention - Keep walkways clutter free and well lit, Wear proper footwear, Use a rollator at all	N 484		

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N 484	Continued From page 18	N 484		

times when ambulating ... " The record failed to evidence notification to the HHA of safety measures for anticoagulant and oxygen therapy precautions.

During an interview on 9/21/20 at 11:29 AM, employee A, administrator, indicated the home health aides (HHA) were instructed to have every patient placed on universal precautions, but would also notify them if a patient was diabetic or on fall precautions. When queried if a HHA should be notified of anticoagulant or bleeding precautions, employee A indicated the aide should be notified. Also, the HHA would know the patient is on bleeding precautions by reading the note that indicated the patient takes Coumadin. (Not within the scope of practice for a HHA)
3. Clinical record review on 8/17/2020 for patient #7 with start of care date 1/23/2018 and certification period of 7/11/2020-9/8/2020 evidenced a document titled "Home Health Certification and Plan of Care" dated 7/11/20 and signed by physician on 7/17/2020. This document had a subcategory titled "Safety Measures" which stated "...Anticoagulant Precautions [safety measures to prevent bleeding while taking blood thinners]...."

Clinical record review for patient #7 evidenced an untitled document, identified by employee A as the HHA (home health aide) care plan, dated 7/11/2020 and signed by employee A, RN (registered nurse). This document failed to evidence anticoagulant precautions.

The record failed to evidence communication from the nurse to the HHA as to the responsibilities of the HHA when providing care to the patient, related to anticoagulant precautions.

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N 484	Continued From page 19 During an interview on 9/21/2020 at 11:30 a.m. employee A indicated the HHA care plan failed to include anticoagulant precautions.	N 484		
N 486	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to coordinate services with other health providers serving the patient in 3 out of 3 patients receiving care from other healthcare agencies, in a total of 8 patient records reviewed. (#2, #6, #8) The findings include: 1. An undated agency policy titled "Coordination of Client Services" which stated "... Agency will coordinate care with other medical providers involved in patient's care ... the agency documentation will also clarify what the plan is ... Documentation must address the coordination activities ... Involvement of the care team must be apparent in the record ... How and when communication happens must be documented...." 2. Clinical record review on 9/18/20 for patient #2, start of care 5/16/18, certification period 11/7/19 - 11/20/19, evidenced an untitled agency document identified as a recertification reassessment, dated 11/2/19 and digitally signed by former employee N. This document had an area subtitled "Supportive Assistance" which stated "... Patient receives attendant care from	N 486		

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N 486	Continued From page 20 [entity D name] and Skilled nursing services from [entity B name]. Co-ordination [sic] of Care completed." There failed to be evidence on this document of what was coordinated, who they coordinated with, and what specific services each agency provided to the shared patient. Clinical record review evidenced an agency document titled "Coordination Of Patient Care" dated 11/2/20 and signed by employee B. This document indicated the address, visit times and service personnel each entity provided. This document failed to evidence the specific duties/tasks/treatments each entity provided to their shared patient. 3. Clinical record review on 9/17/2020 for patient #6 with start date of 11/1/2016 and certification period 8/12/2020 to 10/10/2020 evidenced a document titled "Home Health Certification and Plan of Care" dated 8/12/2020 and signed by physician on 9/1/2020. This document indicated the patient received care from entity E as well as attendant/homemaker from entity M. Clinical record review failed to evidence coordination of care. Clinical record review evidenced the last documentation of coordination of care on agency document titled "Coordination of Patient Care" was dated 7/22/2020. Record review failed to evidence what care was provided, coordination of activities, and how communication occurred. 4. Clinical record review on 8/17/2020 for patient #8 with start of care date 6/20/2019 and certification period 4/15/2020 - 6/13/2020 evidenced an untitled document identified by employee A as OASIS [Outcome and Assessment Information Set- a standardized assessment used in home health] discharge assessment, dated 6/12/2020 and signed by employee D, RN [registered nurse]. This	N 486		

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N 486	Continued From page 21 document had a subcategory titled "Supportive Assistance" which stated "Structured Family Care provided by entity N (South Bend, IN). Coordination of care completed." Record review failed to evidence what care was provided, coordination of activities, with whom coordination was communicated, and how communication occurred. Clinical record review evidenced the most recent "Coordination of Patient Care" document for this patient was dated 4/9/2020. This document failed to evidence what care was provided, coordination of activities, and how communication occurred. 5. During an interview on 9/21/2020 at 11:35 a.m. employee A indicated coordination of services was documented on "Coordination of Patient Care" forms for all patients who received services from other agencies.	N 486		
N 522	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the plan of care was followed as ordered by the physician in 3 of 5 active clinical records reviewed, in a total sample of 8 clinical records reviewed. (Patient #3, #6, #7) The findings include:	N 522		

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N 522	Continued From page 22 1. Agency policy C- 580, titled "Plan of Care" stated "Policy ... Home care services are furnished under the supervision and direction of the client's physician ... Purpose ... To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... Special Instructions ... 2. The Plan of Care shall be completed in full to include: ... C. Type, frequency, and duration of all visits/services ..." 2. Clinical record review on 9/18/20 for patient #3, start of care 12/7/17, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/24/20 - 9/21/20, dated and signed by employee D on 7/24/20. This plan of care indicated a primary diagnosis of hypotension unspecified and had an area subtitled "Orders and Treatments" which stated "... Notify physician of: ... Diastolic BP [blood pressure] greater than (>) 90 or less than (<) 60...." Clinical record review evidenced an agency document titled "Resumption of Care" dated 8/29/20 and digitally signed by employee C. This document had an area subtitled "Vital Signs" which stated "... BP Left Lying 152/92...." The clinical record failed to evidence the skilled nurse notified the primary care physician of the patient's elevated diastolic blood pressure, per orders. During an interview on 9/18/20 at 3:16 p.m., the administrator indicated from what she could see the physician was not notified of the elevated diastolic blood pressure as indicated on the plan of care. 3. Clinical record review on 9/17/2020 for patient #6 with start date of 11/1/2016 and certification period 8/12/2020 to 10/10/2020 evidenced a	N 522		

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N 522	Continued From page 23 document titled "Home Health Certification and Plan of Care" dated 8/12/2020 and signed by physician on 9/1/2020. This had a subcategory titled "SN [skilled nurse] Interventions" which stated "SN to instruct the patient to keep a diet log...." Clinical record review failed to evidence any patient diet log. During a home visit on 9/16/2020 at 9:05 a.m. no patient diet log was observed. During an interview on 9/21/2020 at 11:42 a.m. employee A indicated the clinical record failed to evidence a patient diet log and offered no further information or documentation. 4. Clinical record review on 8/17/2020 for patient #7 with start of care date 1/23/2018 and certification period of 7/11/2020-9/8/2020 evidenced a document titled "Home Health Certification and Plan of Care" dated 7/11/20 and signed by physician on 7/17/2020. This document had a subcategory titled "Safety Measures" which stated " ... Anticoagulant Precautions [safety measures to prevent bleeding while taking blood thinners]...." Clinical record review evidenced documents titled "Skilled Nurse Visit" dated 7/23/2020, 8/6/2020, and 8/20/2020. These documents failed to evidence anticoagulant precautions were taken during the visits. During an interview on 9/21/2020 at 11:30 a.m., employee A evidenced the nurse's notes failed to evidence anticoagulant precautions and offered no further information or documentation.	N 522		

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N 524	Continued From page 24	N 524		
N 524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure a complete, accurate, and identified duration was established for 6 of 8 clinical records reviewed. (#1, #2, #3, #6, #7, #8). The findings include: 1. Record review on 9/17/2020 evidenced an agency's undated policy titled "Plan of Care"	N 524		

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N 524	Continued From page 25 stated "PURPOSE ... to develop a plan of care individualized to meet specific identified needs...." This document also stated "SPECIAL INSTRUCTIONS ... The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures. m. Medical supplies and equipment required ... r. Discharge plans...." 2. Clinical record review on 9/21/20 for patient #1, start of care 6/20/18, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/9/20 - 8/7/20, dated and digitally signed by employee D on 6/4/20. This document had an area subtitled "Medications" which indicated the following medications were being taken by the patient: Norco (for pain), Xanax (for anxiety), Tramadol (for pain), albuterol sulfate (for breathing), metformin (for diabetes), pantoprazole (for stomach), lisinopril (for blood pressure), zanaflex (for muscle spasms), aspirin (for blood thinner), nifedipine (for blood pressure / angina), miralax (for constipation), humalog (for diabetes), and Lantus (for diabetes). Clinical record review evidenced an agency document titled "Skilled Nurse Visit" dated 6/17/20 and digitally signed by employee D on 6/17/20. This document had an area subtitled "Pain" which stated "... Current Pain Management & Effectiveness: Norco, tramodol [sic], IBprofin [sic]...." The medication Ibuprofen (for pain) failed to be listed on the plan of care. Ibuprofen also was listed as a treatment for pain on "Skilled Nurse Visit" notes dated 7/1/20 and 7/15/20, both digitally signed by employee D. During an interview on 9/21/20 at 2:50 p.m., the administrator indicated she didn't see it on the "485" and indicated she did not see it under	N 524		

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N 524	Continued From page 26 "orders." The plan of care evidenced an area subtitled "Orders and Treatments" which stated "... HHA [home health aide], up to 6 hrs [hours]/day x 7 days/week x 9 weeks...." This plan of care failed to individualize the hours for the home health aide visits. The administrator was informed of this concern on 9/21/20 at 2:59 p.m. 3. Clinical record review on 9/18/20 for patient #2, start of care 5/16/18, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/7/19 - 11/20/19. This document evidenced an area subtitled "Medications" which stated "... Lac-Hydrin External 12 % sparingly ml [mililiter] to affected areas daily...." This failed to evidence where the medication was to be applied to and/or for what reason the medication should be applied. During an interview on 9/18/20 at 2:05 p.m., the administrator indicated she assumed it was a lotion you use for venous stasis. Then the administrator questioned "You want them to clarify it in there?" The plan of care had an area subtitled "Orders and Treatments" which stated "... HHA: Up to 4 hrs / day x 5 days / week x 9 weeks...." This plan of care failed to individualize the hours for the home health aide. During an interview on 9/18/20 at 2:33 p.m., the administrator indicated it (frequency) was the way the nurse consultant told them to write it. The administrator also indicated whatever PA (prior authorization through Medicaid) allowed them	N 524		

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N 524	Continued From page 27 that's what they put and further stated they were also advised due to Covid to put that due to hours changing for whatever reason. 4. Clinical record review on 9/18/20 at 3:04 p.m., for patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/24/20 - 9/21/20, dated and digitally signed by employee D on 7/24/20. This plan of care evidenced a primary diagnosis of hypotension, unspecified and had an area subtitled "Orders and Treatments" which stated "... HHA: Up to 4 hours / day x 5 days / week x 9 weeks ... SN [skilled nurse] Interventions SN will educate patient and family on stay at home order, social distancing, wearing mask and gloves while in public. SN will educate aptient and/or family on handwashing to prevent the spread of COVID-19 virus. ... SN to assess patient for diet compliance SN to instruct the caregiver and patient to remove clutter from patient's path such as clothes, books, shoes, electrical cords, or other items that may cause patient to trip SN to instruct patient to wear proper footwear when ambulating" This plan of care failed to be individualized for the home health aide hours, and skilled nurse intervention. During an interview on 9/18/20 at 3:04 p.m., the administrator indicated based on assessment, we have certain hours approved. The administrator also indicated the document was individualized because the patient may have adult day services or dialysis. During an interview on 9/18/20 at 3:28 p.m., the administrator was queried as to what skilled nurse interventions were in place for the primary diagnosis of hypotension. The administrator indicated I don't see anything.	N 524		

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N 524	Continued From page 28 5. Clinical record review on 9/17/2020 for patient #6 with start date of 11/1/2016 and certification period 8/12/2020 to 10/10/2020 evidenced a document titled "Home Health Certification and Plan of Care" dated 8/12/2020 and signed by physician on 9/1/2020. This document had a section titled "Medications" which stated "... Cyclobenzaprine HCl [a medication used to treat muscle spasms] Oral 10 MG [milligrams] 1 Tab(s) Daily...." During a home visit for patient #6 on 9/16/2020 at 9:00 am, a review of the patient's home medication list, verified by patient as current, failed to evidence Cyclobenzaprine HCl. Clinical record review of the medication list on the plan of care evidenced the order "Meclizine HCL [a medication used to treat dizziness and motion sickness] Oral 12.5 MG [milligrams] 1 Tab(s) by mouth three times daily as needed. (Can have up to 3 tablets daily)." This order failed to evidence the indication for the as needed medication. Clinical record review of the medication list on the plan of care evidenced the order "Protonix [a medication used to control excess stomach acid] Oral 40 MG [milligrams]1 Tab(s) by mouth daily in the evening...." During a home visit for patient #6 on 9/16/2020 at 9:00 am, a review of the patient's home medication list, verified by patient as current, indicated patient takes Protonix in the morning. Observation of patient's home medication list evidenced Amlodipine [a medication used to treat high blood pressure] and Hydralazine [a medication used to treat high blood pressure].	N 524		

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N 524	Continued From page 29 The plan of care failed to evidence these medications. The home care agency failed to ensure an accurate plan of care was made for the patient. During an interview on 9/21/2020 at 11:42 a.m. employee A acknowledged the findings and offered no further information or documentation. 6. Clinical record review on 8/17/2020 for patient #7 with start of care date 1/23/2018 and certification period of 7/11/2020-9/8/2020 evidenced a document titled "Home Health Certification and Plan of Care" dated 7/11/2020 and signed by physician on 7/17/2020. This document had a subcategory titled "Goals and Outcomes" which stated "Discharge plans: Discharge when reliable caregiver available to assist with patient's medical needs...." The plan of care failed to be individualized as the patient had no caregiver, and lived alone as evidenced by: Clinical record review of this plan of care also evidenced a subcategory titled "Orders and Treatments" which stated "... Patient lives alone. Patient has no caregiver...." Clinical record review for patient #7 evidenced a document titled "OASIS-D1 [Outcome and Assessment Information Set- a standardized assessment used in home health] Recertification...." dated 9/4/2020 and signed by the nurse which stated "Patient lives alone. Patient has no caregiver...." During an interview on 9/21/2020 at 11:30 a.m. when asked if this plan of care is individualized, employee A stated, "Yes". 7. Clinical record review on 8/17/2020 for patient	N 524		

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N 524	Continued From page 30 #8 with start of care date 6/20/2019 and certification period 4/15/2020 - 6/13/2020 evidenced a document titled "Home Health Certification and Plan of Care" dated 4/15/2020 and signed by physician on 5/13/2020. This document had a subcategory titled "Medications" which stated "Plurogel Burn and wound dressing Gel - Apply topically to wound area every 3 days after cleansing with Saline wound rinse...", and "Saline Wound Wash External 0.9 % sparingly ml Cleanse affected areas as ordered...." The plan of care failed to evidence the location on the body where the medications were to be used. 8. During an interview on 9/21/2020 at 11:35 a.m., employee A indicated the agency failed to ensure medication orders in the plan of care were complete.	N 524		
N 527	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This RULE is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure the skilled nurse contacted the primary physician for a change in condition and / or pain management, in 2 of 5 active clinical records reviewed, out of a total of 8 clinical records reviewed. (#1, #3) The findings include:	N 527		

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N 527	Continued From page 31 1. The undated agency policy titled "Medical Supervision" stated "... 3. Physician will be contacted when any of the following occurs: a. Condition changes. b. Expected response to treatment or medication changes...." The undated agency policy titled "Pain Assessment/Management" stated "Policy ... The Agency will work with the client, family and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal. The plan will be reviewed and modified if the client does not have pain relief. ... 6. The follow-up assessments will address effectiveness of the pain management program and identify if there is a need for referral for additional or alternative therapy. If the established plan is ineffective and the pain management needs cannot be met within the agency pain management parameters, a referral will be made to an alternative provider...." 2. Clinical record review on 9/21/20 for patient #1, start of care 6/20/18, certification period 6/9/20 - 8/7/20, evidenced an agency document titled "Skilled Nurse Visit" dated 7/15/20 and digitally signed by employee D on 7/15/20. This document had an area subtitled "Pain" which stated "... Comments: Patient states that she is not getting the relief that she needs with her pain medication." There failed to be any evidence on this document that the physician was contacted regarding the ineffective pain medication relief. During an interview on 9/21/20 at 2:52 p.m., the administrator indicated she would call the physician and report the patient's pain concerns and indicated she didn't see a communication	N 527		

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N 527	Continued From page 32 note in the patient's clinical record. 3. Clinical record review on 9/18/20 for patient #3, start of care 12/7/17, certification period 7/24/20 - 9/21/20, evidenced an agency document titled "Resumption of Care" dated 8/29/2020 and signed by employee C. This document had an area subtitled "Cardiovascular" which stated "... Edema LLE [left lower extremity] (lt [left] knee) 2+ ... Comments: Patient instructed to elevate his feet and not wear tight fitted soaks [sic] to relive [sic] edema." The clinical record failed to evidence the skilled nurse informed the primary care physician of the 2+ edema to the patient's left knee. During an interview on 9/18/20 at 3:16 p.m., the administrator indicated she didn't see "off hand" whether the skilled nurse informed the physician of the left knee edema.	N 527		
N 533	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all	N 533		

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N 533	Continued From page 33 personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. This REQUIREMENT is not met as evidenced by: Based on record review, the home health agency failed to ensure the home health aide followed the registered nurse established nursing care plan in 2 of 9 clinical records. (#1, #3) The findings include: 1. The undated agency policy titled "Home Health Aide Services" stated "... 2. The nurse or therapist assesses the need for personal care services and includes the services in the physician plan of care (orders). A specific care plan is developed documenting the Aide services to be provided. 3. The Aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse/therapist. ... 8. All services provided by the Home Health Aide shall be documented in the clinical record." 2. Clinical record review on 9/21/20 for patient #1, start of care 6/20/18, certification period 6/9/20 - 8/7/20, evidenced an agency document titled "Aide Care Plan" dated 6/9/20 and digitally signed by employee D. This document indicated the home health aide was to provide incontinent care when soiled, record bowel movement per visit, assist in ambulation per patient's request, assist in transfer per visit, turn or position per	N 533		

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N 533	Continued From page 34 visit, change linen on Monday AM and when soiled, light housekeeping per visit, make bed per AM visit, assist to dress per visit, back rub/massage per patient's request, check pressure areas per visit, comb hair per AM visit, oral hygiene denture care per visit, partial bath/sponge per PM visit, pericare when soiled, shampoo hair per patient's preference, skin care per visit, tub/shower per AM visit, and universal precautions per visit. Clinical record review evidenced an agency document titled "HHA [home health aide] Visit" dated 6/12/20 and digitally signed by employee E. This document failed to evidence employee E provided the patient with a tub/shower per AM visit. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled "HHA Visit" dated 6/14/20 and digitally signed by employee E. This document failed to evidence employee E provided a partial bath per PM visit. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled "HHA Visit" dated 6/19/20 and digitally signed by employee E. This document failed to evidence employee E made the patient's bed, combed hair, provided foot care, and provided a tub/shower. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled "HHA Visit" dated 6/22/20 and digitally signed by employee E. This document failed to evidence employee E provided a partial bath per PM visit. The home health aide failed to follow the aide care plan.	N 533		

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N 533	Continued From page 35 Clinical record review evidenced an agency document titled "HHA Visit" dated 7/1/20 and digitally signed by employee E. This document failed to evidence employee E provided a tub/shower per AM visit. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled "HHA Visit" dated 7/4/20 and digitally signed by employee E. This document failed to evidence employee E made the patient's bed, combed hair, and provided foot care. The home health aide failed to follow the aide care plan. Clinical record review evidenced an agency document titled "HHA Visit" dated 7/27/20 and digitally signed by employee E. This document failed to evidence employee E changed the patient's linen. The home health aide failed to follow the nursing care plan. 3. Clinical record review on 9/18/20 for patient #3, start of care 12/7/17, certification period 7/24/20 - 9/21/20, evidenced an agency document titled "Aide Care Plan" dated and digitally signed by employee D on 7/24/20. This aide care plan indicated the home health aide was to provide incontinent care when soiled, record bowel movement per visit, assist in ambulation per visit, assist in transfer per visit, change linen Mondays and when soiled, light housekeeping per visit, make bed per visit, assist to dress per visit, check pressure areas per visit, comb hair per visit, pericare when soiled, shampoo hair per patient's preference, skin care per visit, tub/shower per visit, and practice universal precautions per visit.	N 533		

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N 533	Continued From page 36 Clinical record review evidenced agency documents titled "HHA Visit" dated 7/24/20, 7/29/20, 8/4/20, 8/5/20, 8/10/20, and 9/4/20 all digitally signed by employee M. These documents failed to evidence the home health aide combed the patient's hair. The home health aide failed to follow the aide care plan.	N 533		
N 542	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. This RULE is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure necessary revisions were made to the plan of care in 1 of 3 patients with observed home visits. (9) The findings include: An undated agency policy C-580, titled " Plan of Care" stated "Policy ... Home care services are furnished under the supervision and direction of the client's physician ... The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary ... Purpose ... To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs ... Special Instructions ... 2. The Plan of Care shall be completed in full to include: ... i. Functional limitations and precaution. j. Activities permitted or restrictions ... m. Medical supplies and equipment required ... 10. Professional staff shall promptly alert the	N 542		

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N 542	Continued From page 37 physician to any changes that suggest a need to alter the Plan of Care ..." Clinical record review for patient #9, start of care 2/19/20, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 8/17/20 - 10/15/20, which had an area subtitled "DME [durable medical equipment] & Supplies" that stated "Insertion Kit. Foley Catheter [sterile tube inserted into the bladder by way of the urethra]. Exam Gloves. Irrigation Set. Leg Bag [urine collection bag]. Alcohol Pads ... "An area subtitled "Goals and Outcomes" stated "Patient receives skilled nursing care from [entity O]. Patient Foley catheter was removed by [entity O] ... "The plan of care failed to evidence a current and accurate assessment of DME and supplies as evidenced by: During an observation on 9/18/20, at 4:12 PM, the patient's bathroom evidenced grab bars, diaper/briefs, and chux pads (absorbent, disposable underpad). During an interview on 9/18/20, at 4:36 PM, the patient indicated he/she can tell when they have to urinate. He/she can get themselves to the bathroom and on the toilet by use of motorized wheelchair and grab bars. The patient was observed wearing a diaper/brief, and failed to evidence a foley catheter.	N 542		
N 543	410 IAC 17-14-1(a)(1)(D) Scope of Services Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:	N 543		

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N 543	Continued From page 38 (D) Initiate appropriate preventive and rehabilitative nursing procedures. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure preventative measures were initiated in 1 of 1 patients who performed point of care lab testing, out of 8 clinical records reviewed. (#5) The findings include: An undated agency policy C-715, titled "Anticoagulant Therapy" which stated "Policy ... The agency will, as a component of Medication Management, use a defined anticoagulation program to individualize the care provided to clients receiving anticoagulation therapy ... Purpose ... To educate clients/families and agency staff on safety practices and reporting expectations of potential for adverse drug reactions an interactions ... Special Instructions ... 2. Physician orders will indicate if the dose of therapy is to maintain therapeutic levels or to achieve higher levels. Orders will indicate if "finger stick" measurements in the home are acceptable for testing. Frequency of testing and reporting expectations will be identified ... 9. Incidence of adverse events and/or noncompliance will be documented and reviewed as a component of the agency performance improvement plan ..." An agency document titled "Job Description" which had an area subtitled "Position Title: Registered Nurse (RN)" stated "The Registered Nurse (RN) plans, organizes and directs home care services and is experienced in nursing with emphasis on community health education and experience ... He/She completes an initial home	N 543		

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N 543	Continued From page 39 health assessment of patient and family to determine home care needs ... He/She provides health care instructions to the patient as appropriate per assessment and plan of care. The RN prepares communicates with the Director of Nursing (DON) regarding the patients' needs and reports any changes in the clients' condition; obtains/receives physician's orders as required ..." Clinical record review on 9/21/20, for patient #5, start of care 4/30/18, evidenced a document titled "Home Health Certification and Plan of Care" for certification period from 6/18/20 - 8/16/20. This document had an area subtitled "Orders and Treatments" which stated "Patient has an INR [international normalized ratio; lab test performed to identify blood clotting issues] machine, Results are sent to [person I, physician]'s office weekly. [Person I]'s [sic] states - patient's goal is to maintain INR between 2-3. Coumadin [blood thinning medication] medication adjusted prn [as needed] per weekly INR results ... SN [skilled nurse] to ... Educate/Instruct/Monitor medication and diet compliance and management and disease process management with teaching and interventions ..." Record review evidenced a document titled "Patient Communication" which was digitally signed by employee A, administrator, on 8/12/20. This document stated "Called and spoke with patient regarding INR results. Educated on the importance of calling INR results in weekly to lab and following up with [person I]. Reports did miss calling in lab results a couple of times but has been calling into [person I]' [sic] office. Advised to continue follow up with [person I] and if needs assistance remembering to call lab that office could give her a reminder call weekly. Reports will	N 543		

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N 543	Continued From page 40 do better at calling into lab and will let office know if needs assistance. Agreed ... Called and spoke with nurse with [person I]. Verified INR results have been stable and no medication changes ... "The communication note evidenced the SN failed to initiate interventions immediately when dealing with Coumadin levels, a blood thinning medication that requires frequent testing to ensure levels are therapeutic. During an interview on 9/21/20 at 11:22 AM, employee A explained the process in which patient #5 checks their own INR with the machine in home. The patient was supposed to report the results to the lab, and the lab would report to the doctor. They indicated Employee C, RN was supposed follow up with patient or the doctor will call Preference Health Services with the update. Record review evidenced this process was not followed.	N 543		
N 545	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. This RULE is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure coordination of care in 1 of 5 active patients, in a total sample of 8 patient records reviewed. (9) The findings include: An undated agency policy C-360, titled "Coordination of Client Services" stated "Policy ...	N 545		

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N 545	Continued From page 41 The agency will integrate services, whether they are provided directly or under contract, to assure the identification of client needs and factors that could affect client safety and effectiveness of treatment ... Purpose ... To coordinate care delivery to meet individual client needs ... To modify the plan to reflect needs or changes identified by members of the team and avoid duplication of services ... To determine the continuation of services and/or future plans for care ... Special Instructions ... 2. The agency will coordinate the nursing, therapy, aide, and social work services. Agency will coordinate care with other medical providers involved in patient's care. (I.e. - wound clinic, dialysis center, other home health care agencies, personal service agencies, etc) ... 10. Coordination will include providers of care who are not part of the agency ... " Record review for patient #9, start of care 2/19/20, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 8/17/20 - 10/15/20, which had an area subtitled "Orders and Treatments" stated "SN [skilled nurse]: PRN [as needed] visits x [for] 9 weeks ... HHA [home health aide]: Up to 2 hrs[hours]/[per] day x 9 weeks ... " Another area section "Goals and Outcomes" that stated "Patient received skilled nursing care from [entity A] ... Patient receives attendant and homemaking services from [entity C] ... " Record review evidenced an agency document titled "Coordination of Patient Care" which was signed by employee I, office manager, on 8/12/20. This document indicated the patient had received services from Preference Health Services Monday through Friday, 4:01 PM to 6:00 PM. It revealed the patient had received skilled nursing once a week and an aide from 9:00 AM to	N 545		

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N 545	Continued From page 42 10:00 AM, on Tuesday and Friday from entity A. The document also indicated the patient had received homemaking/attendant care on Monday and Wednesday, from 5:00 AM to 11:30 AM, by entity C. Record review failed to evidence coordination of care to prevent duplicate services. Record review evidenced a document titled "Aide Care Plan" for the period of 8/17/20 - 10/15/20, digitally signed by employee D, owner/registered nurse, on 8/17/20. This document indicated supplies and tasks that were to be performed for the patient and stated "Incontinent Care ... When Soiled ... Change Linen ... Weekly and when soiled ... Light Housekeeping ... Per Visit ... Assist to Dress ... Per Visit ... Partial Bath/Sponge ... When soiled ... Tub/Shower ... Per patient's request ... " During a home visit observation on 9/18/20, at 4:04 PM, this writer observed employee G, HHA, mopping the kitchen floor and taking out the garbage. Returned inside the home, and fixed a cup of coffee for patient #10, who lived in the same home as patient #9. During an interview on 9/18/20, at 4:25 PM, employee G indicated they have taken care of patient #9 and patient #10. He/she explained that the schedule indicated the patient #10 received care from 12:00 PM, to 4:00 PM, and patient #9 received care from 4:01 PM to 6:00 PM. The HHA indicated they would take care of both patients the entire time, but patient #9 was much more independent and required less time/assistance. During an interview on 9/18/20, at 4:36 PM, patient #9 indicated he/she can take themselves to the bathroom, transfer to the toilet, change brief, dress self, and wash up in front of the	N 545		

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N 545	Continued From page 43 bathroom sink independently with use of motorized wheelchair and assistive devices. The patient indicated they refused a bath every day because he/she was fearful of getting the bandages on their legs wet, even though employee G has assured they will keep the bandages dry. Employee G agreed. During an interview on 9/21/20, at 11:13 AM, employee A, administrator, indicated the patient received SN from entity A, and attendant homecare from entity C which provided light housekeeping, meal preparation, and sweeping. Additionally, when questioned why the agency would provide 3 PRN SN visits, if SN services were provided by entity A, Employee A indicated in the event they could not make it. A SN from Preference would need to assess and make changes to the aide care plan.	N 545		
N 548	410 IAC 17-14-1(a)(1)(I) Scope of Services Rule 14 Sec. 1(a) (1)(I) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (I) Assist the physician, chiropractor, podiatrist, dentist or optometrist in evaluating level of function. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the skilled nurse evaluated level of function in 1 of 1 discharged patients clinical records reviewed, out of a total of 8 records reviewed (#8) The findings include:	N 548		

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N 548	Continued From page 44 Record review on 9/17/2020 evidenced an undated agency policy titled "Comprehensive Client Assessment" which stated "The Comprehensive Assessment must accurately reflect the patient's status, and must include ... functional ... status...." Clinical record review on 8/17/2020 for patient #8 with start of care date 6/20/2019 and certification period 4/15/2020 - 6/13/2020 evidenced an untitled document identified by employee A as OASIS [Outcome and Assessment Information Set-a standardized assessment used in home health] discharge assessment, dated 6/12/2020 and signed by employee D, RN [registered nurse]. This document had a subcategory titled "(M1860) Ambulation/Locomotion ... " This indicated the patient was " ... Chairfast, unable to ambulate and is unable to wheel self...." This document had a subcategory titled "Functional Abilities and Goals" which indiated the patient's ability to transfer to and from a bed to a chair was coded as "88" [Not attempted due to medical conditions or safety concerns]. Clinical record review for patient #8 evidenced a document titled "Aide Care Plan" dated 4/15/2020 and signed by the nurse. This had a subcategory titled "Activities Permitted". The activities "Up as Tolerated", "Transfer Bed-Chair", and "Wheelchair" were marked with a check mark. During an interview on 9/21/2020 at 11:35 a.m. employee A indicated patient #8 was able to transfer with assistance.	N 548		
N 584	410 IAC 17-14-1(g) Scope of Services Rule 14 Sec. 1(g) Home health aides shall be	N 584		

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N 584	Continued From page 45 supervised by a health care professional to ensure competent provision of care. Supervision of services must be within the scope of practice of the health care professional providing the supervision. This RULE is not met as evidenced by: Based on record review, the registered nurse (RN) failed to supervise the home health aide (HHA) to ensure competent care was provided for 1 of 3 patients receiving home health aide services (#7) out of a total of 8 patient records reviewed. Findings include: Record review on 9/17/2020 evidenced an undated agency policy titled "Home Health Aide Supervision" which stated " ... Agency shall provide Home Health Aide services under the direction and supervision of a Registered Professional Nurse ... The aide visit record is reviewed by the supervising nurse ... to assure services are being provided according to the care plan...." Clinical record review on 8/17/2020 for patient #7 with start of care date 1/23/2018 and certification period of 7/11/2020-9/8/2020 evidenced an untitled document, identified by employee A as the HHA (home health aide) care plan, dated 7/11/2020 and signed by employee A, RN (registered nurse). This care plan indicated shampoo hair, back rub, shave, comb hair, and assist with bedside commode were all to be performed "Per patient's request". The record contained a group of documents titled "HHA [home health aide] Visit", dated	N 584		

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N 584	Continued From page 46 7/13/2020-9/8/2020, signed by home health aide. Review of these documents evidenced "N/A" for shampoo hair on 7/13/2020,7/14/2020, 7/15/2020, 7/16/2020, 7/17/2020, 7/21/2020, 7/22/2020, 7/23/2020, 7/28/2020, 7/29/2020, 7/30/2020, 7/31/2020, 8/3/2020, 8/4/2020, 8/10/2020, 8/11/2020, 8/12/2020, 8/17/2020, 8/18/2020, 8/19/2020, 8/20/2020, 8/21/2020, 8/24/2020, 8/25/2020, 8/26/2020, 8/27/2020, 8/28/2020, 8/31/2020, 9/1/2020, 9/2/2020, 9/3/2020, and 9/4/2020. Record review failed to evidence reason why patient's hair was not shampooed. Clinical record review evidenced "N/A" for back rub/massage on 7/13/2020,7/14/2020, 7/15/2020, 7/16/2020, 7/17/2020, 7/20/2020, 7/21/2020, 7/22/2020, 7/23/2020, 7/24/2020, 7/27/2020, 7/28/2020, 7/29/2020, 7/30/2020, 7/31/2020, 8/3/2020, 8/4/2020, 8/5/2020, 8/6/2020, 8/7/2020, 8/10/2020, 8/11/2020, 8/12/2020, 8/13/2020, 8/14/2020, 8/17/2020, 8/18/2020, 8/19/2020, 8/20/2020, 8/21/2020, 8/24/2020, 8/25/2020, 8/26/2020, 8/27/2020, 8/28/2020, 8/31/2020, 9/1/2020, 9/2/2020, 9/3/2020, 9/4/2020, 9/7/2020 and 9/8/2020. Record review failed to evidence reason why patient did not receive back rub/massage. Clinical record review evidenced "N/A" for shave on 7/13/2020,7/14/2020, 7/16/2020, 7/17/2020, 7/21/2020, 7/22/2020, 7/23/2020, 7/24/2020, 7/27/2020, 7/28/2020, 7/30/2020, 8/3/2020, 8/4/2020, 8/5/2020, 8/6/2020, 8/12/2020, 8/14/2020, 8/17/2020, 8/20/2020, 8/21/2020, 8/24/2020, 8/25/2020, 8/26/2020, 8/27/2020, 8/28/2020, 9/1/2020, 9/3/2020, 9/4/2020, 9/7/2020 and 9/8/2020. Record review failed to evidence reason why the patient was not shaved.	N 584		

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N 584	Continued From page 47 Clinical record review evidenced "N/A" for combing hair on 7/15/2020 and 8/11/2020. Record review failed to evidence why the patient's hair was not combed. Clinical record review evidenced "N/A" for assist with bedside commode on 7/15/2020, 7/16/2020, 7/17/2020, 7/20/2020, 7/21/2020, 7/22/2020, 7/23/2020, 7/24/2020, 7/27/2020, 7/28/2020, 7/29/2020, 7/30/2020, 7/31/2020, 8/3/2020, 8/4/2020, 8/5/2020, 8/6/2020, 8/7/2020, 8/10/2020, 8/11/2020, 8/12/2020, 8/13/2020, 8/14/2020, 8/17/2020, 8/18/2020, 8/19/2020, 8/20/2020, 8/21/2020, 8/24/2020, 8/25/2020, 8/26/2020, 8/27/2020, 8/28/2020, 8/31/2020, 9/1/2020, 9/2/2020, 9/3/2020, 9/4/2020, 9/7/2020 and 9/8/2020. Record review failed to evidence reason why patient did not receive assistance to bedside commode. On 9/21/2020 at 11:30 a.m., the agency was notified of concern, management staff acknowledged concerns, and had nothing more to submit for review.	N 584		
N 610	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all clinical record entries were clear, complete, and appropriately authenticated and dated in 3 of 8 clinical records	N 610		

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N 610	Continued From page 48 reviewed. (#2, #3, #8) The findings include: 1. An undated agency policy titled "Clinical Documentation," stated " ...To ensure that there is an accurate record of the services provided, client response and ongoing need for care." 2. Clinical record review on 9/18/20 for patient #2, start of care 5/16/18, certification period 11/7/19 - 11/20/19, evidenced an agency document titled "HHA [home health aide] Visit" dated 11/14/19, which indicated employee F provided services. This document failed to be digitally signed and dated by employee F. 3. Clinical record review on 9/18/20 for patient #3, start of care 12/7/17, certification period 7/24/20 - 9/21/20, evidenced an agency document titled "HHA [home health aide] Visit" dated 7/28/20 and indicated employee M provided care. This document failed to be digitally signed and dated by employee M. During an interview on 9/18/20 at 3:07 p.m., the administrator was shown the unsigned agency document and was queried whether the document was signed, to which the administrator stated "No." 4. Clinical record review on 8/17/2020 for patient #8 with start of care date 6/20/2019 and certification period 4/15/2020 - 6/13/2020 evidenced an untitled document identified by employee A as OASIS [Outcome and Assessment Information Set-a standardized assessment used in home health] discharge assessment, dated 6/12/2020 and signed by employee D, RN [registered nurse]. This document had a section titled "Vital Signs." No	N 610		

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N 610	Continued From page 49 documentation was evidenced in this section. This document also had a section titled "Integumentary Status" [assessment of the patient's skin]. The box by "Wound" was marked with a check mark. The section had a subsection titled "Comments" which stated "Hx [history] of healed pressure areas. No open, red, bruised or discolored areas noted...." This document had a section titled "Skilled Intervention: Assessment/ Instruction/ Performance (Cont'd)" which stated "... wounds on R [right] and L [left] Hip are healed just covered to prevent reopening and the coccyx [tailbone area] are improving slowly...." During an interview on 9/21/2020 at 11:35 a.m. employee A indicated the assessment failed to evidence vital signs and offered no further documentation. Furthermore, the OASIS discharge assessment for patient #8 evidenced a subcategory titled "(M2020) Management of Oral Medications...." which indicated the patient had no oral medications prescribed. Clinical record review evidenced a document titled "Home Health Certification and Plan of Care" dated 4/15/2020 and signed by physician on 5/13/2020. This plan of care had a subcategory titled "Medications". This list of patient medications included the following oral medications: " ...Ibuprofen [a medication used to treat fever and pain] ... Lisinopril-Hydrochlorothiazide [a medication used to treat high blood pressure] ... Multi Vitamin/Minerals ... Metformin [a medication to treat diabetes] ...Hydralazine [a medication used to treat high blood pressure] ...Tamsulosin [a medication used to treat enlarged prostate] ... Donepezil [a medication used to treat	N 610		

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N 610	Continued From page 50 Alzheimer's]... Hydrochlorothiazide [a medications used to treat high blood pressure] ... Aspirin, Bumetanide [a medication used to treat swelling and high blood pressure] ... Oxybutynin [a medication used to treat overactive bladder] ... Vitamin D3 and Klor-Con [a potassium supplement] ...." During an interview on 9/21/2020 at 11:35 a.m. employee A indicated she did not know if patient #8 had a wound at time of discharge.	N 610		