STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157552	A. BUILDING 00 B. WING	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
JOY HEALTH SERVICES LLC	2825 E 96TH ST INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 Dates: 9/17/20-9/18/20, and 9/21/20-9/23/20 Facility #: 003692 Provider #: 157552 Medicaid #: 200454120 Census: 100 At this Emergency Preparedness survey, Joy Health Services was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. Quality Review Completed on 10/02/2020 by Area 3	E 0000		
G 0000 Bldg. 00	This visit was for a Federal Recertification and State Re-licensure survey, in conjunction with two complaints, of a Home Health Provider. Survey Dates: September 17-18, 21-23, 2020 Complaints:	G 0000		

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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	IN00254065 - substantiated, no deficiencies cited IN00244206 - substantiated, no deficiencies cited Facility #: 003692 Provider #: 157552 Medicaid #: 200454120 Total Active Census: 100 Active Skilled: 89 Active aide only: 77 These deficiencies reflect State Findings in accordance with 410 IAC 17.			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.			

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	(xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Based on record review and interview, the agency failed to ensure the plan of care included patient-specific interventions or measurable outcomes for 2 patient records reviewed in a sample of 8. (#1, #4) Findings include: 1. An agency policy, revised on 10/13/10, titled, "Care Planning Process", stated, ".... Procedure: 2. Based on the client's identified needs, the plan of care will include ... ii. Reasonable, measurable, and individualized goals ... iv. Actions to be taken to meet those client goals ... v. Type, frequency, and duration of above actions ...." 2. Record review for patient #1 included a plan of care for the certification period of 8/28/20 to 10/26/20. Diagnoses included Sepsis, Acute pulmonary edema, cerebral palsy, seizures, and dysphagia (difficulty swallowing food or liquids). Skilled nurse visits were ordered for 3-5 days per week, 8-10 hours per day. Goals stated, ".... nurse will change patient's G-T [gastric/ stomach tube] when needed with no complications throughout certification period ... nurse will administer patient's feeding as ordered per MD [medical doctor] and patient will tolerate feedings well throughout the certification period ... skilled nurse [SN] will maintain head of bed in upright position	G 0574	**A mandatory in-service was held for all clinical staff and a review of the policy and procedure regarding the Plan of Care was presented as well as a review of the Condition of Participation regarding what the Plan of Care was to contain. Various scenarios were given to the staff to write a Plan of Care and were reviewed by the attendees lead by the Assistant Clinical Manager. A test was also given to the attendees and is in each of their personnel files. Employees involved with the medical records requested by the surveyors have been counseled and a copy of the counseling report has been placed in their personnel file.** 100% of all new admissions will be reviewed to ensure that the appropriate clinical, patient specific interventions and measurable goals are in the Plan during the fourth quarter of 2020. 100% of all recertifications will also be reviewed to ensure that the goals have been updated with	10/21/2020

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	during feeding to prevent aspiration throughout this cert [certification] period ... patient will remain free from GI [gastrointestinal] complication/ issues during this cert period end date ... client will be free of serious injuries from seizure activity during this certification period ... client will be free from infection during the authorized care episode ... wound will be free of infection during this 60 days ... wound will heal by end of certification ...." The plan of care failed to evidence measurable goals or the specific interventions. 3. Record review for patient #4 included a plan of care for the certification period of 7/16/20 to 9/13/20. Diagnoses included Diabetes mellitus due to underlying conditions and End stage renal disease. The patient was being treated for 5 feet/ankle wounds and had an amputation of the left leg below the knee. Skilled nurse visits were 3 times per week. Safety measures stated, ".... low and high blood sugar precautions and treatments ...." Goals stated, ".... patient/caregiver will verbalize three S/S [signs/symptoms] of infection and methods to prevent by cert [certification] end ... will demonstrate compliance with measures to support circulation by cert end ... will verbalize compliance with measures to prevent trauma to affected areas ... patient demonstrates no new trauma or wounds by cert end ... wound will heal within cert period ... infection will gradually clear by end of certification period ...." Patient #4's plan of care for the certification period of 7/16/20 to 9/13/20 was reviewed and evidenced the same goals as the previous certification period. The plan of care failed to evidence specific, individualized, and measurable goals for this patient. During the exit conference on 9/23/20 at 1:15 PM, employee D (administrator) acknowledged that the		patient specific measurable goals. The review of the Plan of Care will also include a review of the visit notes to ensure that the goals are being addressed with each visit and documented as well as ensuring that updates to the Plan of Care are documented when a goal has been accomplished or a patient condition has changed. If significant improvement is demonstrated during the fourth quarter, the audit committee will continue to review 10% of all new admissions and recertifications to ensure the issue continues to improve throughout the calendar year of 2021. **The Clinical Manager is responsible to ensure this is accomplished**	

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	goals were not specific to the patient. 410 IAC 17-13-1(a)(1)(D)(iii)			
G 0706 Bldg. 00	484.75(b)(1) Interdisciplinary assessment of the patient Ongoing interdisciplinary assessment of the patient; Based on record review, and interview, the skilled nurse failed to provide ongoing blood glucose assessments for a diabetic patient in 1 of 2 patients with diabetes. (#4, #8) Findings include: An agency policy, dated 4/2/03, titled, "Client Clinical Record", stated, ".... Medical record must contain all information pertaining to the care being rendered ... initial or ongoing reassessment ... documentation of lab tests, procedures or studies with results ... client's response to care and services ...." An agency job description for Staff nurse/RN (registered nurse), dated 1/25/12 and signed by employee C, stated, ".... Position Responsibilities: 3. Insures [sic] that skilled nursing care has been provided as outlined in the physician's Plan of Care, 4. Initiates preventive and rehabilitative nursing procedures as appropriate for the patients care and safety ...." Clinical record review for patient #4's plan of care, start of care 3/18/20, for the certification period of 7/14/20 to 9/13/20 included the diagnoses End stage renal disease and Diabetes mellitus. The orders contained instructions for the care of 5 feet/ ankle wounds with skilled nurse (SN) visits 3	G 0706	**A mandatory inservice was held for all clinical staff and a review of the policy & procedure "Client Clinical Record" was presented as well as the review of the COP's, LG706 and the IAC to remind the staff of their obligation to include all the items noted in these documents. Employees were administered a test and it is located in their personnel file. The employee involved in the medical records noted in the 2567 has been counseled and the counseling document is located in their personnel file. Stressed in the inservice was that any patient that is to be checking a given test due to their condition such as diabetes does not mean that we do not have to check the test and document the findings during our home visit and document our findings. Also stressed was the fact that any test or activity that is in the Plan of Care must be addressed with each visit and documented in the medical**	10/21/2020

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	times per week and stated, ".... SN to instruct patient/ caregiver on effects of poor diabetic control as related to neuropathy ... SN to assess for effects of diabetes and instruct patient/ caregiver in : S/S [signs and symptoms] of hyper/hypoglycemia [high and low blood sugar] ...." SN visits were reviewed from 7/17/20 to 9/11/20. Visits occurred every Monday, Wednesday, and Friday during this period but failed to evidence any blood sugar values were obtained to indicate that the patient's diabetes was controlled. On 9/21/20 at 3:15 PM, employee D was queried if blood sugars were measured in any other area of records. "No". 17-12-2(g)		**record as well as any education that is to be done is also documented in the medical record with each visit. Ten percent of all medical records will be audited to ensure this is being done and documented appropriately during the fourth quarter, 2020. If improvement is demonstrated during the fourth quarter audits, this will become an automatic review for the audit committee during the calendar year of 2021. Any employee that is not complying with the requirement, will be counseled and if they continue to be in non-compliance, they will be warned and terminated if the behavior does not improve. The Clinical Manager is responsible for this correction**	