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	157620	A. BUILDING 00 B. WING	07/12/2019

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Date: July 9, 10, 11, 12; 2019 Facility Number: 011301 Provider Number: 157620 Census = 37 At this Emergency Preparedness survey, Servant's Heart Home Health Services was found not to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. The requirement at 42 CFR, Subpart 484.102 is NOT MET as evidenced by: the agency failed to have policies in place to notify state and local authorities of missing staff and patients, and failed to have a training and testing program for staff.	E 0000	This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.	
E 0021 Bldg. 00	Based on record review and interview, the agency failed to ensure the emergency preparedness plan had policies and procedures to inform state and local officials to follow up with staff and patients that they were unable to contact for 1 of 1 agency. Findings include:	E 0021	**How will this deficiency be corrected?** Agency Policy B400 was revised and updated with appropriate State and Local Contact names and numbers to call in the event that on-duty staff and/or patients are unable to be located or contacted. These numbers were	08/09/2019

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

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

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	During a review of the emergency preparedness plan on 7/12/19, the plan failed to evidence a plan to inform state and local government when unable to contact a patient or staff. During an interview on 7/12/19 at 10:15 AM, the administrator was asked if the agency had a policy to follow up with staff and patients to inform state and local authorities when unable to contact them. The administrator stated that in reality the agency would start to call people if they could not find someone, but it is not spelled out in their policy.		obtained and confirmed by our local Emergency Management Agency. This policy was revised on 7/31/19 and was approved by Advisory Board special meeting on **8/5/19.** All staff members were given a copy of this policy and a written inservice on Emergency Preparedness during mandatory staff meetings scheduled for 8/6/19 with nurses and on 8/8/19 with aides. An emergency training drill for all staff will be conducted on 8/9/19 to test staff and find any problems in communicating or understanding of this emergency plan. **How will this deficiency be prevented from recurring?** This policy will be reviewed at least quarterly for any corrections or updates needed on contact names and numbers. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Alternate Administrator, and Clinical Manager will conduct the training drill on 8/9/19 and follow up with reviewing the results to find any issues with the agency's emergency plan. The Administrator/Alternate Administrator will review and update the emergency plan quarterly and as needed to ensure	

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			compliance with this regulation .	
E 0036 Bldg. 00	Based on record review and interview, the agency failed to ensure the emergency preparedness plan contained a training and testing plan for staff for 1 of 1 agency. Findings include: During a review of the emergency preparedness plan on 7/12/19, the plan failed to evidence a written training and testing plan for staff. During an interview on 7/12/19 at 10:40 AM, the administrator was asked if they agency had a training and testing program for emergency preparedness. The administrator stated that she knew they trained staff. She stated that about 6 weeks ago the agency started an annual review for the home health aides that consisted on going over emergency preparedness policies with management. This was currently not done with nurses but she stated they "need to."	E 0036	**How will this deficiency be corrected?** During a mandatory staff meetings on **8/6/19 and 8/8/19,** all staff (including aides and nurses) were given written information and a written inservice on Emergency Preparedness. An oral review of all emergency policies and procedures was also completed during this meeting. An in house emergency drill will be done on 8/9/19 and our Emergency Plan will be tested. All Employees will participate in this drill. Results will be documented and reviewed, and our plan will be revised and/or updated as needed to improve outcomes in the event of an emergency situation. **How will this deficiency be prevented from recurring?** Effective as of 8/1/19, all new staff will be given a written inservice on our Emergency Preparedness Policies and Procedures that must be successfully completed during their orientation. The Administrator, Clinical Manager or designee will perform annual reviews for each employee on their date of hire, and they will	08/09/2019

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			complete a written inservice to review for any changes or updates. Each employee's annual evaluation date has been placed on the schedule through 8/8/2020 and the schedule will be updated with every new employee's annual hire date going forward. This will ensure that all employees have an annual review of the Emergency Plan. **Who will be responsible to ensure compliance with this regulation?** **The Administrator, Alternate Administrator, and Clinical Manager will ensure that all Emergency training and testing is completed by 8/9/19 and remains current and up to date.**	
G 0000 Bldg. 00	This was a Federal Recertification and State Licensure home health survey. This survey was announced as fully extended on July 11, 2019 at 3: 40 PM. Facility #: 011301 Provider #: 157620 Medicaid #: 200852690	G 0000	This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are	

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	Survey dates: July 9, 10, 11, 12; 2019 Skilled Services: 20 Home Health Aide only: 17 Total Current Census: 37 Record reviews with home visit: 3 Record review without home visits: 2 Discharged record reviews: 2 Total clinical records reviewed: 7 Servant's Heart Home Health Services is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning July 12, 2019 to July 12, 2021 for being found out of compliance with the Conditions of Participation 42 CFR 484.55 Comprehensive Assessment; 42 CFR 484.60 Care planning, coordination of services, and quality of care; 484.65 Quality assessment and performance improvement (QAPI); 484.70 Infection prevention and control and 484.75 Skilled Professional Services. These deficiencies reflects State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings. Quality Review completed 07/30/19		a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.	
G 0510 Bldg. 00	Based on record review, and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained the	G 0510	**How will this deficiency be corrected?** The Administrator and/or Clinical Manager will conduct a chart audit	08/09/2019

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	patient's current health and psychosocial status (See G528); failed to ensure that the comprehensive assessment contained individual patient strengths and preferences (See 530); failed to ensure that the comprehensive assessment contained a complete review of medications and that the medication list was maintained (See G536); and failed to ensure the comprehensive assessments were updated with accurate and pertinent information and changes (See G544). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment.		of 100% of our patients charts and determine if the most current Comprehensive Assessment is complete, thorough and includes all essential information according to our Policy C-145 (attached). This audit will be completed by August 9, 2019. Assessments will be reviewed for appropriate documentation regarding pertinent patient needs such as catheters, trachs, ventilators, G tubes, wound care, IV infusions, drainage tubes, DME needs, etc. Assessments will be monitored for information regarding mental health status, updated medications, and all other pertinent assessment criteria. Particular attention will be given to those areas to ensure that the assessment meets requirements of the agency's policies and of professional standards. Any problems noted will be returned to the clinician for correction and reviewed for accuracy once again. **How will this deficiency be prevented from recurring?** A mandatory staff meeting will be held on 8/6/19 with nurses to review the proper procedure of completing a Comprehensive Assessment. A written in-service will be given to all nurses during this meeting with a requirement of successful completion by August 9, 2019. In addition to this, 100% of all comprehensive assessments	

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			completed by August 9, 2019 will be reviewed by the Administrator, Clinical Manager and/or RN Case Managers for accuracy and to ensure that they meet professional standards regarding Comprehensive Assessments. If all assessments during this time are satisfactory, 10% of all comprehensive assessments will be reviewed by the Administrator, Clinical Manager and/or RN Case Managers throughout the end of the next 2 quarters for QAPI on 12/31/2019 to ensure compliance with this regulation. **Who will be responsible to ensure compliance with this regulation?** The Administrator and the Clinical Manager.	
G 0528 Bldg. 00	Based on record review, and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained the patient's current health and psychosocial status for 4 of 7 records (#2, 3, 4, 7). Findings include: 1. An undated agency policy titled "Comprehensive Client Assessment," Policy #C-145 stated " ...PURPOSE: ...To collect data about the client's health history (physical, functional and psychological) and their needs as	G 0528	**How will this deficiency be corrected?** The Administrator and/or Clinical Manager will conduct a chart audit of 100% of our patients charts and determine if the most current Comprehensive Assessment is complete, thorough and includes all essential information according to our Policy C-145 (attached). This audit will be completed by August 9, 2019. Assessments will be reviewed with close attention paid to high risk patients,	08/09/2019

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	appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each individual's response to care. To identify clients medical, nursing, rehabilitative, social and discharge ...." 2. The clinical record of patient #2 was reviewed on 7/9/18 and indicated a start of care date of 10/01/12. The record contained a POC (plan of care) for the certification period of 07/02/19 - 08/30/19. The registered nurse (RN) failed to ensure the comprehensive assessment contained complete information regarding current health status of the patient as evidenced by: The recertification comprehensive assessment dated 06/27/19 failed to identify the specific medications and treatments the patient had been refusing, recent blood sugar readings or complications related to not taking medications as ordered by the physician.3. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The registered nurse (RN) failed to ensure the comprehensive assessment contained complete information regarding the current health status of the patient as evidenced by: The recertification comprehensive assessment dated 5/24/19 failed to identify the patient's need for homecare. It failed to determine how often the catheter needed to be changed, anything about the catheter irrigations, how often and what medications or fluids would be used to complete the catheter irrigation. 4. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of		patients who routinely refuse treatments or medications, and/or patients with catheters, G tubes, trachs, ventilators, surgical drains, wound care, and/or IV infusions. DME will be reviewed to ensure that tube sizes, specific suppliers, and other essential information is provided on the assessments. Assessments will be reviewed to ensure they meet requirements of the agency's policies and of professional standards. Any problems noted will be returned to the clinician for correction and reviewed for accuracy once again. **How will this deficiency be prevented from recurring?** A mandatory staff meeting was held on 8/6/19 with nurses to review the proper procedure for completing a Comprehensive Assessment. In addition, a written in-service was given to all nurses with a requirement for successful completion by August 9, 2019. After completing the review of all current assessment and obtaining corrections as needed, audits of 100 % of all comprehensive assessments will continue to be done by the Administrator, Clinical Manager, and/or RN Case Managers thru 8/31/2019. If no further problems are found during this time, 10% of all comprehensive assessments will be reviewed by the Administrator,	

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	8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19. The registered nurse (RN) failed to ensure the comprehensive assessment contained complete information regarding the current health status of the patient as evidenced by: The recertification comprehensive assessment dated 6/17/19 failed to identify a pain assessment, ventilator settings, specific orders and needs regarding tracheotomy wound care and suctioning, and what doctor and equipment company manage the ventilator and supplies. 5. The clinical record of patient #7 was reviewed on 7/10/19 and indicated a start of care date of 5/3/19. The record contained a plan of care for the certification period of 5/3/19-7/2/19. The registered nurse (RN) failed to ensure the comprehensive assessment contained complete information regarding the current health status of the patient as evidenced by: The start of care comprehensive assessment dated 5/3/19 failed to identify why the patient needed IV therapy, who administered the IV antibiotics, what the drains in the abdomen were for, who emptied them, and if a dressing (wound care) was to be completed over the drains, who changed and how often PICC line dressings were to be changed, the dose of heparin the IV was to be flushed with, and which doctor and pharmacy managed the labs and IV antibiotics. 6. The administrator was notified of these concerns on 7/12/19 at 11:23 AM and she had nothing else to submit for review. 410 IAC 17-14-1(a)(1)(B)		Clinical Manager, and/or RN Case Managers throughout the end of the year for QAPI on 12/31/2019 to ensure compliance with this regulation.. If all assessments during this time are satisfactory, 10% of all comprehensive assessments will be reviewed by the Administrator, Clinical Manager, and/or RN Case Managers throughout the end of the first 2 quarters of 2020 for QAPI (ending on 06/30/2020) to ensure compliance with this regulation. **Who will be responsible to ensure compliance with this regulation?** The Administrator and the Clinical Manager.	

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G 0530 Bldg. 00	Based on record review and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained individual patient strengths and preferences for 4 of 7 records reviewed (#2, 3, 4, 7). Findings include: 1. An undated agency policy titled "Client Reassessment / Update of Comprehensive Assessment," Policy # C-155 stated " ... Each professional discipline will be responsible for reassessing care / services at least every 56-60 days while the client is receiving skilled services. ... clarifying the client's personal goals and his / her expectations of the home care services ... The assessment will identify the problems, needs, and strengths of the client ...." 2. The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The record contained a plan of care for the certification period of 05/03/19 - 07/01/19 that indicated diagnoses of COPD (chronic obstructive pulmonary disease), Type 2 diabetes, blindness and chronic ischemic heart disease. The Adult Re-Assessment OASIS (Outcome and Assessment Information Set) dated 06/27/19 failed to evidence patient's strengths and care preferences. 3. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19 that indicated diagnoses of multiple sclerosis, myositis, neuromuscular	G 0530	**How will this deficiency be corrected?** **Our agency corrected this deficiency by developing a new assessment form which is attached. (See "Patient Directed Goals, Preferences, Strengths and Coordination of Care" form.)** **This form lists strengths and preferences to choose from during a patient assessment, and also allows for the nurse to write in any strengths or preferences that might not be already listed. This form will be completed as a part of every admission and recertification assessment and updated as needed for any changes that might occur. A mandatory staff meeting was held on 8/6/19 with all nurses to ensure that everyone understands this new form and how to use it.** **How will this deficiency be prevented from recurring?** **All Comprehensive Assessments (recertifications and admission assessments) starting 8/6/19 will be audited by the Administrator, Clinical Manager, and/or RN Case Managers for 100% of our patients through 12/31/2019 to ensure the documentation for**	08/09/2019

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	dysfunction of the bladder, and personal history of MRSA (methacillin-resistant staphylococcus aureus). The recertification comprehensive assessment dated 5/24/19 failed to evidence patient strengths and care preferences. 4. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated diagnoses of dependence on respirator, chronic respiratory failure, dysphasia, and encounter for attention to gastrostomy. The recertification comprehensive assessment dated 6/17/19 failed to evidence patient strengths and care preferences. 5. The clinical record of patient #7 was reviewed on 7/10/19 and indicated a start of care date of 5/3/19. The record contained a plan of care for the certification period of 5/3/19-7/2/19 that indicated diagnoses of vascular access device, aortic graft, chronic pancreatitis, and change in surgical dressing. The start of care comprehensive assessment dated 5/3/19 failed to evidence patient strengths and care preferences. 6. The administrator was notified of these concerns on 7/12/19 at 11:35 AM and she had nothing else to submit for review.		**patient's strengths and preferences is noted on each assessment and POC.** **If no problems are found, the agency will continue to audit 10% of all patient charts during the next 4 quarters (or thru 12/31/2020) to ensure that we are complying with this regulation and no further problems occur.** **Who will be responsible to ensure compliance with this regulation?** **The Administrator, Clinical Manager, and RN Case Managers will all work together to audit charts and to maintain appropriate information regarding strengths and preferences on all comprehensive assessments and POC's for the patients. The Administrator will give oversight to ensure these audits are completed.**	
G 0536 Bldg. 00		G 0536	**How will this deficiency be**	07/19/2019

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	Based on observation, record review, and interview, the registered nurse (RN) failed to ensure that the comprehensive assessment contained a complete review of medications and that the medication list was maintained for 7 of 7 records reviewed (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. An undated agency policy titled "Comprehensive Client Assessment," Policy #C-145 stated " ... ... The Comprehensive Assessment will include a review of all medications the client is using. This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicative drug therapy and non-compliance with therapy ...." 2. The clinical record of patient #1 was reviewed on 7/9/19 and indicated a start of care date of 04/06/12. The clinical record contained a POC (plan of care) for the certification period of 05/06/19 - 07/04/19. The record failed to evidence specific indications for PRN (as needed) medication: Albuterol, and failed to evidence a medication drug to drug interaction check had been completed. 3. The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The clinical record contained a POC for the certification period of 07/02/19 -08/30/19 and included the following medications, but not limited to: lorazepam, hydrocodone, morphine and hydroxyzine. The record failed to evidence a medication drug to drug interaction check had been completed.		**corrected?** All patient medication lists were reviewed, put into layman terms, and then entered into Drugs.com for a drug to drug interaction report. This medication review was conducted by the Administrator and the Clinical Manager and was completed by 7/19/19 for all patients. The reports were printed and attached to the patient's med list in their charts. All major and/or moderate drug interactions were sent by fax to each patient's physician and a fax verification form was received on each one of them to ensure that the physician received the information. Any new orders received by the physician as a result were noted on the patient's POC and patient education was provided to ensure they were aware of the change in the medications. **How will this deficiency be prevented from recurring?** Going forward, it will be our protocol that every recertification period and with every medication change a drug interaction report will be obtained and the patient's physician will be notified. This protocol will be explained to all nurses during a mandatory staff meeting on 8/6/19. Chart audits will be conducted by the Administrator, Clinical Manager, and/or RN Case Managers of	

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	On 7/12/19 all medications from the agency POC were checked on Drugs. com for interactions. The review indicated Major interactions with the following: lorazepam, hydrocodone, morphine, and hydroxyzine. The Drugs.com Major interaction definition stated "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit." 4. The clinical record of patient #5 was reviewed on 07/10/19 and indicated a start of care date of 09/08/16. The clinical record contained a POC for 06/26/19 -08/24/19. The record failed to evidence a medication drug to drug interaction check had been completed. 5. The clinical record of patient #6 was reviewed on 07/10/19 and indicated a start of care date of 01/23/18. The clinical record contained a POC for 05/23/18 - 07/21/18. The record failed to evidence specific indications for PRN (as needed) medications: clotrimazole, miralax, nystatin, desitin, maalox, mupirocin, diazepam, and neosporin, and failed to evidence a medication drug to drug interaction check had been completed.6. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The record failed to evidence a medication drug to drug interaction check was completed, and that the assisted living facility (ALF) and home health medication orders were the same as evidenced by: On 7/9/19 all medications from the agency plan of care were checked on Drugs.com for interactions. The interactions showed major interactions with buspirone and escitalopram, buspirone and trazodone, and escitalopram and trazodone. The Drugs.com Major interaction definition stated		100% of our patients during this first 2 quarters through 12/31/2019. This audit will be done to monitor for drug interaction reports, appropriate medication lists, and physicians being notified of any major and/or moderate interactions. If no problems are found, the agency will continue to audit 10% of all patient charts during the next 4 quarters (or thru 12/31/2020) to ensure that we are complying with this regulation and no further problems occur. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to audit charts and to maintain appropriate medication lists and interaction reports. The Administrator will give oversight to these audits to ensure they are conducted.	

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	"Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit." The agency medication list indicated routine acetaminophen while the ALF indicated it was as needed (PRN). The agency medication list indicated colace 100 mg (milligrams) BID (2 times per day) while the ALF indicated the colace had been discontinued. The agency medication list had cranberry capsule 200 mg while the ALF did not have a cranberry order. The agency medication list had Linzess 145 mcg (micrograms) while the ALF indicated the Linzess had been discontinued. The agency medication list indicated Miralax powder BID while the ALF indicated the miralax was PRN. The agency medication list indicated nystatin cream to be applied PRN at bedtime while the ALF indicated the nystatin cream was BID. The agency medication list indicated trazodone 50 mg at bedtime while the ALF indicated trazodone 100 mg at bedtime. During an interview on 7/9/19 at 10:34 AM, the administrator stated that if a medication change occurs the agency will notify the ALF via fax and vice versa, or will verbally follow up. 7. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for			

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	the certification period of 6/18/19-8/16/19. The record failed to evidence a medication drug to drug interaction check was completed. 8. The clinical record of patient #7 was reviewed on 7/10/19 and indicated a start of care date of 5/3/19. The record contained a plan of care for the certification period of 5/3/19-7/2/19. The record failed to evidence a medication drug to drug interaction check was completed. 410 IAC 17-14-1(a)(1)(B)			
G 0544 Bldg. 00	Based on record review and interview, the registered nurse (RN) failed to ensure the comprehensive assessments were updated with accurate and pertinent information and changes for 3 of 6 recertification records reviewed (#2, 3, 4). Findings include: 1. An undated agency policy titled "Client Reassessment / Update of Comprehensive Assessment," Policy # C-155 stated "POLICY: The Comprehensive Assessment will be update and revised as often as the client's condition warrants ... Each professional discipline will be responsible for reassessing care / services at least every 56-60 days while the client is receiving skilled services. ... clarifying the client's personal goals and his / her expectations of the home care services ... The assessment will identify the problems, needs, and strengths of the client ...." 2. The clinical record of patient #2 was reviewed on 7/9/18 and indicated a start of care date of	G 0544	**How will this deficiency be corrected?** The Administrator and/or Clinical Manager will conduct a chart audit of 100% of our patients charts and determine if the most current Comprehensive Assessment is complete, thorough and includes all essential information according to our Policy C-145 (attached). This audit will be completed by August 9, 2019. Assessments will be reviewed especially for diabetic patients and recent blood sugar readings, patients who routinely refuse treatments or medications, and/or patients with catheters, G tubes, trachs, ventilators, surgical drains, wound care, and/or IV infusions. Close attention will be paid to the DME needs documented for patients to ensure that ventilator settings, tube sizes, specific suppliers, and	08/09/2019

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	10/01/12. The record contained a POC (plan of care) for the certification period of 07/02/19 - 08/30/19. The registered nurse (RN) failed to ensure the comprehensive assessment contained complete information regarding current health status of the patient as evidenced by: The recertification comprehensive assessment dated 06/27/19 failed to identify the specific medications and treatments the patient had been refusing, recent blood sugar readings or complications related to not taking medications as ordered by the physician.3. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The registered nurse (RN) failed to ensure the comprehensive assessment contained updated information regarding the current health status and needs of the patient as evidenced by: The recertification comprehensive assessment dated 5/24/19 failed to identify the patient's need for homecare. It failed to determine how often the catheter needed to be changed, anything about the catheter irrigations, how often and what medications or fluids would be used to complete the catheter irrigation. 4. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19. The registered nurse (RN) failed to ensure the comprehensive assessment contained updated information regarding the current health status and needs of the patient as evidenced by: The recertification comprehensive assessment		other essential information is provided on the assessments. The assessments will be reviewed for physician orders to be in place with trach care, wound care, IV boluses/rates, and G Tube feeding rates. Particular attention will be given to all of these areas to ensure that the assessments meet the requirements of the agency's policies and of professional standards. Any problems noted will be returned to the clinician for correction and reviewed for accuracy once again. **How will this deficiency be prevented from recurring?** A mandatory staff meeting was held on 8/6/19 with nurses to review the proper procedure of completing a Comprehensive Assessment. In addition, a written in-service will be given to all nurses with a requirement of successful completion by August 9, 2019. After completing the review of all current assessment and obtaining corrections as needed, audits of 100 % of all comprehensive assessments will continue thru the end of this quarter on 9/30/2019. If problems continue, the nurse who is not meeting professional standards with assessments will be re-educated once again and will be monitored for all assessments for a period of another 90 days. If this nurse continues to have difficulty after	

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	dated 6/17/19 failed to identify a pain assessment, ventilator settings, specific orders and needs regarding tracheotomy wound care and suctioning, and what doctor and equipment company manage the ventilator and supplies. 5. The administrator was notified of these concerns on 7/12/19 at 11:50 AM and she had nothing else to submit for review. 410 IAC 17-14-1(a)(1)(B)		that 90 day period, her employment may be terminated. If no further problems are found after the first quarter ends on 9/30/19, 10% of all comprehensive assessments will be reviewed by the Administrator and/or Clinical Manager throughout the end of the year for QAPI on 12/31/2019 to ensure compliance with this regulation.. If all assessments during this time are satisfactory, 10% of all comprehensive assessments will be reviewed by the Administrator and/or Clinical Manager throughout the end of the first 2 quarters of 2020 for QAPI (ending on 06/30/2020) to ensure compliance with this regulation. **Who will be responsible to ensure compliance with this regulation?** The Administrator and the Clinical Manager.	
G 0570 Bldg. 00	Based on observation, record review and interview the Registered Nurse (RN) failed to ensure a complete and individualized plan of care was developed (see tag G 574); failed to ensure verbal orders were included in the plan of care (see tag G 576); failed to ensure physician orders were in place before providing care (see tag G 580); failed to ensure the revised plan of care was current and complete (see tag G 586); failed to	G 0570	**How will this deficiency be corrected?** The Administrator, Clinical Manager and/or RN Case Managers will conduct a chart audit of 100% of our patients' current Plan of Cares and look for the following in each one: 1. POC's are complete and	08/09/2019

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	ensure the physician was alerted to patient changes (see tag G 590); failed to coordinate patient care to be delivered (see tag G 608); failed to ensure that a medication list was provided to the patient in layman's terms (see tag G 616) and failed to provide clinical manager contact information in the admission packet (see tag G 622). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care Planning, coordination, quality of care.		accurate for patient's specific needs and care 2. Verbal Orders are all noted in updated POC's 3. MD orders were received prior to SOC date 4. MD's are alerted to any patient changes or concerns 5. Coordination of Care is documented and taking place between all staff members (aides and nurses) and between agency staff and ALF's or other agencies involved with patient's care 6.Med lists are in layman terms, accurate, and interactions noted to MD Any problems found on the POC's will be corrected and sent to the physician for review and signature. **How will this deficiency be prevented from recurring?** A mandatory staff meeting was held on 8/6/19 with nurses to review the importance of all the above information. Each nurse will be instructed to review their patient's POC's and ensure the information is up to date, appropriate, and meets all requirements for compliance with regulations. Nurses were instructed when doing recertifications to contact all aides who provide care for the patient	

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			(by phone if they are not present) to obtain a verbal report from the aide regarding any changes or concerns for each patient. The nurse will document this information shared on the Coordination of Care form. (See the attached form.) The aides will also be instructed during their mandatory meeting on 8/8/19 to contact the patient's Case Manager RN, Clinical Manager, or Administrator by phone for any immediate concerns. The aides will complete the Coordination of Care form for written documentation of any urgent information shared at any time with the nurse. A new form was developed to utilize when providing care for patients in ALF's or with other agencies (see attached form "Coordination of Care For Facility/Other Providers") in order to comply with regulations regarding patients that the agency shares with other providers. The nurses were instructed on how and when to use this form during the mandatory meeting on 8/6/19 . This form will ensure that all med lists, POC's, treatment plans and any other pertinent information is communicated between our agency and the other provider. After completing the chart audit and obtaining corrections as needed, audits of 100 % of all new admissions and recertifications	

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			will continue thru the end of this quarter on 9/30/2019 to verify all of the above information is in place and correct in each patient's chart. If no further problems are found during this time, 10% of all recertifications and admissions will be reviewed by the Administrator, Clinical Manager and/or RN Case Managers throughout the end of the year for QAPI on 12/31/2019 to ensure compliance with this regulation. If all assessments during this time are satisfactory, 10% of all recertifications and admissions will be reviewed by the Administrator, Clinical Manager and/or RN Case Managers throughout the end of the first 2 quarters of 2020 (ending on 06/30/2020) to ensure compliance with this regulation. **Who will be responsible to ensure compliance with this regulation?** The Administrator, the Clinical Manager, and the RN Case Managers will work together to ensure compliance with all of these regulations. The Administrator will give oversight to these audits and ensure they are completed.	
G 0574 Bldg. 00				

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	Based on record review and interview, the agency failed to ensure the plan of care (POC) included all pertinent treatments, goals, durable medical equipment, and correct frequencies of visits in 4 of 7 records reviewed. (#1, 3, 4, 7). Findings include: 1. An undated agency policy titled "Plan of Care," Policy #C-580 stated, " ...The plan of care is based on a comprehensive assessment and information provided but the client / family and health care members ... The Plan of Care shall be completed in full to include: ... Type, frequency, and duration of all visits / services ... medications, treatments, and procedures ... Medical supplies and equipment required ... treatment goals ...." 2. The clinical record of patient #1 was reviewed on 7/9/19 and indicated a start of care date of 04/06/12. The clinical record contained a POC (plan of care) for the certification period of 05/06/19 - 07/04/19. The POC's DME (durable medical equipment) indicated the patient had a Mickey button that was to be changed every 3 months by the family and bilateral SMO's (supramalleolar orthotics) . Further, the medication listing stated: "AquaPhor-as directed...Destitin [sic] as directed...Miralax-daily...probiotic-daily...." The POC failed to evidence the size of the Mickey button, the use of AFO's, (ankle foot orthotics) the dose of Miralax and probiotic, and the frequency and use for AquaPhor and Desitin. During an interview on 07/09/19 at 5:30 PM, the family member of patient #1 indicated the patient used AFO's now as she had outgrown the SMO's. 3. The clinical record of patient #3 was reviewed	G 0574	**How will this deficiency be corrected?** Some patient's RN Case Managers do not work in the office but only out in the field, and they are not able to log on to the software program utilized by the agency to complete the POC. Therefore, the Administrator takes the information from the Comprehensive Assessments that these Case Managers submit and develops the patient's POC. Going forward, the Administrator will ensure each patient's RN Case Manager reviews the POC before it is sent to the physician to ensure that it is correct and up to date. An audit of 100% of the patient's current POC's will be performed by all RN Case Managers by **8/9/19** to ensure that all incorrect information is corrected and up to date on every current POC. **Special attention will be given to the following areas during this audit:** Ø **Ventilators, settings, specific orders for humidity, etc., related supplies** Ø **Mickey buttons, G tubes sizes, placement checks, rates for feeding** Ø **Orthotics and DME supplies** Ø **Medications (appropriate uses, dosages, frequencies)** Ø **Catheter sizes, balloon sizes, and related DME and**	08/09/2019

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	on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19 that indicated diagnoses, but not limited to, multiple sclerosis, neuromuscular dysfunction of the bladder. The plan of care failed to evidence the catheter and balloon size and specific supplies related to the catheter under DME. 4. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated diagnoses of dependence on respirator, chronic respiratory failure, dysphasia, and encounter for attention to gastrostomy. The plan of care failed to evidence the tracheotomy (trach) and gastrostomy (GT) size and specific supplies related to the both, measurable goals, specific orders for: ventilator settings including specific orders for when to adjust humidity, and trach care and trach suction (including frequency and how to be completed). 5. The clinical record of patient #7 was reviewed on 7/10/19 and indicated a start of care date of 5/3/19. The record contained a plan of care for the certification period of 5/3/19-7/2/19 that indicated diagnoses of vascular access device, aortic graft, chronic pancreatitis, and change in surgical dressing. The plan of care failed to evidence specific wound care orders for drain sites including frequency, clarification if the intravenous (IV) medications were IV push or infusion, specific orders for saline and heparin flushes and when to complete, and measurable goals. 6. During an interview on 7/12/19 at 10:56 AM, the administrator stated the registered nurses		**supplies** **Ø Trach sizes, orders for care, suctioning orders, related supplies** **Ø IV infusions, rates, supplies, PICC line care, orders for labs** **Ø Heparin/saline flushes with appropriate orders for care** **Ø Measurable goals for all the above care/treatments/orders** **Ø All other required elements of the POC to meet regulations and abide by professional standards** **How will this deficiency be prevented from recurring?** As of the date of the end of our survey on 7/12/2019, if the Administrator writes a POC from another RN's comprehensive assessment, the RN Case Manager who performed the assessment must review the POC before it is faxed to the physician. The RN Case Manager reviews the POC for accuracy and ensures all appropriate treatments, medications, and any other pertinent information including the 60 day summary of care is up to date and correct. In addition, each RN Case Manager will participate in auditing 100% of the patient's charts for the next 2 quarters thru 12/31/2019 and ensure that no further problems occur with this issue. The first	

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	would complete the comprehensive assessment and then she would write the plan of care from that. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(D)(ii)		audit for this information will be completed by 8/9/2019. If no further problems are noted by 12/31/2019, 10% of the patient's POC's will be monitored thru 12/31/2020 during each quarter to ensure compliance. A written in-service on completing accurate and appropriate comprehensive assessment will be given to all nurses with a requirement of successful completion by August 9, 2019. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to maintain accurate and up to date POC's for the patients. The Administrator will give oversight to the chart audits and ensure they are completed each quarter	
G 0576 Bldg. 00	Based on record review and interview, the agency failed to ensure all physician orders were recorded in the plan of care (POC) for 1 of 7 records reviewed (#3). Findings include: The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19.	G 0576	**How will this deficiency be corrected?** A mandatory meeting of all RN's will be held on 8/6/19 and all nurses will be re-educated on the importance of having a physician's order before starting services. This information will be written and verbal. A written reminder will be placed in the front of the nurse's admission packets as well to	08/06/2019

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	An agency physician order dated 5/22/19 and signed by the director of nursing stated "Change SP [suprapubic] catheter using 20 FR [french] catheter and 10 CC [cubic centimeters] balloon due to blockage and no urine flow to be changed 1 x [time] by VO [verbal order] and PRN [as needed]". The record failed to evidence this order on the plan of care. During an interview on 7/12/19 at 2:59 PM, the administrator looked in the record for patient #3 and stated she did not see that the order was incorporated into the plan of care either.		ensure that no RN performs an admission before ensuring that we have a physician's order to start care. (See attached form "Admission Check List".) **How will this deficiency be prevented from recurring?** The Administrator ,Clinical Manager and/or RN Case Managers will audit 100% of the new admission charts for the next 2 quarters thru 12/31/2019 and ensure that no further problems occur with this issue. If no further problems are noted by 12/31/2019, 10% of the patient's POC's will be monitored thru 12/31/2020 during each quarter to ensure compliance. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to ensure that the agency obtains physician's orders prior to starting care for new patients. The Administrator will give oversight to all new admissions and ensure that the agency remains compliant with this regulation.	
G 0580 Bldg. 00	Based on record review and interview, the agency failed to ensure the skilled nurse did not provide	G 0580	**How will this deficiency be corrected?** A mandatory meeting was held on	08/06/2019

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	wound care absent of a physician's order for 1 of 7 records reviewed (#2). The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The clinical record contained a POC for the certification period of 07/02/19 -08/30/19 and indicated diagnoses of COPD (chronic obstructive pulmonary disease), Type 2 diabetes, blindness and chronic ischemic heart disease. The record failed to evidence wound care orders and advising patient of treatment for a cut on the patient's left index finger. A skilled nurse assessment form dated 05/30/19 by Employee B indicated, " Skin-Pt (patient) cut L (left) index finger this AM (morning), when she stuck finger in tomato juice can ...This nurse cleansed finger with an alcohol wipe then applied Triple ATB (antibiotic) ointment et (and) a bandaid ..." A skilled nurse assessment form dated 06/06/19 by Employee B indicated, at the visit, the patient complained of pain in left index finger; 'About a 10. It is sore I can't hardly touch it.' Employee B then stated, " Pt c/o (complained of) L index finger that she cut 5/30/19 being more sore, This nurse examined finger et area surrounding cut is red et swollen. Actual cut appears to be closed...." Employee B notified the physician on this date who wanted to see the pt the following day. Transportation issues were an issue and Employee B notified the Administrator. Employee B then stated, "... [name of administrator] agreed with this nurse that pt should soak finger in Epsom salt et warm water. Pt informed...." The agency failed to ensure the skilled nurse did not advise the patient of wound treatment absent of a physician's order.		8/6/19 and all nurses were re-educated regarding the importance of obtaining a physician's order prior to providing wound care or any other kind of treatment/medication administration, etc. The specific issue of putting antibiotic ointment on a cut before calling the physician was discussed and all nurses stated verbal understanding about this regulation. Nurses were also re-educated about the need to contact a physician immediately if a change or concern is noted regarding their patient. **How will this deficiency be prevented from recurring?** The Administrator ,Clinical Manager and/or RN Case Managers will audit 100% of all patient charts for the next 2 quarters thru 12/31/2019 and ensure that no further problems occur with this issue. Assessments will be reviewed to ensure there is no documentation of wound care being performed without an MD order. If no further problems are noted by 12/31/2019, 10% of the patient's charts will be monitored to ensure that all appropriate physician's orders have been obtained thru 12/31/2020 during each quarter to ensure compliance. **Who will be responsible to ensure compliance with this**	

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	A skilled nurse assessment form dated 06/13/19 by Employee B indicated the patient was seen by the physician on 6/10/19 and an antibiotic was ordered for the finger. During an interview on 7/11/19 at 10:21 AM the Administrator stated, "I think it's good care to apply Triple antibiotic ointment to a cut before calling the doctor." 410 IAC 17-13-1(a)		**regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to ensure that the agency obtains physician's orders prior to providing any kind of wound care, treatments, or medication administration.	
G 0590 Bldg. 00	Based on record review and interview, the agency failed to ensure registered nurse (RN) reported changes to the physician for 1 of 7 records reviewed (#2). Findings include: The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The clinical record contained a POC for the certification period of 07/02/19 -08/30/19 and indicated diagnoses of COPD (chronic obstructive pulmonary disease), Type 2 diabetes, blindness and chronic ischemic heart disease. The POC 60 day summary failed to evidence specific medications the patient was refusing, blood sugar results and education related to medications or symptoms related to disease process. The record failed to evidence physician notification of each episode the was patient's non-compliant with medications and failed to evidence physician notification for 7 days after the injury to the patient's left index finger that led to pain and	G 0590	**How will this deficiency be corrected?** All nurses were contacted on 8/2/19 and informed that any patient refusals to comply with physician orders must be reported immediately to their doctor and noted on the patient's POC. RN's were also instructed that patients should be educated regarding the possible consequences for refusing those meds. A mandatory meeting of all nurses was held on 8/6/19, and re-education was given regarding the importance of notifying physicians of any change of condition and/or refusal of medications. Nurses were also reminded to document the specific medications or treatments a patient refuses versus stating "most of" (being very vague) when noting these refusals.	08/06/2019

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	ultimately antibiotic use as evidenced by: A skilled nurse assessment form dated 05/30/19 by Employee B indicated, " Skin-Pt (patient) cut L (left) index finger this AM (morning), when she stuck finger in tomato juice can ...This nurse cleansed finger with an alcohol wipe then applied Triple ATB (antibiotic) ointment et (and) a bandaid ..." The RN failed to notify the physician on 5/30/19. A skilled nurse assessment form dated 06/06/19 by Employee B indicated, at the visit, the patient complained of pain in left index finger; 'About a 10. It is sore I can't hardly touch it.' Employee B then stated, " Pt c/o (complained of) L index finger that she cut 5/30/19 being more sore, This nurse examined finger, area surrounding cut is red et swollen. Actual cut appears to be closed...." Employee B notified the physician on this date who wanted to see the pt the following day. The RN failed to report the injury to the physician when it first occurred. A skilled nurse assessment form dated 06/13/19 by Employee B indicated, "Pt had OV (office visit) w (with)/[name of physician] 06/10/19 to check cut on L index finger; prescribed ATB-Keflex (500 mg [milligram]) 1 cap P.O. (by mouth) tid (three times daily) x 7 D (days) ...." During an interview with Employee B on 7/11/19 at 3:23 PM, they indicated they had stopped doing the medication set ups over a year ago for patient #2 because the patient refuses medications. When asked how this was documented, Employee B stated, "Continues to refuse most meds" is noted. Further, Employee B indicated the patient will take insulin, inhalers and will obtain blood sugars. Employee B indicated there		On 7/12/19, we contacted the physician for patient #2 and scheduled an appointment for her to resolve this issue regarding her refusal to take so many medications. She was seen by him on 7/29/19 , and he discontinued several of her medications at that time including her insulin which he determined was no longer necessary. Patient #2's legal guardian accompanied her to this visit. A revised medication list was faxed to the agency, and an updated POC was sent to the physician to confirm her orders and to ensure that they were being followed correctly. **How will this deficiency be prevented from recurring?** The Administrator and/or Clinical Manager will conduct a chart audit of 100% of our patients charts thru 9/30/19 to ensure that no other patients are refusing medications or treatments without being reported to the physician. Nursing assessments will also be reviewed to confirm patient education is being provided regarding any refusals. If no further problems are found, the Administrator, Clinical Manager and/or RN Case Managers will then audit 10% of all patient charts thru 12/31/2019 and ensure compliance with this regulation. If no problems are noted after that time, 10% of the patient's charts will continue to be	

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	was a book in the patient's kitchen with the written sliding scale parameters. When asked if the physician had been notified about the patient refusing insulin and specific medications, Employee B indicated they do not notify the physician each time. Employee B indicated the physician was aware of the patient's refusal of medications because the home health aides accompany the patient to doctor appointments 410 IAC 17-13-1(a)(2)		monitored to ensure that all refusals are reported, documented appropriately, and patients have received education regarding the refusals thru 12/31/2020 to ensure compliance. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to ensure compliance with this regulation. The Administrator will give oversight to this issue.	
G 0592 Bldg. 00	Based on record review and interview, the agency failed to ensure the recertification plan of care (POC) contained revised and current information for 3 of 6 recertification records reviewed (#1, 3, 4). Findings include: 1. An undated agency policy titled "Plan of Care," Policy #C-580 stated, " ...The plan of care is based on a comprehensive assessment and information provided but the client / family and health care members ... The Plan of Care shall be completed in full to include: ... Type, frequency, and duration of all visits / services ... medications, treatments, and procedures ... Medical supplies and equipment required ... treatment goals ...." 2. The clinical record of patient #1 was reviewed on 7/9/19 and indicated a start of care date of	G 0592	**How will this deficiency be corrected?** A mandatory meeting was held on 8/6/19 and all nurses were re-educated regarding the importance of completing an accurate and specific POC for each patient. The problems noted during the survey were discussed to ensure that each nurse has a good understanding of how to correct the situation going forward. An audit of 100% of the patient's current POC's will be performed by the Administrator, the Clinical Manager, and all RN Case Managers by **8/9/19** to ensure that all incorrect information is corrected and up to date on every current POC.	08/09/2019

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	04/06/12. The clinical record contained a POC (plan of care) for the certification period of 05/06/19 - 07/04/19. The POC's DME (durable medical equipment) indicated the pt had a Mickey button that was to be changed every 3 months by the family and bilateral SMO's (supramalleolar orthotics) . Further, the medication listing stated: "AquaPhor-as directed...Destitin [sic] as directed...Miralax-daily...probiotic-daily...." The POC failed to evidence the size of the Mickey button, the use of AFO's, the dose and frequency of Miralax and the probiotic, and the frequency and use for AquaPhor and Desitin. During an interview on 07/09/19 at 5:30 PM, the family member of patient #1 indicated the patient uses AFO's (ankle foot orthotics) now as she has outgrown the SMO's. 3. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19 that indicated diagnoses, but not limited to, multiple sclerosis, neuromuscular dysfunction of the bladder. The revised plan of care failed to evidence the catheter and balloon size and specific supplies related to the catheter under DME. 4. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated diagnoses of dependence on respirator, chronic respiratory failure, dysphasia, and encounter for attention to gastrostomy. The revised plan of care failed to evidence the tracheotomy (trach) and gastrostomy (GT) size and specific supplies related to the both, measurable goals, specific orders for: ventilator settings including specific orders for when to		**Special attention will be given to the following areas during this audit:** **Ventilators, settings, specific orders for humidity, etc., related supplies** **Mickey buttons, G tubes sizes, placement checks, rates for feeding** **Orthotics and DME** **Medications (appropriate uses, dosages, frequencies)** **Catheter sizes, balloon sizes, and related DME and supplies** **Trach sizes, orders for care, suctioning orders, related supplies** **IV infusions, rates, supplies, PICC line care, orders for labs** **Heparin/saline flushes with appropriate orders for care** **Measurable goals for all the above care/treatments/orders** **All other required elements of the POC to meet regulations and abide by** **professional standards** **How will this deficiency be prevented from recurring?** The Administrator, Clinical Manager, and each RN Case Manager will participate in auditing 100% of the patient's charts for the next 2 quarters thru 12/31/2019 and ensure that no further problems occur with this	

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	adjust humidity, and trach care and trach suction (including frequency and how to be completed). 5. The administrator was notified of these concerns on 7/12/19 at 11:23 AM and she had nothing else to submit for review. 410 IAC 17-13-1(a)(1)(ii, ix, xiii)		issue. If no further problems are noted by 12/31/2019, 10% of the patient's POC's will be monitored thru 12/31/2020 during each quarter to ensure compliance. In addition, a written in-service on completing accurate and appropriate comprehensive assessment will be given to all nurses with a requirement of successful completion by August 9, 2019. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to maintain accurate and up to date POC's for the patients. The Administrator will give oversight to the chart audits and ensure they are completed each quarter and no further issues occur with inaccurate and/or incomplete POC's.	
G 0608 Bldg. 00	Based on observation, record review, and interview the agency failed to ensure the skilled nurse (SN) coordinated care with the assisted living facility (ALF) for 1 of 1 records reviewed of patients in an ALF (#3). Findings include:	G 0608	**How will this deficiency be corrected?** A new form was developed to utilize whenever the agency is sharing a patient with another provider or facility. This form (see attached "Coordination of Care for Facilities or Other Providers")	08/09/2019

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	The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The record failed to evidence any documentation or coordination denoting which duties / tasks the home health and the ALF would be doing for the patient. The record also failed to evidence any coordination with the ALF regarding the patient's care this certification period. During an interview on 7/9/19 at 10:34 AM, the administrator stated the agency was not doing much coordinating with this ALF, but the director of nursing (DON) talked with the nurses during visits. The ALF and agency did not share careplans. 410 IAC 17-12-2(g) 410 IAC 17-14-1(a)(1)(f)		identifies which agency is providng primary care and which one is providing secondary care and will list what services each agency will provide for the patient. For every patient who receives services with our agency and another provider or facility, the Coordination of Care for Facilities or Other Providers form was completed and sent to the other provider for signature. Our agency provided each other provider with a copy of the patient's current POC and med list, along with any other information the other provider requested. The ALF for patient #3 has been very challenging to coordinate with due to not being able to locate or contact the person(s) in charge. We have made attempts thru contacting in person, by phone, by email, and by fax and as of 8/7/19 are still trying to make contact with someone who can sign this form. We will continue to make every effort to coordinate care with this ALF. If we are unable to do so by August 11 (which is the end of our 30 day window to complete our correction), we will give this patient a 15 day notice of discharge due to not being able to comply with this regulation while providing care for him. An additional form was created to	

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			use on routine SN visits to notify the facility of what care was furnished and if any concerns were noted during the visit. (See attached form “Coordination of Care – Skilled Nurse Visit Report”). This form is printed on NCR paper in order to enable both agencies to receive a copy of the information shared. All patient charts were reviewed on 8/2/19 to identify and ensure that any patient who we share with other providers will have this Coordination of Care for Facilities or Other Providers form completed appropriately. **How will this deficiency be prevented from recurring?** These new forms were explained to all the nurses during the mandatory meeting on 8/6/19 and they will be required to assist in maintaining coordination of care with other providers to comply with this regulation. The Administrator, Clinical Manager, and each RN Case Manager will participate in auditing 100% of the patient’s charts thru 12/31/2019 and ensure that no further problems occur with coordination of care with other providers. If no further problems are noted by 12/31/2019, 10% of the patient’s will be audited for having other providers involved in their care thru 12/31/2020 to ensure compliance.	

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G 0616 Bldg. 00	Based on record review, and interview, the agency failed to ensure that a medication list in layman's terms was provided to the patient for 7 of 7 records reviewed (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. The clinical record of patient #1 was reviewed on 07/09/19 and indicated a start of care date of 04/06/12. The clinical record contained a POC (plan of care) for the certification period of 05/06/19 - 07/04/19. The plan of care and medication list contained medical abbreviations when referencing the medications. The record failed to evidence the medication list given to the patient was put into layman's terms that were easy for the patient to understand. 2. The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The clinical record contained a POC for the certification period of 07/02/19 -08/30/19. The plan of care and medication list contained medical abbreviations when referencing the medications.	G 0616	**Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to maintain coordination of care for all patients as required. The Administrator and Clinical Manager will give oversight to this issue. **How will this deficiency be corrected?** A med list review of 100% of all active patients was conducted on 7/15/19. All meds for every patient were revised and put into layman terms. The nurses were instructed in the meeting on 8/6/19 to ensure that patients have current med lists in layman terms in the patient's home folders. All aides will also be instructed to notify the RN Case Managers or Clinical Manager if a patient does not have their current med list in their homes. **How will this deficiency be prevented from recurring?** **The aides and nurses were all instructed to check for these med lists to be in the patient's home folders at least weekly, and to report to the office if**	08/09/2019

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	The record failed to evidence the medication list given to the patient was put into layman's terms that were easy for the patient to understand. 3. The clinical record of patient #5 was reviewed on 07/10/19 and indicated a start of care date of 09/08/16. The clinical record contained a POC for the certification period 06/26/19 -08/24/19. The plan of care and medication list contained medical abbreviations when referencing the medications. The record failed to evidence the medication list given to the patient was put into layman's terms that were easy for the patient to understand. 4. The clinical record of patient #6 was reviewed on 07/10/19 and indicated a start of care date of 01/23/18. The clinical record contained a POC for the certification period 05/23/18 - 07/21/18. The plan of care and medication list contained medical abbreviations when referencing the medications. The record failed to evidence the medication list given to the patient was put into layman's terms that were easy for the patient to understand. 5. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The plan of care and medication list contained medical abbreviations when referencing the medications. The record failed to evidence the medication list given to the patient was put into layman's terms that were easy for the patient to understand. 6. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The plan of care and medication list contained medical abbreviations		**another list is needed.** The Administrator, Clinical Manager, and each RN Case Manager will participate in auditing 100% of the patient's charts thru 12/31/2019 and ensure that no further problems occur with this issue. If no further problems are noted by 12/31/2019, 10% of the patient's will be audited for appropriate medication lists thru 12/31/2020 to ensure compliance **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to maintain med lists as required. The Administrator and Clinical Manager will give oversight to this issue.	

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	when referencing the medications. The record failed to evidence the medication list given to the patient was put into layman's terms that were easy for the patient to understand. 7. The clinical record of patient #7 was reviewed on 7/10/19 and indicated a start of care date of 5/3/19. The record contained a plan of care for the certification period of 5/3/19-7/2/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The plan of care and medication list contained medical abbreviations when referencing the medications. The record failed to evidence the medication list given to the patient was put into layman's terms that were easy for the patient to understand. 8. During an interview on 7/9/19 at 3:12 PM, the administrator stated that the agency plan of care is kept in the patient's home, and it is not in layman's terms.			
G 0622 Bldg. 00	Based on record review and interview the agency failed to ensure the director of nursing's name and contact information was included in the admission packet and the patients were given a copy for 1 of 1 agency. Findings include: During a review of an agency's admission folder on 7/9/19, a bound book titled "new admission packet" was reviewed that is left in the home. The packet failed to evidence the name and contact information for the director of nursing (DON).	G 0622	**How will this deficiency be corrected?** This deficiency was caused by confusion regarding the title "Clinical Manager". The agency was referring to R.N. Case Managers as Clinical Managers when the term first was used. We now understand that the "Director of Nursing" is actually referred to as the Clinical Manager. The agency changed the first page of the Admission Packet that is given to patients at the SOC to	08/02/2019

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	During an interview on 7/9/19 at 11:58 AM, the administrator was asked if the DON's name and contact information is in the admission book given to patients. The administrator stated "just mine."		reflect the Clinical Manager (DON's) name. (See attached page from Admission Packet "Welcome" page with Naomi Boss RN, Clinical Manager's name listed.) **How will this deficiency be prevented from recurring?** The previous page with the incorrect contact information has been removed from all admission packets and discarded. A copy of the updated and corrected information page was given to all patients. All new admissions going forward will have the contact information for the Administrator and the Clinical Manager (DON) on the first page of their Admission Packet. **Who will be responsible to ensure compliance with this regulation?** The Administrator made the correction to the Admission Packet information and will ensure that this information remains up to date going forward.	
G 0640 Bldg. 00	Based on record review and interview, the agency failed to develop an effective, ongoing, home health agency wide, data-driven Quality Assurance and Performance Improvement [QAPI]	G 0640	**How will this deficiency be corrected?** A new QAPI program will be presented to the Advisory Board for approval by 8/9/19. This	08/09/2019

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	program (see tag G 640); failed to show measurable improvement in health outcomes, patient safety, and quality of care and failed to measure, analyze, and track the quality indicators of adverse patient events (G 642); failed to obtain and utilize quantity indicator data derived from OASIS [outcome and assessment information set], and additional related patient data to monitor safety and effectiveness and quality of services provided (G 644); failed to identify and focus the QAPI [quality assurance and performance improvement] and PIP [performance improvement program] programs on high risk, high volume or problem-prone patient areas (G 648); failed to evidence tracking and analyzing of adverse events and the implementation preventative actions (G 654); failed to implement and measure its success in tracking performance after a performance improvement project [PIP's] need for falls was identified (G 656); the agency's governing body failed to ensure the QAPI program identified clinical concerns, was data-driven, and reflected the complexities of the agency to maintain an ongoing program for quality improvement (G 660). The cumulative effect of this systemic problem resulted in the agency is out of compliance with the Condition of Participation 484.65 Quality assessment and performance improvement. Findings include: An agency document titled, "Professional Advisory Board Meeting Minutes October 27, 2018" indicated, "... Performance Improvement /Quality Assurance - A. No patient complaints were received other than related to staffing requests (patients who prefer one caregiver over another). B. Trends / Plan for corrections: Some		program will address the following: Examine OASIS reports for measurable improvement in health outcomes Monitor patient safety issues (i.e. falls) Monitor adverse patient events and implement preventative actions Monitor effectiveness and quality of services Identify high risk/high volume patient areas Identify infection control related issues and implement preventative actions Monitor patient complaints, identify any trends that are noted, and implement corrective actions to improve patient satisfaction in the areas identified This QAPI program will be accomplished by the following: **HOSPITALIZATION LOG**: A hospitalization log will continue to be maintained and monitored every quarter by the Administrator and/or Clinical Manager. Information from the hospitalization log that has already been entered since Jan 1, 2019 thru July 31, 2019 will be analyzed for possible trends that have happened so far this year. Reasons for hospitalization will be identified on this log, and any trends noted will be addressed with preventative efforts to decrease the number of	

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	plan of cares did not have the correct frequency and duration of visits noted. This was corrected during a chart audit and will be monitored over the next 2 quarters at least, longer if the trend continues. C. No ISDH surveys since July 2016 when we had no citations ... Plan for the next Professional Advisory Board meeting to be held again in October 2019...." During the review of the agency's QAPI program on 7/12/19, the binder failed to evidence an adequate QAPI program including skilled nurses and home health aide contributions with on-going data-driven with aggregated data to assist the agency to provide improved patient outcomes. An agency document was reviewed titled "Infection Control Log: December 2017-January 2018," which indicated patient "flu-like symptoms" dated 12/14/17, 12/30/17, 1/9/18, and 1/18/18. The report also indicated employee flu-like symptoms on 1/4/18, 1/6/18, 1/8/16, 1/10/18, 1/14/18, and 1/19/18, Influenza A on 12/14/17, and upper respiratory infections on 12/27/17, 1/4/18, and 1/9/18. During an interview on 7/9/19 at 11:47 AM, the administrator was asked why there were no reported infections since January of 2018. The administrator stated, "I don't think we've had any." During an interview on 7/10/19 at 12:58 PM, the administrator was asked who was involved with QAPI. The administrator stated herself, and the director of nursing mainly. She said if the agency is working on a performance project then she may involve all nurses involved in the project. During an interview on 7/12/19 at 12:30 PM, with		hospitalizations during the next quarter. The effectiveness of this effort will determine whether to continue the interventions being used or to develop new ones that might be more successful. All nurses in the agency will be utilized to provide patient education and interventions to decrease hospitalizations as needed. At the current time (8/7/19) only 3 patients have been hospitalized this year. Ø **PATIENT FALL LOG**: A patient fall log will continue to be maintained and monitored every quarter by the Administrator and/or Clinical Manager. Information from the patient fall log that has been entered since Jan 1, 2019 thru July 31, 2019 will be analyzed for possible trends that have happened so far this year. (As of 8/7/19, only 1 fall has been reported this year, and it was during a time when our staff was not scheduled to be with the patient.) Patients who are a high fall risk will be identified on admission and re-evaluated with each recertification assessment and as needed with any changes that occur. All patients who are a high risk for falls will continue to be noted in the patient safety concerns on home health aide assignments and on their POC. Ø **COMPLAINT LOG**: The patient complaint log will continue to be maintained, and every	

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	the administrator indicated when asked what high-risk, high-volume or problem-prone areas have you identified for your QAPI program, she stated "none; not having a high volume right now." The Administrator indicated she had, in the past, compiled data for blood pressure, medication non-compliance, smoking cessation, infections, and hospital admissions, but did not have enough information to perform tracking and trending. The Administrator indicated she was unaware the Governing Body of the agency must approve the QAPI Program. Lastly, the Administrator stated they do not look at OASIS data for the QAPI program. During an interview on 7/12/19 at 12:33 PM, the administrator stated there was no Governing Body approved programs for quality implemented and maintained for improved patient safety. During an interview on 7/12/19 at 12:35 PM with the Administrator, she indicated she had, in the past, compiled data for blood pressure, medication non-compliance, smoking cessation, infections, and hospital admissions, but did not have enough information to perform tracking and trending. Further, the Administrator stated they do not look at OASIS data for the QAPI program and stated she was unaware she could get the information from OASIS. During an interview on 7/12/19 at 12:50 PM, when asked how the agency is tracking adverse events, she stated, "By incident reports in [software system]; I don't think we have that many." During an interview on 7/12/19 at 12:52 PM, when asked how the agency is incorporating complaint investigations into the QAPI program, she stated, " I have a complaint log and I look at them."		quarter will be reviewed for any trends. If a complaint is reoccurring, corrective actions will be implemented and then outcomes reviewed during the next quarter. If no improvement is noted, a new plan of correction will be implemented and the outcome monitored. This system will continue until the outcome has improved and continues to be successful. The Administrator responds to and investigates all patient complaints within 24 hours. The resolution to the complaint is documented in the complaint log and complaints are followed up as needed to ensure resolution has been maintained. Ø **INFECTION CONTROL PROGRAM:** Quality improvement and risk management for infection control will be ongoing. The agency will assign a QI committee to investigate compliance and monitor the effectiveness of the infection control pro-gram. Data will be collected from: Clinicians OASIS Data - M2430 Reason for Hospitalization; M116 UTI's Medical Records Lab reports Direct Observation - Screening criteria for the agency will include fever, new antibiotic order, purulent drainage from a wound, change in color or odor of urine, change in consistency or color of sputum,	

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	During an interview on 7/12/19 at 1:00 PM, the administrator "Need to start doing that." when asked if she monitored staff infections. Lastly, during the interview on 7/12/19 at 1:00 PM, the administrator stated: "I didn't know it had to be approved by the advisory board (the agency's governing body)." Regarding the details of data to be collected that had been approved by the Governing body for the QAPI program. 410 IAC 17-12-2(a)		respiratory rales and rhonchi, and increased serum leukocytes, GI infections, change in mental status, and/or other signs of infection. Once the agency is made aware of these patients, a designated infection control nurse will review the evidence (e.g., clinical signs and symptoms, available laboratory data, nursing and physician progress notes) and apply the definition of home-care acquired infection if applicable. This approach will enhance both sensitivity (more nurses observing and reporting patients with clinical signs and symptoms of infection) and specificity (one nurse applying the definition of infection). The use of a single infection control nurse will also improve the reliability of data. The infection control nurse will review the infection control log once a month and report any concerns to the Administrator. This data will be documented in the infection control log and will be updated as needed. (See attached Infection Control Log form.) Infections will be logged for both patients and employees. This log will be reviewed by the QI committee every quarter and as recommended by the Infection Control nurse for any serious outbreaks that occur. Monitoring the results of the Infection Prevention and Control Program	

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			will allow the agency to determine if the techniques already in effect are working well, or if changed conditions (internal or external) require new or revised techniques. This process of monitoring will provide control and coordination of the Infection Prevention and Control Program and also cause the infection control process to renew itself through new information. **ADVERSE EVENT TRACKING** A new log was developed to track Adverse Events. (See attached Adverse Event Log). Every quarter the QAPI Committee will: 1. Review the care provide to patients with events. 2. Implement a plan to improve the care. 3. Develop analytic models that could be used to identify patients that were at risk for events. 4. Provide nurses with the risk factors that potentially lead to adverse events. 5. Ensure that all staff members are provided information of any findings and receive education and training to prevent similar adverse events from reoccurring The QAPI committee will monitor Adverse Events such as mortality rates, emergency department visit patterns and hospital readmissions for high-risk patients. Plans will be developed with measurable goals if trends are noted. If no improvement in	

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			outcome is noted by the next quarter and the trend continues, a different approach will be implemented. **HIGH RISK/HIGH VOLUME PATIENTS** ***The agency will identify High Risk/High Volume patients by reviewing the following criteria upon admission and/or recertifications:*** 1. Patients who are at high risk for falls 2. Patients who take multiple medications with major drug interactions 3. Patients who are non-compliant with medications and/or treatments 4. Patients who have pressure ulcers 5. Patients who have been re-hospitalized for the same diagnosis 6. Patients with poor family/community support 7. Patients with diagnosis of diabetes, renal disease, COPD, and/or CHF The agency will identify vulnerable patients by noting their high risk on the POC and ensuring that their services match their actual needs. These patients will be logged on the High Risk/High Volume Patient Log (See attached form) and their information will be reviewed by the QAPI committee every quarter.	

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G 0680 Bldg. 00			**How will this deficiency be prevented from recurring?** As noted above, the QAPI Committee has been formed to ensure compliance along with an Infection Control Nurse assigned to monitor and evaluate all of the above. QAPI/PIP's. QAPI and Advisory Board meetings will be scheduled quarterly, with the first one being before 8/9/19, and the next one scheduled for 10/18/19. The agency was previously meeting once a year with the Advisory Board, but will now increase meetings to four times per year to ensure compliance with the new regulations. **Who will be responsible to ensure compliance with this regulation?** The Advisory Board will be kept apprised of all findings during each quarterly meeting and will approve of any further PIP's going forward. The Administrator will give oversight to all QAPI/PIP efforts and ensure that these efforts continue and the agency complies with these regulations.	

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	Based on record review, observation, and interview, the agency failed to ensure personnel followed infection control precautions when caring for patients with communicable diseases and wounds (See Tag G 682) and failed to ensure that an agency-wide infection control program was maintained for the surveillance, identification, prevention, control of staff and patient infections (See Tag G 684). The cumulative effect of these systemic problems resulted in the agency's inability to ensure safe home health agency care was provided as required by the Condition of Participation 484.70 Infection Prevention and Control.	G 0680	**How will this deficiency be corrected?** **An updated INFECTION CONTROL PROGRAM has been developed:** The agency will assign a QAPI committee to investigate compliance and monitor the effectiveness of the infection control pro-gram. Data will be collected from: o Clinicians o OASIS Data - M2430 Reason for Hospitalization; M116 UTI's o Medical Records o Lab reports o Direct Observation - Screening criteria for the agency will include fever, new antibiotic order, purulent drainage from a wound, change in color or odor of urine, change in consistency or color of sputum, respiratory rales and rhonchi, and increased serum leukocytes, GI infections, change in mental status, and/or other signs of infection. New appointment for an Infection Control Nurse: A newly designated Infection Control Nurse (Naomi Boss, R.N.) will be appointed. The Infection Control Nurse will be educated and understand the principals and purposes of infection control, and will be well informed of the agency's Infection Control policies and protocols. The Infection Control Nurse will maintain the Infection Control Log and review	08/09/2019

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			the evidence (e.g., clinical signs and symptoms, available laboratory data, nursing and physician progress notes) and apply the definition of home-care acquired infection if applicable. This approach will enhance both sensitivity (more nurses observing and reporting patients with clinical signs and symptoms of infection) and specificity (one nurse applying the definition of infection). The use of a single infection control nurse will also improve the reliability of data. The infection control nurse will review the infection control log once a month and report any concerns to the Administrator. This data will be documented in the infection control log and will be updated as needed. (See attached Infection Control Log forms.) Infections will be logged for both patients and employees. **How will this deficiency be prevented from recurring?** The Infection Control log will be reviewed by the QI committee every quarter and as recommended by the Infection Control nurse for any serious outbreaks that occur. Monitoring the results of the Infection Prevention and Control Program will allow the agency to determine if the techniques already in effect are working well, or if changed conditions (internal or external) require new or revised techniques. This process of monitoring will	

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			provide control and coordination of the Infection Prevention and Control Program and also cause the infection control process to renew itself through new information. Staff and patient education will be utilized on a continual basis (through inservices for staff and via patient education information provided by Skilled Nursing staff for patients / caregivers) in an effort to reduce incidents of infection and prevent outbreaks. **Who will be responsible to ensure compliance with this regulation?** **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager/Infection Control Nurse, and/or RN Case Managers will work together to monitor and prevent infections. The Advisory Board will give approval to any PIP's utilized to reduce any known trends or problems related to infection control. The Administrator will give oversight to all of these efforts and collaborate with staff as needed to engage the entire agency in infection control efforts.	
G 0682 Bldg. 00		G 0682	**How will this deficiency be**	08/09/2019

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	Based on observation, record review, and interview, the agency failed to ensure all staff followed infection control policies and standard precautions for 3 of 3 home visits observed (#1, 2, 3). Findings include: 1. An undated agency policy titled "Handwashing / Hand Hygiene," Policy # D-330, stated "POLICY: In an effort to reduce the risk for infection in patients and staff members, thorough hand washing / hand antisepsis is required of all employees. ... When washing hands with soap and water, wet hands first with water, apply on amount of product recommended by manufacturer to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of hand and fingers. Rinse hands with water and dry thoroughly with a disposable towel ...." 2. An undated agency policy titled "OSHA Infection Control / Exposure Control Plan," Policy # B-405 stated, " ... Client infection control procedures shall include, but not limited to: a. wearing and changing gloves as necessary during the delivery of patient care. b. Appropriate patient wound and skin care and dressing techniques following sterile or aseptic dressing procedures ... f. frequent hand washing by home health care employees: Before and after the provision of patient care ... After handling soiled or contaminated materials ... After removing gloves ...." 3. Bladder Irrigation Guidelines. (2012). ACI Urology Network -Nursing. "Procedure: Explain to patient, Maintain asepsis (this is done as an aseptic procedure to prevent a UTI as the closed urinary drainage system is		**corrected?** During a mandatory staff meeting for both Home Health Aides and Skilled Nurses, every staff member was given copies of the agency's policies regarding Hand Washing (See attached policy D330) and OSHA Exposure Control Plan (See attached policy B 405). The policy D330 regarding hand washing was revised and changed to "rub hands together for 30 seconds" instead of 15 seconds (change approved by Advisory Board). All staff were informed of this change and instructed to follow the new policy for washing hands for 30 seconds with lathering of soap prior to rinsing with water. Every staff member was given a supply of pocket-sized hand sanitizer and packs of disinfecting hand wipes to use in patients' homes, and they were advised to keep these supplies with them at all times. Verbal discussion and education was also given regarding the situations that led to our survey citations and the appropriate measures that need to be taken to correct these issues. All staff members were given a written inservice regarding hand washing (see attached inservice "Infection Control in the Home Care Setting") that was completed and reviewed	

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	being broken), place blue sheet under the catheter and drainage bag connection, Prepare sterile setup with 500 ml N/S in kidney dish, Place unsterile jug on bottom of trolley, PPE and sterile gloves, Place sterile towel under site where urinary catheter and drainage bag attached. Clean catheter and drainage bag connection with chlorhexidine wipes, disconnect and wrap the drainage bag end in a chlorhexidine swab and if possible give to the patient to hold. If not keep the end wrapped in clean packaging or gauze. Using 50 ml volumes of normal saline, irrigate the catheter by flushing in and drawing back to evacuate any clot or debris. If resistance is encountered reasonable pressure can be used, (except following renal transplant or bladder surgery). Empty each returned syringe directly into the unsterile jug." 4. During a home visit observation on 07/09/19 at 5:10 PM with Patient #1, (start of care 04/06/12), Employee B, RN (registered nurse) was observed providing skilled care. Employee B performed a 12 second hand wash under running water, dried hands with paper towel and donned clean gloves. Employee B prepared the patients' formula and poured it into the feeding bag, then primed the tubing on the feeding pump. Removed gloves, and immediately put on new gloves. Employee B assisted the patient to a changing table and removed the patients' shorts and opened brief, followed by cleansing the peri area with wipes. Employee B placed a new brief on the patient, pulled up the patients shorts and assisted to sitting position, then to a standing position. Employee B adjusted shorts and shirt as patient stood next to changing table. Employee B walked to kitchen area holding soiled brief in right hand, removed left glove and opened a gate that led to the garage / trash can. Employee B disposed of		during the meeting. Employees were re-educated on when to wash hands and change gloves, as well as how to avoid cross contamination issues. Every employee performed a demonstration on appropriate hand washing and was checked off on this demonstration by an R.N. All R.N.'s demonstrated the appropriate hand washing technique and were checked off by the Administrator before they were allowed to check off any other employees. **How will this deficiency be prevented from recurring?** When Supervisory Visits are performed with the aides, they will be monitored for appropriate technique for hand washing and for appropriate use of gloves. The RN will require the aide to show proof of having hand sanitizer available and easily accessible. (See Supervisory Visit Form attached) All staff will be required to complete an inservice on Hand Washing and Infection Control at the time of their hire, during annual reviews and as needed. If a staff member is not utilizing appropriate measures after having successfully completed these inservices, they will receive disciplinary action up to and including termination of employment.	

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	brief, left glove and then removed right glove and disposed of it in the trash can, closed the gate and returned to the kitchen sink to perform an 18 second hand wash under running water. Employee B dried hands with paper towel and donned clean gloves. Employee B attached feeding tube to Mickey button and started the feeding and also fed the patient yogurt. When the feeding was completed, Employee B detached the feeding tube from the Mickey button, discarded the yogurt container and gloves in the trash can and performed a 5 second hand wash under running water in the kitchen. Dried hands with paper towel and put on clean gloves. Employee B rinsed the feeding bag and tubing with water, then removed gloves and performed a 5 second hand wash under running water and dried hands with paper towel. The registered nurse failed to adequately perform hand hygiene when she scrubbed soaped hands under the running water, failed to wash hands for policy required time on all occurrences, and failed to remove gloves, complete hand hygiene, and apply new gloves at proper intervals. 5. During a home visit observation on 7/10/19 at 8:55 AM with Patient #2, (start of care 10/01/12), Employee D, HHA (home health aide) was observed providing personal care. Employee D was present on arrival, and was preparing the patient's breakfast. Employee D was then observed performing a 20 second hand wash at 9:35 AM. Employee D then gathered the patient's shower supplies and began to warm the shower water. Employee D then performed a 20 second hand wash, dried hands with paper towel and donned clean gloves. Employee D assisted the patient to the bathroom and removed the patient's gown and brief and then assisted the patient to the shower chair. Employee D provided the		The nurses were given written procedures on performing catheter flushes and G tube feedings (see attached procedures D-170 and E-160) using professional standards and appropriate nursing techniques. All their questions were answered and they verbalized understanding regarding what they need to do going forward to correct these issues. **Who will be responsible to ensure compliance with this regulation?** The Administrator, the Clinical Manager, and/or R.N. Case Managers will work together to promote good practices with all staff regarding this issue. The Administrator will give oversight to all.	

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	patient a wash cloth to protect the eyes as the Employee shampooed and rinsed hair, then back, left arm and hand then right arm and hand. Employee D handed the soaped wash cloth to the patient to allow the patient to perform her anterior torso, and peri area, the employee rinsed the upper body, then with the same cloth, the employee washed the lower extremities and feet and then rinsed the rest of the anterior torso, peri area. The employee then dried the patients torso, peri area, feet and legs. Employee D then assisted the patient to sit on the commode, and applied deodorant to both axilla, followed by assisting the patient with brief and shoes. Employee D then applied lotion to hands, arms. Employee D then assisted the patient with a clean dress and applied lotion to legs and feet. Employee D then removed gloves, discarded them in trash can, retrieved a paper towel and dried own face of sweat. . The home health aide failed to remove gloves, complete hand hygiene, and apply new gloves at proper intervals.6. During a home visit observation on 7/10/19 at 4:15 PM, with patient #3 (Start of care 3/25/19), employee A, director of nursing (DON), was observed providing skilled care. Employee A started the visit with a 5 second hand wash under running water. Employee A removed the catheter bag from the catheter hub and cleaned the hub with alcohol pad before instilling 60 milliliters (ml) of cloropectin into the patient's bladder. Employee A left the cloropectin in for 1 minute, and drained into a disposable cup. Employee A then went to repeat the process and while she attempted to instill the medication into the bladder she sprayed the chloropectin all over the patient and surveyor. Employee A held the syringe with her left hand and started wound care to the right leg: removed old dressing, applied sterile water to gauze by tipping the sterile water bottle upside down to wet the gauze, cleansed the			

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	wound, applied antibacterial cream to new gauze, applied the medicated gauze to the patient's leg, allowed the catheter with syringe attached catheter to sit on patients leg, and then taped dressing on leg into place. Employee A removed gloves and applied more tape to the wound and completed a 10 second hand wash under running water. Employee A then applied new gloves, disconnected the syringe from the patient's catheter and spilled the disposable cup of bladder fluid drainage on the floor. Employee A used paper towels to attempt to dry up the floor and spread the spillage into a bigger area by wiping with her foot throughout kitchen. Employee A removed gloves, cleaned used supplies up and threw trash away. Employee A applied sterile water to gauze by tipping the sterile water bottle upside down to wet the gauze then cleaned suprapubic catheter stoma, removed gloves, recapped the sterile water bottle, put supplies away and completed a 14 second hand wash under running water. Employee A obtained patient's vital signs, did a quick assessment and ended visit with a 10 second hand wash under running water. The director of nursing failed adequately perform hand hygiene when she scrubbed soaped hands under the running water, failed to wash hands for policy required time on all occurrences, failed to remove gloves, complete hand hygiene, and apply new gloves at proper intervals, failed to complete one skilled task at a time to avoid cross contamination, failed to prepare sterile water soaked gauze without contaminating the bottle of water, and failed to clean drainage from the bladder off the floor with a cleaning solution. 7. During an interview on 7/11/19 at 10:00 AM, the administrator stated the staff should be washing their hands for at least 15 seconds			

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	scrubbing vigorously outside of the water, not under the running water until scrub was complete. 410 IAC 17-12-1(m)			
G 0684 Bldg. 00	Based on record review and interview the agency failed to ensure that an agency-wide infection control program was maintained for the surveillance, identification, prevention, control of staff and patient infections for 1 of 1 agency. Findings include: An undated agency policy titled, "Infection Control Surveillance Policy B-401" provided by the Administrator on 7/12/19 at 2:50 PM stated, "...will establish data monitoring and collecting system to detect infections or identify changes in infection trends which could use surveillance techniques as follows: Total surveillance - all infections identified in patients and employees. Targeted surveillance - specific infections, populations, or procedures. Outbreak surveillance -specific infections or infection clusters within multiple individuals at the same time ...." An agency document titled, "Professional Advisory Board" dated, 10/27/18, indicated "...Policy Updates - 10/26/17-Policy B 401-Infection Prevention / Control-updated to meet new ISDH regs...." The agency infection control plan failed to include staff infections, communicable infections not requiring antibiotics, documentation when these	G 0684	**How will this deficiency be corrected?** **An updated INFECTION CONTROL PROGRAM has been developed:** The agency will assign a QI committee to investigate compliance and monitor the effectiveness of the infection control pro-gram. Data will be collected from: o Clinicians o OASIS Data - M2430 Reason for Hospitalization; M116 UTI's o Medical Records o Lab reports o Direct Observation - Screening criteria for the agency will include fever, new antibiotic order, purulent drainage from a wound, change in color or odor of urine, change in consistency or color of sputum, respiratory rales and rhonchi, and increased serum leukocytes, GI infections, change in mental status, and/or other signs of infection. The agency infection control plan will include tracking both patient and staff infections (See attached Infection Control Logs for patients and staff members) and	08/09/2019

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	infections occurred, and root cause analysis and tracking of the situation to ensure sick or exposed staff did not spread infections to patients as evidenced by: During an interview on 7/09/19 at 11:44 AM, the Administrator indicated she did not believe she had to log staff infections unless she was reporting them to the state. An agency document was reviewed titled "Infection Control Log: December 2017-January 2018," which indicated patient "flu like symptoms" dated 12/14/17, 12/30/17, 1/9/18, and 1/18/18. The report also indicated employee flu like symptoms on 1/4/18, 1/6/18, 1/8/16, 1/10/18, 1/14/18, and 1/19/18, Influenza A on on 12/14/17, and upper respiratory infections on 12/27/17, 1/4/18, and 1/9/18. During an interview on 7/9/19 at 11:47 AM, the administrator was asked why there was no reported infections since January of 2018. The administrator stated "I don't think we've had any."		documentation when these infections occur with root cause analysis and tracking of the situation to ensure infections don't spread to other patients and/or staff. New appointment for an Infection Control Nurse: A newly designated Infection Control Nurse (Naomi Boss, R.N.) will maintain these logs and review the evidence (e.g., clinical signs and symptoms, available laboratory data, nursing and physician progress notes) and apply the definition of home-care acquired infection if applicable. This approach will enhance both sensitivity (more nurses observing and reporting patients and/or staff with clinical signs and symptoms of infection) and specificity (one nurse applying the definition of infection). The use of a single infection control nurse will also improve the reliability of data. The infection control nurse will review the infection control logs once a month and report any concerns to the Administrator. This data will be documented in the infection control logs and will be updated as needed. **How will this deficiency be prevented from recurring?** The Infection Control logs will be reviewed by the QI committee every quarter and as	

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			recommended by the Infection Control nurse for any serious outbreaks that occur. Monitoring the results of the Infection Prevention and Control Program will allow the agency to determine if the techniques already in effect are working well, or if changed conditions (internal or external) require new or revised techniques. This process of monitoring will provide control and coordination of the Infection Prevention and Control Program and also cause the infection control process to renew itself through new information. Staff will be given inservices on their date of hire and annually regarding infection control. Patient education will be provided by Skilled Nursing staff for patients / caregivers) on admission, recertifications, and whenever indicated by patient's specific needs in an effort to reduce incidents of infection and prevent outbreaks. All staff were educated about these new protocols and processes during mandatory meetings. Employees were also instructed to report any diagnosed infections, signs/symptoms of contagious illnesses, fevers, or any other condition that might make them unsafe to provide care for their patients. These reports will be logged in the Staff Infection Log to monitor for Infection Control	

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			purposes. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager/Infection Control Nurse, and/or RN Case Managers will work together to monitor and prevent infections. The Advisory Board will give approval to any PIP's utilized to reduce any known trends or problems related to infection control. The Administrator will give oversight to all of these efforts and collaborate with staff as needed to engage the entire agency in infection control efforts.	
G 0700 Bldg. 00	Based on observation, record review and interview, the SN (skilled nurse) failed to assess and provide patient care according to professional standards (See G706); failed to follow the plan of care (See G710); failed to provide patient /caregiver education (G714); failed to prepare clinical notes completely and accurately (See G716); failed to ensure that all skilled nurses (SN) participated in the agency's quality assessment performance improvement (QAPI) program (See G720). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.75	G 0700	How will this deficiency be corrected? A mandatory meeting of all RN's was held on 8/6/19 and concerns regarding the issues with not providing care according to professional standards were discussed. Nurses were re-educated on procedures such as GT feedings and Catheter care (see attached procedures D-170 and E-160). Written information was given to each nurse on the proper way to check placement prior to Mickey button feedings.	08/09/2019

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	Skilled Professional Services.		Nurses were reminded of the importance of having a physician order for any intervention, medication, treatment, or other therapy provided to a patient. Documentation protocols were discussed regarding the importance of being specific and not leaving any information blank . Examples of thorough assessment information will be given to each nurse. (See “Head to Toe Physical Assessment” form and “Complete Head-to-Toe Physical Assess Sheet”). The nurses were instructed to provide and document patient education for disease management, symptom control, medications, treatments, and all other aspects of patient care that require teaching for the patient to receive quality care. Written patient education materials obtained from the Home Health Quality Improvement (HHQI) website were given to all the nurses with encouragement to use them frequently. All nurses will be involved in QAPI going forward by engaging them in gathering data such as infection control, complaint logs, hospitalizations, and high risk/high volume patient information. They will be expected to participate in monitoring those areas of concern and taking part in interventions to	

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			improve outcomes for any problem areas. The nurses were informed of this expectation during the mandatory nurses meeting on 8/6/19. How will this deficiency be prevented from recurring? An audit of all 100 % of all comprehensive assessments will conducted by August 9, 2019 and problems will be corrected. This audit of 100% of all Comprehensive Assessments will continue thru 9/30/2019. Particular attention will be paid to ensure that proper procedures are being followed for standards of professional care (i.e. GT placement checks noted before feedings, sterile technique used for catheter changes, etc.) During the mandatory nurses meeting, nurses will be asked to inform the Administrator of any procedure or nursing intervention that they might need re-training or education. The Administrator will work one-on-one with any nurse who reports they need re-education in order to meet professional guidelines of care. The Administrator and/or Clinical Manager will then make unannounced visits with R.N's and/or LPN's when they are providing patient care to ensure that the nurse is following professional guidelines with care.	

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G 0706 Bldg. 00			These visits will take place at least bi-weekly thru 9/30/19. If problems are found, the nurse who is not meeting professional standards will be re-educated once again and will be monitored for a period of another 30 days thru 10/30/2019. The Administrator will observe the nurse's care and provide one-on-one education to correct any problems noted. If this nurse continues to have difficulty after that 30 day period, their employment will be terminated. Nurse were informed of this plan during the mandatory meeting on 8/6/19. If no further problems are found after the first quarter ends on 9/30/19, 10% of all comprehensive assessments will be reviewed by the Administrator and/or Clinical Manager throughout the end of the year for QAPI on 12/31/2019 to ensure compliance with this regulation. If all assessments during this time are satisfactory, 10% of all comprehensive assessments will be reviewed by the Administrator and/or Clinical Manager throughout the end of the first 2 quarters of 2020 for QAPI (ending on 06/30/2020) to ensure compliance with this regulation.	

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	Based on observation, record review and interview, the SN (skilled nurse) failed to assess and provide patient care according to professional standards for 1 of 2 skilled nursing visits observed. (#1). Findings include: 1. An agency policy titled Administration of Enteral Feedings - Gastrostomy of Jejunostomy Tube Policy # E -160 Pediatric Considerations" dated August 2002, stated, " ... 5. Verify feeding tube placement per policy. a. For a gastrostomy tube, attach syringe and aspirate gastric secretions ...." 2. Avanos (2018). Retrieved July 12, 2019, from https://www.mic-key.com/pt-resources/faqs/ " ... Before feeding, check the MIC-KEY* tube to be sure it is not clogged or displaced outside the stomach. You may do this by drawing 5-10 ml of air into a syringe. Place a stethoscope on the left side of the abdomen just above the waist. Inject the air into the MIC-KEY* extension set feeding port and listen for the stomach to "growl." Try again if you do not hear the sound. If you still do not hear it, do not proceed to feed. Contact your specialist and report the problem. Another method is to connect the extension set to the feeding tube and attach a catheter tip syringe with 10 ml of water to the extension set feeding port. Pull back on the plunger. When stomach contents appear in the tube, flush the tube with water... 1. Wash hands with soap and water then dry hands thoroughly before touching the tube. 2. Inspect the skin around the stoma before and after feeding. Make sure the skin is clean and dry, free of infection, and check for any gastric leakage	G 0706	How will this deficiency be corrected? A mandatory meeting of all RN's was held on 8/6/19 and concerns regarding the issues with not providing care according to professional standards were discussed. Nurses were re-educated on procedures such as GT feedings and Catheter care (see attached procedures D-170 and E-160). Nurses were reminded of the importance of having a physician order for any intervention, medication, treatment, or other therapy provided to a patient. Documentation protocols will be discussed regarding the importance of being specific and not leaving any information blank . Examples of thorough assessment information will be given to each nurse. (See "Head to Toe Physical Assessment" form and "Complete Head-to-Toe Physical Assess Sheet"). A written handout on the proper placement check for Mickey Buttons was given to all nurses during this meeting. All nurses will be involved in QAPI going forward by engaging them in gathering data such as infection control, complaint logs, hospitalizations, and high risk/high volume patient information. They will be expected to participate in	08/09/2019

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	...." 3. The clinical record of patient #1 was reviewed on 07/09/19 and indicated a start of care date of 04/06/12. The record contained a plan of care (POC) for the certification period of 05/06/19 - 07/04/19. The POC indicated the patient received G tube bolus feedings with Peptamen Jr. by pump QID (four times daily). During a home visit observation on 07/09/19 at 5:10 PM with patient #1, employee B, Registered nurse (RN), was observed providing skilled care. The RN prepared the formula for the patient and poured it into the feeding bag. Employee B then attached the feeding pump tubing to the patients' Mickey button and started the feeding pump at 600 ml / hr. The RN failed to assess the placement of the GT prior to feeding. During an interview on 07/10/19 at 11:15 AM with the Administrator, they indicated they would expect the nurse to verify placement of the mic-key button prior to beginning a feeding. 410 IAC17-12-2(g)		monitoring those areas of concern and taking part in interventions to improve outcomes for any problem areas. The nurses were informed of this expectation during the meeting on 8/6/19. How will this deficiency be prevented from recurring? An audit of all 100 % of all comprehensive assessments will conducted by August 9, 2019 and problems will be corrected. This audit of 100% of all Comprehensive Assessments will continue thru 9/30/2019. Particular attention will be paid to ensure that proper procedures are being followed for standards of professional care (i.e. GT placement checks noted before feedings, sterile technique used for catheter changes, etc.) During the mandatory nurses meeting, nurses were asked to inform the Administrator of any procedure or nursing intervention that they might need re-training or education. The Administrator will work one-on-one with any nurse who reports they need re-education in order to meet professional guidelines of care. The Administrator and/or Clinical Manager will then make unannounced visits with R.N's and/or LPN's when they are providing patient care to ensure that the nurse is following	

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			professional guidelines with care. These visits will take place at least bi-weekly thru 9/30/19. If problems are found, the nurse who is not meeting professional standards will be re-educated once again and will be monitored for a period of another 30 days thru 10/30/2019. The Administrator will observe the nurse's care and provide one-on-one education to correct any problems noted. If this nurse continues to have difficulty after that 30 day period, their employment will be terminated. **If no further problems are found after 9/30/19, 10% of all comprehensive assessments will be reviewed by the Administrator and/or Clinical Manager throughout the end of the year for QAPI on 12/31/2019 to ensure compliance with this regulation. If all assessments during this time are satisfactory, 10% of all comprehensive assessments will be reviewed by the Administrator and/or Clinical Manager throughout the end of the first 2 quarters of 2020 for QAPI (ending on 06/30/2020) to ensure compliance with this reg**	
G 0710 Bldg. 00		G 0710	**How will this deficiency be**	08/09/2019

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	Based on record review and interview, the registered nurse (RN) failed to follow the plan of care (POC) for 3 of 7 records reviewed (#2, 4, 5). Findings include: 1. The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The clinical record contained a POC for the certification period of 07/02/19 -08/30/19. The POC orders stated "... SN (skilled nurse) to visit 1 x [time] week x 9 weeks to set up med planner ...." The RN failed to follow the POC for medication set up. During an interview with Employee B on 7/11/19 at 3:23 PM, they indicated they had stopped doing the medication set ups over a year ago for patient #2 because the patient refuses medications. When asked how this was documented, Employee B stated, "Continues to refuse most meds" is noted. Further, Employee B indicated the patient will take insulin, inhalers and will obtain blood sugars. Employee B indicated there was a book in the patient's kitchen with the written sliding scale parameters. When asked if the physician had been notified about the patient refusing insulin and specific medications, Employee B indicated they do not notify the physician each time. Employee B indicated the physician is aware of the patient's refusal of medications because the home health aides accompany the patient to doctor appointments. 2. The clinical record of patient #5 was reviewed on 07/10/19 and indicated a start of care date of 09/08/16. The clinical record contained a POC for certification period 04/27/19 - 06/25/19. The POC orders stated, "SN (skilled nurse) to provide 40 hours per week during day shift (8 a-4 p Mon thru		**corrected?** The Administrator and/or Clinical Manager will conduct a chart audit of 100% of all current Plan of Cares and verify that the services we are providing are documented appropriately regarding orders for Discipline, and Treatments (Amount/Frequency/Duration). This audit will also include verification that all other orders on the POC are current and being followed as written. Any problems found on the current POC's will be corrected and sent to the physician for review and signature. **How will this deficiency be prevented from recurring?** A mandatory staff meeting was held on 8/6/19 with nurses to review the importance of accurate POC's and following orders as written. Each nurse was instructed to review their patient's POC's and ensure the information is up to date, appropriate, and meets all requirements for compliance with regulations. The Administrator, Clinical Manager, and each RN Case Manager will participate in auditing 100% of the patient's POC's thru 12/31/2019 and ensure that no further problems occur. If no further problems are found during this time, 10% of all Plan of Cares will be reviewed by the	

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	Friday) and 40 hours per week during night time hours (10 p-8 a Mon thru Fri) x 9 weeks ...." The SN failed to provide nursing visits according to physician order and the agency failed to provide overnight hours according to physician order. Nursing Assessment visit notes evidenced the following hours provided by the skilled nurse for the certification period 04/27/19 - 06/25/19: Monday, 4/29, 10.28; Tuesday 4/30, 9.45; Wednesday 5/1, 10.42; Thursday 5/2, 9.04; Friday 5/3, None Monday 5/6, 9.34; Tuesday 5/7, 10.33; Wednesday 5/8, 10.38; Thursday 5/9, 9.15; Friday 5/10, None. Monday 5/13, 6.4; Tuesday 5/14, 11.17; Wednesday 5/15, 11.3; Thursday 5/16, 11; Friday 5/17, None. Monday 5/20, 10.49; Tuesday 5/21, 8.31; Wednesday 5/22, 9.5; Thursday 5/23, 7.4; Friday 5/24, 5.21 Monday 5/27, 11.27; Tuesday 5/28, None; Wednesday 5/29, no time out; Thursday 5/30, 2 visits: 2.19 and 6.23; Friday 5/31, 11.03 Monday 6/3, 12; Tuesday 6/4, 11.58; Wednesday 6/5, 10.59; Thursday 6/6, 6; Friday 6/7, None. Monday 6/10, 10.1; Tuesday 6/11, None. Wednesday 6/12, 11.12; Thursday 6/13, 6.25; Friday 6/14, 4.19 Monday 6/17, 11.42; Tuesday 6/18, 12; Wednesday 6/19, None. Thursday 6/20, 10.02; Friday 6/21, 8.08		Administrator and/or Clinical Manager throughout the next four quarters for QAPI (thru 12/31/2020) to ensure compliance with this regulation. **Who will be responsible to ensure compliance with this regulation?** The Administrator, the Clinical Manager, and the RN Case Managers will work together thru rigorous chart audits and QAPI programs to ensure compliance with all of these regulations.	

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	Monday 6/24, 5.25; Tuesday 6/25, 10.19. During an interview on 07/10/19 at 2:27 PM, the Administrator stated "[family member] alters SNV (skilled nurse visit) hours to meet the patient needs due to the patient working and his many appointments. [family member] is the primary nurse for the patient; I probably need to change that." Further, the Administrator indicated the agency has been unsuccessful in finding night time hours to care for the patient at this time. 3. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated a skilled nurse (SN) frequency of 12 hours per day, 7 days per week for 60 days. The skilled nurse failed to following the plan of care frequency as evidenced by: On week 1 of the certification period, 3 SN visits were completed on 6/18/19 (12 hours), 6/20/19 (12 hours), and 6/21/19 (10 hours). The SN failed to make a visit on 6/19/19 and failed to stay for 12 hours on 6/21/19. On week 2 of the certification period, SN visits were completed every day: 6/22/19 there was no end time to verify number of total hours worked, 6/27/19 (10 hours) and 6/28/19 (4 hours). The SN failed to complete 12 hour visits. On week 3 of the certification period, SN visits were completed every day: 6/29/19 and 6/30/19 (10 hours), 7/3/19 (4 hours), 7/4/19 (8 hours), and 7/5/19 (10.5 hours). The SN failed to complete 12 hour visits. 410 IAC 17-14-1(1)(a)(H)			

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G 0714 Bldg. 00	Based on observation and record review, the skilled nurse (SN) failed to provide patient /caregiver education for 1 of 2 home visits with with skilled nursing (#3). Findings include: The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19 that indicated diagnoses of multiple sclerosis, myositis, neuromuscular dysfunction of the bladder, and personal history of MRSA (methacillin-resistant staphylococcus aureus). During a home visit observation on 7/10/19 at 4:15 PM, with patient #3, employee A, director of nursing (DON), was observed providing skilled care. The director of nursing completed catheter irrigation, wound care, obtained vital signs and completed a partial nursing assessment. The DON failed to complete any education to the patient or the assisted living (ALF) staff about diagnoses, medications, diet, safety, or skilled procedures. Skilled nurse documentation failed to evidence education was given to the patient or ALF staff. The administrator was notified of these concerns on 7/12/19 at 11:23 AM, and had nothing more to submit for review. 410 IAC 17-14-1(a)(1)(g)	G 0714	**How will this deficiency be corrected?** During a mandatory staff meeting with all nurses on 8/6/19, patient education was discussed and the nurses were reminded of written materials regarding many disease processes that have always been available to them. These materials were obtained from the HHQI website, and they were printed and handed out to each nurse during the meeting. These patient handouts cover several diseases such as Diabetes, COPD, CHF, Anticoagulant Therapy, Depression, Asthma, Medication management, Fall Risk and many other topics. The nurses were encouraged to utilize this material frequently with their patients and instructed that this is a requirement in order to provide quality care and meet standards of professional services. Several of the nurses have revealed that they do provide patient education but have not documented doing so. They have been reminded of the importance of documenting patient education. The agency now has a new assessment form with several areas to note patient teaching provided, and the nurses were instructed to use this form	08/09/2019

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			appropriately to ensure that patient teaching is documented and verifiable. The agency has an additional new form (See attached form "Coordination of Care – Skilled Nurse Visit Report"). The nurses were instructed to document any patient teaching provided in ALF's (or with any other providers who share patients with us) on this form. This form is printed on NCR (carbon) paper to enable both providers to maintain a copy of the information shared. **How will this deficiency be prevented from recurring?** The Administrator, Clinical Manager, and/or RN Case Managers will participate in auditing 100% of the patient's assessments thru 12/31/2019 to ensure that patient education/teaching is being provided and documented appropriately. If no further problems are found during this time, 10% of all patient assessments will be reviewed by the Administrator and/or Clinical Manager throughout the next four quarters for QAPI (thru 12/31/2020) to ensure compliance with this regulation. **Who will be responsible to ensure compliance with this regulation?** The Administrator and/or Clinical Manager will give oversight to ensure that we are in compliance	

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			with regulations regarding patient teaching.	
G 0716 Bldg. 00	Based on record review, and interview, the skilled nurse (SN) failed to prepare clinical notes completely and accurately for 6 of 7 records of patients receiving SN services (#1, 2, 3, 4, 7). Findings include: 1. The clinical record of patient #1 was reviewed on 7/9/19 and indicated a start of care date of 04/06/12. The clinical record contained a POC (plan of care) for the certification period of 05/06/19 - 07/04/19. The POC's DME (durable medical equipment) indicated the pt had a Mickey button that was to be changed every 3 months by the family and bilateral SMO's (supramalleolar orthotics) ...." The skilled nurse failed to document verification of placement of Mic-key button, and accurate information as evidenced by: During a home visit observation on 07/09/19 at 5:10 PM with patient #1, employee B, Registered nurse (RN), was observed providing skilled care. The RN prepared the formula for the patient and poured it into the administration bag/tubing. Employee B indicated the patient's mother pre-sets the rate of the bolus on the feeding pump. Employee B attached the tubing to the feeding pump and started the feeding by pump at 600 ml / hr. Skilled nurse documentation failed to evidence feeding rate, or confirmation with the physician about feeding rate.	G 0716	**How will this deficiency be corrected?** During a mandatory staff meeting on 8/6/19 all nurses were re-educated on the crucial importance of thorough and accurate documentation. Written information was given for re-education on the principals of good nursing documentation. (See attached “Documentation Checklist” as one example. Other materials were also presented but not attached due to the number of pages.) Nurses were informed that documentation must meet professional standards in order to maintain employment with the agency. All nurses verbalized understanding to this requirement and had all of their questions answered regarding this important issue. The Administrator, Clinical Manager, and/or RN Case Managers will participate in auditing 100% of the patient’s charts to ensure appropriate documentation on any nursing notes submitted since 7/15/19. Any problems found will be corrected by the nurse who submitted the documentation	08/09/2019

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	During an interview on 07/09/19 at 5:30 PM, the family member of patient #1 indicated the patient uses AFO's (ankle foot orthotics) now as she has outgrown the SMO's. Skilled nurse documentation failed to evidence anything about the use of AFO's. 2. The clinical record of patient #2 was reviewed on 7/9/18 and indicated a start of care date of 10/01/12. The record contained a POC (plan of care) for the certification period of 07/02/19 - 08/30/19 and indicated the patient was blind, "non-compliant" with diabetic diet, medications and treatments. The record failed to evidence documentation of specific medications the patient was refusing, the amount of insulin the patient has been taking based on sliding scale, and complete documentation of assessments without things left blank. An OASIS (outcome and Assessment Information Set) recertification dated 06/27/19 included, but not limited to the following diagnoses: COPD (chronic obstructive pulmonary disease), type 2 diabetes and blindness. The record indicated, the patient "Continues to refuse most meds", however is "able to take injectable medications at the correct times if : (a) individual syringes are prepared in advance by another person: OR (b) another person develops a drug diary or chart." "Measurable Goals and Outcomes" on the assessment indicated, "The patient's safety will be enhanced throughout the home care service as evidenced by: 'blank' within: 'blank' period of time The patient's weight will be maintained between 'blank' and 'blank' for this cert (certification) period...The patient's pain will be controlled and managed at the patient's own comfort level as verbalized by the patient/caregiver within 'blank' period of time...The patient's home environment		before 8/9/2019. **How will this deficiency be prevented from recurring?** Going forward, any new nurses hired will be instructed on proper documentation requirements and given the written material regarding good nursing documentation for orientation purposes. Nurses will also be re-evaluated on annual reviews for their documentation skills and performance. The Administrator/Clinical Manager and/or RN Case Managers will conduct audits of 100% of all nursing notes thru 9/30/19. If no problems or issues are noted, audits will continue with review of nursing notes for 10% of all charts thru 12/31/2019 and then through the first 2 quarters of 2020 (ending on 6/30/2020). If any nurse has reoccurring problems with appropriate documentation, they will be given further training and inservices regarding this issue. If problems persist and the nurse is not able to meet the necessary requirements after receiving adequate training and re-education, employment could be terminated. **Who will be responsible to ensure compliance with this regulation?** **The Administrator and/or Clinical Manager will give oversight to the nurse's**	

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	will be clean & safe, as evidenced by 'blank' within period of time...The patient will reach maximum functional potential, as evidenced by 'blank' within 'blank' period of time...The patient will have psycho/social needs met as evidenced by 'blank' within 'blank' period of time...." During an interview with Employee H and the Administrator on 7/11/19 at 3:00 PM, they indicated the sliding scale perimeters for the Novolog were written on a sheet in the kitchen. The record failed to evidence documentation of what the sliding scale was. During an interview with Employee B on 7/11/19 at 3:23 PM, they indicated they had stopped doing the medication set ups over a year ago because the patient refuses medications. When asked how this was documented, Employee B stated, "Continues to refuse most meds" is noted. Further, Employee B indicated the patient will take insulin, inhalers and will obtain blood sugars. Employee B indicated there was a book in the patient's kitchen with the written sliding scale parameters. When asked if the physician had been notified about the patient refusing insulin and specific medications, Employee B indicated they do not notify the physician each time. Employee B indicated the physician is aware of the patient's refusal of medications because the home health aides accompany the patient to doctor appointments.3. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19 that indicated a skilled nurse frequency of 3 times per week for bladder irrigation. The agency recertification comprehensive		**documentation to ensure compliance with this regulation.**	

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	assessment dated 5/24/19 failed to evidence all questions answered as evidenced by a blank answer on M2200 for the need for therapy. 4. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19. Skilled nurses notes on 6/17/19, 6/18/19, 6/20/19, 6/25/19, 6/26/19, and 7/2/19 failed to evidence the pain section of the assessment was complete. 5. The clinical record of patient #7 was reviewed on 7/10/19 and indicated a start of care date of 5/3/19. The record contained a plan of care for the certification period of 5/3/19-7/2/19 that indicated a skilled nurse one time per week for 1 week, 2 times per week for 2 weeks, and then 1 time per week weeks 3-9. Skilled nurse visits completed on 5/3/19, 5/6/19, 5/10/19, 5/13/19, 5/20/19, and 5/28/19 all failed to evidence the condition of the skin around the PICC [peripherally inserted central catheter] line and around the drain sites. Also, no measurements were obtained for the drain sites. Lastly, no education was documented to the patient and / or family about the care and maintenance of the PICC line, IV [intravenous] antibiotics, or drain site wound care. A skilled nurses note completed on 5/6/19 failed to evidence completed cardiovascular, sleep, medication changes, functional status, pain, and wound assessments. 6. During an interview on 7/10/19 at 10:30 AM, the administrator stated she would like the nurses to fill out the assessments completely and write			

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	N/A [not applicable] if it doesn't apply because that is good practice. 7. During an interview on 7/12/19 at 10:56 AM, the administrator stated she took responsibility for nurses not documenting things well on comprehensive assessments. 410 IAC 17-14-1(a)(1)(E)			
G 0720 Bldg. 00	Based on record review and interview, the agency failed to ensure that all skilled nurses (SN) participated in the agency's quality assessment performance improvement (QAPI) program for 1 of 1 agency. Findings include: During review of the agency's QAPI program on 7/12/19, the binder failed to evidence skilled nurses contributed to the QAPI program. During an interview on 7/10/19 at 12:58 PM, the administrator was asked who is involved with QAPI. The administrator stated herself, and the director of nursing mainly. She said if the agency was working on a performance project then she may involve all nurses involved in the project.	G 0720	**How will this deficiency be corrected?** A new QAPI program was presented to the Advisory Board for approval by 8/9/19. In an effort to involve more nursing staff with the QAPI program, an Infection Control Nurse (Naomi Boss, R.N.) and a QAPI committee have also been created. The QAPI committee will be comprised of other nursing staff who will investigate compliance and monitor the effectiveness of the infection control pro-gram. All nursing staff will be required to participate in chart audits and in projects as needed for Performance Improvement data gathering and interventions that are implemented as a result of these efforts. Nurses were informed of this requirement and assigned to the QAPI committee during the mandatory meeting on 8/6/19.	08/09/2019

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			How will this deficiency be prevented from recurring? The revised QAPI program will ensure that all nursing staff are involved in QAPI projects and activities going forward. QAPI meetings will take place quarterly and be posted on nurse's schedules to mandate attendance and participation. The next QAPI meeting will be posted on the schedule for 10/1/2019. Nurses will be informed of the requirement to participate in QAPI on their hire date going forward. Nurses will also be evaluated on their participation and performance with QAPI on the annual review. **Who will be responsible to ensure compliance with this regulation?** The Administrator and/or Clinical Manager will work together to ensure compliance with this regulation.	
G 0798 Bldg. 00	Based on record review and interview, the Registered Nurse failed to ensure that the aide care plan was indiidualized with specific, not generic, tasks to be completed for each shift the aides provided care for 1 of 7 charts reviewed (#2). Findings include:	G 0798	How will this deficiency be corrected? All home health aide care plans were reviewed and corrected to reflect individualized and specific, not generic, tasks to be completed for each shift that the aides provided care. Nurses were informed of this requirement and	08/09/2019

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	An undated agency policy titled "Medical Supervision; C-645" indicated, " ... 13. Agency Responsibilities include: a. Prompt reporting of a change in patient condition ...e. Timely notification of change in condition...." An undated agency policy titled, "Home Health Aide Care Plan; C-760" indicated, "Policy A complete and appropriate Care Plan identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... 6. The home health aide cannot be responsible for performing any procedure that is not assigned to him / her in writing by the Registered Nurse or that is beyond his / her ability...." The clinical record of patient #2 was reviewed on 7/9/18 and indicated a start of care date of 10/01/12. The record contained a POC (plan of care) for the certification period of 07/02/19 - 08/30/19. Orders for home health aide: "HHA to visit 4 hrs / day x (times) 7 days a week x 60 days ... These visits are routinely done in 2 visits per day, except for Sundays when [patient] prefers the aide to come in the afternoon ...." The record contained an agency document titled "Home Health Aide Assignment Sheet" dated and signed as reviewed by Employee B on 06/27/19 stated, "... Assigned tasks: ... Skin care: ... Monitor for skin issues - report any new concerns ... Medication reminders: 9 A.M., 2 P.M., and 8 P.M... Document whatever [patient] refuses to do that's on this assignment sheet...." The aide care plan failed to identify what timeframe (every visit or once a week for example) the tasks were to be completed. 410 IAC 17-14-1(m)		need for correction to assignments during the mandatory meeting on 8/6/19. All aides were given corrected assignment sheets for their patients during the mandatory meeting for aides on 8/8/19. They were also re-educated on the scope of the services that they can provide to ensure compliance with regulations. **How will this deficiency be prevented from recurring?** A review of 100% of all new or revised home health aide care plans will be performed by the Administrator, Clinical Manager and or RN Case Managers thru 9/30/19. If no problems are noted, this review will continue for at least 10% of all new or revised home health aide care plans thru the end of the year on 12/31/2019. If issues reoccur, the review will continue throughout the next 2 quarters (thru 6/30/2020) and new tactics to resolve the problem will be utilized until no further problems are noted. **Who will be responsible to ensure compliance with this regulation? The Administrator and/or Clinical Manager will give oversight to ensure that this issue does not reoccur and all HHA assignments are clear,**	

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			concise, and specific to patient needs.	
G 0800 Bldg. 00	Based on record review and interview, the agency failed to ensure a home health aide was not providing a service not within their scope of practice, such as wound care for 1 of 1 records reviewed of a patient receiving wound care from a home health aide in a sample of 7. (#2) Findings include: The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The clinical record contained a POC for the certification period of 07/02/19 -08/30/19 and indicated diagnoses of COPD (chronic obstructive pulmonary disease), Type 2 diabetes, blindness and chronic ischemic heart disease. The agency failed to ensure the HHA did not provide wound care. A home health aide visit note dated, 6/3, 6/4, 6/5, 6/6, and 6/7 by Employee K, home health aide stated, "Cut on index finger on left hand-Ointment and Bandaid..." During an interview on 07/11/19 at 10:17 AM the Administrator stated, "with [patient], [Employee K] may have assisted [patient] to put triple antibiotic on her cut." During an interview on 7/11/19 at 10:21 AM the Administrator stated, "I think it's good care to apply Triple antibiotic ointment to a cut before	G 0800	**How will this deficiency be corrected?** During a mandatory meeting for all home health aides, re-education was given regarding the scope of service for all aides and what they can and cannot do for patient care. A mandatory inservice was given to all aides (see “Identifying Tasks Outside the Scope of Practice for Home Health Aides”) with completion required by 8/9/19. Written handouts were also given to all aides to remind them of their scope of service. Aides were also re-educated to strictly follow their assignments for their patients and not deviate from any instructions given to them regarding the services they provide for their patients. **How will this deficiency be prevented from recurring?** The inservice “Identifying Tasks Outside the Scope of Practice for Home Health Aides” will be required for all newly hired aides as well as added to the annual inservices for the aides to review. During the meeting for the nurses, all RN Case Managers were informed of the importance of	08/09/2019

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	calling the doctor." 410 IAC 17-14-1(g)		compliance with this regulation and instructed to give oversight to the aides during Supervisory Visits to ensure they are functioning in their proper scope of practice. A chart audit of 100 % of all home health aide documentation submitted since 8/9/19 thru 9/30/19 will be performed. If no problems are noted, chart audits will continue for 10% of all aide documentation thru the end of this year on 12/31/2019 to ensure that no further problems are noted. If problems continue, chart audits will increase to 100% of all charts again and new tactics to correct the issue will be utilized until this issue resolves. **Any issues of aides performing a task outside of their scope of service after this re-education will result in one last written warning. If this continues after the aide receives that written warning, their employment will be terminated.** **Who will be responsible to ensure compliance with this regulation?** The Administrator and/or Clinical Manager will work together to ensure compliance with this regulation.	
G 0804				

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Bldg. 00		G 0804	**How will this deficiency be corrected?** **During a mandatory meeting on 8/8/19, all aides were re-educated regarding the importance of reporting changes in the patient's condition to the nurse. The specific incidents of this survey citation were discussed to ensure the aides comprehended what the breach in policy involved and how to avoid similar situations in the future. The nurses were also reminded during their meeting of the importance of reporting concerns to the physician and obtaining MD orders prior to providing any kind of care or treatment.** **The aides were given an inservice (see " Recognizing and Reporting Changes in Body Function") and instructed to complete it by 8/9/19.** **The aides were also re-educated on the use of the revised form "Coordination of Care - R.N. Case Management AND Home Health Aide". They were instructed to first call the RN, Clinical Manager, or Administrator to report any new concerns or changes with their patients, and then document who they reported this concern to including the**	08/09/2019

Based on record review and interview, the agency failed to ensure a home health aide (HHA) failed to report changes in the patient condition and the refusal of the patient to take insulin as ordered for 1 of 7 charts reviewed (#2).

Findings include:

An undated agency policy titled "Medical Supervision; C-645" indicated, " ... 13. Agency Responsibilities include: a. Prompt reporting of a change in patient condition ...e. Timely notification of change in condition...."

An undated agency policy titled, "Home Health Aide Care Plan; C-760" indicated, "... The home health aide cannot be responsible for performing any procedure that is ... beyond his / her ability...."

The clinical record of patient #2 was reviewed on 7/9/18 and indicated a start of care date of 10/01/12. The record contained a POC (plan of care) for the certification period of 07/02/19 - 08/30/19. Orders for home health aide: "HHA to visit 4 hrs / day x (times) 7 days a week ...."

The record contained an agency document titled "Home Health Aide Assignment Sheet" dated and signed as reviewed by Employee B on 06/27/19 stated, "... Assigned tasks: ... Skin care: ... Monitor for skin issues - report any new concerns ... Medication reminders: 9 A.M., 2 P.M., and 8 P.M... Document whatever [patient] refuses to do that's on this assignment sheet...."

A HHA visit note dated 5/25, 5/26, 5/28, and 5/31/19 signed by Employee L, HHA indicated, "...

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	B.S. (blood sugar) 13 pts (points) over 150, refused Ins (insulin) shot, said it will be ok, B.S. @ 163... No new skin conditions, but cut her finger on a tomato juice can. [HHA] encouraged her to change the bandage and put more triple antibiotic, but said it was ok for now... Concerns reported to (Nurse's name): [blank]...." The visit note failed to evidence that the RN (registered nurse) was notified of the refusal of insulin or the cut on the finger. A HHA visit note dated 6/3, 6/4, 6/5, 6/6, and 6/7/19 signed by Employee K indicated, "...Cut on Index finger on Left hand - ointment and bandaid ... Concerns reported to (Nurse's name): [blank] ...." During an interview on 07/11/19 at 3:17, the Administrator indicated changes in condition reported to the RN by the HHA are documented in Case Management Progress Notes. The record failed to evidence any notes related to refusal of insulin or a cut on the patient's index finger. Further, the Administrator stated "the HHA's do not notify the nurse if [patient] refuses the insulin or we would be calling the doctor every day." 410 IAC 17-14-1(m)		**date and time it was reported.** **How will this deficiency be prevented from recurring?** **All new aides hired going forward will complete the inservice** **"Recognizing and Reporting Changes in Body Function" as well as being required to complete it every year on their annual review.** **R.N. Case Managers were instructed during a mandatory meeting to observe and monitor the aides during Supervisory Visits to ensure that they have reported any significant changes as required.** **Any aide who fails to follow this policy after 8/9/19 will receive one final written warning regarding the importance of reporting patient changes and/or concerns to the nurse. If this aide has any further incidents after the final warning, their employment will be terminated.** **Who will be responsible to ensure compliance with this regulation?** **The Administrator and/or Clinical Manager will give oversight to the aides regarding this regulation and ensure that all aides are complying with this requirement.**	

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G 0966 Bldg. 00	Based on record review and interview, the agency clinical manager failed to provide oversight of patient care services provided for 1 of 7 record reviews (#2). Finding includes: The clinical record of patient #2 was reviewed on 7/9/18 and indicated a start of care date of 10/01/12. The record contained a POC (plan of care) for the certification period of 07/02/19 - 08/30/19, which indicated the patient was blind, "non-compliant" with diabetic diet, medications and treatments. The director of nursing failed to ensure oversight was provided with this case and that the staff were completing care per orders. During an interview with Employee B on 7/11/19 at 3:23 PM, they indicated they had stopped doing the medication set ups over a year ago because the patient refuses medications. When asked how this was documented, Employee B stated, "Continues to refuse most meds" is noted. Further, Employee B indicated the patient will take insulin, inhalers and will obtain blood sugars. Employee B indicated there was a book in the patient's kitchen with the written sliding scale parameters. When asked if the physician had been notified about the patient refusing insulin and specific medications, Employee B indicated they do not notify the physician each time. Employee B indicated the physician is aware of the patient's refusal of medications because the home health aides accompany the patient to doctor appointments.	G 0966	**How will this deficiency be corrected?** **The Administrator and the Clinical Manager reviewed this citation on 8/5/19 and discussed methods to ensure that appropriate oversight is being given to patient care. The Clinical Manager will contact all nurses (either by phone or in a face to face meeting) at least once every 2 weeks to ensure that any new concerns or changes in their patient's care have been reported. (See attached form "Clinical Manager Report – Bi-Weekly Staff Report Documentation")** **How will this deficiency be prevented from recurring?** **The Clinical Manager will begin utilizing this report starting on 8/6/19 and complete it at least every other week with all nursing staff. The Clinical Manager may choose to contact staff members more often if deemed necessary due to critical information being reported.** **Any concerns noted by the Clinical Manager will be reported to the Administrator immediately and a plan for resolution or intervention will be implemented. The completed report form will be**	08/09/2019

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	During an interview on 07/11/19 at 3:45 PM, the agency administrator indicated she was unaware Employee B had not been performing a medication set up as ordered for patient #2 for over a year. 410 IAC 17-12-1(d)		**submitted to the Administrator for review every 2 weeks (unless urgent information is reported that requires immediate attention). This plan will be monitored for outcomes and will continue to evolve as necessary until the concern is resolved.** **The Clinical Manager was notified that this protocol must be followed going forward in order to comply with regulations and ensure good oversight is being given to all staff. The Clinical Manager verbalized understanding to this protocol and agrees that it is important for the quality care that the agency wants to provide to their patients.** **The Clinical Manager will also make frequent unannounced visits to supervise nurses and aides who are providing care. These visits will be documented on Supervisory Visit forms. (See attached SV form for aides and RN's and LPN's).** **Who will be responsible to ensure compliance with this regulation?** The Administrator will ensure that this new protocol is followed by the Clinical Manager and that the report is submitted regularly as	

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G 0968 Bldg. 00	Based on record review and interview the Clinical Manager failed to ensure Registered Nurses updated and implementd changes to the plan of care (POC) to reflect the individual needs of the patient in 4 of 7 records reviewed (#1, 2, 3, 4). Findings include: 1. An undated agency policy titled "Plan of Care," Policy #C-580 stated, " ...The plan of care is based on a comprehensive assessment and information provided but the client / family and health care members ... The Plan of Care shall be completed in full to include: ... Type, frequency, and duration of all visits / services ... medications, treatments, and procedures ... Medical supplies and equipment required ... treatment goals ...." 2. The clinical record of patient #1 was reviewed on 7/9/19 and indicated a start of care date of 04/06/12. The clinical record contained a POC (plan of care) for the certification period of 05/06/19 - 07/04/19. The POC's DME (durable medical equipment) indicated the patient had a Mickey button that was to be changed every 3 months by the family and bilateral SMO's (supramalleolar orthotics) . Further, the medication listing stated: "AquaPhor-as directed...Destitin [sic] as directed...Miralax-daily...probiotic-daily...." The director of nursing failed to ensure a revised plan of care was completed to evidence on the POC the size of the Mickey button, the use of AFO's, (ankle foot orthotics) instead of SMO's, the dose	G 0968	required. **How will this deficiency be corrected?** The Clinical Manager has just recently been promoted to this position (effective 7/1/19) and is still undergoing orientation and training to fulfill all of the requirements. The Administrator and the Clinical Manager reviewed this citation on 7/15/19 and discussed the appropriate and patient specific information that should be noted on the POC for every patient. Since that time, the Clinical Managers has shown improvement in the POC's that she has developed with the continued suggestions and oversight of the Administrator. The Clinical Manager will be participating in all QAPI projects effective immediately, including chart audits and assessment reviews. She is gaining new knowledge on regulations and performance issues that need to be monitored and/or corrected. She has been assisting with the development of POC's since her hire date and is now demonstrating improvement in the details that need to be documented in each POC to maintain professional standards and comply with regulations. The	08/09/2019

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	of Miralax and the probiotic, and the frequency and use for AquaPhor and Desitin. During an interview on 07/09/19 at 5:30 PM, the family member of patient #1 indicated the patient uses AFO's now as she has outgrown the SMO's. 3. The clinical record of patient #2 was reviewed on 7/9/18 and indicated a start of care date of 10/01/12. The record contained a POC (plan of care) for the certification period of 07/02/19 - 08/30/19 and indicated the patient was blind, "non-compliant" with diabetic diet, medications and treatments. The director of nursing failed to ensure a revised plan of care was completed to indicate to the physician via the POC the specific medications and treatments the patient was refusing. During an interview with Employee B on 7/11/19 at 3:23 PM, they indicated they had stopped doing the medication set ups over a year ago because the patient refuses medications. When asked how this was documented, Employee B stated, "Continues to refuse most meds" is noted. Further, Employee B indicated the patient will take insulin, inhalers and will obtain blood sugars. Employee B indicated there was a book in the patient's kitchen with the written sliding scale parameters. When asked if the physician had been notified about the patient refusing insulin and specific medications, Employee B indicated they do not notify the physician each time. Employee B indicated the physician is aware of the patient's refusal of medications because the home health aides accompany the patient to doctor appointments. During an interview on 07/11/19 at 3:45 PM, the agency administrator indicated she was unaware		Administrator is monitoring the Clinical Manager's performance on a daily basis throughout the work week and providing education and training on the tasks that the Clinical Manager completes. The Administrator and Clinical Manager working together will review every current POC thru 9/30/19 to ensure that all are completed and accurate. The Clinical Manager will review the POC's to ensure that the Registered Nurses update and implement changes to the plan of care (POC) to reflect the individual needs of their patients. Any POC's that are not accurate will be corrected and sent to the physician for review and signature. **How will this deficiency be prevented from recurring?** After completing the audit on 9/30/19 of all POCs if no further problems are noted, audits of 10 % of all POC's will continue by the Administrator and the Clinical Manager thru the end of this year on 12/31/2019. If no further problems are found during this time, 10% of all comprehensive assessments will be reviewed by the Administrator and/or Clinical Manager throughout the end of the next 2 quarters on 6/30/2020 to ensure compliance with this regulation. **Who will be responsible to**	

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	Employee B had not been performing a medication set up as ordered for patient #2 for over a year.4. The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19 that indicated diagnoses, but not limited to, multiple sclerosis, neuromuscular dysfunction of the bladder. The director of nursing failed to ensure a revised plan of care was completed to evidence the catheter and balloon size and specific supplies related to the catheter under DME. 5. The clinical record of patient #4 was reviewed on 7/9/19 and indicated a start of care date of 8/21/18. The record contained a plan of care for the certification period of 6/18/19-8/16/19 that indicated diagnoses of dependence on respirator, chronic respiratory failure, dysphasia, and encounter for attention to gastrostomy. The director of nursing failed to ensure a revised plan of care was completed to evidence the tracheotomy (trach) and gastrostomy (GT) size and specific supplies related to the both, measurable goals, specific orders for: ventilator settings including specific orders for when to adjust humidity, and trach care and trach suction (including frequency and how to be completed).		**ensure compliance with this regulation?** The Administrator will give oversight to the Clinical Manager as she continues to increase in understanding and knowledge of the regulations and in responsibility giving oversight to the rest of the clinical staff.	
G 0978 Bldg. 00	Based on record review and interview, the agency failed to ensure a written agreement was in place with the assisted living facility (ALF) for 1 of 1 patients reviewed who lived in an ALF (#3). Findings include:	G 0978	**How will this deficiency be corrected?** A new form was developed to utilize whenever the agency is sharing a patient with another provider or facility. This form (see attached “Coordination of Care for Facilities or Other Providers”)	08/09/2019

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	The clinical record of patient #3 was reviewed on 7/9/19 and indicated a start of care date of 3/25/19. The record contained a plan of care for the certification period of 5/25/19-7/23/19. The agency failed to obtain a written agreement with the assisted living to delineate tasks between the home heath agency and the ALF. During an interview on 7/9/19 at 11:18 AM, the administrator stated they have no written contracts for any shared patients. 410 IAC 17-12-2(d)		identifies which agency is providng primary care and which one is providing secondary care and will list what services each agency will provide for the patient. For every patient who receives services with our agency and another provider or facility, the Coordination of Care for Facilities or Other Providers form was completed and sent to the other provider for signature. Our agency provided each other provider with a copy of the patient's current POC and med list, along with any other information the other provider requested. The ALF for patient #3 has been very challenging to coordinate with due to not being able to locate or contact the person(s) in charge. We have made attempts thru contacting in person, by phone, by email, and by fax and as of 8/7/19 are still trying to make contact with someone who can sign this form. We will continue to make every effort to coordinate care with this ALF. If we are unable to do so by August 11 (which is the end of our 30 day window to complete our correction), we will give this patient a 15 day notice of discharge due to not being able to comply with this regulation while providing care for him. An additional form was created to use on routine SN visits to notify the facility of what care was furnished and if any concerns were	

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			noted during the visit. (See attached form “Coordination of Care – Skilled Nurse Visit Report”). This form is printed on NCR paper in order to enable both agencies to receive a copy of the information shared. All patient charts were reviewed on 8/2/19 to identify and ensure that any patient who we share with other providers will have this Coordination of Care for Facilities or Other Providers form completed appropriately. **How will this deficiency be prevented from recurring?** These new forms were explained to all the nurses during the mandatory meeting on 8/6/19 and they will be required to assist in maintaining coordination of care with other providers to comply with this regulation. The Administrator, Clinical Manager, and each RN Case Manager will participate in auditing 100% of the patient’s charts thru 12/31/2019 and ensure that no further problems occur with coordination of care with other providers. If no further problems are noted by 12/31/2019, 10% of the patient’s will be audited for having other providers involved in their care thru 12/31/2020 to ensure compliance. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical	

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			Manager, and RN Case Managers will all work together to maintain coordination of care for all patients as required. The Administrator and Clinical Manager will give oversight to this issue.	
G 0984 Bldg. 00		G 0984	**How will this deficiency be corrected?** The Administrator and the Clinical Manager reviewed this citation on 8/5/19 and discussed the appropriate procedures for providing skilled wound care, catheter care, and checking placement prior to providing GT feedings. Written information was given to the Clinical Manager for the proper procedure to check placement with Mickey Buttons. Cross contamination issues were also discussed. The Clinical Manager voiced understanding regarding the seriousness of performing these nursing skills per professional guidelines and standards. She was given access to the agency's Clinical Procedure manual **(Briggs Corporation, "*Home Health Agency Clinical Manual*")** which has extensive, step-by-step information on professional standards and guidelines regarding procedures for hundreds of nursing skills. She	08/09/2019
	Based on observation, record review, and interview, the Clinical Manager failed to ensure the Registered Nurse (RN) completed skilled care per professional standards for 2 of 2 home visits where the RN was observed (#1, 3). Findings include: 1. An agency policy titled Administration of Enteral Feedings - Gastrostomy of Jejunostomy Tube Policy # E -160 Pediatric Considerations" dated August 2002, stated, " ... 5. Verify feeding tube placement per policy. a. For a gastrostomy tube, attach syringe and aspirate gastric secretions ...." 2. Avanos (2018). Retrieved July 12, 2019, from https://www.mic-key.com/pt-resources/faqs/" ... Before feeding, check the MIC-KEY* tube to be sure it is not clogged or displaced outside the stomach. You may do this by drawing 5-10 ml of air into a syringe. Place a stethoscope on the left side of the abdomen just above the waist. Inject the air into the MIC-KEY* extension set feeding port and listen for the stomach to "growl." Try again if you do not hear the sound. If you still do not hear it, do not proceed to feed. Contact your			

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	specialist and report the problem. Another method is to connect the extension set to the feeding tube and attach a catheter tip syringe with 10 ml of water to the extension set feeding port. Pull back on the plunger. When stomach contents appear in the tube, flush the tube with water...1. Wash hands with soap and water then dry hands thoroughly before touching the tube. 2. Inspect the skin around the stoma before and after feeding. Make sure the skin is clean and dry, free of infection, and check for any gastric leakage ...." 3. The clinical record of patient #1 was reviewed on 07/09/19 and indicated a start of care date of 04/06/12. The record contained a plan of care (POC) for the certification period of 05/06/19 - 07/04/19, which indicated: " ... Infinity pump, GT (gastrostomy tube)... Mickey button ... Nutritional Req (requirements) ...G tube bolus feedings with Peptamen Jr. via pump QID (four times daily)...." The RN failed to assess the placement of the GT prior to feeding. During a home visit observation on 07/09/19 at 5:10 PM with patient #1, employee B, Registered nurse (RN), was observed providing skilled care. The RN prepared the formula for the patient and poured it into the administration bag/tubing. Employee B indicated the patient's mother pre-sets the rate of the bolus on the feeding pump. Employee B attached the tubing to the feeding pump and the patients Mickey button without verification of GT placement, and started the feeding by pump at 600 ml / hr. The RN failed to verify GT placement with auscultation or verify the ordered rate per hour. During an interview on 07/10/19 at 11:15 AM with the Administrator, they indicated they would		was encouraged to utilize this resource whenever needed, along with many other available resources to refresh her skills and understanding on proper nursing techniques. **How will this deficiency be prevented from recurring?** The Administrator will observe the Clinical Manager providing catheter and wound care to ensure compliance and ensure that she is now meeting professional standards for care. These supervisory visits will be completed by 8/9/19. The Clinical Manager will then assist the Administrator in making unannounced visits with R.N's and/or LPN's while they are providing patient care to ensure that the nurse is following professional guidelines. These visits will take place at least bi-weekly thru 9/30/19. These visits will be documented with the use of the Competency Evaluation guides that are available in the **Briggs Corporation, "*Home Health Agency Clinical Manual" to ensure accurate and consistent check offs.*** The Clinical Manager will also assist the Administrator in reviewing nursing documentation for patients with wound care, catheter care, GI feedings and other high risk procedures to	

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	expect the nurse to verify placement of the mic-key button prior to beginning an enteral feeding and if the feeding was to be given by pump, a rate should be ordered by the physician.4. During a home visit observation on 7/10/19 at 4:15 PM, with patient #3 (Start of care 3/25/19), employee A, director of nursing (DON), was observed providing skilled care. Employee A removed the catheter bag from the catheter hub and cleaned the hub with alcohol pad before instilling 60 milliliters (ml) of cloropectin into the patient's bladder. Employee A left the cloropectin in for 1 minute, and drained into a disposable cup. Employee A then went to repeat the process and while she attempted to instill the medication into the bladder she sprayed the chloropectin all over the patient and surveyor. Employee A held the syringe with her left hand and started wound care to the right leg: removed old dressing, applied sterile water to gauze by tipping the sterile water bottle upside down to wet the gauze, cleansed the wound, applied antibacterial cream to new gauze, applied the medicated gauze to the patient's le all while holding onto the catheter syringe with the left hand and completed all wound care with right hand. Employee A allowed the catheter with syringe attached catheter to sit on patients leg, and then taped dressing on leg into place. The director of nursing failed to complete one skilled task at a time to avoid cross contamination and provide care in accordance with current professional standards. During an interview on 7/11/19 at 2:30 PM, the DON stated she sometimes does wound care first and probably should have done it that way during the home visit.		ensure that the nurses are documenting appropriately and thereby demonstrating the use of professional standards of care. **Who will be responsible to ensure compliance with this regulation?** The Administrator will give oversight and monitor the Clinical Manager's ability to perform according to professional standards and provide oversight to other staff to ensure they are doing the same.	
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Bldg. 00	This visit was a State Licensure survey of a home health agency. Facility #: 011301 Survey Dates: July 9, 10,11, 12: 2019 Active Patients: 37 Discharged Patients: 12 Record Review with Home Visit: 3 Record Review without home visit: 4 Total records reviewed: 7 Total home visits: 3	N 0000	This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.	
N 0458 Bldg. 00	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 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.	N 0458	**How will this deficiency be**	08/09/2019

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	Based on record review and interview, the agency failed to ensure that employees had annual performance evaluations for 2 of 6 employee records reviewed (B, D). Findings include: 1. During the review of employee files on 7/10/19, the list of current employees included employee B, registered nurse, date of hire 12/23/13 and first patient contact date 12/27/13. The employee file failed to evidence an annual evaluation for 2017. 2. During the review of employee files on 7/10/19, the list of current employees included employee D, home health aide, date of hire 1/28/16 and first patient contact date 2/1/16. The employee file failed to evidence an annual evaluations from 2017-2019. 3. During an interview on 7/11/19 at 2:15 PM, the administrator stated the agency do not do regular evaluations any longer for the home health aides. The administrator stated they would do a self evaluation program which would allow the aides to obtain points to obtain raises earlier than one time per year. She stated that skilled nurses do get regular evaluations and she was unsure where employee B's 2017 evaluation was.		**corrected?** The Administrator and/or Clinical Manager will audit 100% of the employee files to ensure that all staff have received an annual evaluation. Any staff member who is not up to date with their annual review will receive one no later than 8/09/19. **How will this deficiency be prevented from recurring?** The Administrator, Clinical Manager and/or designee will post every current staff member's annual review date on the schedule thru 8/1/2020. Any new staff member hired after 8/1/2019 will have their review date entered on the schedule for their first annual evaluation. An audit of all personnel's annual review dates will be conducted by the Administrator, Clinical Manager and/or designee every quarter for the next 4 quarters thru 7/31/2020 to ensure compliance. If no problems are found, personnel evaluation dates will be audited every year during the first quarter to ensure no further issues occur. **Who will be responsible to ensure compliance with this regulation?** The Administrator/Alternate Administrator and/or Clinical Manager will review and ensure compliance with this regulation.	

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N 0460 Bldg. 00	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. Based on record review and interview, the agency failed to ensure the director of nursing (DON) was appointed by the governing body for 1 of 1 agency. Findings include: A letter from the Indiana State Department of Health (ISDH) was sent to the agency on 6/13/19 confirming the staff change of DON to employee A, effective 7/1/19. A review of the governing body minutes was completed on 7/9/19. A meeting was held 10/27/18 and indicated "... [employee K] has been promoted from alternate director of nurses to director of nurses ...." The governing body failed to meet and appoint employee A as the new DON as evidenced by no meeting since 10/27/18 and no documentation to support this change. During an interview on 7/12/19 at 3:20 PM, the administrator stated that since her and the	N 0460	**How will this deficiency be corrected?** An Advisory Board meeting was conducted on 8/5/2019 and members voted on appointing Naomi Boss RN as DON/Clinical Manager. Other revised policies were also voted on by the Board. Meeting minutes were completed to document the decisions made. (See attached Professional Advisory Board Meeting Minutes Aug 5, 2019.) Due to the urgent nature of this meeting, it was conducted on a one-on-one basis with each Board member. **How will this deficiency be prevented from recurring?** The Advisory Board was informed of the new regulations that requires their approval for changes in Administration/Management personnel. Advisory Board	08/09/2019

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	alternate administrator discussed the matter and they were the owners they assumed that was appropriate. She did not realize a formal governing body appointment had to be completed.		meetings will be conducted at least quarterly in order to comply with QAPI regulations. Any new appointments to be made in Administration/Management will be voted on prior to making the change going forward. The next Advisory Board Meeting is scheduled for October 18, 2019 and will cover QAPI and PIP plans, the result of this survey and Plan of Correction, as well as any other issues that need to be discussed. **Who will be responsible to ensure compliance with this regulation?** The Administrator will oversee these changes and ensure that Advisory Board Meetings are held at least quarterly and no further issues occur with compliance to this regulation.	
N 0529 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure 60 summaries were complete and	N 0529	**N0529** **How will this deficiency be corrected?**	08/09/2019

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	contained contained specific information, such as non-compliance with medications for 1 of 6 records reviewed that were recertified to an additional 60 days. (#2) Findings include: The clinical record of patient #2 was reviewed on 07/09/19 and indicated a start of care date of 10/01/12. The clinical record contained a POC for the certification period of 07/02/19 -08/30/19. The POC orders stated ... SN (skilled nurse) to visit 1x [time] week x 9 weeks to set up med planner, assess Cardio / Resp system ... assist with symptom control, monitor new / worsening edema and / or SOB (shortness of breath) ... review BSG (blood sugar glucose) results .... Goals...Mona's will maintain optimal level of symptoms control for her disease process (and as much as possible given her resistance to taking pain medications) x 60 days ...." The POC 60 day summary failed to evidence specific medications the patient was refusing, blood sugar results and education related to medications or symptoms related to disease process. During an interview with Employee B on 7/11/19 at 3:23 PM, they indicated they had stopped doing the medication set ups over a year ago for patient #2 because the patient refuses medications. When asked how this was documented, Employee B stated, "Continues to refuse most meds" is noted. Further, Employee B indicated the patient will take insulin, inhalers and will obtain blood sugars. Employee B indicated there was a book in the patient's kitchen with the written sliding scale parameters. When asked if the physician had been notified about the patient refusing insulin and specific medications, Employee B indicated they do not notify the		A mandatory meeting for all nurses was conducted on 8/9/19, and all nurses were re-educated on the importance of notifying the physician of any changes or concerns such as medication refusals. Discussion took place regarding when to notify the doctor of a concern or change in patient's condition and the requirement for every patient's POC to be updated with specific information. An audit of 100% of all current POC's including the 60 day summaries will be performed by all RN Case Managers by **8/9/19** to ensure that all information is correct and up to date. **How will this deficiency be prevented from recurring?** Each RN Case Manager will participate in auditing 100% of their patient's charts for the next 2 quarters thru 12/31/2019 to ensure that no further problems occur with this issue. The first audit for this information will be completed by 8/9/2019. In addition, a written in-service on completing accurate and appropriate comprehensive assessment will be given to all nurses with a requirement of successful completion by August 9, 2019. **Who will be responsible to ensure compliance with this regulation?** The Administrator, Clinical Manager, and RN Case Managers will all work together to maintain	

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	physician each time. Employee B indicated the physician was aware of the patient's refusal of medications because the home health aides accompany the patient to doctor appointments.		accurate and up to date POC's and 60 day summaries for the patients. The Administrator will give oversight to the chart audits and ensure they are completed each quarter. If no further problems are noted by 12/31/2019, 10% of the patient's POC's will be monitored thru 12/31/2020 during each quarter to ensure compliance. **When will this deficiency be corrected?** This deficiency will be corrected on all assessments by the end of the audit completed by August 9, 2019	